Victorian Healthcare Association

Investing in the health of all Victorians

Submission to the Treasurer of Victoria on:

The Victorian State Budget 2009 - 2010

Prepared By:

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'Investing in the health of all Victorians'

The Victorian Healthcare Association Submission on:

The 2009-2010 Victorian Government State Budget

The Victorian Healthcare Association welcomes the opportunity to submit to the public consultation on 2009-2010 Victorian Budget priorities.

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. Our members are public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

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Victorian Healthcare Association

Overview

By any objective measure, Victoria enjoys a healthcare system at the forefront of health systems within Australia.

Retaining boards of governance has enabled service innovation and planning that reflects the needs of local communities, albeit within the constraints of limited resources. Victoria has the highest ratio of public residential aged care beds of all Australian States, and is served by a unique blend of integrated and 'stand-alone' community health services.

Data provided through the Australian Government's 'The state of our public hospitals' report released in June 2008 illustrates a health system within Victoria that is structured through complementary service modalities.

At 2.3 beds/1000 population, Victoria has the lowest bed ratio within Australia. The effectiveness of this statistic is underpinned through greater utilisation of the Hospital in the Home initiative than is evident in other States, innovative programs such as the Hospital Admission Risk Program (HARP), and through the appropriate use of dedicated day procedure units enabling 56% of all admissions to be treated within the day.

The Victorian Healthcare Association's (VHA) mission is to contribute to the achievement of "optimal health outcomes for all Victorians". Despite Victoria's good record on public health, the VHA is concerned that this state is at a crossroads in terms of our capacity to continue to meet the contemporary and future healthcare needs of Victorians.

The latest statistics from the Department of Human Services (DHS) found **only four of nine** key performance indicators relating to urgent care and elective surgery were achieved. In addition, the 2007 Auditor General's report on Public Hospital Financial Performance and Sustainability identified significant issues in relation to ongoing funding within the public hospital system.

Unfortunately, the capacity for many health services to 'benchmark' and analyse their performance against peers is virtually non-existent. This is a significant shortcoming when services are expected to perform to a high standard in a dynamic, fiscally challenging environment.

That we find ourselves in such a position is borne of an absence of systematic and transparent approaches to data collection, service planning, capital priorities, workforce planning, and funding mechanisms.

Casemix funding provides a mechanism for technical efficiency, but creates disparities of equity due to allocative inefficiencies and scalability. The VHA does not propose wholesale change, but believes that capacity exists to improve these equity issues through longer term planning, differential costing, and the removal of some categories of care (e.g. obstetrics) from DRG weighted casemix approaches.

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A systematic rethink of the structural and funding systems that have historically underpinned our healthcare system is required if Victoria is to meet the healthcare needs of its residents into the future.

Without fundamental reform, the VHA is concerned that current levels of public healthcare will be unsustainable. An ageing population and workforce, rising rates of preventable chronic illness, and a population boom are combining to place unprecedented strain on the state's healthcare capacity.

The VHA acknowledge the health of the Victorian community is something that is clearly important to all levels of government and to all bureaucratic departments serving government.

At a time when economic conditions are contracting, it is often tempting to view portfolios that consume large tracts of government outlays such as health, as prime targets for savings. The VHA discourages the Victorian Government from such temptation, and encourages a bold approach to long-term planning and service development that ensures the health and well-being of Victorians into the next decade and beyond.

Appropriate investment in new infrastructure will provide long-term economic stimulus at a time when private sector investment is contracting. Ongoing investment in replacing outdated infrastructure also improves economic efficiency and environmental outcomes.

The VHA believes this State budget is the ideal platform for the government to commit to transparent processes and announce a range of initiatives to ensure that the Victorian community does not slip into a healthcare abyss over the next decade.

The following commitments are sought to avoid such an outcome.

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1. A state-wide health plan

Victoria urgently needs a 2020 health plan that aligns proposed capital expenditure priorities with government health policy. Such a plan is particularly urgent given predictions Victoria's population is expected to increase by 40 per cent by 2036, straining all resources, including health infrastructure.

The combined stress of an ageing population, a shrinking health workforce, increasing prevalence of preventable chronic disease and population pressures makes a measurable health plan a necessity for Victoria.

Population projections for Victoria indicate ongoing population growth over the next decade. Within this period, the first wave of 'baby-boomers' will begin to feed demand for health services. The combination of these factors requires the development of a state-wide health plan to identify the guiding principles and service benchmarks that will underpin service development until 2020.

Included within the identifiable principles must be measurable objectives for:

- Overnight and day stay bed numbers,
- Access to rehabilitation and sub-acute services
- Access to primary healthcare and preventative services (including dental care)
- The maintenance and future growth of State-based residential aged care
- High level population health outcomes for the top five illness categories (as a minimum) matched to state-wide integrated service frameworks to address these illnesses. The VHA acknowledges the investment in and commitment to cancer services under the 2008 Victorian Cancer Action Plan as an example of this approach.

The 2020 health plan must include identifiable strategies for metropolitan and rural health that address the disparity in health status that exists across Victoria. The disparity is particularly evident in rural areas, for Indigenous communities and lower socio-economic groups across the state.

The unique needs of service sustainability within rural Victoria must be addressed. This must encompass specific strategies to maintain emergency and maternity services to ensure they are accessible to all Victorians, to address the important role emergency transport can play in ensuring appropriate clinical pathways, and the provision for growth in public residential care.

Importantly, the setting of measurable planning objectives for the State is not considered by the VHA to create conflict with the governance role of boards. The strategic decisions of boards will reflect local resource capacity to meet and maintain clinical standards in the delivery of services. The Victorian Government – via the 2020 health plan – has the responsibility to create objective clinical guidelines that underpin service delivery, and objective planning guidelines to guide infrastructure commitments and service development.

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By linking capital investment priorities to evidence-based assessments of need, the Victorian Government stands to avoid accusations of political bias by increasing transparency. This will ensure spending is equitable and in line with pre-determined priorities.

A 2020 health plan must include a new methodology for capital depreciation. Such a methodology could reflect funding depreciation through grants held by local planning networks or regional DHS offices that allocate money for capital works and equipment renewal based on regional planning priorities.

The imperatives driving the urgent need to address this issue are two-fold:

i. General population growth

The Victorian community is growing at approximately 1,000 people per week.

Applying the recently reported National low of 2.3 beds/1,000 people to the population growth figures indicates that Victoria needs an additional 120 beds per year to maintain existing capacity. Applying an arithmetic equation to such an important planning need may be simplistic. On the other hand, the absence of a clear plan for growth in bed numbers is a weakness in current planning for system capacity and leads to ad-hoc strategy. This was evident in the recent commitment to 272 beds negotiated as part of an enterprise agreement between the Victorian Government and the Australian Medical Association (AMA) Victoria.

ii. Ageing Population

Further exacerbating rising demand is our ageing community.

Australian Bureau of Statistics (ABS) data indicates the number of people in Victoria aged 65 and over will increase by 156,384 or 31.4% in the decade from 2006 to 2016.

The cohort is disproportionately represented in bed occupancy, due to the chronic and acute ill health experienced as part of the ageing process.

DHS has identified that those aged over 70 occupy 42% of all public hospital bed days. Extending this further for illustrative purposes, the VHA hypothesizes that people aged over 65 occupy 50% of all bed days. With just over 12,000 beds currently available within Victoria, this suggests a need for an additional 1,884 beds by 2016 to cope with the bed pressure from our ageing demographic. This represents almost 270 beds per annum growth from 2009 to 2016!

The needs of this cohort extend well beyond acute bed demand. Sub-acute and primary healthcare services to treat and prevent chronic illness will also be in high and increasing demand. This will necessitate a range of 'self-help' preventative strategies to complement illness treatment to ameliorate a systemic overload of the healthcare system.

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The picture presented by our ageing community is of a burgeoning and on-going spike in demand for all services linked to the health of our community. Included within this picture is residential aged care.

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1.1 Metropolitan Health

The current Metropolitan Health Strategy (Directions for your health system) was endorsed in 2003, yet this strategy has not been updated despite significant change in metropolitan growth rates over the past six years. No comprehensive health plan envisioning the health needs of Victorians through to 2020 exists for Melbourne, within the public domain.

A comprehensive **2020 Metropolitan Health Plan** that links state government policy to health service funding is long overdue. Victoria now has a water plan and a transport plan, but lacks a healthcare plan that offers healthcare providers and the electorate a long-term blueprint for the state's public healthcare system. This is despite the combined impact of population growth and population ageing that will necessitate an additional 400 beds per annum to sustain current system capacity.

Metropolitan Health Key Recommendations

To place public healthcare policy beyond the blame game and to create a long term vision for the healthcare of Victorians, the VHA is calling on the Victorian Government to articulate a **2020 Metropolitan Health Plan by November 2009** that:

1. Articulates a vision for the public healthcare system to 2020 and beyond. The vision must include measurable objectives for acute, speciality, sub-acute, primary, and residential care
2. Links future capital infrastructure investment with pre-determined priorities based on need (new infrastructure is urgently required in the growth corridors of Casey/Cardinia, Wyndham/Melton, and Whittlesea/Hume. In addition, an ambulatory care centre is required to meet the needs of a burgeoning residential population within the Docklands precinct)
3. Invests an increasing proportion of the health budget in non-bed based primary and preventative services
4. Identifies the referral linkages between major regional providers and metropolitan health services
5. Identifies the linkage between hospitals and ambulatory care services

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1.2 Rural Health

The State Government is continuing to invest in rural health yet it is an unfortunate fact that people living in rural and remote Victoria continue to experience inequitable access to public healthcare facilities.

The State Government has developed the 'Rural directions for a better state of health 2007' discussion paper – but it lacks clear timelines, capital commitments and plans for recurrent expenditure.

The VHA welcomed the 'rural directions' paper, but is concerned that most of the service development initiatives highlighted in the paper are, as yet, unfunded. The integral role of ambulance services and the better use of paramedics in the development of appropriate clinical delineation and care pathways are not addressed in the discussion paper.

1.2.1 Regional self-sufficiency

The need to enable regional self-sufficiency in relation to radiotherapy, coronary and renal care must be fast-tracked through capital and recurrent funding commitments in 2009 to ensure that the full suite of services underpinning regional self-sufficiency is in place within the next three years.

The unique need for service sustainability within rural Victoria must also be addressed. In particular, identifiable strategies for the maintenance of emergency and maternity services must be developed to ensure horizontal equity of access for all Victorians.

1.2.2 Emergency services

A strategic review of emergency services provision in Victoria is needed to safeguard the availability, sustainability and quality of 24-hour care at rural health services.

The VHA asserts that this review is urgently needed at a time of critical shortages of after hours general practitioners' (GPs) that is already overburdening the rural health system. The review must consider:

- Access and proximity to other emergency services and after hours medical services
- Demand issues experienced in high population growth areas and weekend/holiday destinations
- Costs borne by health services in the provision of urgent and emergency services

Central to the review should be an investigation into the use of a standardised system of data collection and increased investment in telemedicine to assuage some of the issues presented through workforce shortages in rural areas.

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Data collection currently occurs in designated emergency service departments across rural Victoria, but does not occur on any consistent basis in smaller facilities that offer urgent and primary care.

To safeguard the skills and quality of care at rural health services, the VHA recommends a renewed focus on workforce issues in rural Victoria.

One major issue confronting rural health services is how to maintain the "currency of practice" skills of their nursing and clinical staff to ensure they have the range of skills needed for emergency medicine.

The VHA seeks a commitment in 2009 to the creation of a pool of funds ($5m per year for two years) for piloting innovative approaches to the maintenance or integration of emergency services for small rural health services.

The approach adopted in the **Rural Maternity Services initiative** could be used as a guide to how such funds are accessed by services. Funding should be prioritised for innovations that demonstrate capacity for replication. The strategy must include a commitment for a new funding approach to be rolled-out to all rural agencies from the commencement of 2011-12.

1.2.3 Maternity services

The rural directions paper included a commitment to *'ensuring the sustainability of maternity services through a multifaceted approach addressing such issues as workforce shortage, patient access, models of care and system development'.* The paper goes on to state that *'maternity services will continue to be supported and strengthened in local hospitals'* and that *'sub-regional and regional hospitals will be strengthened to meet increasing demand, retain a specialist workforce and support local hospitals in the delivery of maternity care'.*

The VHA seeks a commitment to remove maternity funding from the Casemix funding model and to replace it with a streamed funding model linked to the needs of the client and the cost of maintaining a viable local maternity service. The VHA also seeks a commitment to a funding pool that creates the capacity to implement the recommendations of the 'Rural Directions' paper in relation to maternity services in 2009.

In particular, strategies must:

- Support the development of sub-regional models of care and system support. This will involve the sub-regional hospitals taking a more active role in the support of local services within their areas, and
- Support for the establishment of the Victorian Maternity Clinical Network (MCN). This provides an opportunity to develop a consistent managed approach to the delivery of safe high quality maternity services in Victoria. The MCN will support improved patterns of referral; positive working relationship between clinicians; use of agreed clinical practice guidelines; opportunities for greater skill development for midwifery and medical staff and provide opportunities for innovative approaches to workforce constraints.

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1.2.4 Residential aged care services

Victoria has the highest representation of public residential aged care beds of all Australian States. This is not considered a weakness by the VHA; moreover, it is seen as an important adjunct to the viability of rural health services, where the majority of these residential care beds are co-located. As such, any rural health strategy must include a vision for the growth of bed numbers in the residential category.

A large proportion of residential care beds are located in smaller rural communities and are not large sites in terms of bed numbers. Traditionally, the private sector has been uninterested in developing 'smaller' isolated facilities. With concern mounting in the private sector about the viability of involvement in 'high-care', this is unlikely to change in the near future.

Demand for beds will increase as the population continues to age. As a result, the number of public residential care beds in rural Victoria will need to expand within the next decade.

The VHA seeks a commitment from government to the inclusion of growth capacity for public residential care within the endorsed macro strategy for rural health.

1.2.5 Ambulance services

Reliable access to an ambulance in rural Victoria is integral to the appropriate delineation of clinical streams. The VHA is concerned that this vital cog of the health system may be hampered by conflicting operational priorities limiting equity of access to urgent services

The VHA seeks a commitment in the 2009-10 budget to a direct funding relationship between DHS and Ambulance Victoria for all maternity and NETS inter-hospital transfers. The VHA also seeks a commitment to develop a consistent terminology for transfer triage between health services and Ambulance Victoria. The VHA seeks a commitment to the development of such a model by June 2010, and further articulation of the direct funding relationship between DHS and Ambulance Victoria to include urgent care transfers from the commencement of the 2010-11 budget years.

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Rural Health Key Recommendations

To improve health service delivery and to ensure equity of access to health service provision for rural Victorians, the VHA seeks a commitment from the state government to act now to:

1. Enable regional self-sufficiency in relation to radio-therapy, coronary and renal care by fast-tracking capital and recurrent funding commitments in 2009 to ensure that the full suite of services underpinning regional self-sufficiency are in place within the next 3 years.
2. Review emergency services funding to take into account the high cost of ambulance transfers to larger regional centres and partner Ambulance Victoria to investigate the role paramedics can play in primary healthcare delivery in rural areas
3. Remove maternity funding from the casemix funding model. Health services must be resourced to design and implement maternity services that meet local needs. This requires the examination of new ways to stem the diminishing availability of obstetric services in regional Victoria
4. Include growth capacity for public residential aged care within the endorsed macro strategy for rural health
5. Create a pool of funds ($5m per year for 2 years) to be available for piloting innovative approaches to the maintenance or integration of emergency services for small rural health services
6. Commit to a direct funding relationship between DHS and Ambulance Victoria for all maternity and NETS inter-hospital transfers in the 2009-10 budget
7. Commit to consistent terminology for transfer triage between health services and Ambulance Victoria by June 2010, and further articulation of the direct funding relationship between DHS and Ambulance Victoria to include urgent care transfers from the commencement of the 2010-11 budget years.

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2. Workforce

A **workforce strategy,** consistent with the service principles and parameters identified within the state-wide plan, is needed to address measurable growth in service demand over the next decade. The creation of such a strategy must clearly identify the costs of maintaining a professional workforce, and the methods to facilitate a move away from professional silos to a workforce based on capability and competency.

Current DHS analysis of workforce shortages suggest that by 2016 demand for health services will increase by 54%, but that the health workforce will only increase by 37%. The absence of synergy between these two statistics should not be interpreted to imply productivity gains; moreover, Victoria is facing significant health workforce shortages over the next decade.

The solution to this dilemma has two elements:

i. The creation of roles that complement our trained professionals by relieving them of the routine and time consuming elements of their job
ii. Increased numbers of trained professionals

This issue is not unique to Victoria and is currently the subject of significant review at a national level. The VHA supports the current work being undertaken federally to examine the capacity for professions - other than medicine - to access the Medical Benefits Schedule (MBS).

The VHA also supports the appropriate use of skilled nursing professionals in accident and emergency departments and ambulatory care centres. Of concern to the VHA is that the criteria to attain registration as a nurse practitioner is set at a very high level (Masters). Models applied successfully in other jurisdictions do not require study to this level and must be considered when defining the future application of skilled nurses within independent care settings.

The VHA is concerned that the present focus of our health workforce centres on professional discipline rather than professional competence. The VHA seeks a commitment through the 2009-10 budget to a transparent analysis of training within health science faculties, with a view to identifying skill stratification that may be applied to competency based care provision.

As an adjunct to this process, the VHA seeks the development of standardised processes for testing professional competencies within the public healthcare system.

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Workforce Key Recommendations

To ensure a sustainable workforce to deliver the health service objectives of the Victorian community to 2020 and beyond, the VHA is calling on the state government to:

1. Develop a innovative workforce strategy which breaks down silos to secure a workforce that can meet future demand over the next decade
2. Invest in a review of "currency of practice" and "scope of practice" issues to allow more flexible, innovative workforce solutions to meet the health needs of Victorians
3. Increase the numbers of trained professionals through attractive career pathways and contemporary courses
4. Invest in telemedicine to support clinicians practising in rural areas
5. Further enabling the application of nurse practitioners in all appropriate clinical settings

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3. Capital Infrastructure

While the VHA applauds the Victorian Government for increasing capital investment funding for health infrastructure in recent budgets, it believes the process lacks transparency and a coherent strategy.

This view is backed by a VHA-commissioned Funding and Productivity study by ACCESS Economics that found the existing system for allocating capital funding to Victorian health services is overly complicated, and the extent to which the investment priorities link to economic and/or social cost benefit is unclear.

The report found that access to capital is approved by various administrators of funding streams based on analysis of the particular business case compared to capital funding bids by other public health services. Capital funding is not specifically linked to productivity targets or outcomes and there appears to be no systematic analysis of where capital can be most productively invested.

The existing capital grants process is inefficient and open to subjective interpretation of need. At present there are 11 sources of capital funding where grants are allocated largely on an ad hoc basis with little reference to longer term plans and needs across the system. The complex grants framework requires consolidation into a single body with a single stream of finance for investment in infrastructure and equipment that is allocated on the basis of economic and social cost benefit.

Capital is a key element constraining the future capacity of the Victorian healthcare system. Linking capital funding to areas of identified potential productivity improvement could well unlock significant gains for the overall efficiency and effectiveness of the healthcare system. Indeed, productivity dividends will become increasingly difficult to meet without the benefit of strategic capital investment.

To ensure that capacity exists to meet future demand, the state government must develop a **10-year infrastructure investment plan** for our public healthcare system.

This plan must comprise the following identifiable components:

- Address infrastructure replacement
- Address new infrastructure to meet growth demand
- Be viewed as a 'living' document that is updated at least every two years
- Where new infrastructure needs are identified, they must be matched to population health needs and horizontal equity objectives

The VHA seeks a 10 year infrastructure investment plan to not only shape capital investment into the future, but to also increase the transparency of the processes behind such a plan and to reduce the inefficiencies created through current application processes.

The 10-year plan must identify the infrastructure in need of replacement or upgrade, and the strategic investments in new infrastructure required to meet increasing demand.

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A process for prioritising the capital investment strategy must accompany the statement to ensure on-going transparency from planning to project commitment. This will help to overcome the risk that major capital investments consume the available resource pool to the disadvantage of multiple smaller projects.

3.1 Planning for future infrastructure investment

No state-wide strategy currently exists for the long-term funding of health service capital infrastructure. What exists is an election cycle plan, with annual modifications according to fiscal capacity - in other words, a capital budget.

The Victorian community deserves a longer term vision that reflects their strategic needs for health service infrastructure. The amount to be expended in any particular period is a matter of budgetary necessity, but is definitively different to an infrastructure strategy.

The Rural Directions for a Better State of Health policy highlights the enhancement of the physical infrastructure and equipment of health facilities as one of its key strategies. However, the potential of strategies such as ensuring node and hub status for regional centres is yet to be fully realised. Similarly, the 2003 Metropolitan Health Strategy: Directions for Your Health System is outdated with facilities such as the Box Hill Hospital yet to be finalised, and significant population growth in the North and the West unaddressed.

Since the articulation of these documents, population growth and ageing has risen dramatically and replacement and new beds are required to meet the acute needs of Victorians, despite the success of programs such as HARP. Therefore, the infrastructure strategy must be based on both the need to replace or upgrade existing stock, and the need to invest in additional infrastructure to meet increasing demand created by population growth and ageing.

The VHA believes more work is needed to ensure transparent systems and processes are in place to prioritise funding based on need to ensure high quality health services for Victorian's into the future.

3.2 Population growth

With predictive data indicating that service demand from population growth will grow exponentially over the coming decade, it is more important than ever that the DHS ensures capital funding decisions respond to growth and population health needs.

Much of Victoria's existing health service infrastructure is nearing the end of its useful life, with significant infrastructure unable to be further 'patched up'. The Victorian Transport Plan is an example of government responding to population growth. The VHA believe Victoria requires a similar plan for health services, fully aligned to current inter-governmental planning strategies.

For example, the population growth of Melbourne city is expected to rise by 35.4% as a result of Docklands' affordable housing developments. This will require new

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infrastructure such as an ambulatory care centre located at Docklands with links to Melbourne's acute facilities.

In outer Melbourne, the growth around Whittlesea in the north and Wyndham in the west will require additional infrastructure to maintain current service delivery and new infrastructure to meet increases in demand. Furthermore, the growth in Casey and Cardinia (28.3% and 41.3% respectively) will require improvements to current facilities and also new facilities to meet need.

3.3 Independent community health centres

In 2008, the DHS instigated a transition process in which independent community health centres could change their structure from an incorporated association to a company limited by guarantee. This change creates a new relationship with the DHS for these services. The DHS has stated that "funding for capital works will continue subject to departmental service planning priorities and available funding". The VHA believe this process needs to be further articulated as part of a state-wide infrastructure planning framework.

Capital Infrastructure Key Recommendations

The VHA seeks a commitment from the state government to act now to improve the infrastructure from which public healthcare is delivered throughout Victoria by:

1. Developing a **10-year infrastructure investment plan** for capital investment in Victoria that is aligned with current policy, transparent in process, takes into account new environmental building standards and ensures appropriate facilities for local communities
2. Analysing alternative strategies to incorporate depreciation costs into DHS capital funding methods. This may be facilitated through the creation of pooled funding in each region to match the depreciation of the health services within that region
3. Simplifying the planning process for capital works applications
4. Creating a transparent process in partnership with industry, for prioritising the capital investment priorities to ensure high quality health services for Victorian's into the future.

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4. Information Technology & planning data

The HealthSMART strategy in its current form has failed to evolve at a pace that is acceptable to a modern healthcare system. Issues include the approach applied to financing implementation at individual agencies and the implementation strategy at a macro level.

Articulation of a **system-wide ICT strategy** is imperative to informing service development into the future. The current approach is unsustainable due to the unfunded contribution costs expected from individual agencies, the absence of product choice and product suited to need, and the absence of state-wide unique patient identifiers.

The VHA acknowledges the importance of contemporary population health data to informing service development and individual agency strategy. A system-wide ICT strategy must include articulation of the process to be applied in developing and maintaining publicly accessible data of this nature.

4.1 Unfunded contribution costs

In 2008-09 a new cost contribution and governance model was introduced for rural IT alliances. Almost without exception, this model created a significant increase (in many cases doubling) in the expected contribution of smaller healthcare agencies to the cost of their rural alliance.

The VHA supports a fair and equitable approach to cost contribution, but asserts that the capacity for agency contribution and the cost-benefit return of what is mandatory participation have not been appropriately considered in the implemented changes.

The VHA views the creation of an integrated approach to data collection and ICT capacity as an essential investment in public infrastructure. The VHA seeks from the Victorian Government a commitment to recognising ICT in this manner by further reviewing the method of funding rural alliances, and in particular, by recognising through the grants process that the increasing cost of contemporary ICT is not a cost that is reflected in the funding models applying to small rural health services in particular. To address this, the VHA seeks an additional $5m ($1m for each rural IT alliance) in 2009-10 to overcome the current impediment to system development created by budgetary pressures.

4.2 Absence of product choice

Further hindering a timely roll-out of the ICT aspirations of the HealthSMART strategy is a view within rural Victoria that the product suite approved through the HealthSMART strategy does not reflect the needs of the end user. This is particularly the case with the clinical systems, where even the largest of the regional providers have expressed concern at the suitability of the selected product, and with the patient management system mandated for rural community health services.

The VHA seeks a commitment from the State Government to review the current approach to product selection, with a view to providing a competitive product suite

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that includes a layering of sophistication modelled to the varying size and capacity of the organisations within which the product will be applied.

4.3 State-wide unique patient identifier

To improve patient outcomes, the VHA supports the development of e-Health records to streamline patient data across the acute and non-acute sectors to ensure health professionals have access to vital patient information.

The VHA seeks a commitment from the State Government to finalise the state-wide ICT strategy by November 2009, and to include within such a strategy a time-frame for introducing a unique patient identifier for application across all public healthcare facilities within the State.

4.4 Population and population health data

The dearth of accurate, local data to inform health system planning is a major impediment to the structural reform of Victoria's public healthcare system.

The technology exists to create a national data base of healthcare statistics available to government departments, healthcare services, academia and the general public.

Yet, thus far the coordinated will and dollars to invest in data collection is lacking. Traditionally, health services have reported on the basis of productivity. In recent years, this was extended to include quality and safety requirements. The next logical step is to mandate population health reporting and require public hospital boards report to the population health needs of the community that they serve.

Unfortunately, this approach is not yet possible. Research by the VHA in 2008 identified major flaws in data collection across the state. This included conflicts in the planning and reporting cycles of health service providers and a lack of data configured to the local level needed by health service boards to make informed service planning decisions.

The Victorian Government, via the Department of Human Services, has a vital role to play in supporting better data collection to inform health service planning. Access to accurate, local data is vital to planning healthcare service delivery, especially in adopting preventative approaches to healthcare that will, in the long term, reduce the burden on the hospital system by facilitating community based care for people living with a chronic illness.

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Information Technology & planning data Key Recommendations

The VHA recommends that the Victorian Government invest more resources in ICT and data collection by:

1. Providing an additional $5m ($1m for each rural IT alliance) in 2009-10 to overcome the current impediment to system development created by budgetary pressures.
2. Committing to review the current approach to product selection, with a view to providing a competitive product suite that includes a layering of sophistication modelled to the varying size and capacity of the organisations within which the product will be applied.
3. Supporting the creation of a national data bank that integrates health data from various sources that is publicly available, managed by a major university, has geographic information system (GIS) capability and is available to the general pubic.
4. Finalising of the state-wide ICT strategy by November 2009, and to include within such a strategy a time-frame for introducing a unique patient identifier for application across all public healthcare facilities within the State.
5. Working with the health sector to introduce a methodology for population health reporting and accountability that includes a set of industry-agreed key performance indicators, linked to mandated public reporting cycles and DHS priorities

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5. Flexible Funding Models

Flexible funding models create opportunity for local innovation and value creation.

The financial system for health services is unnecessarily complex. This is adding to the overall administrative burden within the healthcare system. Where possible, single streams of funding need to be delivered to health services within the annual budget including allowances for new capital expenditure and depreciation.

The VHA also purports that the process of funding applied to EBA outcomes creates unreasonable disparity in the capacity for individual agencies to meet the cost of the outcome, depending upon whether they are a 'winner' or 'loser' in the funding model. For those agencies who assert that they have not received adequate funding to cover the wage bill at their hospital, the difference, in effect, amounts to a further efficiency dividend to government.

Many agencies are finding it increasingly difficult to find the productivity targets set for them by government. Much of the low hanging fruit has been picked and any further productivity expectation at a system level will require significant capital to be invested to enable further productivity capacity.

The objective should be to realign funding models to fully reflect cost and productivity capacity, with the improvement of population health outcomes at the centre of each activity and process.

The VHA seeks a commitment from the State Government to review health system funding in the following manner.

5.1 Small Rural Health Funding

Rural Victorian health services face escalating costs and a funding system that prevents them from meeting the needs of their local communities.

The DHS has agreed with the VHA to undertake a review of this funding model during 2009.

In advance of the outcome of this review, the VHA seeks a commitment from the Victorian Government to apply a cost inflation factor equivalent to that received by the State through the Australian Healthcare Agreement, to the annual indexation of budgets for Small Rural Health Service (SRHS) commencing from July 2009.

5.2 Casemix Funding

The VHA seeks a new approach to the funding of maternity services and recommends that 'streamed' funding for maternity services replace the current model of funding through casemix formula.

The removal of maternity funding from the casemix pool will enable maternity service providers to develop models of care that are more closely aligned to the birthing objectives of the mother. The current system encourages bed-based clinical approaches and does not effectively enable a shared care approach between service

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providers. This is particularly important within rural communities, where the care of the mother and new-born may be shared between a small rural service and a regional birthing centre.

5.3 Benchmarking

The Victorian healthcare system is at the forefront of service delivery in many areas. However, the current system is overly complicated and does not incorporate an evidence based review and benchmarking process that systematically provides feedback to service providers on a cost centre by cost centre basis.

This is a failing of the existing healthcare system as research on the effectiveness and cost of service delivery is sporadic. There potentially exist significant gains to be unlocked through a systematic research based review process.

The VHA seeks a State Government commitment to undertake a performance review process that involves service providers and that carefully analyses the costs associated with maintaining and improving the healthcare capital stock in addition to operating costs.

The outcome of the review process should be to establish relevant benchmarks and to create a business case for a funding pool that allows service providers to achieve equal capacity to change their processes towards best practice State benchmarks.

5.4 Bonus Funding

The incentives in the bonus funding framework and in the hospital funding system more generally discourage co-operation and information sharing between hospitals.

Each hospital is essentially pitted against other hospitals in the region and across the State as they fight it out for resources and funding for the community they service and for their own staff.

The current system has created adversaries of hospitals, rather than sharing of information and best practice techniques.

For co-operation to occur between hospitals the incentive structures must align improved performance across the region with financial incentives. The VHA seek a commitment from the State Government to facilitate a process through which such an approach may be applied to bonus funding pools from July 2010.

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Flexible Funding Models Key Recommendations

To create opportunity for innovation and value creation, the VHA seeks a commitment from the state government to:

1. Increase the indexation rate applied to Small Rural Health Service funding from July 2009 to match that received by the State through the Australian Health Care Agreement
2. Create a dedicated funding pool for maternity services
3. Develop fiscal benchmarks and create a funding pool to enable operational support to all health services to change their processes in accord with the identified best practice
4. Align the awarding of financial incentives to area based improvement in population health outcomes

Conclusion

The VHA looks forward to working constructively with the Victorian Government in the coming budgetary year. The intention of this organisation's submission is to represent the views of members and to "optimise health outcomes for all Victorians".

Please contact me on (03) 9094 7777 to clarify any information in this submission.

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