Victorian Healthcare Association

Investing in the health of all Victorians

Submission to the Treasurer of Victoria on:

The Victorian State Budget 2010 - 2011

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'Investing in the health of all Victorians'

The Victorian Healthcare Association Submission on:
The 2010-2011 Victorian Government State Budget

The Victorian Healthcare Association welcomes the opportunity to submit to the public consultation on 2010-2011 Victorian Budget priorities.

The Victorian Healthcare Association

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

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1. Executive summary - A state-wide health plan

Victoria's ageing population will create a public healthcare crisis within 10 years unless government accepts the need for a significant injection of capital and recurrent funding, coupled to a commitment to move the service paradigm more deliberately to ambulatory and community based solutions.

This statement is not simple rhetoric, but is based upon the governments own data sets and projections in demographic movement. Quite simply, the inconvenient truth of ageing is about to slap us in the face!

In its submission to the Legislative Council Standing Committee on Finance and Public Administration-Inquiry into Public Hospitals (the Submission), the Victorian Government noted:

'While Victorians enjoy health outcomes that are among the best in the world, new and existing pressures are challenging the public hospital system, including the ageing population and the increasing prevalence of complex and chronic diseases, such as heart disease, diabetes and cancers' (p4)[1].

'The Victorian Government is committed to meeting these challenges and ensuring it continues to deliver a world-class hospital system. In doing so, the public hospital system in Victoria is able to deliver quality health services which meet the demand, standards and quality of care, resourcing and access levels required, and is able to provide accurate and reliable performance data for reporting, funding and planning' (p4)[2].

Service Demand and Fiscal Pressure

Data presented in the submission indicated an increase in hospital funding of $3.843b (112 per cent) to $7.268b in the 10 year period 1999-00 to 2008-09.

Other health system funding increased by $1.636b (103 per cent) to $3.219b in the same period. Included within 'other' is mental health, ambulance, dental, aged care, primary health and public health.

The overall increase in the 10 year period was $5.479b (109per cent) to $10.487b (p6)[3].

The submission observed that '*since 1999, demand for hospital services in Victoria has grown substantially, with 43 per cent growth (an extra 403,709 presentations per year) in emergency department presentation, 34 per cent (351,345) more admissions, and 20 per cent (210,776) more specialist clinic treatments.*

'The increasing demand for public hospital services is driven by a wide range of factors, including population growth, ageing population, increases in chronic and

[1] Victorian Government, Legislative Council Standing Committee on Finance and Public Administration-Inquiry into Public Hospitals (2009)
[2] IBID
[3] IBID

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complex disease, access to primary care, new technologies and community expectations' (p.9)[4].

The VHA observes that the proportional breakdown of funding between hospitals (acute) and other health service appropriations has remained constant over the 10 year period 1999-00 to 2008-09.

The breakdown is about 70 per cent (trending from 68 per cent to 69 per cent) to hospitals (acute) and 30 per cent (trending from 32 per cent down to 31 per cent) to other health services. With contemporary health system design focussing on ambulatory solutions and preventative measures, it is curious that in Victoria we have trended marginally away from funding community and preventative approaches, which are the current focus of health and political discourse .

In 1999, the Victorian population was 4,707,600 people, with 597,865 (12.7 per cent) aged greater than 65. Separations attributed to this demographic in 1999 amounted to 326,721, 31.4 per cent of the total. This represents a ratio of 546.5 separations per 1000 persons greater than 65 years, compared to a ratio of 174 per 1000 persons less than 65 years.

By 2008, the population had moved to 5,293,323, with 719,355 (15.7per cent) aged greater than 65. Separations attributed to this demographic in 2008 amounted to 508,373 (36.5 per cent) of the total. This represents a ratio of 706.7 per 1000, compared to a ratio of 193.4 per 1000 for those aged less than 65.

By 2021, the population of Victoria is predicted to grow to 6,332,776. Of this total, those aged greater than 65 is predicted to be 1,106,646 (17.5per cent) – see Appendix 1 for detail.

If the last decade represents a linear demand curve relative to population, then by 2021 Victoria can expect to be challenged with service demand amounting to 2,128,483 (up 52.8per cent on 2008) separations from public hospitals in Victoria.

If the Victorian health system manages to hold demand at the separation ratio evident in 2008, then by 2021 it can expect to be challenged with service demand amounting to 1,792,800 separations in total (up 28.7per cent on 2008) - see Appendix 2 for detail.

The system of public health service delivery within Victoria is often quoted as being at the forefront of service systems within Australia.

The VHA believes that this outcome has been achieved because of the leadership demonstrated through the devolved governance model that characterises its service

[4] Victorian Government, Legislative Council Standing Committee on Finance and Public Administration- Inquiry into Public Hospitals (2009)

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system. The flow-on of devolved governance is the capacity to make decisions at the point of service.

The VHA observes that these outcomes are being achieved in a context of significant fiscal pressure being applied into the health system the Victorian government. There continues to be a belief within the Victorian government that there is 'fat' within the system that can be recouped through 'efficiency savings', 'productivity' expectations, and under-funding of enterprise bargaining outcomes.

The VHA further observes that the result of this fiscal pressure is that the capacity of the system to achieve further efficiencies is in fact 'stripped' from the system. This occurs due to workforce pressures that lower morale (adding to overhead cost), cross-subsidisation within the industry that disguises the true unit price associated with service delivery, and the cushioning of the true result from core business by revenue flows from business activities.

The result is that agencies that have been 'efficiency' leaders, recording favourable financial outcomes for many years, are at significant risk of recording unfavourable financial returns under the same leadership structure. That this occurs almost every year is a clear signal that the current 'mix' of funding methodologies is characterised by inconsistent results for individual agencies. The VHA asserts that the reason for this is multi-faceted. Persons include the suitability to purpose of infrastructure; staff turnover and vacancy rates; the extent to which the casemix price attached to a DRG is skewed by one or two providers who enjoy the efficiency of scale that other providers simply cannot match; and a siloed approach to funding that leads to high compliance and bureaucratic oversight costs.

Appendix 3 illustrates the appropriations by output type in each of the past two budget periods[5], and the allocation to agencies delivering services[6].

The table shows that funding allocations to service agencies increased by 5.7per cent ($423.4 million) in 2009-10 at a time when the budget appropriation increased by 7.9 per cent ($792.4 million).

Of concern, is that the unallocated portion of the budget appropriation has increased – suggesting that at a time of significant fiscal pressure being applied at the agency level, bureaucractic oversight of service delivery agencies has taken a larger slice of the appropriation.

The VHA is concerned that the methodology applied to funding the bureaucracy is inefficient, as *prima facie,* it appears linked to the output dollars appropriated. In other words, when the headline reads $1billion additional health funding, it should in fact read, health service funding up $740 million and bureaucratic oversight up $260million! In a system of devolved governance, this amplifies the inefficiency that

[5] Department of Treasury and Finance, 2009-10 Budget paper no. 3, Service delivery, p87
[6] Department of Human Services, Victorian health services policy and funding guidelines 2009-10

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siloed funding approaches create[7]. Oversight cost should be based upon the partnership with the service agency, not with the outputs of the service agency.

Applying the value associated with recent bed announcements ($321.5 million for 300 beds), and recognising that acute health accounts for 70 per cent of appropriations from the group, realises a required budget increase for each year of the next decade of between $517 million and $875 million.

Recommendation

The VHA recommends:

i. That budget appropriations increase by at least $600 million (in 2008 value) each year to the appropriation group identified in Appendix 3.

ii. In recognition that this is at the lower end of the forecast range, that a further $50m (year on year) be allocated to non-bed based services within the appropriation group, and

iii. To ensure funding transparency, that appropriations differentiate between funding to service agencies and funding to bureaucratic oversight.

The submission detail

The detail embedded within this submission further identifies the system investments required to ensure that the government objective to '***deliver quality health services which meet the demand, standards and quality of care, resourcing and access levels required, and is able to provide accurate and reliable performance data for reporting, funding and planning'*** will be achieved to the advantage of all Victorians.

[7] Access Economics, 2009, Victorian public hospital funding and productivity.

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2. Service reform

An increase in healthcare services is needed to cope with the growing healthcare demand, driven in part by the increasing population and the increasing complexity of that demand as the population ages and the rates of chronic disease rise. For example, an additional 338 to 572 (see appendix 2) beds per annum is needed to sustain current system capacity. A lack of access to services, contributes to poorer health outcomes.

In grappling with the ever increasing cost of public healthcare, the government has applied a range of productivity expectations. Data analysis by Access Economics shows labour productivity is slowing and it is taking more staff time to achieve patient separation, which will result in upward pressure on costs.

For the health system to cope with the increasing pressure, there needs to be real reform now in how healthcare services in Victoria are planned, funded and delivered.

2.1 Metropolitan health

Metropolitan Victoria has seen record growth rates over the past few years, yet there is still no comprehensive **2020 Metropolitan Health Plan** envisioning the health needs of Victorians through to 2020. 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.

The **2020 Metropolitan Health Plan** must include:

- A vision for the public healthcare system to 2020 and beyond
- Measurable objectives for acute, sub-acute, primary, and residential care
- Intersectorial partnerships to address the social determinants of health. For example, the plan must link with the urban planning sector to ensure that public healthcare services are included in projects designed to increase the residential population
- Strategies that link future capital infrastructure investment with pre-determined service priorities based on need
- An increasing proportion of the health budget committed to non-bed based primary and preventative services
- Identification of the referral linkages between major regional providers and metropolitan health services
- Identification of the linkage between hospitals and ambulatory care services

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2.2 Rural health

The VHA welcomes the new *Rural Directions – for a stronger healthier Victoria* policy for its broad vision for rural and regional health services. However, it lacks clear timelines, capital commitments and plans for recurrent expenditure.

People living in rural and remote Victoria continue to experience inequitable access to public healthcare facilities. In order to provide the right support in the right place, the connections from regional to sub-regional to local need to be strengthened.

2.2.1 Regional self-sufficiency

The maxim to "provide high volume, low complexity services close to home with low volume, high complexity services in concentrated areas" has some merit as a broad policy goal. However this overlooks the reality that the provision of services in rural and regional areas is complex due to geographical and socioeconomic considerations. In order to sustain the "hub and spoke" model there needs to be greater recognition of the unique needs of many communities, better regional leadership and co-ordination, more flexibility in funding models and more clearly defined scope of practice.

Investment is needed in the regional "hubs" to ensure their capacity to provide the full range of services outlined in *Rural Directions – for a stronger healthier Victoria.* This is particularly so for cardiac catheterisation services. The VHA applauds the State Government's Cancer Action Plan, but would like to see more collaborative funding with the Federal Government. This will prevent fragmentation of cancer infrastructure in regional and rural Victoria.

There is also a need to strengthen the "spokes" through improved communication systems and transportation to ensure rural residents have reliable access to the "hubs", without incurring extra costs or delays. Innovation and collaboration between the health services needs to be incentivised.

The VHA recommends a range of capacity building initiatives and funding model reviews to enable the Victorian health sector to realise the policy objectives of *Rural Directions – for a stronger healthier Victoria*.

2.2.2 Rural emergency services

Communities in rural Victoria need equitable access to quality 24-hour care. A state-wide shortage of after hours general practitioners (GPs) is overburdening the healthcare system. According to the "Minimal emergency care"[8] policy, all health services must ensure that adequately trained staff are available at all times to provide minimum emergency care, including mental health triage. As the medical labour market tightens, funding for more innovative models will be needed. Examples of approaches that can address need include the Bendigo Health project, "Mental Health Capacity Building in Small Rural Hospitals".

[8] Appendix 1, Rural directions – for a stronger healthier Victoria

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The model of concentrating complex services in one area also threatens the sustainability of rural emergency departments as the well resourced regional and metropolitan departments attract the experienced emergency practitioners, while the rural areas struggle to recruit credentialed staff.

The VHA recommends that a review of emergency services be undertaken that:

- Measures a health service's geographical access and proximity to other emergency services and after hours medical services
- Analyses demand issues experienced in high population growth areas and weekend/holiday destinations, using standardised data collection
- Measures the costs that are borne by health services in the provision of urgent and emergency services
- Explores funding models that enable workforce innovation, GP incentives and resourcing fluctuating presentations
- The Victorian Government analyse competent emergency workforce availability and strategies to maintain the range of skills needed for emergency medicine

Emergency departments continue to operate unsustainably and significant resources are wasted on cross-subsidisation by health administrators[9]. The VHA believes 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.

2.2.3 Residential aged care services

Victoria has the highest representation of public residential aged care beds of all Australian states, with public sector services accounting for 14.4 per cent of places state-wide. Most of these places (82 per cent) are in rural Victoria and are co-located with acute and primary healthcare services. The strength of public sector residential aged care in Victoria is thus an important component of the viability of rural health services.

Of those beds located in rural Victoria, 81 per cent 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. The state government policy objective to *Facilitate access to residential aged care services in rural and regional areas* will therefore remain an important goal.

The VHA welcomes the imminent release of a state-wide planning framework for public residential aged care services. The VHA seeks a commitment from the State Government to fund growth in public residential aged care capacity in those communities where private investment is not forthcoming, as in the recent example of Sea Lake Bush Nursing Service. Conversely, government support for reshaping service scope and capacity, must be forthcoming.

[9] Access Economics, 2009, Victorian public hospital funding and productivity.

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2.2.4 Ambulance services

The provision of the right service in the right location often necessitates the transfer of patients. The delineation of the range and complexity of services provided across rural Victoria, based on capacity, is a key Victorian policy that is being embraced by rural health services. Implementation of such policy however, necessitates access to timely, reliable and effectively funded ambulance services across rural Victoria. The VHA remains concerned that access to this vital cog of the health system is being hampered by conflicting operational priorities.

The quality of care received by rural Victorians in small communities is being negatively impacted by the current triage and funding approaches between health services, the Department of Health (DH) and Ambulance Victoria (AV). The operation of ambulance services within Victoria and the quality of care received in rural communities would be improved through the implementation of a direct funding relationship between the DH and AV for all maternity, NETS and urgent inter-hospital transfers. Implementation of this initiative would increase productivity and responsiveness for rural ambulance services across Victoria.

2.2.5 The early years

Health equity is a goal for a healthier Victoria. Rural populations have been affected by drought, bushfires, floods, economic hardship, and an ageing population. There is also a high proportion of young children in rural areas with poor access to health services due to geographical isolation and low socioeconomic status. Lack of access to services also contributes to poorer health outcomes and further entrenches health inequality.

It is important to target the vulnerable early years to ensure that the services provided have maximum effect. To ensure access to services for all Victorian children the VHA believes that greater investment in outreach services for children aged 0-5 years old is required in rural and remote Victoria.

2.2.6 Early intervention

Chronic diseases currently comprise more than 70 per cent of Australia's overall disease burden due to death, disability and diminished quality of life. The VHA supports the Early Intervention in Chronic Disease (EIiCD) initiative that focuses on community-based early intervention services for people with chronic diseases. The evaluation conducted by the Australian Institute for Primary Care reveals that the "EIiCD initiative successfully demonstrated the capacity of the community health sector to engage with a client population requiring a more integrated approach to chronic disease management"[10]. The program has been a successful driver of internal change within individual agencies and resulted in positive changes in client care. The VHA believes equitable access to the EIiCD program across Victoria is required.

[10] Australian Institute for Primary Care (2008) *Early Intervention in Chronic Disease in Community Health Services Initiative: State-wide Evaluation.* Melbourne: Australian Institute for Primary Care, La Trobe University

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2.2.7 Hospital Admission Risk Program

The VHA supports Government investment in the Hospital Admission Risk Program (HARP) through regional health services. This model has proven successful in improving health outcomes; empowering clients and improving the management of people with defined chronic diseases and complex needs. Despite this success, the VHA is concerned that there remains an inequity of access and opportunity, as HARP services are not available in all rural areas.

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Service Reform Recommendations

The VHA recommends that the Victorian Government:

1. Develop a 2020 Metropolitan Health Plan by July 2010.
2. Commit to capital and recurrent funding to ensure that the full suite of services underpinning regional self-sufficiency is in place by 2015.
3. Provide each of the five regional Department of Health offices with $2 million each in discretionary funding to empower them to facilitate small capital works and other local service capacity building projects and incentivise innovative service models and collaborative service delivery, which best meet the needs of their region.
4. Conduct a strategic review of rural emergency services to ensure a sustainable and equitable model of emergency care for rural Victoria.
5. Create a pool of funds ($5 million per year for 2 years) for piloting innovative approaches to the maintenance or integration of emergency services for small rural health services.
6. Fund the growth in capacity in public residential aged care beds as identified in the state-wide planning framework for those communities where private investment is not forthcoming.
7. Develop direct funding relationship between DH and Ambulance Victoria for all maternity and NETS inter-hospital transfers.
8. Develop a direct funding relationship between DH and Ambulance Victoria for all urgent patient transfers, monitored through a quality assurance system, based on the development of consistent terminology for transfer triage between health services and Ambulance Victoria.
9. Address disadvantage by investing $5 million per year recurrent funding in outreach services to all rural and remote children aged 0-5 years old.
10. Extend the *Early Intervention in Chronic Disease Program* to all Victorian community health services.
11. Immediately provide funding and resources for the rollout of HARP to all rural and regional areas, to ensure equitable access.

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3. Funding reform

3.1 Pricing structures

The Victorian Government has committed through *A Fairer Victoria* to equitable access to services for all Victorians. Currently within the Victorian health system there is growing uncertainly regarding the viability and sustainability of current service levels. This concern has been created through government productivity cuts to baseline funding and a failure of funding models to evolve to incorporate the increasing costs of technology and government regulatory requirements associated with service delivery. This is leading more agencies across all Victorian health settings to experience significant fiscal pressure. The capacity of boards to effectively govern and create financial reserves that can be utilised to improve infrastructure and foster innovation, has significantly diminished as a result.

A starker example of the equity issues being faced across Victoria are funding models that do not address the high costs associated with the provision of services in rural locations. For example unit pricing models that do not provide for travel time and the WIES pricing models for rural Victoria not effectively compensating for the additional costs of service delivery or the skewing of pricing by metropolitan providers.

The VHA commissioned Access Economics to undertake a review of Victorian public hospital funding and productivity in 2008. In April 2009 the VHA released the findings of this review which found Victorian health services are facing significant financial burdens. These burdens are impacting upon both service viability and sustainability. The VHA recommend that the DH undertake a review of its funding models.

3.1.1 Maternity services

Maternity services are an example of a vital service where current funding models are disadvantaging rural providers. The WIES price for maternity services is driven by the high activity of metropolitan providers, who effectively skew the cost weight because of the economy of scale that they can achieve. This is in comparison to the low activity of rural providers, who find it difficult to run sustainable models of maternity services within the current Casemix funding model.

The VHA applauds the Victorian Government's Rural Maternity Initiative, which has supported the development of a capability approach to maternity service delivery across rural Victoria. The recent additional funding to this initiative was welcomed by the VHA. The funding models underpinning these services, however, continue to be of concern. The VHA therefore seeks a commitment to removing maternity services from the Casemix funding model and replacing it with a streamed funding model.

3.2 Flexible funding models

Flexible funding models create opportunity for local innovation and development of efficient and effective service delivery models.

The VHA Access Economics report highlights a range of funding reforms that could improve the Victorian healthcare system. Access Economics found that the Victorian

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health system is a leader in service delivery in many areas, however the system is overly complicated and does not incorporate evidence based review and benchmarking processes. Improving funding models to incorporate flexible funding approaches would improve outcomes for Victoria.

3.2.1 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 VHA recommends applying an appropriate cost inflation factor to the annual indexation of budgets of small rural health service (SRHS) equivalent to that received by the state through the National Healthcare Agreement.

The DH has commenced a review of the SRHS Funding Model. The VHA calls on the DH to openly and transparently engage with the Victorian health sector in completion of this review. The findings of the review should inform future policy.

3.2.2 Administrative burden

The current Victorian health funding system of multiple grants requiring different reporting processes is overly bureaucratic and creates an unnecessary administrative burden on health services.

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.

Currently within the health system, operational funding beyond core funding is supplemented with a network of grants that all require administration. At the individual health service level administration of these grants is time consuming and difficult, while earmarking grants for specified purposes limits the ability to innovate.

The VHA believes that the Victorian Government must address the significant overheads created through existing funding models through a review of these models. The aim of the review should be to analyse the effectiveness of any funding approach to the service outcome being sought and sufficient flexibility to enable innovation.

3.3 Productivity goals

Many agencies are finding it increasingly difficult to achieve 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.

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A key finding of the recent Access Economics[11] report was that although arbitrary productivity targets are being set within the Victorian health system funding framework, the broad measure of productivity growth and the actual financial performance of health services indicate that these targets are not being achieved. Other approaches are therefore required to address productivity.

3.4 Funding transparency

Through the VHA's commissioned research and engagement with the health sector it is clear that information provided to health services across Victoria regarding their budget and funding allocations is neither timely nor transparent. As an example budgets for each financial year are not provided until after the commencement of the financial year. A second example is the provision of information to health services regarding their EBA funding allocation well after the commencement of the EBA.

A key goal of the DH must be to ensure that health services are funded in a transparent manner that emphasises accountability and forward planning.

3.5 Funding labour cost

Labour costs continue to rise for health services without commensurate increases in funding. This is particularly the case in rural and regional areas where incentives need to be paid to recruit an appropriate workforce and service structures require fixed staffing rosters independent of day to day demand.

The VHA has seen evidence for a number of years that health services are not fully funded for the costs of implementing EBAs and the amount of compensation awarded by the DH lacks transparency.

Through its research and engagement activities, the VHA has also found 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.

The VHA seeks assurance that all new EBA outcomes and wage negotiations be funded to meet all new obligations arising from the outcome, without causing compromise to existing service levels.

3.6 Capital infrastructure funding

The Submission made the following observation in relation to infrastructure:

'The increasing demand for hospital services has a flow-on impact on the hospital system's physical capacity to meet this demand. The hospital system's infrastructure is important in maintaining and improving patient care, managing service delivery, improving efficiency and working conditions for health care providers, and provides a basis for innovation. Investment

[11] Access Economics, 2009, Victorian public hospital funding and productivity.

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*in infrastructure needs to be a **balanced combination of maintaining existing essential infrastructure and building or purchasing new infrastructure**, consistent with current requirements and service demand.*

***The Victorian Government is focused on planning for the future capital needs of the hospital system** in order to:*

- *ensure the hospital system maintains sufficient service capacity required for current and expected demand growth*
- *maintain existing building infrastructure to ensure it remains fit-for-purpose, meets service and occupational health and safety standards and efficiency requirements*
- *ensure it remains fit-for-purpose with regards to technology (equipment and information technology) in the hospital system.*

Investment and asset-based decisions will be made over the next decade to ensure hospital infrastructure is provided which meets the needs of the Victorian community. The Victorian Government is committed to ensuring improvements in the health asset base in order to maintain current performance standards and enable improved health outcomes' (p16)[12].

In addressing the 'fit-for-purpose' and maintenance of the asset base the government records capital expenditure in the decade to 2008 of $4.7billion. It is worth noting that the building industry comparative index for commercial tender prices in Victoria has increased by 73 points in this period. The figure should therefore be taken as one of scale only, not as one of scope.

The VHA notes that the non-acute hospital component of this investment ($941 million) represents 20 per cent of the total, much less than the 30 per cent average budget appropriation to this service area. Similarly, the allocation to rural Victoria of $780million represents only 16.6 per cent of the total, substantially less than the 27 per cent of Victorian's that live in our regions.

In the Submission, the Government highlights a $321.5 million bed package that includes 100 acute beds, four adult and two neonatal intensive care unit beds, 170 sub-acute beds, and funds for a diversion program for emergency department and short stay capacity.

The VHA applauds this announcement but notes that it will be insufficient in meeting future demand. Appendix 2 illustrates the bed investment required to keep apace with population growth and ageing. The identified range is 340 to 570 beds per annum. The extent to which non-bed based solutions can be developed over the next decade is the variable in this equation.

Appendix 2 further illustrates that the investment in **new** infrastructure required to develop this bed capacity ranges between $6.2 billion and $10.4 billion in the outlook period to 2021.

[12] Victorian Government, Legislative Council Standing Committee on Finance and Public Administration- Inquiry into Public Hospitals (2009)

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Further investment is required to ensure that the service quality objective of government is maintained across the State.

This will require, at a minimum, investment equal to that applied over the past decade ($4.7 billion). As this investment has been heavily skewed to significant infrastructure projects within the metropolitan area, the VHA expects that investment in the decade will be characterised by a skewing to rural and non-acute projects.

The VHA believes there is an ongoing need for improved infrastructure and facilities to support best practice health service provision to meet community need. Capital investment remains a key element constraining the future capacity of the Victorian healthcare system to meet future health needs. Consequently, the VHA seeks a commitment from the State Government to act now to improve the health service infrastructure throughout Victoria. This is required immediately to meet future need of the acute, sub-acute primary healthcare and aged care sectors.

3.6.1 Ten-year capital plan

Whilst the VHA is supportive of the Government's investment in health system capital infrastructure over the last 10 years, the health system lacks a strategic, robust plan (as seen with the Victorian Transport Plan or Cancer Action Plan). Currently, there is no systematic analysis of where capital can be most productively invested in planning Victoria's health services. Investments are also not targeted at where the most effective productivity gains might be achieved.

To resolve this, the Government must engage the health sector in the development of a document that outlines the Victorian health system capital investment priorities for the coming decade, that clearly link to a service plan that reflects measureable health priorities and changing social needs.

The VHA recommends that the Victorian Government immediately develops a publicly accessible, ten-year capital strategic plan for Victoria's health system to ensure capital investment is governed by a transparent process. This should be a public document that is accountable to Parliament. This plan must comprise the following identifiable components:

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

3.6.2 Smaller projects

There is an existing incongruence in the funding of capital projects for minor capital works compared to larger sized projects. The $100,000 level set for minor capital projects is both unmanageable and unrealistic to meet the practical needs of the health sector. In particular, large scale projects in smaller agencies are less costly than in larger agencies yet require a drawn-out and costly application process. The

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VHA recommends that the Victorian Government review both the scope and the quantum of smaller project capital funding.

3.6.3 Macro capital planning

When large scale capital development projects are actioned, such as the redevelopment of the Royal Children's Hospital; the funds available for other capital projects across the state are significantly diminished. This poses considerable problems for maintenance of infrastructure across the health sector.

3.6.4 Depreciation

There are significant cost differentials between maintaining older facilities in comparison to newer facilities. Older facilities and capital equipment are significantly less energy efficient and more expensive to repair and maintain. Currently, there is no consistent method to account for depreciation within health services and service funding models lack an explicit component for depreciation.

The absence of specific funding for depreciation creates inequity between health services as there are significant differences in the age and condition of facilities across Victoria.

Appropriate accounting for and corresponding funding of depreciation over time would allow health services to become more accountable locally for managing their own infrastructure needs. The Victorian Government needs to develop alternative strategies to incorporate depreciation costs into 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.

3.6.5 Investment in community health

Much of Victoria's existing primary healthcare service infrastructure is nearing the end of its useful life, with significant infrastructure unable to be further 'patched up'. There is currently a lack of space and infrastructure in areas of high need and high socio-economic disadvantage. Similarly, the cost of sharing facilities through rent agreements is rising exponentially within Victoria due to a lack of adequate infrastructure.

Services based on models of care provided in community settings have increased and continue to increase significantly. The corresponding investment in community based infrastructure continues to be a concern. Services such as HARP and early intervention in chronic disease, as well as a range of sub-acute services all require community based service delivery localities.

One example of a barrier to funded services caused by lack of infrastructure is the provision of public community dental services.

Infrastructure strategies 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 the Victorian community health platform is a viable model to act as Comprehensive Primary Health

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Care Centres (in accord with the recommendations of the National Health and Hospitals Reform Commission). However, this requires significant resourcing for physical infrastructure to ensure high quality primary healthcare services for Victorians into the future.

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Victorian Healthcare Association

Funding Reform Recommendations

The VHA recommends that the Victorian Government:

1. Increase average infrastructure appropriations of $800m per annum for the next 10 years to **new** bed capacity.
2. Increase average infrastructure appropriations of $470m per annum for the next 10 years to upgrade **existing** infrastructure.
3. Increase a skewing of investment in upgrades to existing infrastructure to rural and non-bed based services for the next 10 years.
4. Review its funding models, particularly WIES and unit pricing, to ensure their adequacy in meeting contemporary service delivery.
5. Remove maternity funding from the Casemix funding model and replace it with a streamed funding model, which is linked to the needs of the client and the cost of maintaining a viable local maternity service.
6. Apply a cost inflation factor to the annual indexation of budgets for Small Rural Health Service (SRHS) equivalent to that received by the State through the National Healthcare Agreement, commencing from July 2010.
7. Commits to creating system wide efficiencies by reviewing and consolidating its arrangement of operational grants to health services and health providers throughout the Victorian health system.
8. Commit to a removal of blanket productivity cuts across the health system, with productivity achieved through innovation and new infrastructure investment.
9. Ensure that the DH detail operational funding budgets for health services by the commencement of June each year. The DH must also provide transparent tracking of movement in the sum of funds available to each agency, in correlation to agency targets, as well as breakdowns of fund allocations.
10. Ensures that all new EBA outcomes and wage negotiations be funded to meet all new obligations arising from the outcome without causing compromise to existing service levels, and that service providers be engaged to agree upon a process of funding that achieve transparency.
11. Immediately develop a publicly accessible, ten-year capital strategic plan for Victoria's health system to ensure capital investment is governed by a transparent process. This should be a public document that is accountable to Parliament.
12. Raise the ceiling for minor projects to $250,000 and that a new 'medium capital' funding stream between $250,000 and $5,000,000 be introduced.
13. Ensure that macro-capital projects — like the redevelopment of state or major metropolitan health services—do not deplete smaller capital growth projects funding.
14. Develop alternative strategies to incorporate depreciation costs into 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.
15. In partnership with the Federal Government, invests $600 million in primary healthcare infrastructure through all of Victoria's state funded primary healthcare services.

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4. Workforce

Victoria can ill afford to neglect its workforce challenges. Workforce limitations remain a key impediment to health sector sustainability in a time of increased service demand. There is a worldwide shortage of healthcare professionals and Victoria is not immune from this shortage, particularly in rural areas.

Current DH analysis of workforce shortages suggest that by 2016 demand for health services will increase by 54per cent, but that the health workforce will only increase by 37per cent. The absence of synergy between these two statistics should signal the need for urgent action.

4.1 Removing professional silos

The shortage of General Practitioners (GP) is straining hospital emergency departments (ED) in rural and regional areas. The impacts include an increase in presentations to the EDs and a decrease in the numbers of visiting GPs available to staff them. Where the GP shortage cannot be rectified, there is a need for more flexible work practices to better utilise the skills of other health professionals, and to relieve GPs of the routine and time consuming elements of their job.

The VHA welcomes innovative workforce strategies, such as multidisciplinary work teams and working with a competency base rather than professional silos. Accordingly, the VHA supports the need for better data on the size, skills mix and distribution of this workforce, including GPs, rehabilitation medicine specialists, geriatricians and allied health staff.

One area the VHA believes is neglected is that of workforce redesign and/or creating new categories of healthcare workers to complement our trained professionals, by relieving them of routine and time-consuming elements of their work.

Workforce reform must also look at “scope of practice” issues to better use the skills of scarce medical professionals, particularly in rural areas. This may mean widening the use of nurse practitioners, physician assistants and allied health practitioners to reduce workload pressures on other scarce health professionals, where it is safe to do so.

The VHA recommends that the Victorian Government investigate the potential of new funding models that support a more effective use of the available workforce. This should include the development of funding incentives that encourage safe workforce redesign and innovation.

4.1.1 Competency based approaches

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 2010-11 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.

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4.2 Workforce strategy

The recruitment and retention of all employment categories is essential to the long-term viability and success of Victoria's health industry. A **workforce strategy** 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.

Funding models are powerful motivators for workforce patterns. 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) to encourage multidisciplinary teams. The VHA also calls for DH to monitor and analyse the workforce patterns following the changes to GP incentive payments in Victoria as a result of changes to the rural to the Australian Standard Geographical Classification (ASGC) system.

4.3 Training the future workforce

4.3.1 Clinical training

The training of the future workforce requires attention now to prevent further workforce shortages. While more tertiary and VET places have been created, investment is required to enable provision of adequate clinical training places. The VHA recommends expansion of clinical placement beyond the traditional tertiary hospitals, placements in alternative settings - such as rural and regional areas, private providers, primary healthcare and aged care - is required. Training the future workforce in alternative settings leads to increased uptake in positions within these settings, as well as a greater understanding of the varied needs of consumers. Training people in rural and regional areas increases the retention of a rural healthcare workforce, thus addressing the specific workforce issues being faced in these areas.

4.3.2 Affordable access to VET

Recent changes to Victorian Government funding for VET qualifications is of concern to the VHA. The implementation of these changes in the coming year will lead to health workers and those wishing to enter the health workforce from other professions facing increased costs. The health sector relies on the continual professional development of its workforce and VET changes mean most health workers will no longer be able to access government subsidised VET training places. Opportunities for further training through VET certification should be funded regardless of whether someone has a prior higher qualification. The VHA believes barriers to continued skills acquisition in healthcare should be removed to address the significant workforce shortages.

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4.3.3 Nurse Practitioner training

The criteria to attain registration as a nurse practitioner are set at a very high level (Masters). This is of concern to the VHA as it impedes workforce redevelopment. 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. Attention must be given to the design of the course to encourage the building of professional competencies, which once assessed, can then be applied immediately. The VHA recommends that the State Government review the criteria that apply to registration as a nurse practitioner. This process should incorporate an investigation of models in place in other jurisdictions.

Workforce Recommendations
The VHA recommends that the Victorian Government:

1. Investigate the potential of new funding models that support a more effective use of the available workforce. This should include the development of funding incentives that encourage safe workforce redesign and innovation.
2. Provide $0.2 million in funding to develop a demonstration project and further funding of $1.5 million to support state-wide implementation.
3. Develop of standardised processes for testing professional competencies within the public healthcare system.
4. Develop an innovative workforce strategy that breaks down silos to secure a workforce that can meet future demand over the next decade.
5. Provide incentives for clinical placements to occur in expanded settings beyond the traditional tertiary hospitals, such as rural and regional areas, private providers, primary healthcare and aged care.
6. Review its changes to the VET funding system and consider providing an exception for health sector applicants.
7. Review the criteria that apply to registration as a nurse practitioner. This process should incorporate an investigation of models in place in other jurisdictions.

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5. Population Health

5.1 Health promotion and illness prevention

Investment by the Victorian Government in health promotion interventions at a local level is vitally important to the health of all Victorians. Although high-quality hospitals and health services will remain a fundamental component of Victoria's healthcare system, the VHA supports increased funding for illness prevention and health promotion through this, and future State Budgets. This shift is fundamental to deal with future challenges of an ageing population, widening social inequities, rising levels of demand and increasing rates of chronic disease.

Despite Victoria being a leader over recent decades, illness prevention and health promotion remain poorly funded relative to the total health budget. This level of funding is both disproportionate and inadequate to meet need. There is now clear and robust evidence that preventative health measures can yield social, economic and health benefits for the community. In addition, evidence demonstrates that comprehensive approaches to preventative health are the most effective approaches and can decrease subsequent costs to society, the health system and the individual. Examples include multi-sectoral strategies to decrease road fatalities and smoking cessation.

5.1.1 Supporting new funding models

Whilst successful prevention initiatives require comprehensive approaches that reach beyond the healthcare sector, the role of health services in prevention cannot be ignored. Healthcare in Victoria is changing rapidly, with expanding roles for health services in developing, implementing and evaluating health promotion and illness prevention within their communities. These changes require adequate resourcing.

Yet, demand-driven funding models continue to be based on 'service hours.' This limits the ability of health services to effectively plan, coordinate and sustain illness prevention and health promotion strategies locally. These established funding models have historically made it easier to treat, rather than prevent chronic disease and illness. These models also fail to support research that underpins evidence-based practice.

It remains difficult to integrate health promotion into health service planning without investment and new funding models. This makes it difficult for health services to reorient their focus to incorporate the social determinants of health rather than focus on a particular health issue or individual risk factor. The VHA seeks a commitment to an interdepartmental spending review with the aim of allocating resources to multi-year projects that address health inequities.

5.1.2 Short term funding and research

Action on the social determinants of health is inherently long-term, with improved health status or reduced social inequity not evident for a number of years. Short-term, time-limited, project-based funding impedes the long-term planning necessary to achieve the social change required to sustainably improve population health

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outcomes. These short timeframes imposed on services, coupled with a lack of funding flexibility to facilitate local context, are barriers to achieving better health outcomes. Simply, implementing health promotion and illness prevention strategies at a local level often results in high levels of frustration within the health sector.

The VHA believes the Victorian Government should review the resourcing and funding structures for integrated health promotion within Victoria. This review must aim to improve organisational capacity and embed program sustainability in order to support effective and efficient long-term projects. One option is the creation of a Victorian Preventative Health Innovation Council responsible for fostering quality health promotion and illness prevention in Victoria by working with stakeholders and the Australian National Preventive Health Agency (ANHPA) to achieve significant system-wide improvement.

The Victorian Auditor-General's Office report into investment in health promotion highlights that health services found it difficult to determine "how to effectively allocate the health promotion budget across a range of areas including staff training, integrating health promotion into service delivery, building community capacity and delivering and evaluating local health promotion initiatives". The report also identified the "need to strengthen the evidence base used to guide and refine the State's investment". The VHA supports the development of a coordinated approach to Go For Your Life rather than funding a range of fragmented initiatives that are not linked or coordinated at either a central or local level. This will help to achieve prevention within health services that is shaped around the health needs of individuals, their families and communities

5.2 Health promoting health services

The World Health Organization has established a framework for health promoting health services based on a change management approach that overhauls traditional structures, cultures and decision-making processes. As yet, no Victorian framework exists to guide health services to become health promoting health services. This silos health promotion staff, hampers benchmarking and mitigates against a system-wide approach based on international best practice.

The VHA believes the Victorian government can strengthen this approach by committing to a Health Promoting Health Services Action Plan that encourages and incentivises participation of all health services in accordance with growing sector interest and global evidence.

This action plan requires short, medium and long-term goals to support change management, training and education and governance models to enable Victoria's health services to incorporate the values, concepts, strategies and standards of health promotion into their organisational structure, culture and systems.

The rationale for the action plan is:

1. To enable organisations to translate the philosophy of the Health Promoting Health Service approach to practical, long-term tangible health promoting settings

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2. To modernise Victoria's health services in alignment with world's best practice standards of health promotion
3. To unify many disparate efforts into a cohesive, holistic approach through significant changes of culture, structure and resources

5.3 Partnership

Much partnership activity at a local level occurs on an ad-hoc basis through unsustainable funding streams. Best practice health promotion and illness prevention require significant investments of time, technical expertise, and resources. However, current policy and funding arrangements do not adequately accommodate the collaboration required to build a healthy community.

In order to maximise the impact and outcomes of resources dedicated to community health promotion, greater evaluation and knowledge transfer requires incentivising and sustainable resourcing. The VHA recommends the Victorian Government invest in partnership arrangements between health services and tertiary education institutions to achieve best practice evaluation of the impact of local health promotion action and initiatives.

The VHA also believes the Victorian Government should create a seed funding program to support new local partnerships on priority health issues facing communities in Victoria. This program must foster the formation of multidisciplinary, multi-sector collaborations to do the preparatory work in establishing robust cross-sectoral partnerships.

5.4 Planning

Anecdotal evidence highlights that Primary Care Partnerships (PCPs), local government and health services currently plan separately as a result of funding and reporting guidelines based on divergent data and varied planning cycles. This results in duplication of effort despite a common focus of meeting the needs of the community.

Only structural change can remove these barriers and ensure plans and requirements align. The VHA seeks assurance from the Victorian Government that connections between Municipal Public Health Plans (MPHPs) and Community Health Plans (CHPs) are strengthened through the Public Health and Wellbeing Plan to reduce duplication, increase collaboration and improve community service planning.

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Population Health Recommendations

The VHA recommends that the Victorian Government:

1. Conduct an interdepartmental spending review with the aim of allocating resources to multi-year projects that address health inequities.
2. Review the resourcing and funding structures for integrated health promotion within Victoria.
3. Develop a coordinated approach to Go For Your Life rather than funding a range of fragmented initiatives that are not linked or coordinated at either a central or local level.
4. Invest $10 million over four years to support the Health Promoting Health Services approach in Victoria, in accordance with international best practice.
5. Invest $10 million over four years to develop partnership arrangements between health services and tertiary education institutions to achieve best practice evaluation of the impact of local health promotion action and initiatives.
6. Invest $5 million over four years to create a seed funding program to support new local partnerships on priority health issues facing communities in Victoria.
7. Ensures that connections between Municipal Public Health Plans (MPHPs) and Community Health Plans (CHPs) are strengthened through the Public Health and Wellbeing Plan to reduce duplication, increase collaboration and improve community service planning.

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6. Benchmarking and Data

Meeting the health needs of our communities requires effective planning and, therefore, access to reliable and accessible data. There is significant potential for improved service planning by giving health services access to reliable sources of existing but unavailable data.

Data brings with it the ability to improve health services through benchmarking and the effective use of data for service planning. The Victorian health system is currently failing to achieve these goals.

6.1 Data

Previous VHA research identified a misalignment of planning cycles and inconsistent data collection that limits the ability of health services and policy planners to compare data and impedes benchmarking of health services to a set of industry-agreed key performance indicators (KPIs).

6.1.1 Health data site

The dearth of accurate, local data to inform health system planning is a major impediment to the structural reform of Victoria's health 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 the coordinated will and dollars to invest in data collection is lacking.

Local needs are best addressed by local decisions that lead to local solutions. The VHA believes widespread access to valid, accessible, appropriate, comprehensive and usable data is vital. Transparent methods of measuring and reporting population health is also needed to enable health services to ensure local programs and services are evidence-based.

The Victorian Government must seek through the COAG process a Federal commitment to the establishment of a national health data site to integrate data from various sources. This site should incorporate Geographic Information System mapping capabilities and be publicly accessible

6.1.2 Health service planning

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 health services to be accountable to report the population health needs of the community that they serve. The Victorian Government - via the Department of Health - has a vital role to play in supporting better data collection to inform health service planning.

The VHA calls on the Victorian Government to invest in ongoing training in 'population health approaches to planning' for the workforce and boards of health and community sectors, as demonstrated by previous investments in clinical governance training. They should develop protocols and enable health service boards to report and be

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accountable for their population health outcomes, matched to a set of industry-agreed key performance indicators. These indicators would be linked to mandated public reporting cycles and DH priorities

6.2 Benchmarking

Benchmarking can be a powerful tool in identifying capacity to achieve productivity if used effectively. Currently there is little opportunity for health services to benchmark against their peers beyond the key performance indicators set via the elective surgery and emergency access monitoring. Many of the small rural health services cannot even use these indicators. Standard reporting tools are therefore needed.

Benchmarking should be used to flag areas for improvement, not to punish poor performance. Benchmarking should encourage information sharing to work collaboratively, not competitively. But benchmarking is about more than just providing good data and must include a process to develop an understating of how to interpret the data effectively.

Health service administrators rely on data analysis and comparison of inputs, operational procedures and outcomes in order to more efficiently manage and operate their services. They need a process that systematically provides feedback to service providers on a cost centre by cost centre basis for comparison. Data that achieves the fundamental objective of enabling capacity to benchmark is not readily available within the Victorian public health system. The Victorian healthcare system cannot afford to continue running blindly.

The VHA calls for:

- Funding to support an external body to develop data sets and standard reporting tools to assist health services to meet state's best practice benchmarks for services grouped alike

- Resources to enable the detailed examination of benchmarking data with a view to identifying areas for improvement and managing that improvement. These resources will include liaison officers within each health service for a period of time to assist with detailed analysis of the data for use in planning and administering projects.

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Benchmarking and Data Recommendations

The VHA recommends that the Victorian Government:

1. Invests $5 million over four years in ongoing training in 'population health approaches to planning' for the workforce and boards of health and community sectors, as demonstrated by previous investments in clinical governance training.
2. Develop protocols and enable health service boards to report and be accountable for their population health outcomes, matched to a set of industry-agreed key performance indicators.
3. Seek through the COAG process a Federal commitment to the establishment of a national health data site to integrate data from various sources. This site should incorporate Geographic Information System mapping capabilities and be publicly accessible.
4. Provide an additional $5m in 2010-11 to implement a 2 stage benchmarking project that in stage 1 develops data sets and standard reporting tools, and in stage 2 undertakes capacity building activities within the health sector to support their implementation and uptake within health services.

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7. E-health

E-health has the potential to improve the quality and safety of health services provided to the Victorian community. Effectively implemented e-health solutions may also create productivity dividends. Realising these dividends will require upfront investment in infrastructure and a review of existing funding models.

7.1 System-wide ICT strategy

The DH is currently developing a 2009-2013 Whole of Health ICT Strategy. As of December 2009 this document was not yet publicly released, nor had the State Government detailed funding to support the realisation of the Victorian health system stated ICT goals. The VHA calls on the Victorian Government Finalise and release its 2010-2013 ICT Strategy, with a funding commitment of $600 million over four years.

Articulation of a system-wide ICT strategy is imperative to inform service development into the future. The existing ICT approach has proven unsustainable due to the unfunded contribution costs expected from individual agencies (which in many instances cannot be supported from a cost benefit perspective), the lack of variation in product choice and product suite to meet individual agency need, and the absence of state-wide funding models to support e-health initiatives.

7.1.1 Unfunded contribution costs

The creation of an integrated approach to data collection and ICT capacity is an essential investment in public infrastructure.

The VHA urges the Victorian Government to recognise the importance of ICT by building the cost of ICT into health system funding models. Currently, the increasing cost of contemporary ICT systems to health services is not reflected in the funding models that apply to health services. As technology costs operate on a price index that differs significantly from general price indexes, it is recommended that a pricing system, recognising fixed costs associated with “site wiring” and variable costs associated with program scale be developed.

7.1.2 Absence of product choice

The VHA’s analysis of the HealthSMART rollout found a timely roll-out of this strategy was hindered by a product suite that did not sufficiently meet the need of the end user. This is particularly the case with clinical systems in rural Victoria, where even the largest regional providers have expressed concern at the suitability of the selected product. An issue also exists with the patient management system mandated for use by rural community health services.

The Victorian Government must review its current approach to product selection for IT projects, with a view to providing a competitive product suite. Such an approach must include flexibility to ensure that product meets business needs. The key criteria should be interoperability and integration of product rather than the current one-size-fits-all approach.

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7.2 National e-health priorities

The VHA recognises the position of the Victorian health sector as a national leader in the area of e-health. The position has been achieved through many of the HealthSMART initiatives. The VHA encourages the Victorian government to continue to play its current leadership role.

The implementation of national e-health priorities including patient, practitioner and provider unique identifiers should be implemented across Victoria as a priority. This will require sufficient infrastructure and funding.

The VHA is concerned that the Australian government is not investing sufficiently in e-health to realise its stated e-health goals. The realisation of a patient controlled electronic health record has the potential to provide significant improvements in patient outcomes, as well as systemic efficiency improvements. This will not be achieved without front end investment.

7.3 Telemedicine

Telemedicine applications are a vital tool to address the workforce and clinical practice challenges that impact health service delivery in rural Victoria. Effective use of telemedicine has the ability to address skill shortages, professional isolation and improve current clinical practice. Barriers to its implementation include insufficient broadband capacity in some rural locations and a lack of supportive funding models.

To address these issues the Victorian Government must provide an additional $2.5 million to Rural IT Alliances to improve wide area networks and access to effective broadband. The VHA also recommends increasing current state-wide funding for telemedicine approaches by $20 million over the next four years.

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Victorian Healthcare Association

E-Health Recommendations

The VHA recommends that the Victorian Government:

1. Finalise and release its 2010-2013 ICT Strategy, with a funding commitment of $600 million over four years.
2. Review all funding mechanisms to incorporate the real costs of ICT to Victoria's health services.
3. Review the current approach to product selection for IT projects, with a view to providing a competitive product suite.
4. Encourage the Federal Government through COAG to considerably increase its investment in e-health to include initial catch up funding of $700 million across Australia, followed by funding of $700 million per year for 5 years.
5. Provide an additional $2.5 million to Rural Health Alliances to improve wide area networks and access to effective broadband.
6. Increase current state-wide funding for telemedicine approaches by $20 million over the next four years.

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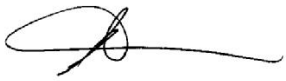
Conclusion

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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Appendix 1:
Victoria's growing and ageing population:

Population	1999	2008	2011	2021	2031	2041	Total change
>65	597,865	719,355	790,018	1,106,646	1,444,946	1,714,440	
Proportion of total	12.7%	13.6%	14.2%	17.5%	20.4%	22.3%	
Increase in decade #		121,490		316,628	338,300	269,494	924,422
% increase in decade		20.3%		40.1%	30.6%	18.6%	38.7%
Total pop.	4,707,600	5,293,323	5,549,810	6,332,776	7,067,688	7,700,177	
Increase in decade #		585,723		782,966	734,912	632,489	2,150,367
% increase in decade		12.4%		14.1%	11.6%	8.9%	38.7%

The table above helps to explain some of the story behind the escalation of demand evident in the period 1999-2008. The period is characterised by overall population growth of 12.4 per cent, and population growth in the >65 demographic of 20.3 per cent.

Moving to decade on decade analysis from 2011, it can be observed that the trend of the last decade is about to be amplified. Population growth escalates to 14.1 per cent in the first decade of this long-view, and then begins to soften on a proportional growth basis. However, raw growth is maintained beyond that of the last decade in each of the next 4 decades.

The significant outlook is that applying to the >65 demographic. In the first outlook decade (2011-2021), growth in this age cohort escalates 40 per cent, followed by a further 30 per cent proportional growth in the decade to 2031. Raw growth does not abate until the decade commencing 2041, and even then, represents a number 1.5 times that reflected in the decade to 2008.

Appendix 2:
Analysis of demand, service and capital growth for acute health: 1999 - 2021

Population	1999	2008	2021 linear	2021 non-linear
>65	597,865	719,355	1,106,646	1,106,646
Separations	326,721	508,373	959,351	782,067
Ratio	546.5/1000	706.7/1000	866.9/1000	706.7/1000
<65	4,109,735	4,573,968	5,226,130	5,226,130
Separations	715,114	884,807	1,112,120	1,010,733
Ratio	174/1000	193.4/1000	212.8/1000	193.4/1000
Total	4,707,600	5,293,323	6,332,776	6,332,776
Separations	1,041,835	1,393,180	2,071,471	1,792,800
Ratio	221.3/1000	263.2/1000	327.1/1000	283.1/1000
Overnight separations = 45% total		624,609	932,162	806,760
Overnight ALOS		6.3	6.3	6.3
Bed days from overnight separations		3,935,037	5,872,620	5,082,588
Same day = 55% total		768,581	1,139,309	986,040
Total bed days		4,703,618	7,011,929	6,068,628
Daily average		12,887	19,210	16,626
Beds required @ 85% occupancy		15,161	22,600	19,560
Bed growth required			7,439	4,399
Annual bed growth required to meet demand			572.2	338.4
Construction cost per bed			$1.4m	$1.4m
Capital budget 'new' infrastructure			$10.4b	$6.2b

Appendix 3 – Analysis of service allocations and budget appropriations to service type

	Acute Health 2008-09	Aged & Home Care 2008-09	Drug services 2008-09	Mental Health 2008-09	Primary & Dental Care 2008-09	Public Health 2008-09	TOTAL 2008-09	Acute Health 2009-10	Aged & Home Care 2009-10	Drug services 2009-10	Mental Health 2009-10	Primary & Dental Care 2009-10	Public Health 2009-10	TOTAL 2009-10
	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m	$m
Metropolitan Health Services	4168.9	60.2	14.3	483.3	63.1	14.1	4804.2	4425.4	63.1	15.1	499.4	66.2	14.7	5084.0
Rural Health Services (excluding SRHS)	1292.5	103.4	3.4	165.7	44.2	.2	1609.3	1369.4	106.8	3.5	171.2	45.2	.2	1696.2
Registered Community Health Services	0	58.6	13.1	14.4	110.1	1.0	197.3	0	65.5	14.1	14.8	116.6	1.0	212.0
Local Government	0	180.6	0	.07	.41	.07	181.1	0	189.6	0	.07	.42	.14	190.2
NGO's	0	170.3	49.3	63.8	15.7	93.5	392.6	0	180.0	51.3	65.8	16.6	101.7	415.5
TOTAL	5461.4	573.1	80.1	727.4	233.6	108.9	7184.6	5792.8	605.0	84.0	751.3	245.1	117.8	7598.0
Budget Appropriation	7015.7	915.5	123.9	883.8	330.3	280.7	9549.9	7602.0	974.3	127.5	945.0	418.2	265.6	10332.6
$Variance	1554.3	342.4	43.8	156.4	96.7	171.8	2365.3	1809.2	369.3	43.5	193.7	173.1	147.8	2734.6
% Variance	22.1%	37.4%	35.4%	17.7%	29.3%	61.2%	24.8%	23.78	37.9	34.1	20.5	41.4	55.66	26.46
SRHS	177.6	59.7	0	2.8	18.6	0	258.7	184.5	61.5	0.2	2.9	19.5	0	268.7
Budget Appropriation							442.9							452.6
$Variance							184.2							183.9
% Variance							41.6%							40.64