Victorian Healthcare Association

SUBMISSION

Activity based funding for Australian public hospitals: Towards a Pricing Framework

21 February 2012

1. Introduction

This submission outlines the Victorian Healthcare Association's (VHA) response to the discussion paper (the paper) entitled; *Activity based funding for Australian public hospitals: Towards a Pricing Framework*.

The VHA agrees to this submission being treated as a public document, and to the information being cited in the final report.

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The Victorian Healthcare Association

The 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.

Context

Activity based funding (ABF) is not new in Victoria. It was introduced in Victoria 18 years ago as Casemix funding with a purpose of achieving efficiency in the distribution of hospital funding and in creating a sense of competition between service providers to model services in recognition of price based on Diagnostic Related Groups (DRG).

From this context, the VHA is well-placed to comment on some of the benefits and shortcomings of ABF. In particular, it is important to recognise that the imperfections of the ABF model have been mitigated in Victoria through a mixture of block grants that provide government the flexibility to sustain services that require additional financial support.

Funding models influence how healthcare services are provided and whether the system can adapt to changing community and health needs. The principles espoused in the paper for setting the efficient price provide for a single unit of measure and price equivalence. This is an important factor in a health care environment that is constantly evolving, and must be applied in a way that ensures that care is delivered in the most effective and efficient environment whether this is bed or non-bed based.

In this regard, the Independent Hospital Pricing Authority (IHPA) has an opportunity to encourage real reform within Australia's healthcare system in executing a funding methodology that creates and encourages choice of clinically safe service options – whether they are bed based, in ambulatory care centres, or at home treatment. The VHA is concerned that this opportunity has not been well articulated in the paper and encourages consideration to iterating the pricing framework narrative to both acknowledge and assert this opportunity.

The power of funding models to influence service provision requires careful consideration in the implementation of any new funding approach. With an expectation to commence from 1 July 2012, the VHA lacks confidence that the IHPA has sufficient time to implement a robust Pricing Framework that is based on well piloted and evaluated guidelines. In this regard, the initial approach to setting the efficient price should only be considered a transitional arrangement.

As part of the arrangement, the IHPA will funnel Commonwealth funding to the states based on their total activity subject to reimbursement based on price. The states, as 'system designers', will then distribute these funds across its health services in ensuring they deliver on the key performance indicators set by the Commonwealth. In this equation, the states will remain the significant funder of hospital services, so it is important that the pricing methodology not impair the capacity of the state to give effect to their role as the system designer.

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2. The VHA's Response

2.1 Do you agree with the proposed principles to guide the development and operation of the Pricing Framework?

Overall, the VHA supports the principles identified in the paper and agree that they articulate the purpose of the IHPA in guiding the development of the Pricing Framework.

The IHPA's general premise to enable greater clarity about who is doing what in order to minimise the duplication of services and to allow for better coordination, is generally supported by the VHA. Establishing an independent pricing authority will also help to reduce the politicisation of health funding and may contribute to a better understanding of how to achieve allocative efficiency. However, allocative efficiency will only be achieved if geo-spatial mapping of the relative distribution of funds follows the application of the technically efficient price.

The VHA welcomes the principle, *Single unit of measure and price equivalence: ABF pricing should support dynamic efficiency and change to models of care with the ready transferability of funding between different care types and service streams through a single unit of measure and relative weights.* The principle implies a shift from acute admissions to one that focuses on the models of patient care that reflect the need of the patient along the care continuum.

The VHA suggests some caution towards the principle *ABF pre-eminence – ABF should be used for funding wherever practicable.* The VHA observes that Victoria's experience illustrates that ABF does not work in all service contexts. By example, maternity services can reflect a skewed 'efficient price' to high volume specialty hospitals. A further point in this regard is the existence of a number of 'price points' within the Victorian casemix approach. These price points generally reflect scalable capacity; that is, the greater the activity level, the lower the price. These examples amplify the need to be cognisant of nuances in applying the pre-eminence of ABF into specialty models of care, models of care that need to be maintained from equity of access perspectives (eg rural considerations), and to models of care that are subject to unpredictable care pathways.

Consistency in applying the principles espoused within the framework will be essential to building confidence in the application of ABF.

2.2 What public hospital services should be included in new funding arrangements?

The labelling of *public hospital services* as eligible for Commonwealth funding is of particular concern to the VHA. Most Victorian public hospitals have rebranded themselves as 'public health services' to emphasise the integration of the acute, sub-acute, aged and community services to best match the client profile. This nuance is recognition of the need to move away from the central focus of bed-based treatment towards a paradigm of moving services into the community.

The VHA is concerned that ABF for hospital based outpatient and emergency treatment but not for primary health services may further exacerbate the fragmentation evident within the health sector as this approach further reinforces funding siloes that result in policy siloes. The VHA acknowledges that hospitals do represent the significant context in addressing acute episodes of ill health, but asserts that the health journey does not always start and end with the admission and discharge from a hospital.

Appropriate and flexible funding mechanisms are required to guide and inform the provision of public health services. When the funding mechanisms are centred on ABF for treatment based services, publically funded health providers will not have the budgetary scope to provide the breadth of services necessary in the entire patient journey. The VHA advocates for the provision of flexible funding arrangements to support innovation and locally appropriate programs. In this regard, ABF offers little scope to integrate prevention and health literacy programs into the continuum of care for individuals.

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The paper makes note that community health services (CHS) are not eligible for Commonwealth funding as a public hospital service. The consequence of excluding CHS from Commonwealth funding reinforces the 'silo' approach that currently exists between all the different sectors of healthcare in Australia. Ultimately this contradicts the 'whole of health' approach that was so prominent in the recommendations of the National Health and Hospital Reform Commission.

The acute sector cannot be sectioned off in isolation and cannot be considered as the sole player within the continuum of care. This is particularly the case in smaller communities where the boundaries between hospital care, and aged and community care become blurred. Block funding to smaller health services is acknowledged as an appropriate response to this tension, and consideration to funding a care journey through a mixture of ABF (acute phase) and block (post-acute) funding must also be given to the IHPA process.

In Victoria a network of 100 CHS operates from approximately 250 sites. Thirty-seven of these services are independently managed and known as 'registered CHS', while the remainder are integrated with rural or metropolitan public health services.

ABF must provide flexible rather than a one-size-fits all approach and provide access to multi-disciplinary teams that focus on holistic approaches to keeping people well, rather than specific episodic care. This will be difficult for state and territories as 'system designers' and will require them to continue their blending of block and activity funding approaches to ensure appropriate care outcomes.

2.3 When should public hospital services be funded on an activity basis or a block grant basis?

- **When is ABF 'impracticable' to apply? Are the proposed criteria for block grant funding suitable?**

The VHA agrees with the criteria for block grant funding as suggested by the paper. The absence of economies of scale as one criterion recognises that some particular services will not be financially viable under ABF. For some particular diagnostic categories, such as inpatient maternity care, there are a small number of service providers who skew the input cost weights making it a challenge for everyone else. Applying block funding where more appropriate will enable each of the States and Territories as system designer, to ensure that an equitable distribution of specific health services, such as obstetrics, can be funded throughout the State/Territory that is linked to the needs of the client and the cost of maintaining a viable maternity service within the community.

The VHA proposes that consideration be given to block funding maternity services. Another example is palliative care, where the illness and care trajectory is the same. That is, small interfaces with an acute service with long episodes of care by providers outside of an acute setting.

- **What are your views on how to determine the efficient cost of block funded services (including those provided by small rural and small regional hospitals)?**

The VHA supports the funding of smaller rural health services through a block funding approach as opposed to funding through an activity basis. Flexible funding models facilitate locally designed and flexible models of care in remote and small rural communities, which addresses inequitable access to services that currently exists in many rural communities.

It is imperative that the IHPA's pricing guidelines acknowledge the mix of overhead costs that impact on small rural and regional services. Smaller services do not enjoy the scale advantages of larger services and can therefore be impacted to a proportionately higher degree by 'lead' cost indicators. For example, the cost of implementing contemporary IT systems, of being a

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price taker for ambulance transportation and for utilities in a monopoly market (as is often the case in rural areas) can be significant in proportionate terms for smaller agencies. These factors must be considered in determining the efficient cost of block funded services. The variable approach to funding patient transport services within discreet jurisdictions must be taken into account. The approach in Victoria, where the transferring hospital pays for the transportation is not consistently applied across Australia.

In rural areas, the availability of medical clinicians determines the provision of services and the subsequent cost. To address this, some rural health services routinely provide financial incentives to attract clinicians who in turn can bill the patient or the health service a 'fee for service' (FFS) rate based on the Medicare Benefits Scheme, which is generally greater than 100%. The lack of choice for rural health services restricts their capacity to negotiate 'sessional rates' with clinicians on par to the normal rates for paying metropolitan clinicians. The lack of availability of junior medical staff also contributes to increased costs. This occurs in ophthalmology where rural patients pay a very high FFS to gain access to gain access to this service.

The efficient cost of block funded services must acknowledge the high costs endured by small rural and regional hospitals, but also the high costs for rural constituents to access healthcare services. Australians living in rural areas face deprivation of health services related to access, availability, affordability and appropriateness as an outcome of where they choose to reside.

To determine the efficient cost of block funding, data must be collected to determine costs and respond to growth and changes in population health. Growth funding consistent with regional level planning and population health data, should be applied to enable the innovation to instigate major service change in addressing the needs of their local community.

- **What factors might warrant the mixed use of ABF and block grant funding?**

Throughout the 18 year history of casemix funding in Victoria, recognition has been afforded to the reality that changes in DRG weights or inadequate indexations of funding in relation to costs of service provision can cause significant fiscal pressure. Thus in order to ensure a sustainable health system, a series of discreet grants has been created to cover the various shortcomings of the ABF approach. Some grants are directed towards covering the costs of particular procedures such as prostheses or dialysis, while others are about contributing to the costs of teaching and professional development that is undertaken in hospitals. Block grant funding should be available to complement ABF to encourage the innovation, training and research toenable better integration in patient care.

If cost is measured poorly, it can result in significant cross-subsidies across services. Providers will be more inclined to shift services to where the funding model covers costs than to services where the funding models result in a deficit. These cross-subsidies introduce the type of behaviour that distorts analysis of the pricing efficiency of care. To this end, the VHA assert that there is a deficit in the capacity to systematically understand the true costs associated in delivering patient care, even more so how these costs compare with the outcomes achieved.

Providing a number of different services or a volume of services does not necessarily correspond to better care. The availability of block grant funding encourages the shift away from performing highly reimbursed services towards encouraging services that truly improve the health status of patients. For chronic conditions, block grant funding enables patient circumstances to be best addressed in a coordinated and multidisciplinary way, placing emphasis on early detection, intervention and prevention.

In transitioning to a new funding model, the VHA recognises that this can create significant financial risks. Provisional block grant funding must be available to minimise the risk that organisations might not maintain their service capacity during the transitioning period. In particular, the timing of grants and the 'pricing risk' associated with the first interpretation of the efficient price are important factors that support consideration to the mixed use of ABF and block funding in the early periods of implementation.

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- **For each of mental health and subacute services, what are the most important priorities in service classification and costing to support a transition to ABF?**

The causal factors contributing to increased demand on health services are changing and co-morbidities are increasing. This requires the health system to focus holistically on a person's needs rather than episodic care. Thus, bed growth is required in more than just acute service capacity and appropriate funding mechanisms must be in place to support this.

Increasing the capacity of subacute and community mental health services across Australia is a strategy that could potentially free up more beds within acute facilities and reduce the bed blockages within emergency departments in public hospitals. However, as these services become funded per activity basis, it is imperative that appropriate funding arrangements acknowledge the priorities of providing subacute care in both bed and in community based care models. The emphasis of funding must be to ensure the effective provision of care in the right place at the right time.

Transitioning mental health and subacute services into ABF must allow the mobility of funds to be used outside acute hospitals into programs that are home and/or community based. VHA members have expressed concern regarding the implications of moving these subacute services into ABF as they perceive a risk that such an approach may place a restriction on their capacity to tailor care to the needs of the patient.

- **What factors should be considered in determining which small rural and small regional hospitals are best funded through block grants?**

Part of the Agreement reached by the Australian and State/Territory Governments at the Council of Australian Government's meeting stipulates that *some small rural hospitals will continue to be funded by block grants where ABF alone would not enable these hospitals to maintain community services obligations*[1].

To determine which hospitals should be block-funded, the Department of Health and Ageing commissioned a project to identify the factors that were likely to result in hospitals not being financially viable under ABF[2]. The data analysis conducted in the project provided evidence that 'scale' of annual separations and bed-days were suitable in setting a threshold below which hospitals would be defined as hospitals that should be block funded. While the project identified that the threshold between 1,700 and 2,000 annual acute Casemix-adjusted separations was appropriate, it noted caution of the implications of defining a block funded hospital entirely from acute separations.

The small rural and regional health service model in Victoria in theory allows services to allocate funding to meet local needs. The missing link is that with local needs, come local expectations. The tension in service provision and system design is to find the appropriate mix of services that can be sustained. Sustainability is often impacted by resource availability and economic rationalism.

Rural Australians expect (and are entitled to) equitable access to health services delivered in metropolitan areas. Block grant funding for small rural and regional hospitals in Australia must be flexible to maintain the service mix of acute beds, community-based programs and population health approaches irrespective of its capability to achieve critical mass. Transport of rural patients to more specialised services must also be considered.

The VHA advocates that while scale of acute separations can be useful in classifying block funded hospitals, ensuring equity of access and regional sustainability must also be fundamentally considered.

An additional point for the IHPA to consider is the relative distribution of service provision currently in existence, and the extent to which this reflects a fair and equitable distribution of services in each State/Territory. The VHA observes that jurisdictions outside of Victoria have significantly greater numbers of small rural agencies operating as multi-purpose services (MPS). In this context, the Commonwealth is contributing a greater proportion of the funding to

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these services than is evident in the more common approach to small rural funding within Victoria.

2.4 How should the national efficient price be set?

- **Do you agree with the proposed definition for a hospital operating at the national efficient price?**

The establishment of a National Efficient Price (NEP) will promote the technical efficiency necessary to improve Australia's health system. However, the NEP must avoid replicating the deficiencies evident in the Victorian ABF model in order to achieve an equilibrium that also encourages allocative efficiency.

The way the system will work means that, in theory, it is up to an individual service to determine which National Weighted Activity Unit (NWAU) they will concentrate their services on, and how their overall budget will be spread across the hospital. Similar to the Weighted Inlier Equivalent Separation (WIES) measurements, the NWAU are intended as a guideline for how resources should be allocated, given that they will be based on an aggregate of data from a range of services to determine the average reality of how care is being provided across Australia.

However, this arrangement must not impede the role of the states/territories as 'system designer' and must ensure sufficient flexibility of approach to enable the system designer to give effect to a health system model that meets the unique needs of the community that they serve.

- **Is a single unified measure the right approach at this stage of development of ABF?**

The VHA supports a single unified measure. Though it is unclear whether the Victorian approach of DRG will be adopted in the national framework to influence the calculation of the NWAU, any mechanism implemented to classify patients treated must be sensitive to clinical need. The single unified price must be attached with different weighted values to take into account the complexities that influence public health service delivery. For example different cost weights should be applied to performing magnetic resonance imaging (MRI) in paediatrics compared to MRI in adults as it is clinically necessary to include a general anaesthetic for a paediatric patient.

In 2009, the VHA commissioned Access Economics to produce a Victorian public hospital funding and productivity study[3]. This study found that the escalating costs of enterprise bargaining agreements (EBA), patient transportation, implementation of mandated technology and building maintenance of old stock cannot always be absorbed into a small rural health service's funding margins without access to funding growth or price loading. Funding arrangements must take into account variation in costs and the different service models required according to location. In particular, the funding model must ensure the viability of the service context and in this regard, will need to reflect the input cost nuances associated with locational context.

The single unified measure must also be weighted for the varying costs between each state and territory. For example, all states and territories carry their own EBA and pricing must also consider the wage disparity necessary to attract a vibrant workforce in isolated and lower socio-economic communities

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- **Do you agree that it is too early in the development path of ABF in Australia to adopt best practice pricing as the standard approach?**

The VHA supports a delay in adoption of best practice pricing as the standard approach. Establishing an appropriate fund for each procedure is difficult and should be based on clinical evidence that is measurable over time.

The challenge associated with best practice pricing and 'reward' pricing has been well documented in Victoria where incentive- based approaches were introduced and quickly ceased, and in the UK where such a model was applied to GP incentive funding but failed to achieve the intended outcome.

Casemix funding in Victoria's acute health sector have demonstrated the many variables within public health services and that standardisation does not always deliver the expected result. There are variances in cost and in performance that produce the underlying cost driver for each individual agency. This needs to be understood and examined to ensure effective implementation as too often there is a discrepancy between theory and what actually occurs in practice.

- **Do you support a pricing strategy based around the middle of the cost distribution? If so, should it be mean or median?**

The VHA believes that the pricing strategy should be based on the median of the cost distribution. As discussed previously, ABF of obstetrics in Victoria illustrates how specialist and major providers can skew prices that disadvantage other public hospital services located both within metropolitan and rural regions. By trimming the outliers through the median approach, the VHA agrees that it will provide *better stability and predictability of prices over time* and this will enable public hospital services to more efficiently and effectively plan their service provision.

- **Do you agree that the IHPA should use an output cost index to adjust cost data in setting the NEP?**

The VHA supports the concept of implementing output cost indices to adjust the NEP. This is recognition that the NEP should not be static and should change with new demands and pressure. The NEP should account for fluctuations in costs, particularly those which are caused by advances in technology.

The VHA is concerned however that instead of applying funding indexation for demographic changes, it will allocate additional funding to public hospitals for treating extra patients - a focus on outputs, rather than health outcomes. Such an approach encourages hospitals to operate like a factory for processing patients, rather than a comprehensive health service that aims to treat the whole person. One of the deficits of our current system is that services focus on the outputs for which they are funded. The result is an insular approach to care rather than one that seeks to create a better economy of care irrespective of who holds the funds.

Without adequate review periods, care will always be skewed to services obtaining the greatest weight, rather than the appropriate contemporary care for the patient.

If an output cost index is utilised it will be important to the successful implementation of the NEP that the principles underpinning pricing differentials are consistently applied. That is, if recognition is afforded to factors of population disbursement or to demographic characteristics, that this is consistently applied at each review point and not simply used as a starting point. Any 'lock-step' movement in differential pricing will imply that the initial principle has been lost.

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2.5 Should there be any adjustments to the national efficient price?

In determining the NEP, the IHPA must give regard to the actual costs of service delivery in as wide a range of hospitals as practicable. It also has a function to produce adjustments or loadings to the NEP in respect of hospital characteristics, including type, size and location.

- **Do you agree that patient-related factors should always have pre-eminence?**
- **Do you think there is a case for a loading for the additional costs of treating Aboriginal and Torres Strait Islander people? If so, what should be the evidence for the loading?**

The VHA acknowledges that patient-related factors should have pre-eminence in justifying adjustments to the NEP but struggles with interpreting what this in fact means.

In this model of pre-eminence, it is unclear as to how system improvement is achieved that doesn't directly reflect the individual needs of a patient. Examples include system sophistication to universal application of the 'health promoting hospital' model, or to the cost associated with training those with chronic illnesses how to better self-manage their illness.

The current grants commission approach applied through the fiscal equalisation modelling provides for the State variances in indigenous population. If a loading is to be applied through the NEP then the approach applied by the grants commission must change or a 'double-loading' will result. The States (as system designer and principle funder) have the option to pay for services at a rate that exceeds the efficient price. In this context, each jurisdiction can design a payment system that better reflects the strategic need of the communities being served.

- **Do you think there is a case for a loading for the differences in costs for hospitals in different locations? If so, what should be the evidence used for the loading?**

ABF models will only achieve veracity where adequate scale (activity) is evident. This is problematic for areas where public hospital service provision is complicated by geographical isolation and socioeconomic factors. The VHA supports the application of price loadings that address the high costs associated with the provision of services in rural locations. This includes the cost of travel and accommodation for locum/agency staff to cover shortages, staff leave, continuing professional development training and education, and the higher operational and infrastructure costs due to the higher costs relating to location and more limited services. The lack of access to amenities and the higher costs associated with ambulance transfers must also be considered.

The provision of public hospital services in low socio economic areas can be more costly due to health workforce shortages in these areas and other complicating factors, such as language, cultural differences and low health literacy rates.

The NEP must be flexible in compensating for the additional costs of service delivery or the skewing of pricing by metropolitan and specialty providers.

- **Do you think there is a case for a loading for the potential differences in costs for 'teaching hospitals'? If so, what should be the evidence used for the loading?**

Investment in training and education is imperative and price loadings should be implemented to provide flexibility to cater for the unique circumstances of communities across Australia, particularly those in rural and regional areas. The VHA commends the paper's recognition that most public hospitals now provide clinical education and thus the definition of 'teaching' hospitals is unclear. All public health services are teaching services, or should be. Therefore all health services should receive loading for teaching and research as a proportionate fraction of funding.

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Recruitment and retention of health professionals represent a significant issue for all health services. Instigating price loadings allow for programs that improve support networks and create better systems that attract young people to stay, train and work in healthcare. The further away you move from a metropolitan CBD, the more difficult it is to maintain a suitable workforce. Although universities and clinical schools are helping to address this issue, there should be support for undergraduate and postgraduate clinical placements in public health services. Providing cost loadings to rural and regional health services for clinical placements could also assist medical students to understand the benefits of rural practice and dispel some of the myths that accompany working outside the city.

Victoria has invested heavily in and encouraged research within its public hospital services to continuously improve outcomes for its patients, and promote better clinical practice and service delivery. According to the National Health and Medical Research Council, for every dollar spent in Australian research and development, an average of $2.17 in health benefits is returned[4]. This is a factor that should not be lost in the application of ABF across the country. It should be encouraged and should act as a basis for additional block grant funding or cost loadings for public hospitals.

The VHA supports the funding of teaching, training and research through block grants from July 2012 and on an activity basis in the long-term, particularly as it will assist in addressing the workforce challenges and maintain capacity to meet increased service demand. In doing so, it can learn from Victoria's experience in the allocation process for training and development grants, the amount of which are exceedingly below the actual cost of training and development within health services. A recent analysis by Bendigo Health suggest that the grants only cover 50-60% of the actual costs and are a key contributor to the large losses within the acute sector.

It is fundamental that the training invested synthesizes effort. Rather than replicating; training and research must be cultivated and build on the existing layers that are in place.

- **Do you think that some form of pay for performance (P4P) incentives should be introduced with a national implementation of ABF?**

While P4P incentives can improve care, the approach is not without issue if poorly designed and not subjected to comprehensive ongoing evaluation and adjustment as circumstances require.

In considering P4P initiatives, one must also be mindful of the potential unintended adverse consequences. The VHA commissioned report from Access Economics[5] found the introduction of bonus funding payments to reward health services that meet productivity targets created an "adversarial environment" from the funding agent and encouraged competition between services, rather than collaboration and partnership. According to Scott (2007), financial incentives may "undermine morale and professional altruism and erode holistic patient care"[6].

Tying financial incentives to timeliness of care indicators is of concern. Access targets that do not account for fluctuating demand should not be used to assess the performance of a health service. Clinicians or organisations serving disadvantaged populations might see a decrease in funding as a consequence of being unable to meet performance thresholds. If performance measures overlook patient preferences and are not risk-adjusted, health services may be inclined to avoid very sick or challenging patient conditions or engage in 'gaming strategies' that results in inadequate patient care[7]. Using hospital discharge and length of stay encourages hospitals to work towards the average, to reduce length of stay and average cost of patient and to increase throughput in order to lower operating costs and therefore increase financial gains for the organisation.

The VHA believes access indicators for timeliness of care are needed but should not be the sole indicator to determine an individual health services' performance. Additional quality and outcome indicators should be developed and validated before financial incentives are tied to performance.

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The VHA supports a phased approach that initially focuses on developing and testing robust, standardised and preferably nationally consistent performance measures and measurement systems that are integral to a fair and consistent P4P scheme. These programs should not just reward the public hospital services that reach predefined thresholds, but also reward all that provide high-quality care.

- **If so, do you think the United States approach (and listing of hospital acquired conditions) is a reasonable place to start?**

The VHA supports the ideology in *paying for quality, or not paying for poor quality*. According to the Victorian Hospital-Acquired Infection Surveillance (VICNISS), hospital-acquired infections have been estimated to cost the Australian healthcare system around $40 million per year[8]. However, there is a lack of current, reliable and local data to support this finding. Thus, if adopting the United States' Medicare list of Hospital Acquired Conditions, it would be essential that these incentives are not only clear and well-articulated but are also based on a robust collection of data.

Implementing a similar approach to the United States' Medicare system could facilitate continuous surveillance and regular monitoring, which is necessary for public hospital services to identify changes in hospital acquired conditions. Hospitals that are found to have higher than expected rates of infections, falls etcetera, could be notified and be encouraged to introduce strategies and interventions that reduce these numbers. This would enable hospitals to respond in an appropriate fashion in order to improve the safety and quality of their service provision.

3. Conclusion

Underpinning the National Health Reform Agreement is the principle that *governments agree that an effective health system that meets the health needs of the community requires coordination between hospitals, GP and primary health care and aged care to minimise service duplication and fragmentation*[9]. What has emerged is a multi-layered funding model that potentially encourages further fragmentation, and changes the rules of engagement as opposed to eliminating the blame game between the two levels of government.

Although the principles identified by the IHPA are encouraging and generally supported by the VHA, the VHA is concerned that the guidelines articulated in the paper will not enable attainment of the expressed principles.

The VHA is concerned that the new funding model may miss the opportunity to enable a health system that is based on a 'whole of health' approach, supporting the seamless coordination of care. In particular, the disregard of the community health sector and the involvement of public health services in Victoria in the provision of community health services and aged care, simply reinforces a system that is currently heavily reliant on hospitals and acute care provision and impedes the capacity for the system to evolve beyond this.

Applying several funding mechanisms to fund different elements within the health system will not change the status quo and will reinforce the fragmentation that presently exists. This approach will not enable our complex health system to adequately cope with increasing health service demand from an ageing Australian community.

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

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