

2014-15 Victorian State Budget Submission

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Introduction

The VHA is the peak body representing self-governing, public and not-for-profit healthcare providers across Victoria. Our members include Victorian public hospitals, rural and regional health services, aged care facilities, community health services and Medicare Locals.

Established in 1938, the VHA's role is to:

- Represent the broad interests of our member agencies;
- Be a recognised and influential thought leader on health policy;
- Further the vital role that healthcare providers play in improving the health and wellbeing of the population through:
- Engaging with stakeholders to inform and influence improvements in public policy;
- Supporting our members in the delivery of appropriate, effective and high quality health services;
- Advocate for Victoria's devolved model of healthcare governance; and
- Lead by example through contemporary governance practice.

Context

By 2022, Victoria's population is projected to grow to 6.45 million people. It is estimated that 4.8 million people will live in metropolitan Melbourne and 1.65 million people in regional Victoria. This represents a growth of 27 per cent and 19 per cent respectively¹.

Victoria is facing a range of health and social challenges including population growth, an ageing population and increasing rates of chronic disease. Victoria's strong healthcare system is being placed under stress by these challenges.

There has been significant reform of health service provision in recent years. Nationally, we have seen the progressive implementation of the National Health Reform Agreement (NHRA), the introduction of the National Disability Insurance Scheme (NDIS), significant reforms to aged care and an agreement to transition Victoria's Home and Community Care (HACC) program to commonwealth control from 2015. In Victoria, the State Government is undertaking major reforms to community mental health, alcohol and other drug services, and the service sector. This has affected services operating in Victoria, including the way they are funded and organised, the relationships they have with other organisations, and the processes and technology used. While many of these reforms have had a positive impact, they have resulted in gaps in some service areas, and duplication in others.

The submission

This submission has been developed and informed using our members' experiences and our own research. Engagement with members has provided insight into the most critical issues affecting healthcare organisations and their provision of services. From this, the VHA has developed five priority policy areas (service planning, system design, capital planning, recurrent funding and eHealth) and over 30 recommendations for government action on policy change and system reform.

The future

Reform is essential in order to build a system that encompasses a ‘whole of health’ approach. The VHA strongly supports the reform principles laid out in the Victorian Health Planning Framework 2012-2022 (VHPF) and is keen to see the Victorian Government deliver on those principles. The success of the VHPF will depend on the commitment to collaboration at all levels of our public healthcare system – including parliamentarians, public servants, health service board directors and executives.

Despite the mounting pressures currently challenging the Victorian public healthcare system, funding models in Victoria continue to be relatively static in their proportional distribution. An analysis of the past nine Victorian state budgets shows the apportionment of the total health budget throughout this period has remained static. That is, the share of the total health budget allocated to eight service areas – acute health, ambulance services, mental health, aged care, primary health, small rural health, public health and drug services – has barely changed from 2004-05 to the current 2012-13 budget. This contradicts much of the Victorian Government’s intention, stated in the VHPF, to move the service paradigm, wherever appropriate, from high-cost, bed based solutions to ambulatory and sub-acute settings.

Primary healthcare is the most commonly accessed component of the health system². In the future the VHA sees community health services, which are principally funded by the State Government, as a key platform for implementing population health approaches, and reducing the burden on the acute budget. As the number of people with chronic and complex conditions increases, primary health care providers are developing new service models that provide more specialised and coordinated care³. Indeed, the VHA views the lack of integrated care as one of the key challenges facing our healthcare system and argues that community health services are very well positioned to respond to this challenge.

The Victorian Government has not yet struck an appropriate balance between spending in acute care and spending in other areas of health, such as non-acute care and health promotion. In the VHA’s view, greater emphasis on primary and preventative health approaches is critical for improving the health of Victorians and for ensuring the long term financial sustainability of the health system.

Going into the future, the many strengths of Victoria’s healthcare system must be preserved. For this reason, the VHA supports the separation of commonwealth and state roles and responsibilities under the NHRA. This agreement ensures that states manage the public hospital system, while the Commonwealth has full funding and program responsibility for aged care (except where otherwise agreed) and has lead responsibility for GP and primary health care in co-operation with the State⁴.

1. Source: “Metropolitan Health Plan Technical Paper”, Victorian Department of Health, 2011

2. Source: “Victorian Health Priorities Framework 2012-2022: Metropolitan Plan” Department of Health, 2011, Page 15

3. Ibid.

4. Source: “National Health Reform Agreement” Council of Australian Governments, August 2011, Page 4

VHA Priority Policy Areas

The VHA has identified five policy priority areas for government action over the short, medium and long term:

- **Short term** – actions that should be taken within 6 months
- **Medium term** – actions that should be taken within 12 to 18 months
- **Long term** – actions that may not be completed within the next 18 months

Further context for these recommendations is provided in the body of this submission.

Service Planning

Under Victoria's devolved governance model, individual healthcare agencies currently plan services for their local populations. However, the VHA believes this approach should be complemented by an increased emphasis on regional and sub-regional planning. This would require the development of strong partnerships between the Department of Health and regional agencies to plan their services for broader populations.

Short term

The Victorian Government should expedite the development of the Primary Health Plan referred to in the VHPF 2012-2022 to further clarify the roles and responsibilities of agencies in relation to primary care. This Plan should be developed in close consultation with the sector.

Medium term

The Victorian Government should provide increased guidance about service provision through the development of planning approaches and tools described in the VHPF 2012-2022².

Long term

Long term service planning undertaken by the Victorian Government should:

- be driven by partnerships between the Victorian Government and health services
- have a clear focus on provision of services by the most appropriate agency in the most appropriate setting – with reference to the priorities of the VHPF 2012-2022, and to the services that exist across geographical boundaries
- explore ways to better connect health service planning with other planning processes across government³.

1. See paragraph 1.1 in main document
2. See paragraph 1.1 in main document
3. See paragraph 1.2 in main document

System Design

A fundamental objective of any healthcare system must be delivery of the right care in the right place at the right time, across the continuum of care. Population health approaches to planning (PHAP) are a key driver in achieving this objective by reducing demand for acute health services, delivering services in community settings wherever appropriate, and improving health outcomes for the broader population.

Short term

The Victorian Government should provide funding to community health services and small rural health services to establish and expand existing hospital admission prevention programs⁴.

The Victorian Government fully implement the recommendations of the Expert Panel on Waiting List Management⁵.

Medium term

The Victorian Government should further invest in integrated health solutions, including prevention and population health approaches. This would require a co-ordinated approach to funding and implementation, informed by an agreed PHAP framework and with funding for health services to undertake research and evaluations to improve the evidence base around PHAP⁶.

Long term

The Victorian Government should commit to the development of funding models focused on broader outcomes as a means of driving health service integration across the continuum of care. This could be trialled for specific disease conditions and procedures in the short term, and rolled out more broadly in the long term⁷.

Capital Planning

The current approach to capital funding is problematic, and impacts service delivery and the underlying financial position of organisations. This issue has been highlighted previously by the VHA and in several reports prepared by the Victorian Auditor General.

Short term

The Victorian Government should release the Health Capital and Resources Plan 2012-2022⁸.

Medium term

The Victorian Government should build on existing initiatives aimed at reducing the impact of depreciation charges on health services⁹.

The Victorian Government provide capital investment for urgent infrastructure upgrades to community health services and hospitals in line with the VHPF 2012-2022, and the health needs of Victoria's growing populations¹⁰.

Long term

The Victorian Government should consider a phased transition to capital funding allocation on the basis of population need, as opposed to strategically through competitive grants, allowing services to better plan for capital replacement¹¹.

4. See paragraph 2.1 in main document

5. See paragraph 2.4 in main document

6. See paragraph 2.6 in main document

7. See paragraph 2.1 in main document

8. See paragraph 4.1 in main document

9. See paragraph 4.4 in main document

10. See paragraphs 4.2 and 4.3 in main document

11. See paragraph 4.5 in main document

Recurrent Funding

Adequate recurrent funding is required to meet the increasingly complex care needs of a growing and ageing population. The VHA has identified several areas where funding is insufficient to cover the costs of service delivery or meet the changing needs of the community.

Short term

The Victorian Government should cease applying productivity savings to public health services unless the savings are:

- underpinned by a formal assessment of the potential for efficiencies to be found
- coupled with investment in infrastructure, equipment and ICT, enabling health services to achieve savings targets
- retained in the health portfolio, and used to test, pilot or implement non bed-based and primary care approaches outlined in the VHPF 2012-2022¹².

Medium term

The Victorian Government should ensure that recurrent funding is:

- indexed at a rate which fully covers increases in the health CPI
- adequate to cover cost increases incurred as a result of enterprise bargaining agreements or legislated increases in superannuation contributions
- adjusted to reflect other unavoidable costs, such as increases in power prices¹³.

Long term

The Victorian Government should take into account changes in the size and composition of local populations when setting recurrent funding levels¹⁴.

eHealth

Victoria has not realised the significant benefits to healthcare provision that can be derived from improvements in technology. Several recent expert reports provide the Victorian Government with a strong base from which to make improvements in this area.

Short term

The Victorian Government should draft a statewide ICT plan which:

- includes the implementation priorities and development of the EMR platform, and identifies the appropriate level of funding required
- addresses the implementation of the PCEHR, including sufficient investment to allow health services to contribute to the development and uptake of the PCEHR
- establishes an ICT capital investment plan for Victoria¹⁵.

Medium term

The Victorian Government should:

- allocate Victoria's ICT investment, including priorities for capital expenditure, according to need and guided by the statewide health ICT plan
- ensure that health services are adequately resourced to implement ICT projects
- ensure expertise is available to plan and implement future clinical ICT development projects, particularly in clinical engagement and leadership, socio-technical systems analysis, health informatics and benefits realisation¹⁶.

Long term

The Victorian Government should detail long term actions and priorities regarding eHealth in the state-wide ICT plan.

12. See paragraph 5.1 in main document

13. See paragraph 5.2 in main document

14. See paragraph 5.3 in main document

15. See paragraph 6.1 in main document

16. See paragraph 6.2 in main document

Summary of Recommendations

Issue	Recommendation
SERVICE PLANNING	
1.1	<p>There is a lack of clarity around the services that different sectors are best placed to deliver, resulting in duplication and inefficiencies.</p> <ol style="list-style-type: none"> 1. The Victorian Government should expedite the development of the Primary Health Plan referred to in the Victorian Health Priorities Framework 2012–2022. 2. Long term service planning undertaken by the Victorian Government should: <ul style="list-style-type: none"> • be driven by partnerships between the Victorian Government and health services • have a clear focus on the provision of services by the most appropriate agency and in the most appropriate setting – with reference to the priorities of the VHPF and the services that exist across geographical boundaries • explore ways to better connect health service planning with other planning processes across government.
1.2	<p>Planning for delivery of services is problematic at a broader regional level and is resulting in services being delivered sub-optimally.</p> <ol style="list-style-type: none"> 3. The Victorian Government should provide increased guidance about service provision through the development of the approaches and tools for planning described in the Victorian Health Priorities Framework 2012-2022.
SYSTEM DESIGN	
2.1	<p>Current resourcing and processes are failing to drive service coordination in a number of areas, such as chronic disease management, rural mental health services and community health services.</p> <ol style="list-style-type: none"> 4. The Victorian Government should commit to the development of funding models focused on broader outcomes as a means of driving integration of health services across the continuum of care. This could be trialled for specific disease conditions and procedures in the short term and rolled out more broadly in the longer term. 5. The Victorian Government should provide funding to community health services to establish or build upon existing hospital admission prevention programs.

Issue	Recommendation
SYSTEM DESIGN	
2.2	<p>Insufficient attention is currently placed on early childhood interventions.</p> <p>6. The Victorian Government should increase the resources directed toward early intervention programs, particularly in areas experiencing excessive waiting times.</p>
2.3	<p>The current approach and mechanisms being used to encourage the integration of advance care planning into routine service delivery are not effective.</p> <p>7. The Victorian Government should provide sufficient funding to encourage the integration of advance care planning into routine health service delivery. This approach must be supported by engagement with the Commonwealth to increase its funding to enable advance care planning discussions to occur as part of commonwealth-funded health provision (e.g. general practice and aged care).</p>
2.4	<p>The scope of reported elective surgery procedures is too narrow and is distorting the reporting of demand and waiting times for elective surgery.</p> <p>8. The Victorian Government should fully implement the recommendations of the Expert Panel on Waiting List Management.</p>
2.5	<p>There are insufficient neonatal intensive care unit (NICU) cots in Victoria.</p> <p>9. The Victorian Government should provide funding to increase the number of neonatal intensive care unit cots, in line with population and preterm neonatal survival rates.</p>
2.6	<p>There is insufficient emphasis on, and funding for, prevention and population health approaches as a means of reducing demand for acute services.</p> <p>10. The Victorian Government should further invest in integrated health solutions, including prevention and population health initiatives, funded and implemented in such a way that a co-ordinated approach is taken across the health sector. Such an approach should be informed by an agreed population health approaches to planning framework and be complimented with funding for health services to undertake evaluations and research to improve the evidence base around population health approaches.</p>
2.7	<p>Refugees arriving in Victoria are not being met with a coordinated response from all relevant commonwealth and state agencies, resulting in pressure on health service budgets.</p> <p>11. The Victorian Government should fund agencies responsible for providing care for refugees at a level commensurate with the demand for their services, in order to reduce the financial burden on acute services. This approach must be complemented with improved coordination with commonwealth agencies to ensure better post-settlement case management processes.</p>

Issue	Recommendation
GOVERNANCE	
3.1 There is a need for ongoing training for boards of health services.	12. The Victorian Government should provide ongoing support to ensure that board members undertake appropriate training which is relevant to their role.
3.2 The Victorian Government does not permit the remuneration of board members of public hospitals (including multipurpose services and early parenting centres).	13. The Victorian Government permits public hospitals (including multipurpose services and early parenting centres) to choose whether to remunerate their board members.
CAPITAL PLANNING	
4.1 There is a lack of transparency around decisions to allocate capital funding through the competitive grants process.	14. The Victorian Government should release the Health Capital and Resources Plan 2012-2022. 15. The Victorian Government should consolidate the capital grants framework into a single stream of funding for investment in infrastructure, equipment and ICT that is guided by the capital plan.
4.2 There is insufficient capital investment available for community health services to cover asset renewal and replacement, and future infrastructure needs.	16. The Victorian Government should provide capital investment for urgent infrastructure upgrades in the community health sector to reflect the goals of the Victorian Health Priorities Framework 2012-2022.
4.3 The amount of capital funding allocated to hospitals does not cover asset renewal and replacement, or future infrastructure needs.	17. The Victorian Government should include the full lifecycle cost of assets in the forward capital plan including the cost of capital renewal and half-life facility upgrade.
4.4 Victorian Department of Health funding models for hospitals and community health services do not take into account non-cash expenditure such as capital depreciation.	18. The Victorian Government should build on existing initiatives aimed at reducing the impact on health services of depreciation charges.
4.5 The protracted process for allocating capital funding undermines the ability of health services to respond to changing levels of demand.	19. In the medium to long term, the Victorian Government should consider a phased transition to a system where capital funding is allocated to health services progressively on the basis of population need, as opposed to strategically through competitive grants processes, allowing services to better plan for capital replacement.

Issue	Recommendation
RECURRENT FUNDING	
5.1	<p>The Victorian Government continues to seek productivity savings in public healthcare services without sufficient investment in infrastructure, equipment and ICT to enable increased productivity.</p> <p>20. The Victorian Government should cease to apply productivity savings to public healthcare services unless the savings are:</p> <ul style="list-style-type: none"> • underpinned by a formal assessment of the potential for efficiencies to be found; • coupled with investment in infrastructure, equipment and ICT, enabling health services to achieve savings targets; • retained in the health portfolio, and used to test, pilot or implement non bed-based and primary care approaches outlined in the Victorian Health Priorities Framework 2012-2022.
5.2	<p>Recurrent funding for community health services and other health services is not keeping pace with the wage index, inflation and increased costs associated with implementing enterprise bargaining agreements.</p> <p>21. The Victorian Government should ensure that recurrent funding is:</p> <ul style="list-style-type: none"> • indexed at a rate which fully covers increases in the health CPI; • adequate to cover cost increases incurred as a result of enterprise bargaining agreements or legislated increases in superannuation contributions; and • adjusted to reflect other unavoidable costs such as increases in power prices.
5.3	<p>Recurrent funding is not responsive to changes in demand due to population and other demographic changes.</p> <p>22. The Victorian Government should take into account changes in the size and composition of local populations when setting recurrent funding levels in order to address population health needs.</p>
5.4	<p>WIES cost weights and block funding only partially cover the increased costs associated with providing services in rural and remote areas.</p> <p>23. The Victorian Government should ensure that the higher cost for providing health services in rural areas is fully recognised in the WIES cost weights.</p>
5.5	<p>Recurrent funding arrangements are affecting the ability of service providers to respond to a number of workforce pressures.</p> <p>24. The Victorian Government should develop and fund a long-term retention strategy for health practitioners in rural areas which:</p> <ul style="list-style-type: none"> • addresses the need for certainty in program funding to enable recruitment and retention of staff; • increases funding for rural scholarships and other education opportunities; and • increases support for up-skilling and initiatives that expand the scope of practice for staff.

Issue	Recommendation
RECURRENT FUNDING	
5.6	<p>The Competitive Elective Surgery Initiative has increased the proportion of complex patients receiving elective surgery in the public sector – this has not been reflected in recurrent funding.</p> <p>25. Public hospitals should receive additional WIES funding for elective surgery procedures to reflect the increased proportion of complex elective surgery patients being treated due to the Competitive Elective Surgery Initiative.</p>
5.7	<p>The cost of ambulance services for rural health services is not adequately covered by existing recurrent funding.</p> <p>26. The Victorian Government should:</p> <ul style="list-style-type: none"> • implement a direct funding relationship between the Victorian Department of Health and Ambulance Victoria for all urgent, maternity and paediatric (including NETS) inter-hospital transfers to replace the current approach, where health service agencies are billed for the transfer; and • increase investment levels in non-emergency patient transport in rural areas and consider contracting private providers to deliver these services.
5.8	<p>Recurrent funding for Urgent Care Services is inadequate, resulting in resources being cross-subsidised from other service areas.</p> <p>27. Recurrent funding of Urgent Care Services should be increased to adequately cater for workforce development costs and to more closely reflect the cost of services delivery.</p>
5.9	<p>Unit pricing for state funded programs operated by community health services often does not meet the cost of providing the service. There is also a lack of transparency around how the unit price for such programs is calculated.</p> <p>28. The Victorian Government should publish the formula used to calculate unit prices for community health services, allowing services to assess how the cost of delivering their services aligns with departmental estimates. If the estimates do not align, the Government should undertake a fully transparent review of the funding process for all services funded via a unit price. The aim of this review would be to ensure that unit prices reflect the true cost of providing services.</p>

Issue	Recommendation
eHEALTH	
6.1	<p>Victoria is lacking direction on the adoption of electronic medical records and the uptake of the Personally Controlled Electronic Health Record.</p> <p>29. The Victorian Government should draft a state-wide ICT plan which:</p> <ul style="list-style-type: none"> • includes implementation priorities, the development of the EMR platform, and identifies the appropriate level of funding required; • deals with matters associated with the implementation of the PCEHR including the investment required to allow health services to contribute to the development and uptake of the PCEHR; and • establishes an ICT capital investment plan for Victoria.
6.2	<p>The ICT infrastructure of most health services is inadequate.</p> <p>30. In accordance with the Ministerial Review of Victorian Health Sector Information and Communication Technology, and the Victorian Auditor General’s report Clinical ICT Systems in the Victorian Public Health Sector, the Victorian Government should:</p> <ul style="list-style-type: none"> • Allocate Victoria’s health sector ICT investment, including priorities for capital expenditure, according to need and guided by the state-wide health ICT plan. • Health services should be resourced adequately to implement ICT projects. • ensure expertise is available to plan and implement future clinical ICT development and change projects, particularly in the areas of clinical engagement and leadership, socio-technical systems analysis, health informatics and benefits realisation.
6.3	<p>There is poor interoperability between the ICT systems currently operating in the Victorian health sector.</p> <p>31. In accordance with the Ministerial Review of Victorian Health Sector Information and Communication Technology, the Victorian Government should:</p> <ul style="list-style-type: none"> • continue to develop and maintain an interoperability maturity model that is relevant to Victorian continuity-of-care and best practice ICT principles • engage with and influence the design of standards associated with national infrastructure supporting interoperability.
6.4	<p>There is insufficient support for rural health services across Victoria to implement or expand teleconferencing and videoconferencing initiatives.</p> <p>32. The Victorian Government should increase funding for telehealth and videoconferencing initiatives, particularly in rural areas and beyond the projects funded.</p>

**2014-15
State Budget Submission**

1. Service Planning

Effective service planning sits at the heart of an effective health system. The current approach to health service planning in Victoria assumes that health providers will service a given population, and will modify service provision according to local need. These arrangements have the potential to facilitate flexibility and responsiveness to local needs, and are only possible due to the strong, devolved governance model in place in Victoria.

Whilst the current system has significant strengths, it also has potential to result in:

- duplication of services;
- inefficiencies;
- service gaps; and,
- unintended behaviours within the broader health system.

In the VHA's view, service planning should be undertaken collaboratively and in response to clearly identified population health needs, utilising the resources and capacity of a range of providers both within a geographic area, in the case of specialist health services, beyond.

The VHA has published a comprehensive framework for applying a population health approach to planning. This involves integrated and collaborative, cross-sectoral planning that aims to improve the health and wellbeing of whole populations, reduce inequities among and between specific population groups, and addresses the needs of the most disadvantaged¹. It requires community, inter-sectoral and whole-of-government engagement, collaboration and action to address the broad range of determinants that shape health and wellbeing.

At its core, this approach involves the targeted application of a range of health, social and government resources to address health needs and inequities. It requires a broad understanding of the sector's capacity to provide care, and an agreement across all relevant providers about the division of work and how this applies to relevant objectives.

A population health approach should be applied when identifying health needs in Victoria, and in deciding how to apply the health sector's finite resources in response to these needs.

The following key issues have been identified in relation to service planning.

1.1. There is a lack of clarity around the services that different sectors are best placed to deliver, resulting in duplication and inefficiencies.

The VHA has identified that there is a lack of clarity around the services that different parts of the health sector are best placed to provide. The Victorian Health Priorities Framework 2012-22 (VHPF) describes the Government's intention to progressively build the capacity of community-based care, and reduce the reliance on acute settings. The VHA applauds this aim as it is fundamental, not only in the interests of slowing the unsustainable growth of healthcare costs, but also responding to population health needs.

However, work must be carried out to ascertain how this will be achieved. For example, the VHPF references an overarching primary care plan dealing with the role of the state, community health services, Primary Care Partnerships, Medicare Locals, hospitals, social services and local government. The absence of such a plan makes it increasingly challenging for providers to develop effective, cross-sectoral approaches and jeopardises the development of partnerships vital to the delivery of improved health outcomes.

1. Source: "Population Health Approaches to Planning", Victorian Healthcare Association, July 2012

Another area of concern to VHA members is the lack of clarity regarding responsibility for early childhood intervention. Early childhood intervention is a fundamental aspect of the health system and should be included in service planning.

Victoria has a history of building collaborative relationships between public service agencies and non-government organisations. However, more work must be done to ensure that such partnerships are a central focus of service planning. Such partnerships must appreciate the constraints under which all partners operate, and should be founded on the basis of mutual respect, trust, authentic consultation, genuine negotiation and a shared recognition of common purpose². A recent report on social service sector reform in Victoria found the current system continues to deliver services in a fragmented manner³. For example, early intervention services are provided by local government, schools and community health but gaps, duplication and a lack of coordination exist.

Recommendation:

1. The Victorian Government should expedite the development of the Primary Health Plan referred to in the Victorian Health Priorities Framework 2012–2022.
2. Long term service planning undertaken by the Victorian Government should:
 - be driven by partnerships between the Victorian Government and health services
 - have a clear focus on the provision of services by the most appropriate agency and in the most appropriate setting – with reference to the priorities of the VHPF and the services that exist across geographical boundaries; and
 - explore ways to better connect health service planning with other planning processes across government.

1.2. Planning for delivery of services is problematic at a broader regional level and is resulting in services being delivered sub-optimally.

The current approach to health service planning does not necessarily result in the optimal and efficient use of acute specialised services across health services' boundaries, due to its reliance on local or bi-lateral partnerships. This is a consequence of the resources necessary for health services to individually “transact” for services, as well as entrenched behaviours, knowledge and referral patterns that inform how services are used. For example, specialist referrals in regional areas can see patients referred to specialists located in metropolitan areas, despite the presence of appropriate services locally. Such patterns may negatively impact access to specialist services in rural and regional Victoria into the future.

The VHA also draws the Government's attention to the ongoing issue of avoidable presentations to hospital emergency departments. The availability and accessibility of primary and community health services can have a significant impact on the utilisation of surrounding hospitals⁴. People who cannot access appropriate primary care options will often choose to use hospitals to meet their immediate (although perhaps not urgent and critical) health care needs⁵. Also contributing to this issue is the inconsistent availability of after-hours provision in non-acute settings, unrealistic community expectations, and a lack of growth funding in other areas which are well placed to help reduce hospital admissions, such as community health. In the VHA's view, improved service planning processes would deliver significant improvements in the management of these issues.

Recommendation:

3. The Victorian Government should provide increased guidance about service provision through the development of the approaches and tools for planning described in the Victorian Health Priorities Framework 2012-2022.

2. Source: “Service Sector Reform: A roadmap for community and human services reform”, Shergold P, July 2013, Page 17

3. Ibid.

4. Source: “Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan” Department of Health, 2011, Page 24

5. Ibid.

2. System Design

Delivery of the right care, in the right place and at the right time should be a central tenet of healthcare provision. System design must take account of population health approaches aimed at reducing demand for more acute health services, and improving health outcomes for the broader population.

The VHA has identified service gaps and inequities (particularly for rural populations and specific population groups such as migrants and older people), duplication and a lack of co-ordination, which continue to undermine the ability of the health system to achieve better population health outcomes.

2.1. Current funding arrangements are failing to drive service coordination.

The VHA is concerned about the lack of coordination and integrated pathways in areas such as chronic disease management, mental health services and in community health services. Implementing clinical pathways reduces the variability in clinical practice, improves quality of care, optimises the use of resources and improves patient outcomes. Funding from multiple state and commonwealth streams and different approaches to funding have contributed to a fragmented system which lacks common objectives and does not incentivise coordination amongst service providers across the continuum of care.

In some instances, current funding streams are also driving unintended behaviours resulting in competition and duplication between organisations. This can result in the existence of duplicate services, service gaps, and unintentional competition between public providers. It can also impact the sustainability of some services while at the same time adding cost to the overall service system. Addressing this issue requires establishing broader agreement across funders regarding the outcomes, objectives and scope of services delivered.

One option to increase co-ordination involves greater investment in care coordination within the community health system, which is currently under resourced. Care-coordination enables complex

and disadvantaged clients to navigate the health system to achieve improved health outcomes. As many clients of community health services live with social disadvantage and experience multiple co-morbidities, a higher degree of coordination and planning is often required. Without this support, which is not funded under current arrangements, individuals are at far greater risk of entering, or re-entering the acute system unnecessarily.

The VHA advocates for much tighter relationships – enabled by appropriate funding arrangements – between community health services, primary health services and hospitals as a way of improving service coordination. In this regard, the VHA wishes to express support for the HealthPathways initiative, a sector led project aimed at overcoming such system design issues. HealthPathways assists clinicians in navigating the patient through our complex primary, community and acute health care system. The initiative provides guidance to general practice to drive consistency in referrals and ensure that appropriate non-acute services (such as allied health) play their proper role in the care continuum.

Recommendation:

4. The Victorian Government should commit to the development of funding models focused on broader outcomes as a means of driving integration of health services across the continuum of care. This could be trialled for specific disease conditions and procedures in the short term and rolled out more broadly in the longer term.
5. The Victorian Government should provide funding to community health services to establish or build upon existing hospital admission prevention programs.

2.2. Insufficient attention is currently being placed on early childhood intervention.

The healthy development of children depends on access to a range of well organised and coordinated programs that promote healthy pregnancies, births, infants and young children. Through such interventions (which can be facility, home, or community based), health services can mitigate the factors that place children at risk of poor health outcomes.

Currently, paediatric allied health waiting lists are prohibitively long, leaving too many children without crucial early interventions. A failure to apply early interventions leaves children at risk of future developmental delays and may also place increased costs on health services who respond to conditions at later developmental stages.

Recommendation:

6. The Victorian Government should increase the resources directed toward early intervention programs, particularly in areas experiencing excessive waiting times.

2.3. The current approach and mechanisms being used to encourage the integration of advance care planning into routine service delivery are not effective.

Advance care planning (ACP) describes the process of patients thinking about and communicating their values and preferences for end of life care due to future incapacity. ACP may lead to, but should not be reduced to, the development of an Advance Care Directive (ACD) and/or the appointment of a substitute decision maker. The VHA is aware the Victorian Department of Health is in the process of developing an Advanced Care Planning Implementation Strategy to guide the implementation of ACP within Victorian health services, which is due to be finalised in 2013.

Although ACP has gained momentum over the last decade, it is still infrequently undertaken in Australia. Studies show that only 0.2 per cent of Australians and 5 per cent of patients in aged care facilities have an advance care plan⁶.

The lack of awareness, national inconsistency and systematic change means that individual treatment preferences and end of life care wishes are at risk of being overlooked.

ACP can help governing bodies to manage healthcare demand in the most effective and humane way. For health services, ACP manifests a focus on holistic care and the complete patient experience. It also empowers patients by giving them control over how their health is managed. ACP also presents an opportunity for health services to reduce costs by avoiding futile (of no benefit at all) or inappropriate (harms outweigh potential benefits) interventions, which many patients at the end of life undergo⁷.

Despite the fact that most Australians have not made an ACD, this does not mean they do not want the right to make one. Demand for more and better ACP will only occur if there is a broad societal and cultural change coupled with appropriate funding measures. This can happen through multi-level reform, especially at the clinical level. Seamless integration of different points of care is necessary to ensure that ACDs are communicated effectively and accurately. A mixture of legislative reform, service reform, stakeholder engagement and community awareness is required in order to increase the number of advanced care plans in Victoria. It is also critical that health services are provided with financial support to cover the staffing costs associate with advance care planning discussions.

Recommendation:

7. The Victorian Government should provide sufficient funding to encourage the integration of advance care planning into routine health service delivery. This approach must be supported by engagement with the Commonwealth to increase its funding to enable advance care planning discussions to occur as part of Commonwealth funded health provision (e.g. general practice and aged care).

6. Source: Australian Health and Hospitals Association. The Health Advocate. Issue 3: April 2010

7. Source: "Difficult but necessary conversations — the case for advance care planning" Scott et al., August 2013

2.4. The scope of reported elective surgery procedures is too narrow and is distorting the reporting of demand and waiting times for elective surgery.

Elective surgery waiting lists currently include surgical procedures in accordance with the therapeutic procedures section of the Medicare Benefits Schedule. Due to waiting lists being formulated with reference to the MBS procedures section, several important indicators of demand for elective surgery are not captured:

- procedures frequently performed by non-surgical clinicians such as endoscopies and dental procedures are excluded from waiting lists;
- procedures where the waiting time cannot be controlled (such as caesarean sections and organ transplants) are excluded from waiting lists; and,
- patients only appear on the waiting list following an appointment with a specialist – meaning that the waiting time from the GP to seeing the specialist is not captured.

In 2012, a Victorian Government appointed expert panel on waiting list management⁸ recommended that waiting lists be expanded to include procedures that are not currently reported and to give better visibility of the time from initial GP/Emergency Room consultation to specialist consultation. These factors will provide greater visibility of the waiting times and to more accurately reflect the demand for hospital services.

The Victorian Government has commenced reporting on the number of patients treated in specialist outpatient clinics on the Victorian Health Services Performance website, however, this does not show the wait times for first surgical appointment by hospital and specialty. A report with this information was released on the Victorian Health Services Performance website for selected hospitals in September 2012 however, no further reports are available.

Recommendation:

8. The Victorian Government should fully implement the recommendations of the Expert Panel on Waiting List Management.

2.5. There are insufficient neonatal intensive care unit (NICU) cots in Victoria

Level III NICU cots are provided in four tertiary hospitals in Victoria. The VHA is aware that in the previous state budget, the government allocated \$2.2m for a further five cots, and that since coming to government has increased the number of cots by eleven. The VHA also supports the Minister for Health's recent announcements regarding the new Monash Children's Hospital as an important step for improving system capacity in the longer term.

Hospitals are reporting that in the last six months finding cots for newborn infants in Victoria has become increasingly difficult. It has also been reported that all four hospitals have been working beyond capacity on several occasions. The VHA is aware of instances where the babies in a multiple birth are cared for in different hospitals, and are separated from each other and their parents for lengthy periods. The VHA envisages that demand for cots will continue to increase as the Victorian population grows and as a higher proportion of preterm babies survive. However, in addition to the commitment to expand system capacity by 2017 through the construction of the Monash Children's Hospital, the VHA sees scope for shorter term action.

Recommendation:

9. The Victorian Government should provide funding to increase the number of neonatal intensive care unit cots, in line with population and preterm neonatal survival rates.

2.6. There is insufficient emphasis on, and funding for prevention and population health approaches as a means of reducing demand for acute services.

Population health planning aims to improve the health and wellbeing of whole populations and to reduce inequities within and between specific population groups. Best practice population health planning is grounded in effective and meaningful community, inter-sectoral and whole-of government engagement. Population health approaches to planning involve a targeted use of local resources

8. Source: Victorian Government appointed Expert Panel. "Expert Panel on Waiting List Management". August 2012

across a range of agencies and organisations to apply preventive and curative health care to populations in need. The VHA supports the prevention and population health approach articulated in Healthy Victoria Together, however emphasises that there is insufficient funding and a lack of coordination and direction around implementation to deliver the full benefit of this approach.

There is also a need for additional effort in developing the evidence base for population health approaches. Evaluation in primary health care is a major challenge given the broad scope of interventions and interrelated action⁹. While there is a significant body of evidence pointing to how effective primary health care systems can reduce overall health system costs and health inequity, evidence regarding performance measurement and evaluation to drive service quality and practice change is limited. The translation of local research into meaningful evidence for use by other services facing similar issues would be beneficial to extend the reach of proven effective models¹⁰. Development of the research capacity of funded services requires leadership and investment from government.

Recommendation:

10. The Victorian Government should further invest in integrated health solutions, including prevention and population health initiatives, funded and implemented in such a way that a co-ordinated approach is taken across the health sector. Such an approach should be informed by an agreed population health approaches to planning framework¹¹ and must be complimented with funding for health services to undertake evaluations and research to improve the evidence base around population health approaches.

2.7. Refugees arriving in Victoria are not being met with a coordinated response from all relevant commonwealth and state agencies, resulting in pressure on health service budgets.

The VHA is concerned that many refugees and new arrivals being settled in Victoria are not receiving adequate health and social care. The VHA recognises the significant expenditure¹² that the Government has committed to the area of refugee health. However, the VHA is aware that despite this commitment, there remains poor handover and communication between the Commonwealth Department of Immigration and Citizenship and the Victorian Department of Health. As a result, new arrivals often do not receive timely treatment and may subsequently present at health services with serious health conditions.

In addition, many rural Victorian communities have received increasing numbers of resettled refugee families without a commensurate increase in funding. One area where a particular gap in funding has been identified is for refugee health nurse positions. The impact on rural health services is exacerbated due to the multiple and complex needs of many refugees and the lack of health and social service infrastructure.

Recommendation:

11. The Victorian Government should fund agencies responsible for providing care for refugees at a level that is commensurate with the demand for their services, in order to reduce the financial burden on acute services. This approach must be complemented with improved coordination with commonwealth agencies to ensure better post-settlement case management processes.

9. Source: "Primary health care in Victoria – A discussion paper" Victorian Department of Health, April 2009, Page 6

10. Source: "Primary health care in Victoria – A discussion paper" Victorian Department of Health, April 2009, Page 6

11. Source: "Population Health Approaches to Planning", Victorian Healthcare Association, July 2012

12. The State Government's 2013-14 Budget committed an additional \$22.2 million over four years in the area of refugee and asylum seeker health.

3. Governance

Health service boards are responsible and accountable for providing high-quality health services and must ensure that health services are governed and managed effectively, efficiently and economically. They do so by ensuring the health service adheres to a practice of high clinical standards, relevant legislation and regulatory requirements, and through the identification of risks.

3.1. There is a need for ongoing training for boards of health services.

Directors are responsible for undertaking ongoing training and development pertinent to the role. The Victorian Government has supported individual director training for a number of years; however this training needs to be expanded and combined with research that will support boards to successfully carry out their role. The VHA feels Victorian health boards should possess adequate skills and knowledge in the following areas:

- Health, business, legal and finance expertise;
- Expertise in governance and service quality (clinical governance);
- Strategic thinking;
- Oversight of strategic, operational and CEO performance;
- Knowledge of the current health context;
- Knowledge of local health and social needs; and
- Knowledge of local health, social and community services.

Recommendation:

12. The Victorian Government should provide ongoing support to ensure that board members undertake appropriate training which is relevant to their role.

3.2. The Government does not permit the remuneration of board members of public hospitals (including multipurpose services and early parenting centres).

All boards of Victoria's hospitals and health services have the responsibility of overseeing the health service on behalf of the Minister and in accordance with government policy and legal obligations¹³. Further, the Victorian Health Services Governance Handbook states the board chair leads the health service and manages key relationships, and that the chief executive officer is appointed by and reports to the board.

In carrying out these responsibilities, the board needs to have the appropriate mix of skills and experience, and the role needs to be carried out professionally.

The VHA notes that currently, members of boards of public hospitals (as defined by Section 33 of the Victorian Health Services Act 1988), and multipurpose services (as defined under Section 115E of the Act) cannot be remunerated for carrying out their responsibilities as a board member¹⁴.

These board members exercise similar governance roles to remunerated board members of metropolitan and regional health services (as defined under the Victorian Health Services Act 1988). Further, these board members need to manage a similar level of organisational complexity, if not scale, as board members who are remunerated.

13. Source: "The Victorian health services governance handbook" Victorian Department of Health, February 2013, Page 8

14. Source: "Appointments to boards of public hospitals, multi-purpose services and early parenting centres – Information for applicants" Victorian Department of Health, November 2013, Page 6

It is the VHA's view that by not allowing public hospitals to remunerate their board members, Victoria is sending a message to the community that is counter to the significant role and responsibility board members of these organisations play.

Recommendation:

13. The Victorian Government permits public hospitals (including multipurpose services and early parenting centres) to choose whether to remunerate their board members.

4. Capital Funding

For hospitals and community health services to maintain an adequate level of service, assets need to be maintained and replaced when necessary. Capital funding is also required to support growth and enable services to be delivered more effectively and efficiently through the use of new technology. Poor infrastructure is an impediment to health service efficiency, and in the long-term, adds to operational costs.

The VHA looks forward to the release of the State Government's Health Capital and Resources Plan 2012-2022 (the Plan) which will set out specific health system capital expenditure priorities until 2022. Critically, the Plan will include an asset development and management framework that establishes principles and criteria for prioritising investment¹⁵.

The VHA is aware of the substantial capital expenditure provided through the Victorian State Capital Program, which in 2012-13 totalled \$635 million¹⁶. The VHA also welcomes the 2013-14 Securing Our Health System initiative, which provides funding for replacement of prioritised highest critical risk capital medical equipment/plant items and essential engineering infrastructure in Victoria. However, a number of issues still exist with Victoria's approach to capital funding.

4.1. There is a lack of transparency around decisions to allocate capital funding through the competitive grants process.

Health service boards are limited in their ability to access capital and are highly reliant on grant funding for infrastructure investment and upgrades. The Victorian Government currently allocates capital grants for asset renewal and replacement strategically across the health sector.

However, the VHA has observed that under this approach there is little transparency in process and an apparent disconnection between identified need and capital funding allocations. Health planning processes can demonstrate a clear need for capital funding but this often does not translate into funding

approval. This results in a great deal of uncertainty for health services, impacting organisations by reducing their ability to plan and deliver services for local populations and offering very little certainty about the timing and allocation of capital funding. In addition, this uncertainty impedes boards from exploring more coordinated, efficient and responsive approaches to service delivery which would optimise the use of capital investments.

One impact of the capital funding process is that it reduces the options boards have for accessing capital. For example, the current funding process prevents organisations from considering leasing arrangements – which require financial certainty both during and beyond the life of a lease. Leasing arrangements may be useful to health services as:

- compared to purchasing, there are lower initial costs to accessing desired capital;
- leasing allows savings or investment in short-term capital needs;
- without ownership of capital, health services are no longer responsible for servicing, repairs and other maintenance costs – leasing may therefore be appropriate for medical equipment that has to be serviced frequently, or that is high-cost and changes frequently;
- leasing arrangements allow health services to access current technology without having to own that technology; and
- lease expenses can be treated as operating expenses, meaning that the capital stock of health services is not impacted by leasing arrangements.

15. Source: "Victorian Health Priorities Framework 2012–2022", Victorian Government, May 2011, Page 6

16. Source: "Victorian Budget 2011-12 State Capital Plan", Victorian Government, May 2012

As the competitive grants process does not provide funding certainty there is a risk for health services that at the conclusion of a given leasing agreement there is potential for a loss of infrastructure without the funding required to enter into another lease. The VHA is advocating for greater transparency around the grants allocation process so that hospitals and community health services can better plan service delivery.

The VHA recommends releasing the Health Capital and Resources Plan 2012-2022 as an important first step in providing increased certainty for health services. The expectation is that this plan will set out specific health system capital expenditure priorities for the next ten years and that these priorities should be in line with population based projections of need and the strategic requirements of the sector.

Recommendation:

14. The Victorian Government should release the Health Capital and Resources Plan 2012-2022¹⁷.
15. The Victorian Government should consolidate the capital grants framework into a single stream of funding for investment in infrastructure, equipment and ICT that is guided by the capital plan.

4.2. There is insufficient capital investment available for community health services to cover asset renewal and replacement, and future infrastructure needs.

For community health to meet the needs of Victoria's growing population and fulfil the Victorian Government's plan for a strong primary and community health sector – as outlined in the VHPF – significant capital investment is required.

Community health services currently have a lack of fit for purpose infrastructure. In some cases this is necessitating the rental of infrastructure which is expensive, inefficient and not fit for purpose.

The VHA notes that capital funding issues are more pronounced for services operating in growth corridors, as those organisations experience increasing demand for services and operate in an environment characterised by infrastructure shortages across a range of industries.

Recommendation:

16. The Victorian Government should provide capital investment for urgent infrastructure upgrades in the community health sector to reflect the goals of the Victorian Health Priorities Framework 2012-2022.

4.3. The amount of capital funding allocated to hospitals does not cover asset renewal and replacement, or future infrastructure needs.

Insufficient funding is currently being allocated for asset renewal and replacement. Ageing and inadequate infrastructure, and out-dated equipment and technology can adversely affect the operational performance of health services.

Current spending levels are not sufficient for public hospitals to continue maintaining and upgrading existing infrastructure and equipment¹⁸. This poses a risk to the sector's ability to keep up with the increasing demand for health services and to maintain assets¹⁹.

A report by the Victorian Auditor General found that for 2011-12, capital replacement indicators deteriorated across the sector signifying that hospitals remain under pressure to meet ongoing financial commitments from their own operations²⁰. It was noted in the report that for 2011-12, 47 per cent of public hospitals (41 hospitals) received capital grants from the Department of Health of less than 20 per cent of their depreciation for the financial year (45 per cent for 2010-11)²¹.

17. Unless document is already publicly available

18. Source: "Public Hospitals: Results of the 2012-13 Audits", Victorian Auditor-General, November 2013, Page 24

19. Source: "Public Hospitals: Results of the 2012-13 Audits", Victorian Auditor-General, November 2013, Page 24

20. Source: "Public Hospitals: Results of the 2011-12 Audits", Victorian Auditor-General, November 2012, Page 25

21. Source: "Public Hospitals: Results of the 2010-11 Audits", Victorian Auditor-General, November 2012, Page 44

The VHA also notes that the Rural Capital Support Fund will conclude at the end of the 2014 financial year. It is not clear to the sector what specific support for rural health services will exist at the conclusion of this program. For 2011-12, 63 per cent of rural hospitals received capital grant funding of less than 20 per cent of their depreciation expense²².

Recommendation:

17. The Victorian Government should include the full lifecycle cost of assets in the forward capital plan including the cost of capital renewal and half-life facility upgrade.

4.4. The Victorian Government's funding models for hospitals²³ and community health services²⁴ do not take into account non-cash expenditure such as capital depreciation.

For community health to meet the needs of Victoria's growing population and fulfil the Victorian Government's plan for a strong primary and community health sector – as outlined in the VHPP – significant capital investment is required.

Community health services currently have a lack of fit for purpose infrastructure. In some cases this is necessitating the rental of infrastructure which is expensive, inefficient and not fit for purpose.

Recommendation:

18. The Victorian Government should build on existing initiatives aimed at reducing the impact on health services of depreciation charges.

4.5. The protracted process for allocating capital funding undermines the ability of health services to be responsive to changing levels of demand.

Under current arrangements, management and boards of hospitals have very limited control over capital funding, but remain accountable for delivering services to a changing population. The lengthy capital allocation process makes it difficult for services to respond adequately to rapid demographic change. Delays in receiving capital funding can result in services being run sub-optimally for extended periods as they struggle to manage the impacts of ageing infrastructure and associated expenditure.

The current strategic approach to allocating capital funding is failing to direct investment to health and community health services with the highest need, and in a prompt manner that allows services to be responsive. The VHA supports an alternative approach to capital funding where funding is allocated progressively through incremental payments as an asset depreciates. Such an approach would provide health services with the long term visibility of capital funding required to plan effectively for the future.

Recommendation:

19. In the medium to long term, the Victorian Government should consider a phased transition to a system where capital funding is allocated to health services progressively on the basis of population need, as opposed to strategically through competitive grants processes, allowing services to better plan for capital replacement.

22. Source: "Public Hospitals: Results of the 2010–11 Audits", Victorian Auditor-General, November 2012, Page 44

23. Source: "Public Hospitals: Results of the 2010–11 Audits", Victorian Auditor-General, November 2011

24. Source: "Primary Health Funding Approach" Victorian Department of human Services, October 2008, Page 6

5. Recurrent Funding

Adequate levels of recurrent funding are required to deliver a standard of care and service that meets the demand of a growing and ageing population with increasingly complex needs. The VHA accepts that the significant resources invested in the Victorian healthcare system warrant an ongoing focus on the provision of financially sustainable and efficient services.

However, a report produced for the VHA by Access Economics in 2009²⁵ showed that while the financing system for public hospitals in Victoria encourages hospitals to produce efficiency gains over time, in practice many hospitals are not meeting the required efficiency targets as:

- efficiency targets are unrealistic; and/or
- hospitals are constrained in other ways from achieving further efficiency gains.

These findings also apply to services delivered in primary health settings in the community. The VHA is not aware of any evidence to suggest the situation has dramatically changed since 2009.

5.1. The Victorian Government continues to seek productivity savings in public healthcare services without sufficient investment in infrastructure, equipment and ICT to enable increased productivity.

The Victorian Government currently applies productivity savings to health services on an arbitrary basis. The VHA's view is that applying blanket efficiency targets, without taking into account the unique circumstances of individual health agencies, leads to varying impacts on agencies and can lead to sub-optimal consequences. The VHA emphasises the following points regarding the application of productivity savings:

- health services that have a high ratio of non-discretionary costs are likely to be disproportionately affected by productivity savings;

- health services that have limited capacity to drive further productivity savings may be forced to resort to expenditure reductions in other areas (for example staffing) which can negatively impact workloads and outputs;
- the level of productivity savings applied must be underpinned by a formal assessment of the potential for efficiencies to be found; and
- there is no clear connection between efficiency dividends and actual efficiency measures²⁶.

The VHA maintains that productivity savings cannot be expected without further investment in infrastructure, including ICT. It is relevant to note that ageing and inadequate infrastructure, equipment and ICT raise the cost of delivering services by increasing the cost of repairs and maintenance and through inefficient and/or outdated infrastructure design.

The VHA also argues that productivity savings attained by health services should be retained within the health portfolio and utilised to further improve the efficiency of Victoria's health system. It is expected that a key purpose of such funds would be to test, pilot or implement non bed-based and primary care approaches outlined in the VHPF.

25. Source: "Victorian public hospital funding and productivity", Access Economics Pty Limited, April 2009

26. Source: "Report of the Review of the Measures of Agency Efficiency", Commonwealth Department of Finance and Deregulation, March 2011, Page 26

Recommendation:

20. The Victorian Government should cease to apply productivity savings to public healthcare services unless the savings are:
- underpinned by a formal assessment of the potential for efficiencies to be found;
 - coupled with investment in infrastructure, equipment and ICT, enabling health services to achieve savings targets;
 - retained in the health portfolio, and used to test, pilot or implement non bed-based and primary care approaches outlined in the Victorian Health Priorities Framework 2012-2022.

5.2. Recurrent funding for community health services and other health services is not keeping pace with the wage index, inflation and increased costs associated with implementing enterprise bargaining agreements.

The cost to organisations of delivering a particular service includes salaries, operational costs and overheads. If recurrent funding fails to cover these costs there is potential for standards of care to suffer or for reductions in the range of services provided. The VHA emphasises that the gap between recurrent funding and labour costs is a source of significant concern within the sector.

The vast majority of the cost of delivering services is associated with labour. In the case of community health services, approximately 80 per cent of the unit price offered by government for these services is directly attributed to wages. Analysis of recurrent funding for audiologists, dieticians and psychologists for example reveals that on average for the past five financial years recurrent funding increases have been approximately 0.14 per cent below wage indexation.

The VHA is also concerned that recurrent funding is not adequately covering the cost of implementing enterprise bargaining agreements (EBAs), and that this is placing considerable pressure on health

services – particularly in public sector residential aged care and community health services. In particular, a number of providers have noted that current funding does not fully cater for the nursing ratios established under the Victorian Public Sector Nurses and Midwives General Agreement, particularly in the area of public sector residential aged care. The VHA argues that at a minimum, recurrent funding should reflect such changes in the wage index and should cover the total cost of implementing state EBAs.

It is also important to note that a number of other costs are placing pressure on health services. For example, superannuation contributions increased by 0.25 per cent on 1 July 2013. Electricity and gas costs have also increased significantly. From 2007 to 2011 Australian retail electricity prices have risen by around 30 per cent in real terms²⁷ and by some estimates prices will have risen by at least 100 per cent from 2008 levels by 2015²⁸. These cost increases have not been addressed by increases in recurrent funding.

Recommendation:

21. The Victorian Government should ensure that recurrent funding is:
- indexed at a rate which fully covers increases in the health CPI;
 - adequate to cover cost increases incurred as a result of enterprise bargaining agreements or legislated increases in superannuation contributions; and
 - adjusted to reflect other unavoidable costs such as increases in power prices.

5.3. Recurrent funding is not responsive to changes in demand occurring due to population and other demographic changes.

The Victorian population is changing. It is estimated that by 2016, over 1.5 million people will be living in regional Victoria and almost 4.5 million people will be living in Melbourne – representing annual growth rates of 1.3 per cent and 1.6 per cent respectively²⁹. Victoria is also experiencing changes in the population's composition and

27. Source: "Energy shock: confronting higher prices" Australian Industry Group, February 2011, Page 17

28. Source: "Energy shock: confronting higher prices" Australian Industry Group, February 2011, Page 8

29. Source: "Victoria in Future 2012" Department of Planning and Community Development, 2012

need due to the ageing population, migration, and seasonal variations. The VHA is concerned that recurrent funding provided through ABF, block funding or community health unit prices does not account appropriately for the increasing demand represented by these demographic changes.

Community health services deliver a number of programs where significant waiting lists exist but recurrent funding is not sufficient to reduce them. This is of particular concern in the many growth areas of the state. For example, some communities have received a large increase in the number of refugees without any further support from Government to provide crucial care via the refugee health nurse program. Homelessness services have also been identified as not receiving increased recurrent funding despite stronger demand.

Recommendation:

22. The Victorian Government should take into account changes in the size and composition of local populations when setting recurrent funding levels in order to address population health needs.

5.4. WIES cost weights and block funding only partially cover the increased costs associated with providing services in rural and remote areas.

To provide high quality services to local populations, rural health services must receive an amount of funding that is commensurate with the costs of service delivery. Health services operating in rural and remote areas may experience higher costs than services in metropolitan areas.

Ambulance services are one area in which funding allocation to rural services is disproportionate to the cost impact of service delivery. According to the Independent Hospital Pricing Authority (IHPA) 'costing data indicated patients from outer regional or remote locations incurred higher costs, irrespective of where they were treated'³⁰.

The VHA is of the view that the Weighted Inlier Equivalent Separation (WIES) does not include adequate weighting to account for the higher cost experienced by rural health services.

Analysis of the price tables contained in the Victorian health policy and funding guidelines 2013–14 for acute services reveals a seven per cent difference in the funding provided to “sub-regional and local” and “outer metro and large regional”. Feedback from the VHA membership indicates that current WIES weightings fall significantly short of the actual costs of service delivery.

Other factors including the reduction in bed day rates paid to public hospitals by private insurers, the annual decreases in DVA patients on acute hospital budgets and the volume pressures brought about by a diminishing rural populations, exacerbate the revenue challenges experienced in rural areas.

Recommendation:

23. The Victorian Government should ensure that the higher cost for providing health services in rural areas is fully recognised in the WIES cost weights.

5.5. Recurrent funding arrangements are impacting the ability of service providers to respond to a number of workforce pressures.

The workforce underpins the ability of organisations to provide care and is fundamental to the ongoing sustainability of the service system³¹. The VHA notes that many health services, particularly in rural areas, are experiencing a number of significant health workforce challenges. The provision of certain and adequate recurrent funding is critical for health services to respond to these challenges. The VHA emphasises the following workforce issues to the Victorian Government:

- There is limited access to a skilled workforce in rural areas (including medical, nurses, midwives and allied health) which is jeopardising service delivery;
- Rural areas have an ageing workforce and increasing rates of retirement. The resultant staff shortages also drive up costs for health services due to an increased reliance on locum services. The maternal and child health nurse workforce has been identified as at particular risk;

30. Source: “The Pricing Framework for Australian Public Hospital Services” Independent Hospital Pricing Authority, February 2013, Page 28

31. Source: “Victorian Health Priorities Framework 2012-2022: Rural and Regional Plan” Department of Health, 2011, Page 15

- The way that programs are funded is making it difficult to recruit and retain appropriately skilled practitioners. A chief concern is that varying recurrent funding levels prohibit health services from offering positions with longer tenure – therefore providing insufficient incentives to attract staff to rural areas. As an example, fluctuation in the funding for occupational therapists has been identified as causing significant disruption to rural health services.

The VHA is aware of at least one case where, due to uncertainty surrounding the funding of key positions by the Department of Human Services, a community health service has discontinued the provision of Individual Support Package facilitation planning³². Due to a significant and seemingly unnecessary delay in committing to the funding of key positions, the community health service was forced to withdraw from providing what had been a longstanding service to the community.

In addition to the provision of adequate funding, the state government must link in with local government and industry strategies to promote rural living and rural practice if health professionals are to be recruited and retained³³. In addition, health services need to be resourced to undertake activities such as mentoring which can assist with developing the skills of less experienced clinicians.

One approach that should be considered in addressing workforce issues is the Federal Government’s Dental Relocation and Infrastructure Support Scheme, which provides relocation and infrastructure grants to encourage and support dentists to relocate to regional and remote areas. Another approach would see increased funding to support collaborative initiatives which include the provision of after-hours medical support and maternity workforce development.

Recommendation:

24. The Victorian Government should develop and fund a long-term retention strategy for health practitioners in rural areas which:
 - addresses the need for certainty in program funding to enable recruitment and retention of staff;
 - increases funding for rural scholarships and other education opportunities; and
 - increases support for up-skilling and initiatives that expand the scope of practice for staff.

5.6. The Competitive Elective Surgery Initiative has increased the proportion of complex patients receiving elective surgery in the public sector – this has not been reflected in recurrent funding.

Elective surgery waiting lists currently exceed 50,000 patients, and the performance of Victoria’s hospitals in relation to national elective surgery targets has declined.

Since 2012, the State Budget has allocated additional funding for one-off elective surgery. The funding has been split between a pool of funds open to Elective Surgery Information System (ESIS) reporting public providers, and a pool open to all public and private providers. In 2013-14, \$15 million was allocated for public and private providers to competitively tender for additional elective surgery. This is in addition to \$9 million pool available for public and private providers delivering surgery under the 2013 Elective Surgery Services Deed of Agreement.

The purpose of this approach is to extend the capacity of elective surgery in Victoria, drive efficiencies and innovation in elective surgery through competition, and extend partnerships between the public and private sector. This initiative is valid for improving access to elective surgery and reducing the size of the waiting list.

32. ISP facilitation planning provides holistic planning for a person with disability. The planning process helps people to identify their goals and support needs, and how best they can achieve these goals.

33. Source: Francis K, 2005 “Health and Health Practice in Rural Australia: Where are We, Where to From Here?” Online Journal of Rural Nursing and Health Care, Vol. 5, No. 1, Page 33

However, the VHA wishes to highlight that in tendering to deliver elective surgeries under the initiative private providers have been able to define the scope of the surgeries they perform to only include lower complexity patients who are younger and have a lower body mass index (BMI). As a consequence, the patient mix for elective surgery for these procedures in the public sector contains a higher proportion of more complex patients. Due to this shift in the patient mix, the average cost of providing elective surgery for patients in the public sector has increased. The VHA argues that the increased average cost to Victorian public hospitals of performing these procedures must be recognised in recurrent funding.

Recommendation:

25. Public hospitals should receive additional WIES funding for elective surgery procedures to reflect the increased proportion of complex elective surgery patients being treated due to the Competitive Elective Surgery Initiative.

5.7. The cost of ambulance services for rural health services is not adequately covered by existing recurrent funding.

It was noted in section 5.4 that recurrent funding is not adequately covering the costs of service delivery in rural areas. The VHA draws the Government's attention to the specific issue of ambulance services.

Ambulance Victoria's retrieval services (whether they are road, air or rotary wing) are an essential part of the broader health service. Without these services rural patients will not have access to specialist care when it is urgently required.

Rural health services are responsible for the cost of retrieval of patients to specialist care in major metropolitan or regional hospitals. The cost of transfer of patients to specialist care can be very expensive and the volumes can be high. The transport charges for rotary wing services in particular are high. Current recurrent funding is not covering the cost to rural health services of ambulance transfers.

The problem is compounded by the shortage of non-emergency transport services in rural areas which forces rural health services to use ambulance services in instances where non-emergency patient transfer services may be more appropriate.

Recommendation:

26. The Victorian Government should:
 - implement a direct funding relationship between the Victorian Department of Health and Ambulance Victoria for all urgent, maternity and paediatric (including NETS) inter-hospital transfers to replace the current approach, where health service agencies are billed for the transfer; and
 - increase investment levels in non-emergency patient transport in rural areas and consider contracting private providers to deliver these services.

5.8. Recurrent funding for Urgent Care Services is inadequate, resulting in resources being cross-subsidised from other service areas.

Urgent Care Services (UCS) are funded to provide initial resuscitation and a limited stabilisation capacity prior to early transfer to a regional or major trauma service. However, in reality many UCS across the state operate like small emergency departments and provide 24 hour x-ray and CT scans, as well as medical and nursing care. The demand placed on UCS is in part due to community expectations exceeding the capability of some rural health services to deliver services.

The VHA emphasises that recurrent funding does not reflect the true cost of service provision in rural areas. The inadequacy of recurrent funding is particularly problematic for hospitals that have presentation numbers which are close to, but remain under, the funded presentation level of 5000 presentations. Such health services deliver a significant service to the community without funding.

As a result of inadequate recurrent funding, equity issues arise due to the variability in UCS capabilities across rural areas (due to workforce and resourcing issues) and there is differential treatment for residents in metropolitan and regional areas: metropolitan residents are able to access services that are fully subsidised, whereas residents in rural areas where the local health service is not adequately funded to provide urgent care do not. Another significant implication of inadequate funding is that UCS find it difficult to attract and retain staff with the skill, experience and capacity to fully carry out their function.

Recommendation:

27. Recurrent funding of Urgent Care Services should be increased to adequately cater for workforce development costs and to more closely reflect the cost of services delivery.

5.9. Unit pricing for state funded programs operated by community health services often does not meet the cost of providing the service. There is also a lack of transparency around how the unit price for such programs is calculated.

Unit prices provided to community health services are intended to cover all operating costs including, salaries, salary on-costs, general operating, corporate overheads and travel³⁴. However, the unit price was formulated prior to the existence of many current non-salary costs.

Community health services have significant IT requirements, fleet maintenance, quality accreditation, infrastructure investments and other non-salary overheads that are placing organisations under significant fiscal pressure. The VHA understands that the unit price offered to community health services has not been reviewed or adjusted to account for such costs.

The VHA also notes that there is very little clarity around the calculations used to determine unit prices used for recurrent funding of community health services. The lack of transparency around the unit price prevents the analysis and comparison of Departmental estimates of operating costs

with the actual costs community health services incur when providing services. This also prevents services from benchmarking their activities.

When recurrent funding does not align with the costs of service delivery, health services must draw resources from other areas, potentially impacting service delivery and the financial position of the organisation.

Recommendation:

28. The Victorian Government should publish the formula used to calculate unit prices for community health services, allowing services to assess how the cost of delivering their services aligns with departmental estimates. If the estimates do not align, the Government should undertake a fully transparent review of the funding process for all services funded via a unit price. The aim of this review would be to ensure that unit prices reflect the true cost of providing services.

34. Source: "Primary Health Funding Approach" Victorian Department of human Services, October 2008, Page 6

6. eHealth

eHealth has the potential to improve the coordination of health services in Victoria, eliminate duplication and waste, reduce the risk of errors, and contribute to an improved standard of care. However, Victoria is not currently realising the potential of eHealth.

The VHA notes the recent release of the Ministerial Review of Victorian Health Sector Information and Communication Technology and welcomes the findings of the review panel. There is a high degree of consistency between the report and the feedback received from VHA members in preparing this budget submission. Therefore, it is encouraging that the Government's response to the panel's recommendations has been positive.

The VHA is particularly supportive of the Government's commitment³⁵ to develop a state-wide health ICT plan, in line with the VHPF and national eHealth initiatives³⁶. The development of this plan should be treated as a priority by the Government.

The VHA has identified the following key issues for ICT development in the public health sector for the attention of the Victorian Government.

6.1. Victoria is lacking direction on the adoption of electronic medical records and the uptake of the Personally Controlled Electronic Health Record.

The Health Sector ICT Review Panel has provided the Victorian Government with a comprehensive list of recommendations to guide the overhaul of Victoria's ICT infrastructure and governance. A primary recommendation referred to the development of a state-wide ICT plan, with a central priority being the development of electronic medical records (EMRs) across the Victorian health system.

EMRs have the potential to streamline inter-health service patient management, with a central record of medical, clinical and pharmacological history. The potential also exists for the EMR to interface with the PCEHR, for example in the production of patient information and discharge summaries. The VHA recognises the significant system gains that can be achieved in having a standardised approach to managing patient records across the health sector, allowing for greater efficiency in emergency departments and consistency in the treatment of patients in different care settings.

The purpose of the personally controlled electronic health record (PCEHR) is to provide a secure electronic summary of people's medical history which will eventually include information such as current medications, adverse drug reactions, allergies and immunisation history in an easily accessible format.

Progress to a PCEHR has been slow. While many health services see the longer term benefits of the PCEHR, there is insufficient funding to support public health services in covering the cost of PCEHR implementation in the near term.

The VHA also notes that the Federal Minister for Health recently announced a review of the implementation of PCEHR across Australia and urges the Victorian Government to continue to work with Commonwealth authorities towards the achievement of national electronic medical records.

35. Source: Health Sector ICT Review Panel Recommendations – Victorian Government Response, October 2013

36. Source: "Ministerial Review of Victorian Health Sector Information and Communication Technology" Victorian Department of Health, October 2013, Page 5

Recommendation:

29. The Victorian Government should draft a state-wide ICT plan which:
- includes implementation priorities, the development of the EMR platform, and identifies the appropriate level of funding required;
 - deals with matters associated with the implementation of the PCEHR including the investment required to allow health services to contribute to the development and uptake of the PCEHR; and
 - establishes an ICT capital investment plan for Victoria.

6.2. The ICT infrastructure of most health services is inadequate.

Discussions with VHA members have consistently indicated that the ICT infrastructure of many health services is inadequate. This is an issue for all health services, hospitals and community health services. It was noted in the Ministerial Review of Victorian Health Sector Information and Communication Technology that “some health service providers are dependent on legacy applications to run critical tasks, or are running services at risk of hardware failure without adequate disaster recovery capabilities in place”³⁷. It is unknown exactly how much of the hardware and applications used by Victorian health service providers is obsolete or at high risk of failure³⁸.

Recommendation:

30. In accordance with the Ministerial Review of Victorian Health Sector Information and Communication Technology, and the Victorian Auditor General’s report Clinical ICT Systems in the Victorian Public Health Sector, the Victorian Government should:
- Allocate Victoria’s health sector ICT investment, including priorities for capital expenditure, according to need and guided by the state-wide health ICT plan³⁹.
 - Health services should be resourced adequately to implement ICT projects.
 - ensure expertise is available to plan and implement future clinical ICT development and change projects, particularly in the areas of clinical engagement and leadership, socio-technical systems analysis, health informatics and benefits realisation⁴⁰.

6.3. There is poor interoperability between the ICT systems currently operating in the Victorian health sector.

Interoperability refers to the ability of clinical ICT systems to work together within and across organisational boundaries to advance the effective delivery of patient healthcare⁴¹. Following the Victorian Government’s decision to end the HealthSmart program in 2012, there has not been an agreed approach on further ICT development in Victoria. The VHA is aware that the Government has agreed to develop a state-wide approach and encourages this approach to be communicated as a matter of priority.

The absence of a coordinated approach to ICT adoption has resulted in service providers implementing systems that are relevant to the needs of the single health service, yet lack the capability to interconnect with systems in a broader

37. Source: “Ministerial Review of Victorian Health Sector Information and Communication Technology” Victorian Department of Health, October 2013, Page 52

38. Source: “Ministerial Review of Victorian Health Sector Information and Communication Technology” Victorian Department of Health, October 2013, Page 52

39. Source: “Ministerial Review of Victorian Health Sector Information and Communication Technology” Victorian Department of Health, October 2013, Page 8

40. Source: “Clinical ICT Systems in the Victorian Public Health Sector” Victorian Auditor General October 2013, Page xiv

41. Source: “Clinical ICT Systems in the Victorian Public Health Sector” Victorian Auditor General October 2013, Page xiii

network. In addition, health services are all still highly reliant on paper records, and are unable to directly access patient information held at other health services. Patient data continues to exist in isolation.

Community health services work with government mandated ICT systems that lack the most basic interoperability requirements. Booking systems used in mandated dental services are also deficient, leading to significant system inefficiencies. Residential aged care services have their own systems for patient management which are not accessible or linked to general practice systems – resulting in GPs not being able to access required information, particularly when providing after hours care.

Recommendation:

31. In accordance with the Ministerial Review of Victorian Health Sector Information and Communication Technology, the Victorian Government should:
 - continue to develop and maintain an interoperability maturity model that is relevant to Victorian continuity-of-care and best practice ICT principles
 - engage with and influence the design of standards associated with national infrastructure supporting interoperability.

6.4. There is insufficient support for rural health services across Victoria to implement or expand teleconferencing and videoconferencing initiatives.

Telehealth and videoconferencing in particular have the potential to deliver improvements in the access and the standard of care – particularly for patients and clinicians in rural areas. Videoconferencing can be used to better assess the needs of critically ill patients requiring retrieval to specialist services, and can provide the rural health service with improved advice and support regarding the retrieval of the patient. Telehealth has also been used to more efficiently provide access to specialist expertise at the point of need.

The VHA also notes that some applications, such as videoconferencing, would be best provided through structures such as the National Broadband Network and may link with larger service providers are able to provide an adequate level of support.

The Health Innovation and Reform Council (HIRC) has provided the Victorian Government with a detailed discussion paper⁴² and 12 recommendations for improving the telehealth capabilities of the Victorian health sector, and streamlining its governance within the Department of Health. The VHA supports the HIRC's recommendations and commends the Victorian Government for accepting the recommendations in their entirety.

Recommendation:

32. The Victorian Government should increase funding for telehealth and videoconferencing initiatives, particularly in rural areas and beyond the projects funded.

42. Source: "Health Innovation and Reform Council Summary of Recommendations" Victorian Department of Health, [http://docs.health.vic.gov.au/docs/doc/806538E8E2088619CA257B890015514A/\\$FILE/HIRC%20Recommendation%20summary.pdf](http://docs.health.vic.gov.au/docs/doc/806538E8E2088619CA257B890015514A/$FILE/HIRC%20Recommendation%20summary.pdf)

7. Managing National Health and Aged Care Reforms

A number of services are transitioning, or have recently transitioned, to national arrangements under the NHRA, including the transfer of HACC funding and policy arrangements to the Commonwealth. The VHA recognises this as a commonwealth responsibility but wishes to draw the State Government's attention to matters with implications for Victoria.

7.1 The transition to commonwealth funding arrangements has resulted in previously state funded services being left unfunded or experiencing significant cuts in funding.

Areas impacted by the transition to commonwealth arrangements include:

- health promotion programs
- implementation of the National Quality and Safety Standards
- rural primary health services programs
- the funding of acute care, such as level two Intensive Care Units (which have not been designated as 'in scope' for commonwealth ABF funding)⁴³.

The VHA believes the Victorian Government should ensure that local healthcare agencies transition to new funding arrangements without disruption to services. This may involve the provision of financial assistance to service providers.

7.2. There is a lack of support for service providers to manage the transition to commonwealth funding arrangements, particularly for smaller rural health services and community health services.

The financial and other impacts of transitioning to commonwealth funding arrangements are often unclear to health service providers. This lack of clarity is compounded by the limited corporate support available to many services (particularly smaller rural hospitals and community health services) to scope and fully deal with those impacts. This has been identified as an issue for sub-acute funding, aged care, the future of HACC funded services, and the implementation of aspects of ABF. There is also considerable uncertainty regarding the impact of NDIS on local service providers. In particular, there are several questions around how NDIS will interact with the local service sector. The VHA considers it vital that service providers receive state government support and assistance during this transition.

43. See "National Pricing Model Technical Specification 2012-2013" IHPA 2013, Page 14

7.3. There are a number of factors undermining the sustainability of rural and small rural health services that provide aged care services.

Several trends have been identified in the changing aged care environment, some of which may impact on the sustainability of aged care services in rural areas if there is insufficient transition support. Specific issues placing pressure on rural health services include the trend towards individuals remaining in the home for longer, increasing consumer acuity levels particularly in residential aged care, and possible increasing competition from private and not-for-profit providers in some areas. Other issues requiring state government attention include:

- Funding of aged care services through the Aged Care Financing Instrument may not adequately cover the costs associated with caring for higher acuity patients and may not be sufficiently indexed to cover rises in the consumer price index⁴⁴.
- The provision of aged care licences in rural areas through state and territory Aged Care Planning Advisory Committees does not appear to be adequately linked with identified need. This can result in public and private providers competing in areas with little demand for services.
- Rural health services are not being allocated enough Community Care Packages to assist in addressing the increased focus on ageing in the home.

A further implication of the changing aged care environment may be an increase in the popularity of HACC packages as an alternative to residential care for those with lower care needs. This may have particular impacts for public sector residential aged care services (PSRACS) that have previously specialised in the provision of low care.

The Victorian Government should play a role in ensuring a smooth transition to commonwealth arrangements, including advocating for Victorian service providers in intergovernmental forums. The State Government may also consider the ability of PSRACS to access capital funding to undertake refurbishments necessary to access higher accommodation supplements.

44. In July 2012, the then Department of Health and Ageing announced that from July 2012 there would be a one off reduction of 1.6 per cent in the amount paid under the ACFI at all care levels from 1 July 2012. This meant that that ACFI subsidy rates will remain at their 30 June 2012 level, denying aged care providers access to an annual funding increase to offset rising costs.



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