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Health 2040

30 October 2015

What principles should guide reform of the Victorian healthcare system?
From your perspective, what would describe the kind of healthcare system you would want to encounter as a patient?

A long term vision is crucial to developing an effective, efficient world class health system. With this in mind, the Victorian Healthcare Association (VHA) welcomes the opportunity to contribute to the Government's "Health 2040" consultation, seeking to shape the vision for the Victorian health system for the next 20 years. As outlined in the Travis Review, a strategic statewide service and infrastructure plan will help Victoria to align health service demand with both service and infrastructure planning.

The key themes of the Health 2040 discussion paper provide a good starting point for a long-term planning framework, and one that should be part of ongoing future planning processes. This submission is structured around the identified key themes, and takes a big-picture perspective on the future of health, health systems, and the delivery of health services. The content of this submission builds upon our previous work, including "Access to elective surgery in Victoria"[1], "Rethinking our health system: state election priorities 2014"[2], and "State budget submission 2015-16"[3]. VHA takes the perspective of our member organisations, which include hospitals, community health services, public sector residential aged care, bush nursing services, primary care organisations and multi-purpose services.

1. A person centred view of healthcare, with equitable access

What sort of things could we do to provide greater choice and personalisation in healthcare?
How do we design for people's experience as well as outcomes?
How do we engage people in designing the healthcare system?
How can the healthcare system improve every individual's end-to-end journey and consider their emotional journey?

In order to properly deliver a person centred health system, individuals and communities must be able to access services within systems that are approachable, relevant, effective and efficient. Accessibility must exist regardless of age, physical ability, cultural background, socio-economic or health status. People must be able to access healthcare that respects their beliefs and customs, promotes respect and dignity, and allows appropriate choice. Recent Parliamentary events such as the Inquiry into End of Life Choices[4] have demonstrated a significant public appetite for inclusion in the health care dialogue, and a desire for values-based conversations to identify the important issues for individuals.

[1] Available from: http://www.vha.org.au/docs/20140416--position-statement--access-to-elective-surgery--incl-report.pdf
[2] Available from: http://www.vha.org.au/docs/rethinking-our-health-system--state-election-priorities-2014.pdf
[3] Available from: http://www.vha.org.au/docs/vha_budget_submission_2015-16-web.pdf
[4] Further information available from: http://www.parliament.vic.gov.au/lsic/inquiry/402

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1.1 Engaging people

While public consultations are one way of assessing public opinion, also contributing to improving accessibility is health literacy, which supports the individual to make informed choices and identify the best option for their circumstances, in partnership with their healthcare provider. Health literacy amongst Australians is considered to be at least adequate for only 41 per cent of the population[5]. This impacts on the ability to obtain, process and understand health information, and to navigate health services. The Victorian Department of Health and Human Services (DHHS) has previously undertaken work on the matter which outlined principles and provided recommendations to guide future implementation actions to improve Victorians' health literacy[6]. This work is ongoing, and the VHA understands that a key issues paper is currently being finalised, which will inform the policy development process and the subsequent Victorian implementation framework.

Without adequate health literacy, it is unreasonable to place the onus on individuals for system and service design. Therefore, the need for population based measures to improve health literacy, as recommended by the Report of the Victorian 2014 Consultation on Health Literacy[7], is critical to developing person centred healthcare.

Health literacy can also be supported through reducing the use of health jargon in policy and other public documents. Encouraging approaches that support the use of plain English in written and other forms of communication helps to break down the mystique of healthcare and medicine, and enables consumers to engage in meaningful conversations about their care. While many key topics are included on platforms such as the "Better Health Channel", more can be done to support individual health and community services to embed plain English approaches to communications, including signage, correspondence and naming of services.

Regardless of health literacy, engagement with people in health and community service settings also occurs through the provision of person centred care. Health does not ostensibly consider itself a service industry, yet at its crux the delivery of healthcare services has many parallels with traditional service industries. While a person oriented approach is well embedded in some health organisations, more could be done to ensure uniformity across the sector. This may begin with clinical training approaches for healthcare workers, but can also be encouraged by actively seeking qualitative feedback from consumers to drive improvements.

Recommendations:

1. To better facilitate person centred healthcare, broad population health measures must be implemented to improve population health literacy and allow meaningful consumer engagement in health system design and planning. Support must continue for existing platforms that provide user friendly, accessible health material for consumers, as these platforms provide opportunities for expansion as the health system continues to evolve.
2. Person centred care should be embedded across the whole health system. Consideration should be given to how this can best be addressed through measures such as clinical education and training, and consumer feedback.

[5] Available from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20June+2009
[6] Available from https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bE1740ADA-3CD8-4678-A591-CB84E98B7FD3%7d&title=Report%20of%20the%20Victorian%202014%20Consultation%20on%20Health%20Literacy
[7] Ibid.

Additionally, regardless of health literacy levels, there are a number of principles that can help to drive a responsive system that meets individual patient needs, and is also efficient and effective.

1.2 Flexibility

Flexibility of healthcare services and systems is one component of delivering a patient centred system. In order for services to be delivered flexibly, there must also be flexibility in the funding of services to ensure that the most appropriate service delivery option can be delivered, without restraint due to strict funding arrangements. For example, home-based chemotherapy is a preferred option of patients requiring such care, and no significant complications have been associated with this approach in Australia[8]. Additionally, home-based options are preferred by patients requiring dialysis. However despite the benefits, restrictive funding arrangements mean that the rate of home-based dialysis in Australia lags behind countries such as New Zealand and Hong Kong[9].

While work to support the flexible delivery of appropriate services is not the responsibility of governments alone, incentives and appropriate policies related to funding can be developed centrally and supported by the independent boards of health service organisations.

The flexibility of care is also relevant to sustainability and innovation within health. The Travis Review flagged the importance of moving away from bed numbers or waiting lists as the key measures of hospital and health service capacity. Flexible service provision requires more than just hospital beds, and by auditing the number of available "points of care", which may include home-based care or telehealth services, a more accurate report on the capacity of health care is possible. Increasing capacity for health and community services to deliver care in non-bed settings allows services to provide care that is more person centred. It also increases service capacity without the need for capital investment.

Flexible service delivery is critical to targeting vulnerable populations and providing equitable access. Along with measures to support health literacy across all population groups, flexibility to support the delivery of culturally safe care is vital to addressing inequities. This includes considering factors such as location of services, communication approaches, hours of care, and cultural competence of health care workers.

Recommendation:

3. A person centred and equitable health system must incorporate flexibility in service delivery. Funding models and incentives for care should be structured to support and encourage flexibility, which may include models of care delivered outside the health service's physical infrastructure.

[8] Rischin et al 2000, Medical Journal of Australia, "A randomised crossover trial of chemotherapy in the home: patient preferences and cost analysis" Available from: https://www.mja.com.au/journal/2000/173/3/randomised-crossover-trial-chemotherapy-home-patient-preferences-and-cost

[9] Source: Kidney Health Australia 2012, "A model for home dialysis, Australia". Available from: http://www.kidney.org.au/LinkClick.aspx?fileticket=BfYeuFvtJcI%3d&tabid=811&mid=1886

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1.3 Accessibility

Individuals and groups with physical activity limitations must be considered when planning and delivering health service infrastructure. This is particularly relevant as the population ages, and as more people survive previously fatal injury and illness with advances in medical technology and care. This will lead to greater levels of impairment than previously experienced. People living with chronic disease will also continue to live longer as a result of these medical advances.

Designing a person centred system must take into account the needs of all population groups, especially the most vulnerable. Vulnerable population groups exist not only because of structural deficits, but also due to accessibility issues. Addressing accessibility must involve consideration of not only physical space, but also proximity to services, and the availability and flexibility of services (see section 1.2). Known priority populations include but are not limited to Aboriginal and Torres Strait Islander people, rural and remote residents, people experiencing mental illness and people experiencing or at risk of homelessness. Special consideration is required to ensure that vulnerable, priority populations are able to access the healthcare they need to learn about and maintain healthy lifestyles and manage their disease or risk of disease. Access can be improved through measures such as investment in the infrastructure required for telehealth services, and providing appropriate funding structures to support the delivery of outreach and remote health interventions, which must allow multidisciplinary involvement. This includes interpreting and population specific services.

As well as structural accessibility, capital planning should give consideration to person centred design and health promoting health services. Characteristics such as optimising natural light and air circulation, and design features that promote calm have been incorporated into a number of new capital works in Victoria, such as the Ballarat Community Health Centre and Royal Children's Hospital. There is an opportunity for this approach to be supported in future capital works, as well as in the redevelopment of older buildings in the coming years.

Initiatives such as Community Advisory Committees, as established in Victorian public health services and introduced in Primary Health Networks, are one model of ensuring that the perspectives and priorities of local population groups are heard and considered when planning and delivering health and community services. These Community Advisory Committees must be reflective of the population accessing the health service to ensure that feedback provided can be utilised to improve service provision and influence service planning. Consumer engagement continues to evolve and has seen the introduction of models such as citizens' juries and participative democracy, which can all contribute to collaboratively shaping health service design.

Recommendations:

4. Health services must be accessible to all people, and special consideration must be given to equity measures targeting priority populations. Accessibility must be considered in relation to infrastructure as well as resource and service access, and particularly for remote access.
5. High risk populations may benefit from increased support in the community to assist with coordination of services and patient advocacy, and consideration should be given to ensuring models of care exist that promote the most appropriate care in the most appropriate location regardless of referral, in a "no wrong door" approach.
6. Support for consumer engagement should continue to allow evolution of engagement models to facilitate collaboration for person centred system and service design.

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2. Preventing and treating chronic disease, early intervention

Where should we focus our efforts to improve prevention and early intervention?
What are the priorities for improving the outcomes and experience of people with chronic disease?
What are the best ways to improve coordination and integration of services for people with chronic disease?

Chronic disease is the leading cause of fatal burden of disease in Australia, as well as being the leading cause of illness, disability and death[10]. This will only increase with advances in medical technology and care as more people survive previously fatal illness. Therefore, addressing chronic disease amongst all age groups must be seen as a key priority for health reform.

The Victorian health system, like many others around the world, tends to favour a model of care that focuses on episodic care, rather than lifetime health and wellbeing, or prevention and management of chronic disease. Instead of focusing on health outcomes, current funding and reporting approaches focus on activity outputs. However, rather than only focusing on providing services to people once they have developed chronic disease, better outcomes for patients and a better return on investment can be achieved by investing in prevention and early intervention. Prevention and early intervention is both effective and delivers savings to government by preventing the development of chronic disease, delaying its onset, and reducing the severity of illness[11].

For prevention activities to be effective, they must be implemented at a population health level and be easy and accessible, seeking minimal investment from target populations. Whilst they should be demonstrated as effective, these activities must not be restricted with regards to the models, locations and organisations who can deliver them. In fact, multi-sector approaches to prevention and early intervention should be encouraged, to facilitate a "no wrong door" approach to health service access, and ensure that arbitrary barriers to service are eliminated.

Coordinated approaches to prevention and early intervention must target local population health priorities. Determining this falls within the remit of Primary Health Networks (PHNs) in genuine partnership with service providers. PHNs are well placed to act as a coordinator for locally introduced programs to avoid duplication and ensure effective use of resources in delivering such services. This may in fact lead to cross-sector relationships, including with local and state governments, to make best use of available resources, skills and expertise.

This coordination of health and community services, regardless of their position on the continuum of care, must align with the roles and responsibilities of any given service. More importantly than who is to deliver programs, there is a need to focus on evaluation of outcomes, to determine effectiveness of programs, projects and models of care.

The importance of evaluation and monitoring of outcomes is not restricted to prevention and early intervention programs. In order to improve outcomes and the experience of people with chronic disease as well as all users of health and community services, evaluation and monitoring must be embedded into all program design. In order to determine priorities, consumer engagement must be utilised in conjunction with peer reviewed literature and benchmarked against the outcomes from best practice examples.

[10] Source: http://www.aihw.gov.au/chronic-diseases/
[11] Applied Economics 2001, "Returns on Investment in Public Health – and Epidemiological and Economic Analysis", Available from: http://www.appliedeconomics.com.au/pubs/reports/health/index.htm

Innovative models, building on social cohesion approaches must also be supported. For example, Australian research has investigated the efficacy of peer-led chronic disease self-management programs, with positive outcomes related to health literacy and disease management[12]. Supporting a "train the trainer" model for these patient groups can have a multiplier effect – improving health literacy in participants, reducing the reliance on health professionals, and creating social support for people with chronic disease.

Given the interest from all stakeholders in preventing avoidable hospital admissions, coordination and integration of services for people with chronic disease must be coordinated with the primary healthcare sector. Full utilisation of community based services will help to best support people to stay at home and receive effective intervention. Multidisciplinary community based care helps to keep people at home, encourages full use of the clinical scope of practice of a range of health professionals, and encourages self-management.

These approaches must still be grounded by a consumer-led approach, which is the ideal lens around which to build services and systems. By re-framing systems to work around a consumer, services and systems are more likely to be accessible and easy to navigate.

This approach must apply not only to macro systems and services, but also models of care. Patients with chronic disease often experience multiple co-morbidities, thus requiring the input of multiple medical specialists. However, this could be streamlined from a service and consumer perspective through encouraging a greater focus on generalist care, and support to better develop and embed relationships between acute, subacute, and community care sectors.

This is not an argument for amalgamating stand-alone, self-governing health service organisations which are a key strength of the Victorian model compared to other jurisdictions. Rather, support should be provided to formalise networks, and incentivise health and community service organisations to work together to provide efficient, effective care for their local populations.

Recommendation:

7. Prevention and health promotion activities must be funded across sectors to ensure appropriate stakeholder engagement and best use of available skill sets and resources, to address chronic disease and prevent avoidable hospital admissions.

3. Improving people's health outcomes and experience

How can we make sure health services are accountable for improving outcomes?
How do we ensure we are focused on the outcomes that matter to Victorians?
What can we do to improve people's experience of healthcare?

Significant narrative currently exists at a Commonwealth level exploring the reforms for health funding. Funding is an obvious, but not so easy, method of addressing accountability. Improving outcomes through incentive based health funding models can be problematic, as the focus can easily shift towards meeting the performance criteria, without regard for quality and safety.

[12] Harvey et al 2008, Australian Health Review "Self-management support and training for patients with chronic and complex conditions improves health-related behaviour and health outcomes", Available from: http://www.publish.csiro.au/?act=view_file&file_id=AH080330.pdf

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However, examples exist of funding models that drive improvement. The National Health Service (NHS) in the UK introduced Best Practice Tariffs (BPTs) to incentivise hospitals to provide evidence based bundles of Best Practice, thereby encouraging appropriate patient care and increasing the likelihood of positive patient outcomes[13].

While published literature is one method of identifying appropriate outcomes, as discussed above (see section 1), there is a need to engage consumers with health service planning, and identification of appropriate, meaningful outcomes. As discussed above, consumer representation must be incorporated into health service planning to support this at a macro level.

At a micro level the ability of individuals to provide input to their healthcare, and to engage in decision making about their care, must be supported by improving health literacy. As outlined above (recommendation 1) levels of health literacy in Australia are inadequate for the majority of the population. This is important because an individual's ability to participate in improving health outcomes is impacted by low health literacy[14].

Navigating a complex health system is difficult for a number of reasons, many of which are modifiable in system or service design. These modifiable factors are particularly important to facilitate a positive patient experience, and reduce frustration. Examples include the use of plain English and avoiding healthcare jargon (see section 1.1), and enhancing flexibility in appointment booking systems and schedules.

Acknowledging consumers and consumer representative groups is a crucial factor in improving the experience in healthcare. Along with Community Advisory Committees (see section 1.2), representation should occur through board engagement and representation, taking into account the required skill mix for effective governance. Good governance is an important component of continuous improvement, which in healthcare is related to health outcomes and people's experience. Victoria's long history of devolved governance encourages board selection to occur from a broad cross section of the population. Promoting diversity in board appointments is crucial to ensuring good governance, and consumer focused design and approach to health service planning. Health and community services must be supported to attract and retain appropriately skilled and diverse board applicants, who have the necessary skills for good governance including knowledge of quality systems and processes, financial, and legal skills. Appointed board members must also be able to access appropriate training and professional development to maintain and build upon their governance skills.

Recommendation:

8. Promoting high quality governance of all health services is essential to improving people's health outcomes and requires support for the appointment process and ongoing training. Board members must possess the necessary skills for good governance and should be reflective of the population they serve to ensure that outcomes that matter to consumers are considered in strategic planning, service delivery and organisational priorities.

[13] Department of Health (NHS) 2012, "A Qualitative and Quantitative Evaluation of the Introduction of Best Practice Tariffs" Available from: http://www.population-health.manchester.ac.uk/healtheconomics/research/reports/bpt-dh-report-21nov2012.pdf
[14] Johnson 2014, Australian Journal of Advanced Nursing "Health literacy: does it make a difference?" Available from: http://www.ajan.com.au/Vol31/Issue3/5Johnson.pdf

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4. Improving the way the system works together – integration, technology and data

How should health services work together to strengthen the delivery of health care in Victoria?
What incentives could be used to encourage more partnering across organisational boundaries in Victoria?
What opportunities do Primary Care Networks provide, and what should they do in the future?

4.1 Integration

Measures to address health and wellbeing are not the sole responsibility of the health sector. Firstly, the health system has substantial overlap with both the aged and disability care systems. A holistic approach to person centred care must include recognition that the overwhelming majority of people requiring services through the disability or aged care system will also require health and community services.

For example, those in residential care, receiving a home care package, or receiving Commonwealth Home Support Programme services will commonly receive health services within aged care programs, and outside of these programs at GPs, community health organisations, and public health services. It is also common for consumers to transition from health settings into aged care programs and vice versa. The national aged care reforms and the roll out of the National Disability Insurance Scheme will have impacts on the operation and service delivery of healthcare in Victoria.

Service models must be designed to ensure that people receive care and support in the most appropriate settings, are supported to transition between service settings, and are able to receive services from multiple systems at one time in an integrated way that minimises duplication. Doing so can both better meet consumer preferences and demonstrate efficiency.

Measuring integration across sectors is possible and should be encouraged. Avoidable utilisation of health services in addition to, or as a replacement for, aged care or disability programs may be seen as a way of measuring the effectiveness of integration and should be included in centralised data collection and reporting (see below, section 4.3).

As well as service integration, health must consider broader contributing factors. Prevention and early intervention also occurs through supporting positive social determinants of health including but not limited to job security, education, food security and housing. The social determinants of health[15] are an upstream approach to health policy, and encourage consideration of many factors that can influence health outcomes. Building upon this theoretical approach, the Health in all Policies (HiAP) approach is endorsed by the World Health Organisation[16], and calls on governments to consider all public policies across all sectors through a health framework, and to recognise the implications of decisions, seek synergies, and avoid harmful health impacts to improve population health and health equity. It emphasises the impacts of public policies on health systems, determinants of health and wellbeing. To support this approach, a Framework for Country Action has been developed[17].

This approach has been undertaken by the South Australian Government. Introduced in 2007 by Professor Ilona Kickbusch (the Adelaide Thinker in Residence), a number of projects have been

[15] Wilkinson & Marmot 2003, "Social determinants of health: the solid facts. 2nd edition" Available from: http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf
[16] Available from: http://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf?ua=1
[17] Available from: http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1

undertaken including the promotion of active transport, encouraging active ageing through employment, and promoting uptake of digital technology[18]. Through this methodology, health can be promoted outside of health services, creating more effective channels to address issues such as risk factors for chronic disease, through avenues such as safe active transport, food security, and health literacy.

This approach to health is fundamental to breaking down the silos that exist between different sectors relevant to health, as well as the historical silos that exist between various segments within the health sector. Understandably, these barriers have developed in part due to the inherent competition that exists when receiving funding from a limited funding supply. Addressing this may go some way to reducing the perceived barriers that exist between and across the spectrum of health and community services, and promote better collaboration.

Streamlining approaches to funding, through management of funding sources as well as simplifying reporting and regulation requirements would significantly improve the efficiency of health services, and reduce the regulatory and reporting burden of publicly funded programs. With the current Commonwealth focus on Federation reform, there is an opportunity for such issues to be discussed between the state and federal governments to determine funding approaches that can facilitate a more efficient and effective healthcare system, that better incentivises integrated prevention and healthcare.

Recommendations:

9. State and territory governments have an important role in designing systems that support people to receive care and support in the most appropriate settings. Transition support is critical for populations who receive services from multiple service systems and/or move between service providers or sectors.

10. State and territory governments have an important role in play in the prevention and management of chronic disease. There is an opportunity for the states to ensure a health lens is applied to all policy and funding decisions, as they may all impact on health and wellbeing. This central oversight is crucial to creating healthy environments and making healthy decisions the easy decisions, without the natural borders of departmental decision making.

4.2 Technology

The increasing use of technology in health care will gain greater momentum as the Commonwealth considers moves towards an opt-out Personally Controlled Electronic Health Record (PCEHR). Whilst the PCEHR requires ongoing review and work to optimise its functionality, it is essential that health and community service organisations are also supported to implement optimal medical technology and ehealth systems that can both support national platforms, and also deliver best practice patient care. Interoperability between the PCEHR and other client records, such as My Aged Care client records, the incoming Carers Gateway, and equivalent systems, must also be ensured to minimise duplication and put the person at the centre of their care. Interoperability between health technology systems must be supported to facilitate communication between organisations, within organisations, and to allow real-time reporting and sharing of information. Innovative opportunities also exist for electronic health records to link to electronic devices which may be able to monitor physiological data, and transmit such data in real-time.

[18] Further information available from: http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+reform/health+in+all+policies/health+lens+analysis+projects

As discussed above (see section 1.2), remote health options are one key component of facilitating person centred care and improving accessibility. Technologies such as telehealth require investment for both infrastructure and service provision. Remote health access is critical to improving health outcomes for consumers who have limited access to health and community services such as rural and regional Victorians, especially for specialist services. Utilising technology to assist access may also reduce the delays experienced by rural and regional Victorians in being referred to and accessing specialist care.

Recommendations:

11. To support health and community service organisations to upgrade existing information and communication technologies to be compatible with the PCEHR and other individual records, future health technology decisions must consider interoperability between systems, including for internal and external reporting across service systems, as well as for remote health delivery and real-time monitoring.

12. Appropriate investment should be prioritised for both infrastructure and service provision utilising technology, especially in areas where health and community service access is limited.

4.3 Data Management

Copious amounts of data are collected by governments at all levels, assisting with reporting, benchmarking and reporting. However, this information is often provided only in a one-way direction, without timely feedback to the services submitting the information. Victoria could be considered to be data rich, but knowledge poor, with little focus on interpretation or meaningful dissemination of data. Centralised data collection should also be supported by centralised and timely data review, to ensure appropriate identification of health performance trends. The data collected by DHHS should be made widely available to the health sector and the public to facilitate benchmarking, performance evaluation and population health planning. An efficient and effective health system requires continuous quality improvement, and data to inform such processes. Provision of data in a timely and meaningful manner assists with transparency and accountability of health and community services and their performance. Further to section 1.1, there is also an opportunity for data review to involve consumers, thus acting to promote health literacy and further engage people.

An additional benefit of improved data management and distribution is improved support and dissemination of innovation. Improvements to data communication would help to support the identification of best practice and successful innovation programs. With this in mind, the Victorian Government department(s) should ensure that formalised networks are supported to share innovation initiatives and projects, for example through Communities of Practice or incubator models. Supporting the strengths that exist within current programs and services will lead to efficient promotion of innovation

Recommendations:

13. Centrally collected data should be reviewed and made available in a timely manner for review by the health sector to encourage benchmarking, performance evaluation and population health planning.

14. Data management is one way of supporting and building upon innovation within the health and community sectors. A strengths based approach should also be encouraged to support pockets of excellence and organic innovation by the sector through initiatives such as incubator models.

4.4 The role of Primary Health Networks

The evolution of PHNs in Australia from Divisions of General Practice, to Medicare Locals and now to their current iteration is met with positive anticipation regarding the potential they have for enabling true regional planning with economies of scale across their geographic areas. PHNs will be tasked with improving health outcomes by integrating and coordinating health services, aiming to reduce fragmentation of healthcare.

In order to deliver integrated, coordinated care, the funding of PHNs must remain flexible to ensure that local population health priorities can be met through locally appropriate interventions and programs, as well as partnerships to achieve healthy outcomes. Funding provided must also support partnerships within health and across sectors in order to embed best-practice health promotion and prevention activities into society more broadly.

Although PHNs are a Commonwealth responsibility, there is an opportunity for Victoria to add value to their role to promote integration with state-based services and local policies. Opportunities exist for Victoria to work with PHNs to address shared priorities and better manage the interface between acute and primary care in a bilateral manner, to better manage avoidable hospital admissions, to keep people well and out of hospital, and to facilitate successful discharge. Victoria must engage with and support PHNs to play an appropriate role in strengthening local primary health programs. Rather than being treated as add-ons, the state has an opportunity to recognise and address PHNs as core components of a fully integrated health system contributing to area based service plans in partnership with local health services.

It is vital that PHNs are supported and funded appropriately to properly fulfil their objectives. In order to simplify the health system for consumers and providers, PHNs must be able to work with key stakeholders within and external to health to develop meaningful, strategic relationships that can be outcomes focused.

Recommendation:

15. There is an opportunity for collaborative funding and support to shape the important work of PHNs and ensure they are relevant and effective for all Victorians. Work should be done to identify shared priorities and to better manage the interface between acute and primary healthcare.

4.5 Medical research

Australia has a long history of undertaking world-class medical research, which is vital to improving patient outcomes and health service delivery. Research into influencing social determinants of health is also gaining traction. With research activities able to deliver clear findings, research projects require support to embed findings into policy and practice. For example, the National Health and Medical Research Council has introduced specific initiatives to support research translation. This shift in focus must also be supported within the health service setting to ensure effectiveness, efficiencies, and best practice outcomes. These types of relationships should be supported between health and community services and research bodies to foster relationships between researchers, academics and clinicians and enhance the translation of research into clinical and social practice.

Recommendation:

16. Increasing priority must be placed on translational research to ensure that best-practice can be embedded within health service delivery. Incentive models should exist to promote collaboration between health and research bodies to drive this work.

4.6 Sustainability

As governments become increasingly cognisant of ensuring sustainable health funding models, it is important that sustainable models of care are supported, and that non-core services and responsibilities can be undertaken in a streamlined fashion.

Relevant examples include duplication of procedural matters, and duplication in reporting and regulatory requirements. This is particularly relevant to Victoria's health and community services that provide services across multiple government departments such as health, aged care, and disability.

The VHA recognises that rigorous regulation is critical to ensuring the safety and quality of our public healthcare system, however, excessive requirements may have the opposite effect. The VHA has previously advocated for work to be done on issues such as accreditation and reporting to work towards unified, streamlined, hierarchical accreditation processes for health and community services. This approach is also necessary for reporting, and consistent reporting frameworks are necessary to reduce the burden on health and community services[19]. Additionally, the Victorian Government has also initiated work to identify ways to streamline reporting in the Community Health sector, and the VHA is actively participating in this process.

In addition, partnerships across and between sectors based on shared priorities could contribute to improving health sector sustainability. As discussed above (see section 4.4), promoting area based service planning would identify shared priorities, and also allow collaboration to share resources, programs and tools to address local population health needs.

Recommendations:

17. Requirement for government reporting should be streamlined and able to be completed through fit-for-purpose platforms.

18. Area-based service planning and partnerships across and between sectors should be encouraged to allow better service integration and sharing of resources to address local population health needs.

[19] Available from: http://www.vha.org.au/docs/2015_submission_reducing-regulation-in-the-health-portfolio-final.pdf

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5. Better health for people in rural and regional areas

What do we need to focus on to ensure that people living in rural and regional areas are able to achieve the same health outcomes as people in metropolitan Victoria?
How can we ensure rural health services are able to contribute to thriving and vital rural communities?
How do we ensure people in rural and regional areas get the high quality and safe care they deserve?

Rural and regional health poses a number of challenges in Victoria. Known gaps in health outcomes exist between rural and metropolitan Victorians, with many contributing factors. These include health workforce shortages and accessibility to healthcare with regards to timing and distance[20].

Rural health services are often key components of a rural community, and can be the largest employer in a rural or regional area, thus creating jobs and stimulating local economies. Rural and regional health services are important in responding to local health priorities, delivering health promotion activities, and providing care close to home. In many rural areas the public health service may be the only provider not only of health services, but of other community services such as disability and aged care.

Models such as peer-led chronic disease prevention and early intervention (see above, Section 2) have the potential to be highly effective in rural and regional areas, to build upon concepts such as social capital, a key social determinant of health.

5.1 Workforce

A skilled, multidisciplinary health workforce is required to deliver positive health outcomes regardless of location. Recruiting and retaining a rural and regional workforce remains a challenge for the Victorian health sector, even with the use of evidence-based approaches to address this, such as providing high quality rural and regional clinical training opportunities for health professionals. Positive experiences in rural placements have been demonstrated to increase the likelihood of a health professional seeking employment in a rural location[21]. This underscores the importance of supporting health service organisations to provide high quality, engaging clinical placement experiences for training health professionals. Quality clinical education also requires quality clinical educators, and health services must be supported to develop the skillset of their educators and the quality of their education programs.

Given the smaller scale of rural and regional healthcare, the skillset of healthcare workers must be broad, to enable management of a large range of conditions and injuries. With health training trending towards increasing specialisation, and the perceived reduction in status of the traditional General Practitioner[22], workforce morale can be impacted as well as the ability to recruit trainees into generalist roles across all health disciplines. Regardless, rural and regional health demands an ability to manage the broadest range of presentations with considerably less resources than those available in metropolitan settings. Support is required to encourage the development of flexible, specialist-generalist health professionals who can provide high quality, accessible and patient centred care in rural and regional settings.

[20] Source: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459022
[21] Playford et al 2006, *Australian Journal of Rural Health* "Going country: rural student placement factors associated with future rural employment in nursing and allied health" Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1584.2006.00745.x/abstract
[22] Source: http://www.ahwo.gov.au/documents/NHWT/The%20health%20workforce%20in%20Australia%20and%20factors%20influencing%20current%20shortages.pdf

Recommendation:

19. Flexibility in training options including support for rurally based training and increased promotion of a specialist-generalist workforce must be supported to develop a skilled multidisciplinary rural and regional workforce.

5.2 Service delivery

As discussed in section 1.1 and 1.2, flexibility of health and community services is a key driver of accessibility, and this is especially relevant for rural and regional areas. With rural and regional areas predicted to experience a relatively larger growth in older population groups compared to metropolitan Melbourne, managing health issues, especially those related to ageing, will be a growing challenge.

Funding for high quality service delivery will need to be flexible to ensure that the best possible health outcomes can be achieved, and these will in part be determined by individual patient circumstances. More responsibility should be given to health services with regards to flexibility of funding allocation, with discretion for setting service targets that are appropriate to local need and the local context.

This flexibility should also extend to rural and regional Victorians accessing care in metropolitan settings. Initiatives such as the Victorian Patient Transport Assistance Scheme go some way to supporting individuals and their carers who must travel to access health services, however, more can be done to promote and extend these programs to increase awareness and accessibility. Along with this program, strategies to address rural and regional equity need to address the issues faced by rural and regional Victorians and ensure that models of care provide the most appropriate service in the right place at the right time.

Investment in health technology, particularly technology which supports remote access (see section 4.2) is also vital to improve rural and regional health outcomes. As well as infrastructure support, funding models must support the provision of services in this manner.

In order to continue to support the delivery of high quality health and community services, the government must ensure that rural and regional health infrastructure is maintained, improved and expanded where appropriate and in accordance with service planning.

Recommendations:

20. Rural and regional health funding models must reflect the importance of remote health service delivery, and be appropriately flexible to consider the variety of ways in which people will interact with health services if they are located in rural or regional Victoria.

21. Access to remote health services is particularly important for rural and regional Victorians, and support should be provided accordingly to ensure equity in health service access.

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6. Valuing our workforce

What more can we do to ensure health workplaces are free from violence and bullying, and health workers are empowered to innovate and participate in reform?
What kind of changes to education and training are needed to support reform?
How can the health workforce be better engaged in designing and delivering on healthcare reform?

Without a highly skilled health workforce, the health sector would not be able to deliver health services across the care continuum. These individuals must be valued, and this appreciation must be explicit. Although potentially unintentional, the disparities between various health sector wages and conditions can impact upon career choice and employment preferences. This can impact upon the ability of sectors with disparate wages and conditions to recruit and retain appropriate staff.

As well as demonstrating support and appreciation for health professionals, there are minimum expectations that must be adhered to for employee workplace safety.

6.1 Protecting our workforce

The historical hierarchical culture of the health workforce, embedded through training and education models, is a complex issue to address and one which requires action from many stakeholders. Current examples exist, with the Royal Australasian College of Surgeons recently completing their report into discrimination, bullying and sexual harassment[23]. System wide approaches to reduce bullying must begin in education and clinical supervision environments. Although vocation specific cultures are a difficult matter to address from a government perspective, organisational culture is a larger component which can provide support for health workers, and encourage reporting of unacceptable behaviours. Building strong and supportive workplaces is one aspect of addressing bullying and harassment that can be driven centrally. Building strong organisational cultures requires true leadership, and health organisations must be supported to empower great leaders to build safe and strong systems.

Addressing violence towards frontline healthcare workers is becoming a greater concern, especially in high-risk settings such as acute psychiatric units and emergency departments. Keeping the workforce safe while maintaining quality care can at times be mutually exclusive, and health and community services must be able to prioritise staff safety. Violence towards healthcare workers is never acceptable, and community standards and attitudes must reflect this. Parallels can be drawn with professions dealing with comparable scenarios such as emergency response teams. Health and community services must be able to learn from comparable industries.

As well as preventing violent incidents in healthcare settings, it is important to identify the reasons for violence. Many contributors are possible, and include mental illness, effects of substances (prescribed, non-prescribed, and illicit), frustration, and cognitive impairment. Addressing the causes is a much more effective method of addressing the problem, and each contributor will require a different action. Examples include management of psychiatric illness, management of substance abuse issues, and providing avenues for patient feedback. These matters require long term social investment in population-wide approaches, and cross sector support from multiple areas of government. This further demonstrates the importance of a Health in All Policies approach (see section 4.1).

[23] Available from: https://www.surgeons.org/media/22086656/EAG-Report-to-RACS-FINAL-28-September-2015-.pdf

Recommendation:

22. Health and community service organisations must be supported to prioritise building strong, supportive and positive organisational cultures that discourage unacceptable behaviours such as bullying, and promote a safe environment where individuals are able to raise concerns without fear of retribution and knowing that concerns will be appropriately followed up.

6.2 Enabling our workforce

The Victorian health workforce is made up of many different health professions, each with its own range of skills, knowledge and abilities. Many of these professions are currently underutilised, and have significant untapped potential. Allowing highly trained health professionals to work to the peak of their training and skillset within safety and quality frameworks will promote not only staff satisfaction, but also increase opportunities for people to receive timely, high quality care in their local environments. For example, extended scope of practice models of care have been shown to be effective in a range of patient groups, but there is limited centralised support to roll out these approaches across the state. Enabling clinicians to work to the limits of their scope of practice, and encouraging ways to safely extend clinical scope of practice will promote innovation and service efficiencies, as well as improve clinician satisfaction[24].

Health professionals are more likely to engage in innovation and reform if they feel their opinions and feedback are valued and contribute to outcomes. With a wide range of professionals and auxiliary staff involved in health service delivery, appropriate representation of the breadth of the health workforce will support engagement with innovation and reform. Similar to diversity with regards to organisational governance, diversity in views will support innovation and promote engagement from more stakeholders in delivering healthcare reform.

As discussed above (see section 6.1), supporting excellence in leadership is particularly relevant for building strong organisational culture, especially when aiming for a culture that promotes innovation. Investment in emerging leaders should also be supported through development and incubator programs.

Recommendations:

23. Health workforce diversity must be valued and appropriately represented in system design, service innovation and reform. Engagement from the wide range of skilled and professional healthcare workers will support diversity of views and innovative reform.

24. Support should be provided for excellence in leadership in emerging and established leaders in order to support strong organisational cultures and foster innovation.

[24] Available from: http://findahealthservice.act.gov.au/c/fahs?a=sendfile&ft=p&fid=1592030095&sid=

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7. Further information

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

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8. Appendix - Recommendations

A person centred view of healthcare, with equitable access

Engaging people

1. To better facilitate person centred healthcare, broad population health measures must be implemented to improve population health literacy and allow meaningful consumer engagement in health system design and planning. Support must continue for existing platforms that provide user friendly, accessible health material for consumers, as these platforms provide opportunities for expansion as the health system continues to evolve.
2. Person centred care should be embedded across the whole health system. Consideration should be given to how this can best be addressed through measures such as clinical education and training, and consumer feedback.

Flexibility

3. A person centred and equitable health system must incorporate flexibility in service delivery. Funding models and incentives for care should be structured to support and encourage flexibility, which may include models of care delivered outside the health service's physical infrastructure.

Accessibility

4. Health services must be accessible to all people, and special consideration must be given to equity measures targeting priority populations. Accessibility must be considered in relation to infrastructure as well as resource and service access, and particularly for remote access.
5. High risk populations may benefit from increased support in the community to assist with coordination of services and patient advocacy, and consideration should be given to ensuring models of care exist that promote the most appropriate care in the most appropriate location regardless of referral, in a "no wrong door" approach.
6. Support for consumer engagement should continue to allow evolution of engagement models to facilitate collaboration for person centred system and service design.

Preventing and treating chronic disease, early intervention

7. Prevention and health promotion activities must be funded across sectors to ensure appropriate stakeholder engagement and best use of available skill sets and resources, to address chronic disease and prevent avoidable hospital admissions.

Improving people's health outcomes and experience

8. Promoting high quality governance of all health services is essential to improving people's health outcomes and requires support for the appointment process and ongoing training. Board members must possess the necessary skills for good governance and should be reflective of the population they serve to ensure that outcomes that matter to consumers are considered in strategic planning, service delivery and organisational priorities.

Improving the way the system works together

Integration

9. State and territory governments have an important role in designing systems that support people to receive care and support in the most appropriate settings. Transition support is critical for populations who receive services from multiple service systems and/or move between service providers or sectors.
10. State and territory governments have an important role in play in the prevention and management of chronic disease. There is an opportunity for the states to ensure a health lens is applied to all policy and funding decisions, as they may all impact on health and wellbeing. This central oversight is crucial to creating healthy environments and making healthy decisions the easy decisions, without the natural borders of departmental decision making.

Technology

11. To support health and community service organisations to upgrade existing information and communication technologies to be compatible with the PCEHR and other individual records, future health technology decisions must consider interoperability between systems, including for internal and external reporting across service systems, as well as for remote health delivery and real-time monitoring.
12. Appropriate investment should be prioritised for both infrastructure and service provision utilising technology, especially in areas where health and community service access is limited.

Data management

13. Centrally collected data should be reviewed and made available in a timely manner for review by the health sector to encourage benchmarking, performance evaluation and population health planning.
14. Data management is one way of supporting and building upon innovation within the health and community sectors. A strengths based approach should also be encouraged to support pockets of excellence and organic innovation by the sector through initiatives such as incubator models.

The role of Primary Health Networks

15. There is an opportunity for collaborative funding and support to shape the important work of PHNs and ensure they are relevant and effective for all Victorians. Work should be done to identify shared priorities and to better manage the interface between acute and primary healthcare.

Medical research

16. Increasing priority must be placed on translational research to ensure that best-practice can be embedded within health service delivery. Incentive models should exist to promote collaboration between health and research bodies to drive this work.

Sustainability

17. Requirement for government reporting should be streamlined and able to be completed through fit-for-purpose platforms.
18. Area-based service planning and partnerships across and between sectors should be encouraged to allow better service integration and sharing of resources to address local population health needs.

Better health for people in rural and regional areas

Workforce

19. Flexibility in training options including support for rurally based training and increased promotion of a specialist-generalist workforce must be supported to develop a skilled multidisciplinary rural and regional workforce.

Service delivery

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Valuing our workforce

Protecting our workforce

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Enabling our workforce

23. Health workforce diversity must be valued and appropriately represented in system design, service innovation and reform. Engagement from the wide range of skilled and professional healthcare workers will support diversity of views and innovative reform.

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