Victorian Healthcare Association

Rethinking our health system

State election priorities 2014

Introduction

Victorians will go to the polls on 29 November 2014 to elect the 58th Parliament of Victoria.

Rethinking our health system outlines 12 policy priorities, which are based on extensive member engagement and on VHA research.

These priorities acknowledge increasing demands on the health system and an ever-tightening economic climate.

In this context, the VHA is calling for a rethink of the way the Victorian healthcare system is designed to:

1. Provide more equitable access to health services
2. Empower health services to make the best decisions for their community
3. Ensure health services are adequately resourced to fulfil their responsibilities

The VHA

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
  - advocating for Victoria's devolved model of healthcare governance, and
  - leading by example through contemporary governance practice.

The context

Victorian health services have experienced significant reform in recent years. They have seen the progressive implementation of the National Health Reform Agreement (NHRA), the introduction of the National Disability Insurance Scheme (NDIS), aged care reforms, and an agreement to transition Victoria's Home and Community Care (HACC) program to commonwealth control from 2015. The Personally Controlled Electronic Health Record (PCEHR) has been developed with the intention of facilitating seamless healthcare delivery and the State Government has made major reforms to community mental health, alcohol and other drug services, and the service sector.

Each of these reforms has affected the way Victorian health services are funded and organised, the relationships they have with other organisations, and the processes and technology they use. While many of these changes have had a positive impact, they have done little to reduce the service duplication which already existed, and in some cases have exacerbated it. They have also failed to ensure that service gaps are filled, and that services are delivered in a truly integrated way. In some areas, there is now less integration than ever due to an increasingly siloed approach to program development and funding.

Victoria is also facing a range of health and social challenges including population growth, an ageing population and increasing rates of chronic disease. By 2021, the state's population is projected to increase by 19 per cent to 6.6 million people, with 5 million people living in metropolitan Melbourne, and 1.6 million in rural and regional Victoria. This represents an increase of 22 per cent and 12 per cent respectively.[1]

On average, people aged over 75 years use five times as many health services as people aged under 75.[2] The number of people aged 75 and over is projected to increase by 40 per cent in metropolitan areas, and by 29 per cent in rural and regional areas.[3] The combination of population growth, ageing and increasing rates of chronic disease will place growing pressure on Victorian health services in the future.

While demand is expected to increase due to these demographic trends, the 2014-15 federal budget has signalled a massive reduction in funding for Victoria's hospital growth after 2017, and a decrease in federal funding for preventative health. This is a significant additional burden on Victoria's acute healthcare providers, who are experiencing ever increasing demand for their services, particularly across the state's metropolitan growth areas and regional centres.

The spectre of reduced hospital funding and increasingly scarce resources across the board will serve to highlight a number of unavoidable facts including the importance of a well-funded and effective primary and community health sector. This sector has a crucial role to play in reducing demand for expensive acute inpatient care.

Additionally, to ensure the most effective use of specialist resources and technology, and equitable consumer access, a statewide approach to providing specialised services is necessary, including a focus on telehealth.

The future

To meet future challenges head on, the Victorian Government needs to change the way our system is funded and organised. While the *Victorian Health Priorities Framework* (VHPF) provides a blueprint to achieve this, there appears to have been little progress against its objectives.

There is an urgent need to progress these objectives by shifting investment from acute inpatient care to preventative and community-based care. The state government needs to develop a clear primary health strategy to set out its expectations for the operation of the primary health sector, and the way it should link with other providers across the system. The introduction of Primary Health Networks (PHNs) has the potential to enable greater coordination and integration of services, and the state government should make every effort to ensure that these benefits are realised.

PHNs also provide an opportunity for the state to devolve responsibility for population health planning to the areas defined by these networks. In turn, health services will need to be granted autonomy in order to work effectively with PHNs and respond to local population needs. Increased autonomy will also allow health services to implement longer-term plans responsive to their local environments, facilitated by a move to a three-year, rather than annual, funding and planning cycle.

Services need access to capital funding for asset replacement on the basis of population need, rather than through the current grant-based process. This should include the ability to seek private capital investment consistent with a sound, reasonable business case for the purposes of improving operational or service model efficiency.

To transfer more authority and responsibility to health services from central agencies, the VHA advocates the creation of sub-regional bodies that are controlled by existing health services. Each body would cover a broad catchment, undertake sub-regional service and capital planning, and receive three-year (rather than annual) funding to allow greater strategic focus.

Under this model, the state will retain a crucial role as the system designer and will need to:

- **provide clarity about the direction of specialised and statewide services**
- **develop and implement system-wide approaches for ensuring supply is better matched to demand**
- **facilitate the provision of technology to permit seamless delivery of care across the system**
- **remove barriers to the efficient and effective operation of the system**
- **provide information that will facilitate improvement in care, and will ultimately inform consumer choice.**

There is an urgent need to progress these objectives by shifting investment from acute inpatient care to preventative and community-based care.

Our election priorities

The VHA has 12 priorities for action by the next Victorian state government. These priorities are organised under three themes.

1.

Theme 1: Provide more equitable access to health services

1. Strengthen prevention and community based care
2. Improve access to specialised care
3. Utilise technology to deliver care seamlessly and cost effectively
4. Provide access to elective surgery in clinically appropriate times

2.

Theme 2: Empower health services to make the best decisions for their communities

5. Provide health services with clarity of their role in the broader health system and in relation to their local community
6. Provide clearer delineation of the roles of boards, the Minister for Health and the Department of Health in healthcare governance
7. Remove unwarranted restrictions for accessing capital, restrictive workforce practices, and excessive compliance obligations

3.

Theme 3: Ensure health services are adequately resourced to fulfil their responsibilities

8. Ensure recurrent funding reflects rising costs
9. Ensure funding adequately reflects changing complexity and patient mix
10. Ensure the cost of urgent patient transfers is funded directly by the Department of Health
11. Reinvest productivity savings from public health services into health innovation
12. Provide health services and clinicians with information that will facilitate improvement in care

1.

Provide more equitable access to health services

Ensuring more equitable access to healthcare is crucial as demand rises and funding becomes more constrained.

The solution is a system-wide approach to matching supply with demand and providing infrastructure that optimises the effectiveness of the sector.

Election Priority 1:
Strengthen prevention and community-based care

Election Priority 2:
Improve access to specialised care

Primary care must be provided in a more systematic way to maximise the use of finite resources, and to respond to local population needs through a balanced system of wellbeing, health promotion, illness prevention, rehabilitation, treatment, and effective care management. This requires development of a clear strategy. Input and coordination will be required from different portfolios – including health, human services, justice, education and early childhood development – to provide a comprehensive people-centred strategy.

The Victorian Government will also need to continue to fund preventative health programs as a means of improving future health outcomes for Victorians, and managing costs within the health system. Collaboration between government, health services, researchers and consumers will ensure that preventative efforts are targeted and evidence-based.

System design must reflect the reality that healthcare is becoming increasingly specialised. A system-wide approach is needed to improve patient flow, appropriately increase capacity, and harness technology and emerging practices, such as telehealth, to deliver services that are effective, safe, cost effective and accessible, particularly in rural areas.

The configuration of rural health services requires specific consideration. Significant population growth is expected in rural and regional areas over the next 10 years, (particularly people aged over 65 years). In many rural areas, health status, outcomes, and health behaviours are significantly poorer than the state average.

Rural health services face the added challenge of accessing the necessary resources to provide services to dispersed populations. This requires innovative service models – which may include tighter integration of health and human services through changes to funding, service and workforce arrangements, and the use of technology such as telehealth to overcome barriers associated with distance.

These ideas are not new. They were articulated in the *2011 Victorian Health Priorities Framework*,[1,2] although only limited progress has been made towards the framework's objectives. Recent Victorian budgets have placed more emphasis on the funding of primary and community health, mental health and drug services.[3] However, funding for these services starts from a low base and they now receive proportionately less of the total Victorian health budget than they did 10 years ago.[4]

Election Priority 3:
Utilise technology to deliver care seamlessly and cost effectively

The Victorian Government accepted the Health Sector ICT Review Panel's recommendations,[5] including implementation of an electronic medical record (EMR) to increase health system productivity and deliver higher standards of care. However, apart from isolated projects, there has been no evidence of widespread or systematic investment in this area.

An individual healthcare identifier (IHI) and supporting initiatives, such as the Personally Controlled Electronic Health Record (PCEHR), are designed to allow information sharing and care coordination between health services. However, most legacy systems used by health services cannot interface with each other or the PCEHR. In future, all health service information systems must be interoperable to enable new partnerships and more integrated care.

Telehealth supports ongoing improvements in care delivery and improves access to specialised services, particularly in rural areas. There are some excellent Victorian examples of telehealth supporting workforce training and access to specialised services in oncology, pain management, and urology. However, funding is limited and telehealth is not being developed and implemented in a systematic way.

Image: Royal District Nursing Service.

Election Priority 4:
Provide access to elective surgery in clinically appropriate times

Our public healthcare system is consistently unable to meet the national elective surgery targets for treating semi-urgent and non-urgent patients in clinically appropriate times. This is a result of a mismatch between demand and supply across the system and constrained capacity in some hospitals.

In addition, the way elective surgery is reported does not reveal the entire story. In particular, endoscopic procedures are not reported on the elective surgery waiting list, smaller hospitals don't report elective surgery activity, and the elective surgery waiting time does not cover the time a patient waits to see a specialist. These factors can disguise the true activity of the system, and potentially create artificial barriers affecting throughput and access. There has been some movement to address this issue through the work of the Australian Institute of Health and Welfare and the Royal Australasian College of Surgeons,[6] and the reporting of waiting times for specialist clinics in Victorian public hospitals.[7] However, this work needs to be further progressed and expanded so reporting of the waiting times for elective surgery more accurately reflects the time patients wait for an elective surgery procedure, and whether the treatment is performed within clinically appropriate times.

A study by the VHA showed that system-wide changes are required in order to provide increased transparency of access to elective surgery and to ensure that demand for surgery is better met.[8]

The way elective surgery is reported does not reveal the entire story … waiting time does not cover the time a patient waits to see a specialist.

VHA Election Priorities

Priority	The next Victorian Government should...
1. Strengthen prevention and community-based care	> Develop a clear primary health strategy that sets out Victoria's expectations for how its primary health sector will work, perform, and link across the health system. > Build further capacity in primary and community care through prioritising an iterative funding transfer each year from acute to primary and community health care. > Increase its commitment and investment into preventative health. > Use population health approaches to planning to inform area-based planning in Victoria, with support and involvement from relevant service providers and commissioning organisations in each region. > Continue to develop funding models, such as packages of care, to drive further integration across portfolios and the care continuum for patients with complex care issues.
2. Improve access to specialised care	> Develop a planning framework that ensures specialised services can operate viably and safely across the state. > Improve access to these services through the use of technology (such as telehealth) and service and funding arrangements (e.g. support for people to more quickly return to a local health service following surgical procedure and/or specialised hospital treatment). > Promote further structured service relationships between referral agencies and local health services.
3. Utilise technology to deliver care seamlessly and cost effectively	> Fast-track implementation of the EMR, supported by appropriate investment. > Adapt legacy systems to initiatives supporting the IHI, such as the PCEHR, particularly in order to support cross-organisation referrals and record sharing. > Ensure any future systems developed/implemented for health services in Victoria are interoperable. > Expand the use of telehealth to improve access to specialised services.
4. Provide access to elective surgery in clinically appropriate times	> Ensure consistency by measuring access to elective surgery through a KPI that reports access within clinically appropriate times.[9] > Expand reporting to include all public health services that undertake elective surgery, increase the scope of elective surgery procedures reported, and include the time that a patient waits for a specialist appointment, in the total waiting time. > Provide investment for systems and mechanisms that improve linkages between surgical procedures and primary health and prevention to improve the quality of specialist referral. > Develop and implement mechanisms for enabling demand to be matched to supply across the system, including "automatic referrals"[10] for facilitating access to specialised surgery, and "indirect referrals"[11] for matching supply to demand for elective surgery across the system. > Increase capacity by investing in further infrastructure where capacity is constrained and through utilising latent capacity that exists in the system (including local health service theatre capacity where appropriate).

2.

Empower health services to make the best decisions for their communities

In a constrained economic environment, the healthcare sector must determine how to respond to ever increasing demand.

In this environment, health services require further autonomy to deliver services that are more responsive to the needs and expectations of their populations, now and in the future.

Election Priority 5:
Provide health services with clarity of their role in the broader health system and in relation to their local community

Election Priority 6:
Provide clearer delineation of the roles of boards, the Minister for Health and the Department of Health in healthcare governance

Our system suffers from duplication, service gaps and inefficiencies caused by a range of factors. These include the lack of sub-regional planning frameworks, the presence of multiple funding streams and funders, and the lack of clearly defined roles for all the participants in health system governance.

In order to address these issues, and to balance the risk to government of granting greater autonomy to services, planning frameworks are required which clearly define the roles and responsibilities of health service boards, the Department of Health, and the Minister for Health.

While the *Health Services Act 1988* outlines the powers of the Minister for Health, the Secretary of the Department of Health and health service boards, in practice the role of the Department of Health is not always clear. In the state's current model of devolved governance, the department is at times heavily involved in the detail of health service operations, but provides limited direction in areas where a statewide perspective would be of benefit. This inconsistency increases uncertainty for health services and potentially stymies local innovation. Planning frameworks must clarify the role of the department and the minister in system design, strategic direction setting, performance monitoring, and the distribution of resources on a regional or sub-regional basis, weighted to population health needs.

The VHA advocates stronger sub-regional decision-making through the creation of sub-regional bodies that are big enough to provide effective service and capital planning. There should be a defined process for the devolution of government power to such sub-regional bodies, which should be controlled by existing health services. Having earned their autonomy, these bodies should receive funding on a three-year cycle and assume responsibility for service and capital planning within their catchment.

In a more devolved system, where services respond most effectively to community and organisational needs, the expertise and processes deployed by boards will continue to be of paramount importance. In this regard, the ongoing development of boards will be an important design consideration

The process for appointment of board members also requires reform. Currently, the state government appoints all board members across the state, including appointment of chair for the 19 largest public health services. This process is often subject to delays and limits the ability of boards to engage in succession planning and skills-based recruitment, which are both common activities of non-health sector boards. The VHA would welcome a move to give individual boards greater influence over these areas, perhaps by allowing board chairs greater responsibility for board member recruitment. In addition, many smaller health services are not currently permitted to remunerate board members. All health services should be given the authority to remunerate board members, although some may choose not to do so depending on their circumstances.

Community health services are a great strength of Victoria's healthcare system, providing a focal point for the delivery of non-acute care in community settings, thereby serving to reduce demand on hospitals. This primary care role coexists with a focus on prevention and early intervention. As well as community health programs delivered by health services, Victoria is home to community health services registered separately under the Health Services Act. The process of registering community health services benefits the state by way of regulatory oversight, service continuity and the ability to ensure the efficient use of state-funded infrastructure. However, current planning guidelines are silent on the positive role of registered community health services as part of the broader system, and ignore the benefits that registration provides the state compared to other community sector providers, a situation which should be rectified.

Election Priority 7:
Remove unwarranted restrictions for accessing capital, restrictive workforce practices, and excessive compliance obligations

Some processes to which health services must comply are a source of inefficiency and reduce their ability to plan and deliver services optimally. The current approach to capital funding is one example. Replacement of assets, such as medical equipment and engineering infrastructure, is through either a competitive grant (for items valued at more than $300k), or through a special purpose grant that is not related to asset replacement needs. Failing to replace assets at the end of their useful life can increase costs for maintenance and may pose a risk to patients or staff.

Funding of new or improved infrastructure is through a competitive grant process. This process is not responsive to changing needs, nor is it based upon clear guidelines for project prioritisation, and consequently lacks transparency. This affects the ability of health services to deliver the productivity increases brought by improved infrastructure (including ICT). In fact, inadequate infrastructure can force inefficient processes, and can contribute to higher staffing costs. The health service's ability to plan for future services is also hindered, as capital improvements are required in order to execute strategic plans consistent with advancements in technology, changes in models of care, and changing population needs.

In order to respond more effectively to the needs of the community, health services are developing new service models that may encompass a broad range of professional roles, or changes in existing roles by extending the existing scope of practice of practitioners. This is particularly important in rural areas where the flexibility of the local health services and health professionals to work across the continuum of care enables people to receive responsive, professional care in their community[1]. However, health services encounter significant barriers to implementing workforce change, particularly changes that involve extending the scope of practice of health professionals. As well as resistance by unions, many of the difficulties in workforce change are created by existing legislation and regulation, funding arrangements that restrict the professional groupings that can provide a health service, and entrenched professional cultures. Change requires examining and removing these barriers and impediments for workforce change.

VHA Election Priorities

Priority	The next Victorian Government should...
5. Provide health services with clarity of their role in the broader health system and in relation to their local community	> Provide a statewide planning framework that includes clearer role delineation between different services, and the capabilities of those services. Funding should be based on these delineations and the population's health needs. This includes clearly articulating the role of registered community health services in respect to the provision of health services in Victoria.
6. Provide clearer delineation of the roles of boards, the Minister for Health and the Department of Health in healthcare governance	> Update the current legislative framework, including the *Health Services Act 1988*, to: – Provide clearer delineation of roles and responsibilities for healthcare governance – Strengthen autonomy and decision-making for broad catchments, potentially through the formation of sub-regional bodies controlled by existing health services. > Move to a process for board appointments which provides greater scope for succession planning and skills-based recruitment. > Enable all health services to choose whether or not to remunerate board members. > Continue to invest in the skill development of boards and mechanisms supporting board operations.
7. Remove unwarranted restrictions for accessing capital, restrictive workforce practices, and excessive compliance obligations	> Allocate capital based on a sound business case, rather than a competitive grants process. Larger capital improvements requiring approval by the Treasurer should continue to be undertaken through the current process. > Remove unjustified barriers, including legislative/regulatory barriers and perverse funding arrangements, which restrict the ability of health services to implement innovative service models requiring workforce change. > Review and remove excessive regulatory and compliance obligations, including rationalising superfluous accreditation processes in partnership with the Commonwealth Government.

Capital improvements are required in order to execute strategic plans consistent with advancements in technology, changes in models of care and changing population needs.

3.

Ensure health services are adequately resourced to fulfil their responsibilities

Health services require a diverse set of resources to deliver high quality care.

In addition to adequate operational funding and physical assets, such as building and equipment, health services also need access to information that can inform improvements in service delivery.

Election Priority 8:
Ensure recurrent funding reflects rising costs

Recurrent funding to health care providers has not kept pace with population increases and rising costs. For instance, the 2014–15 budget reflects funding growth for community health of two per cent. This is not only below inflation, but does not reflect the widening gap between recurrent funding and the rising costs of salaries, operational costs and overheads. For acute providers, while the 2014–15 budget appropriation shows a headline increase of four and a half per cent, the majority of this increase relates to increased activity requirements.

Election Priority 9:
Ensure funding adequately reflects changing complexity and patient mix

Another area where funding does not adequately reflect the cost of providing the service is where Victorian government policy has changed the complexity of the patient mix for patients receiving care within Victoria compared to other states. An example of this is the Competitive Elective Surgery Initiative. As a result of this initiative, surgery for less complex patients for some procedures is more likely to be performed by a private hospital, leaving the public system with an increased proportion of more complex patients. Underlying this issue is the way in which diagnosis related groups (DRGs) are classified.[1] DRGs form the basis of funding activity in hospitals; however, they do not capture factors affecting complexity of treatment such as age, obesity and lifestyle. Further, as the composition of the patient cohort changes as a result of state government policies, the average cost of performing some procedures will increase for Victorian public hospitals.

The increasing complexity of patients receiving community-based services is not adequately reflected in the unit price received for delivering these services. Underfunding of case management for clients with chronic conditions and/or complex needs increases the risk of such clients requiring expensive treatment in the hospital or community sector.

Election Priority 10:
Ensure the cost of urgent patient transfers is funded directly by the Department of Health

A significant cost pressure for many rural health services is the rising cost of patient transport. This cost mostly relates to transferring a patient from one hospital to another, in most instances to receive care that cannot be provided at the rural hospital. For some health services, transport costs can represent as much as four per cent of operating revenue.[2] However, these costs have been escalating in recent years. Analysis of the annual reports of four rural health services where patient transport costs represent between two and four per cent of operating revenue, showed that in the last four years patient transport costs have increased on average by 44 per cent. Operating revenue has increased by an average 16 per cent over the same period.[3] Currently the referring hospital (in most cases the rural health service) is responsible for the cost of patient transport. The reality for these agencies is that there is a reduction in service capacity as a result of meeting the increased cost of patient transfers. The VHA continues to believe that a direct funding relationship should be established between the Department of Health and Ambulance Victoria for all urgent, maternity and paediatric (including NETS) patient transfers, and we call for the next Victorian Government to commit to such an approach.

Election Priority 11:
Reinvest productivity savings from public health services into health innovation

The Victorian Government has been realising productivity savings from Victoria's health sector for many years. These savings may be explicit, such as through reallocation of existing resources,[4] or implicit through funding increases either not keeping pace with rising demand or being less than the increasing unavoidable costs for providing health services (such as wages). The VHA believes that arbitrary savings targets and funding reductions such as these are detrimental to driving innovation and that funding should match the costs of delivering services as already outlined. However, where productivity savings are realised due to government policy, then it is imperative that the resulting funds stay within the health portfolio to be reinvested in system redesign. Further, these funds must be invested in a transparent manner and be focused on delivering improved health outcomes and more effective use of resources.

Election Priority 12:
Provide health services and clinicians with information to facilitate improvements in care

Health services would benefit from comparable information that shows differences in care delivered across providers. This includes information about clinical indicators and information for comparing different models of care for selected procedures.

Reports from overseas and within Australia show that wide, unwarranted, variations in clinical practice are common even where agreed clinical practice guidelines exist.[5] Research has shown that compliance with evidence-based care processes can lead to significant improvements in patient outcomes.[6] Further, provision of comparative information has demonstrated clinical benefit. For instance, peer review (such as through benchmarking) has been shown to be an effective strategy in reducing unwarranted medical practice variation.[7]

The main purpose of clinical indicators is to enable health services to understand differences in provision of services in their region compared to peers, based on factors such as access to services, clinical referral decisions, and the health and wellbeing of a population. Such information enables a health service to understand if action should be taken to address an issue affecting care, such as improving access to non-acute services and/or information or guidelines affecting referral behaviour.

Health services would also benefit from information that compares the effects of different models of care for selected procedures. For example, for hip replacement, there may be benchmark reporting against peers of outcomes such as cost and patient reported outcomes, and inputs such as factors relating to patient complexity, prostheses used, length of hospital stay, and the rehabilitation received. The purpose of the benchmarking is to enable clinicians to understand potential differences in cost and patient outcomes in delivering care in different ways.

There are a number of initiatives underway in Australia for providing information to facilitate improvements in care delivery. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has performed an analysis exploring healthcare variation in Australia for nine specified conditions and interventions between similar regions, based on catchments of selected Medicare Locals. This process is expected to result in the production of a national Atlas of Variation.[8]

For 2013–14, the Victorian Department of Health funded 14 Victorian health services to benchmark hospital standardised mortality ratios, hospital readmissions, and the relative length of stay through the Doctor Foster Intelligence tools. Four of these health services, Alfred Health, Austin Health, Melbourne Health, and Monash Health, are funded to benchmark against 38 other hospitals from across the United States, United Kingdom, Europe and Australia. Agreements are in place for one year, and will be reviewed at the end of the period.[9]

Similarly, 19 Victorian health services, (including a large private health service), subscribe to Health Roundtable to perform benchmarking of hospitals compared to peers on cost and activity.[10]

This information is welcomed by both health services and clinicians, and there is a desire for this to continue. However, the scope of benchmarking is limited and could be expanded particularly in the areas affecting patient care. Specifically, information that benchmarks decisions in care and the impact they have on clinical efficiency, patient safety, and patient experience is not widely available, and this information would be of value to funders and providers of Victorian health services, and ultimately to people using Victoria's public health services.

Health services would benefit from information that compares the effects of different models of care for selected procedures.

VHA Election Priorities

Priority	The next Victorian Government should...
8. Ensure recurrent funding reflects rising costs	> Adjust recurrent funding allocations to health services so they are responsive to: increasing demand; increases in health price index; enterprise bargaining agreements; legislated increases in superannuation contributions; and other unavoidable costs, such as increases in power prices and ambulance transfers.
9. Ensure funding adequately reflects changing complexity and patient mix	> Recognise the rising cost of providing healthcare to patients with multiple co-morbidities and in circumstances of significant complexity, and align funding to health services in recognition of this. > In the long term, refine DRG classifications so they are sufficiently detailed to include the impact of complexities such as age, obesity, lifestyle factors and social disadvantage. > Fund the case management approach used in many community health services to recognise the primary care needs of complex clients presenting with co-morbidities, particularly those living in social disadvantage, or from culturally and linguistically diverse communities.
10. Ensure the cost of urgent patient transfers is funded directly by the Department of Health	> Establish an arrangement where the Department of Health directly funds all patient transfers for all urgent, maternity and paediatric cases (including NETS).
11. Reinvest productivity savings from public health services into health innovation	> Cease applying productivity savings to public health services (explicitly and implicitly) unless the savings are retained in the health portfolio and are explicitly used to fund innovation in the sector.
12. Provide health services and clinicians with information to facilitate improvement in care	> Compile and distribute information to health services concerning clinical practice across different providers. This includes information about key clinical indicators across different regions, and information relevant to the inputs, outputs and outcomes for care delivered for specific procedures. This information should be made available to health services so they can compare their performance against peers as part of ongoing improvements in care, and at a later point is made publicly available with the appropriate context.

Victorian Healthcare Association

References

Introduction

1. Represents projected population increase from June 2011 to June 2021.
   Source: Victorian Department of Transport, Planning and Local Infrastructure, *"Victoria in Future 2014"*, May 2014
   See, VIF2014_LGAs_ERP_5yr_age_sex_2011_2031.xlsx
   Note: Metropolitan areas include the following LGAs, Banyule, Bayside, Boroondara, Brimbank, Cardinia, Casey, Darebin, Frankston, Glen Eira, Greater Dandenong, Hobsons Bay, Hume, Kingston, Knox, Manningham, Maribyrnong, Maroondah, Melbourne, Melton, Mitchell, Monash, Moonee Valley, Moreland, Mornington Peninsula, Nillumbik, Port Phillip, Stonnington, Whitehorse, Whittlesea, Wyndham, Yarra, Yarra Ranges
2. Source: Victorian Department of Health, *"Metropolitan Health Plan Technical Paper"*, 2011, p45.
3. Represents projected population increase from June 2011 to June 2021.
   Source: Victorian Department of Transport, Planning and Local Infrastructure, *"Victoria in Future 2014"*, May 2014
   See, VIF2014_LGAs_ERP_5yr_age_sex_2011_2031.xlsx.

Theme 1

1. See: Department of Health Victoria, *'Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan'*, May 2011
2. See: Department of Health Victoria, *'Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan'*, December 2011
3. Changes in the proportion of health spend by the Victorian Government 2012/13–2014/15: Acute 0.8%, Ambulance -0.5%, Mental Health 1.1%, Aged Care -5.7%, Primary and Community Care 6.8%, Small Rural Health -1.1%, Public Health -11.8%, Drug Services 3.2%.
   Source: Victorian State Budget Papers, 2012/13 and 2014/15.
4. Changes in proportion of health spend by the Victorian Government 2005/06–2014/15: Acute 1.9%, Ambulance 7.4%, Mental Health -3.5%, Aged Care -7.7%, Primary and Community Care -7.4%, Small Rural Health -1.4%, Public Health -5.5%, Drug Services -16.5%.
   Source: Victorian State Budget Papers, 2005/06 and 2014/15.
5. Source: 'Health Sector ICT Review Panel Recommendations – Victorian Government Response, October 2013'.
6. See: AIHW & RACS, *'National definitions for elective surgery urgency categories – Draft proposal for Health Ministers'*, 24 Sept 2012.
7. See: Department of Health Victoria, *'Specialist clinics in Victorian public hospitals: Access policy'*, 2013
8. See: http://www.vha.org.au/docs/20140416--position-statement--access-to-elective-surgery--incl-report.pdf
9. For instance, eliminate waiting list size as a KPI from a health service's Statement of Priorities (SOPs), and emphasise measures that reflect access, such as the NEST measures and the HIP rate.
10. "Automatic Referrals" are a mechanism for referral to specialised hospitals based on specified criteria in order to facilitate access to specialised resources and to address blockages affecting patient throughput in the system.
    Source: Victorian Healthcare Association, *'Access to Elective Surgery in Victoria'*, 16 April 2014
11. "Indirect Referral" refers to mechanisms for matching supply to demand across the health system. This means that if a patient is unlikely to be seen within clinically appropriate times at their local hospital, then they may, with the patient's consent, be referred to another hospital.
    Source: Victorian Healthcare Association, *'Access to Elective Surgery in Victoria'*, 16 April 2014

Theme 2

1. Source: : Department of Health Victoria, *'Victorian Health Priorities Framework 2012-2022: Rural and Regional Health Plan'*, December 2011

Theme 3

1. Diagnosis Related Group. It is a patient classification system that provides a clinical meaningful way of relating the types of patients treated by a health service to the resources used to treat the patient.
2. Source: Analysis of health service annual reports/financial statements
3. Source: Health Service annual reports 2009-10 to 2012-13. The increases were determined by calculating growth in patient transport costs and operating revenue between the years 2009/10 and 2012/13 inclusive. The increases were then weighted according to the proportion of revenue of the health service compared to the total revenue of the group in order to calculate average increase for these categories.
4. See: 2013-14 Victorian Budget, Service Delivery Budget Paper No.3, p17.
5. Source: Kennedy P, Leathley C and Hughes C, '*Clinical practice variation*', MJA 2010; 193 (8): 97.
6. Source: Kennedy P, Leathley C and Hughes C, '*Clinical practice variation*', MJA 2010; 193 (8): 97.
7. Source: ACSQHC, *'Medical Practice Variation: Background Paper'*, 2013, p15.
8. Source: ACSQHC, *'Exploring Healthcare Variation in Australia: Analyses resulting from an OECD study'*, June 2014.
9. Source: Victorian Department of Health, *'Victorian health policy and funding guidelines 2013–14, Part 1'*, August 2013, p29
10. Source: Health Roundtable, www.healthroundtable.org (as at 30 June 2014)

Victorian Healthcare Association

Rethinking our health system
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