# 2020-2021
## STATE BUDGET SUBMISSION

## SHIFTING THE LOAD

Growth in demand for health services is relentless. Hospitals are reporting surges in demand driven by a number of well-established factors including: an ageing population; an increase in the prevalence of chronic diseases; population growth; variable access to primary care; and an increase in mental health issues. Social disadvantage is on the rise and, with poor health more common among people who experience poverty, social isolation, discrimination and/or a lack of education or employment, this growth in social disadvantage is impacting demand for health services with higher rates of preventable hospitalisation, chronic disease and premature death; presentations to emergency departments related to mental illness over the 10 years to 2017-18 have risen by a massive 68 per cent alone.

Other emerging threats including the climate crisis, antimicrobial resistance and changing disease patterns are also having far reaching impacts on the system. These threats are resulting in increased resource utilisation and higher costs; stretching staff capacity and capability, availability of drugs and supplies and the capacity of the system to offer alternative means of providing care.

While the Victorian Healthcare Association calls on the Victorian Government to provide an immediate 'band aid' of funding to enable the system to function effectively in the short-term, few would agree that continuous increases in funding is sustainable nor would many agree that injections of funds is appropriate without fundamental shifts in the way care is delivered. There are things that can and must be done now, within the existing architecture of the Victorian health system, to relieve pressure and better plan for demand at the system level.

### A WELLNESS APPROACH TO CARE

As part of that shift, the Victorian Healthcare Association calls for funding for an innovative program that focuses on reducing unplanned acute admissions and re-presentation to emergency departments through a comprehensive and responsive service mix and a focus on vulnerable and disadvantaged individuals. Through this program, people would receive both the clinical care they require as well as the non-clinical supports needed to keep them well and, where possible and appropriate, out of hospital, impacting demand and resulting in financial efficiencies. Through care coordinators, based either in the local hospital or community health service, the program would move beyond the healthcare setting, linking vulnerable individuals with proactive social supports in areas that, if not resolved, will have a detrimental impact on their health and, ultimately, result in greater cost to the healthcare system.

> *"The complexities of the social, political, economic and environmental factors that influence health and inequalities in health, and the fact that most of these determinants lie outside of the exclusive jurisdiction of the health sector, requires the health sector to act in collaboration with other sectors of government and society to more effectively address those factors that influence health and well-being."*
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> Health equity through intersectoral action: An analysis of 18 country case studies, World Health Organization and the Public Health Agency of Canada.

It is proposed the program focus on frequent users[1] of emergency departments and urgent care centres; compared to occasional users of emergency departments, frequent users represent a small subset of the population who often share similar challenges, including homelessness, low income, social isolation, mental illness, substance misuse and chronic co-morbidities. This small percentage of users tends to have a disproportionate impact on the healthcare system, for example, a Canadian study of just over 14,000 patients found that while frequent users of emergency departments represented only 3.1 per cent of patients, they accounted for 13.8 per cent of visits, experienced significantly longer hospital stays and higher admission rates, resulting in significant costs;[2] Victoria is similarly affected by the impact of frequent attendees.

The program would enable health services to collect and analyse data on frequent users of emergency departments, including on their social determinants to understand the factors impacting health and wellbeing outcomes, with a regular review. Those people identified as frequent users would be connected with a care coordinator who would initially connect with the person face-to-face in the health service and, if that is not possible, within 48 hours following discharge under a telehealth model. The care coordinator would then continue to contact the individual on a number of days throughout the week, with the frequency decided in collaboration with the person, to check how they are feeling and to discuss how the person is managing with those factors that influence health and wellbeing. Should a person report, or the care coordinator identify signs of deterioration, rapid escalation in clinical care can take place.

1. It is proposed that frequent users of emergency departments be categorised as those with three to four emergency department visits per year.
2. Althaus F, Paroz S, Hugli O, Ghali WA, Daeppen JB, Peytremann-Bridevaux I, Bodenmann P. 2011, Effectiveness of interventions targeting frequent users of emergency departments: a systematic review, Annals of Emergency Medicine, vol. 58, no. 1, pp. 41–52.

Care coordination will ensure appropriate clinical and, importantly, social supports are in place for the person, linking them with services they may need to better manage their health and wellbeing. Such services may range from a social housing appointment, to an appointment with a clinical educator or specialist, connecting them with a local social program or exercise group, My Aged Care or an addiction cessation support service. In addition to practical needs assistance and care coordination, care coordinators could also offer outreach, home visits and crisis intervention. The person's general practitioner would remain in place and the service would not replace but would link in, through the sharing of data and information, with services such as hospital in the home.

This case management approach would assist in decreasing acute care utilisation among frequent users of Victoria's public emergency departments and urgent care centres and support individuals to improve their own health and contribute to the more efficient use of healthcare resources while health services will benefit from more effective early intervention services in the community.

## CASE STUDY

A new social prescribing program under trial at **IPC Health** in Melbourne's west funds a wellbeing coordinator to assess a patient's social, financial and life-management needs and support them to connect to appropriate services and groups in their community. The program's success has been attributed to strong integration between GPs, practice nurses and the wellbeing coordinator, which has helped highlight appropriate patients to refer for social prescribing. Many of these patients have been identified while preparing care plans with a practice nurse. The program goes beyond setting up initial connections with the wellbeing coordinator, who is non-clinical, follows up regularly, making phone calls to the care recipient. While the program is yet to be fully evaluated, it is expected it will result in significant savings as well as improved outcomes for people utilising the service.

## PREDICTING DEMAND

There is a wealth of health data that could be analysed to help forecast demand for healthcare services and there are already promising early examples of how artificial intelligence in healthcare is being used to anticipate patient volumes and the number of admissions, with remarkable accuracy, in Australia and across the globe.

Being able predict demand has benefits for the health system, for health services and to patients. At the system level, demand forecasting tools enable decision makers to analyse health status at the population level, determine the impacts of different interventions and make more informed program and policy decisions. Health services benefit through the improved detection of disease outbreaks, greater visibility over bed availability, better decision making related to staff resourcing and more efficient scheduling of elective surgery. Patients benefit from faster delivery of emergency care, better quality of care and reduced time spent in hospital.

In other jurisdictions, the roll-out of demand forecasting technology has shown significant economic benefits for health systems in the areas of improved service efficiency and patient outcomes. For example, the Queensland Government is using the CSIRO's Patient Admission Prediction Tool (PAPT) to forecast the demand on hospital beds, staff resources and elective surgery in a bid to cut patient waiting times.

The software analyses historical data to predict, with around 90 per cent accuracy, how many patients will present at emergency departments and when. It also predicts a patient's medical needs and urgency of care. PAPT is now being extended to predict diseases such as influenza and the hospital admissions of patients with chronic diseases. The system was initially rolled out to 30 major hospitals across the state in 2011 and fully rolled out in 2014.

In 2011, it was estimated to have provided a $97 million per annum benefit to that state's economy due to improved patient outcomes, including reducing mortality, and $3 million per annum due to improved service efficiency. It has been estimated that the potential value of improved patient outcomes is over $248 million per annum and $23 million per annum due to projected direct productivity gains if implemented across Australia's health system.

## THE VHA CALLS ON THE VICTORIAN GOVERNMENT TO COMMIT:

/ Funding growth of at least 6 per cent per cent for the state's public hospitals over the forward estimates with this funding growth applied across metropolitan, regional and rural services and quarantined for acute care service delivery to keep pace with growing demand and in line with CPI and population growth.

/ $200 million over the forward estimates to design, implement and evaluate the proposed social care model across Victoria's public hospitals and community health services, with funds that are recouped through the program, reinvested in areas of need in public health services.

/ $10 million to roll out the Patient Admission Prediction Tool across all Victorian hospitals.

## IN ADDITION, THE VHA ASKS THE VICTORIAN GOVERNMENT TO:

/ Fund all recommendations of the Community Health Taskforce including committing to fund an uplift in the Community Health Program unit price in line with DHHS review.

/ Fund the roll-out of demand forecasting technology.

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