



Victorian Healthcare Association

SUBMISSION

*Senate Finance and Public Administration Committee
Inquiry into the COAG Reforms Relating to Health and
Hospitals*

26 May 2010

1. Introduction

This submission paper outlines the Victorian Healthcare Association's (VHA) position regarding the Australian health system reform decisions and issues identified in the recent Council of Australian Governments (COAG) agreement on 20 April 2010.

The Victorian Healthcare Association

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

Current Service Context

There are over 110 public hospitals in Victoria. These public health facilities provide a broad range of services including inpatient and outpatient medical and surgical services, rehabilitation, mental health, aged care and primary healthcare services.

Victoria has a proud history in primary healthcare, structured through a network of over 100 community health services operating from about 250 sites. These services plan and implement programs, services and projects according to local needs and funding agreements, with a particular connection to local communities.

Many of the rural and regional health services also provide Residential Aged Care. One feature of small rural public hospitals is that they provide health services across the care continuum, not just episodic care. In addition, a key component of Victoria's health system is the goal of regional self-sufficiency, which enables patients to access the care they require close to home.

The COAG Reforms

The VHA acknowledges that the COAG reforms relating to health and hospitals build on many successful aspects of the Victorian health system, including activity based funding, an integrated and community-based approach to primary healthcare and devolved governance models. This is a vote of confidence in the Victorian health system and its workforce. The coming years provide an opportunity to build on the strengths of the Victorian system and continue to improve the services provided to local communities. It is hoped that further investments to support these health initiatives will flow in coming years.

Despite this, true health reform should evolve the health system from its current, disproportionate emphasis on hospital waiting lists and episodic care to a system of interlinking elements that includes aged care, emergency care, acute care, primary health care, early intervention, chronic disease management, illness prevention and health promotion. The siloed approach taken through the COAG reform process reinforces a view that these elements are separate functions within the health system, when they are, in fact, functions that must successfully meld as one to create a successful and sustainable system.



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One of the major concerns the VHA holds is that the current reform process may jeopardise some of the benefits of Victoria's existing state-funded healthcare infrastructure.

2. The VHA's Response

2.1 Governance

National Health and Hospital Network

The VHA agrees with the concept of the National Health and Hospital Network. The VHA believes the health system will only achieve optimal patient outcomes when key stakeholders work co-operatively to implement care models. The VHA supports a national agreement across governments that establish goals for Australia's health system, backed by coherent policies and strategies to drive health system performance at all levels.

The VHA is concerned that the current reform proposals continue to divide funding and policy responsibility for primary and acute/sub-acute healthcare between the Commonwealth and the States. This could perpetuate the current fragmentation in the healthcare system. It is important that any Commonwealth health policy work is done in collaboration with the States. The VHA welcomes the mandate for formal bilateral agreement between the federally-administered Primary Health Care Organisations (PHCO) and the state-administered Local Health Networks (LHN).

Local Hospital Networks

The VHA applauds the COAG agreement to introduce a devolved governance model for the LHNs nationwide. Within such a framework, local service delivery models and solutions remain in place to strengthen the health system. The Victorian example of local Boards of Governance facilitates innovative models of health service delivery to communities of interest and community based decision making. This decentralised governance model of health service delivery benefits local communities, particularly rural communities where it enables the continued vibrancy of small, local health services.

The number and boundaries of LHNs in each state should vary depending on the ability of the networks to respond to their communities of interest. In the 1990's, Victoria underwent a rationalisation of the number of hospital networks. Victoria's current mix of hospital networks and small rural health services should remain under the National Health and Hospital Network.

Primary Health Care Organisations/Medicare Local

The VHA welcomes the development of Primary Health Care Organisations (PHCO) across Australia to improve access to care and promote service coordination and integration. However, the VHA is concerned about the transition of Divisions of General Practice (DGP) to PHCO. The VHA, in partnership with General Practice Victoria (GPV) has a joint position (attached) regarding the implementation of the Federal Government's proposed reforms for the primary healthcare sector. This position proposes that PHCO evolve from the joining together of local providers and networks.



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Rather than evolve from Divisions of General Practice, the VHA recommends potential partners include the local division of general practice, existing coordination and planning partnerships and collaborations, such as the Primary Care Partnership in Victoria, local governments, local communities and a variety of primary healthcare service providers. Creating a new organisation that melds existing organisations and draws on historic partnerships offers the best opportunity for system-wide cooperation and coordination. The VHA/GPV joint position calls for the creation of a new organisation that encompasses all stakeholders.

The VHA welcomes a strong local governance model for PHCO and supports the broad community and health professional representation, as well as business and management expertise. Governance arrangements need to ensure PHCO promote service and health planning for their local community, based on a broad understanding of the social determinants of health and the wide range of health and community services available to address identified community needs. The arrangements for participation in the PHCO governing body needs to address any potential conflict of interest by representatives of provider groups.

It is vital that the sophistication of this approach is not lost in a one-size-fits-all reform process. In developing its model for PHCO, the Federal Government should agree to some variation between states while holding to the same principles across all jurisdictions. This will ensure that the existing strengths Victoria's primary health infrastructure are not lost.

The Primary Care Partnership (PCP) Strategy, initiated by the Victorian Department of Human Services (now Department of Health), demonstrates the benefits of a collaborative approach that is at the forefront of health reform and has expanded primary health into alternative settings. These partnerships equate to 10 years of partnership within each community in Victoria. Many of these partnerships bring together health, social and welfare services to meet the needs of Victoria's most vulnerable.

The VHA would like the Senate Inquiry to address the following questions:

1. How will the Commonwealth responsibility for primary healthcare transition?
2. Which level of government will determine the priorities?
3. To what extent will current service levels be maintained?
4. How are the boundaries for Medicare Locals in Victoria to be determined?
5. How are capital expenditure priorities to be determined?
6. Is there a Victorian position that can be accommodated in the establishment of Primary Health Care Organisations?

The VHA is concerned with the Federal Government's decision to rename PHCO - 'Medicare Locals'. The VHA believes this is at odds with the process outlined in the NHHN Agreement and further aligns the concept of PHCO with a medical model of health, rather than a broader social model of health. The VHA also notes that this language continues to build community understanding that Medicare Locals will emerge solely from Divisions of General Practice.

In addition, the VHA notes the interchangeable use of primary care and primary health care in the health reform documentation. These terms have significant



differences in meaning and PHCO must focus on a broad concept of primary healthcare that seeks to change the personal, social, political, environmental and economic determinants of health to create better health in communities, cities or regions. Consequently, these services will need to go far beyond the boundaries of traditional General Practice.

2.2 Funding

Problems with the current funding system for health include a lack of cohesive and consistent policy direction, an inefficient use of resources through service duplication, a lack of clear accountabilities - which allows the politicisation of health funding - and a failure to create a truly integrated and seamless health system. All levels of government must recognise the impacts of their funding decisions on the other.

The COAG agreement to pool the funding from both the Commonwealth and the State into a state-based, intergovernmental payment authority will help to alleviate the fragmentation that currently occurs with different funding sources. The VHA hope this will help to streamline the process and simplify the administration.

The increased transparency and independence of the payment authority will also help to reduce the politicisation of health spending. The health system must be for all Australians, for a common good and a bipartisan approach is needed for long-term policy initiatives.

Acute and Sub-acute Funding

Flexible funding

The development of flexible funding models is one of the VHA's strategic priorities. The VHA supports the agreement to fund smaller rural health services with block funding for a flexible rather than a one-size-fits-all approach. Flexible funding models facilitate locally designed and flexible models of care in remote and small rural communities, which addresses inequitable access to services that currently exists in many rural communities.

In 2009, the VHA commissioned Access Economics to produce a *Victorian public hospital funding and productivity study*. This study found that the escalating costs of enterprise bargaining agreements, patient transportation, implementation of mandated technology and building maintenance of old stock cannot always be absorbed into a small rural health service's (SRHS) funding margins, without access to funding growth. Funding arrangements must recognise variations in costs and different delivery models required according to location and provide the resources to safeguard both financial and workforce viability in affected areas.

The VHA supports increasing the funding equivalent to national average medical benefits and primary healthcare service funding, appropriately adjusted for remoteness and health status. This will help to ensure the sustainability of services across all of Australia.

When implementing more flexible funding models, the VHA cautions all levels of government to guard against service fragmentation. Small rural health services provide integrated services across the care continuum, so must be funded to provide





primary, acute, sub-acute and aged care services. The multi-purpose service (MPS) model must work in concert with the other LHNs, funded by the independent payment authority and administrated by the states.

Activity-based funding

The 2010 COAG agreement reinforced the March 2008 COAG agreement to adopt national activity-based funding (ABF) for public hospital services. Casemix based funding approaches have been used in Victoria since the early 1990's. Yet it is important to note that while ABF provides a mechanism for technical efficiency, it creates disparities of equity due to allocative inefficiencies and scalability (the size of an organisation). All acute services must be funded adequately to provide high quality healthcare.

While the VHA supports ABF, it believes that capacity exists to ensure greater funding equity via longer term planning, differential costing, and the removal of some categories of care – such as obstetrics - from DRG weighted casemix approaches. A blend of ABF and block grants allow for the cost disparities in providing services in rural and regional areas, and the Australian public's changing preferences for care. Health service organisations must be resourced to design and implement health services that meet local needs

Performance linked funding

It is widely acknowledged that funding of the health system is fragmented and performance accountabilities vary between levels of government. The COAG agreements mention the need to link funding with a set of performance-based health indicators, however, the COAG agreement to tie financial incentives to timeliness of care indicators is of concern.

The VHA believes there is a need to develop more valid and reliable access indicators before tying financial incentives to them. The risk of unintended outcomes from incentive funding was demonstrated in Victoria recently with the waiting list data manipulation issue. Access targets that do not account for fluctuating demand should not be used to assess the performance of a health service.

The VHA also believes access indicators for timeliness of care should not be the sole indicator to determine an individual health services performance. There is a need to develop additional quality and outcome indicators before financial incentives are tied to performance. The transparency of funding processes is vitally important. More work is needed to ensure funding applications are prioritised on the basis of need so that all Australians have access to high quality health services into the future.

Capital funding

COAG agreed that the Commonwealth would increase its contribution to 60 per cent of capital expenditure. The capital funding must target priority areas and be more transparent and evidence-based in its application. This should include appropriate investment in new infrastructure that provides long-term solutions, such as student accommodation to increase student clinical training opportunities for the future workforce. Evidence indicates that ongoing investment in replacing outdated health infrastructure will both improve economic efficiency and environmental outcomes.





The VHA-commissioned Access Economics *Victorian hospital funding and productivity study* found that the healthcare system will be unsustainable without major reinvestment in infrastructure – particularly in population growth areas. A productivity analysis is needed to identify where investments are likely to provide the greatest returns. If the Commonwealth and State governments work together, the funding can be provided in a more transparent and planned way.

The VHA applauds the COAG agreement to increase capital funding to improve access to sub-acute services. This needs to be implemented immediately.

Primary Healthcare Funding

The VHA supports the notion of one level of government assuming policy and funding responsibility for primary healthcare to improve efficiency, effectiveness and consistency of approach. This should not preclude state and territory governments, with their significant intellectual property in the area of primary healthcare service delivery, from involvement in determining the distribution of primary healthcare services.

One issue the VHA believes needs highlighting is the number of community health services in Victoria that are integrated with a public health service or hospital. This approach should be maintained, where suitable, and is particularly important in rural areas to facilitate the best use of scarce resources and expertise.

The VHA is concerned about the fund-holding role of PHCO. Initially, the only fund-holding that the PHCO are expected to undertake is for service coordination, improving the quality of care and population health. Over time, that may expand to include funds for services in the PHCO catchment area. When determining what funds PHCO hold, it will be important for the Federal Government to ensure transparency and guard against potential conflicts of interest.

The risk of PHCO not holding funds for all primary healthcare service delivery in an area is that they may lack authority and accountability to realise their service coordination and population health planning goals.

2.3 Service Reform

Acute/Sub-acute Service Reform

The COAG agreement to increase the capacity of some health services is welcomed, but there are questions around the choice of services.

The increased capacity of subacute services across Australia is a significant move that is welcomed by the VHA. This move will free up beds within acute facilities and reduce the bed blockages within emergency departments in public hospitals. The additional funding to build emergency department capacity is welcomed but emergency services in Victorian rural and regional areas must also be addressed. The COAG agreement to implement a four hour national access target for emergency departments will cause public expectation in many communities where resources are scarce, both in terms of capital infrastructure and workforce allocation. The decision to modify this four hour expectation in rural areas must be effectively communicated to the public.



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The VHA believes that extra funding for elective surgery to reduce public elective surgery waiting lists is erroneous. When the federal government has spent money on previous elective surgery 'blitzes' to increase the numbers of public elective procedures performed, the demand for public hospital services rises and the waiting lists remain stagnant.

Essentially, these waiting lists are a flawed measure and will continue to be populated, regardless of the number of 'blitzes'. Whilst this surgery is important, it only accounts for approximately 15 per cent of all public hospital admissions.

The VHA applauds the provision of further flexible funding to allocate resources across the emergency department, elective surgery and sub-acute service modalities to ensure resources are being spent where they are most needed. However, it is important to ensure that these funds are allowed to be used outside acute hospitals if appropriate, as is the case for home and community based programs such as the Hospital Admission Risk Program (HARP) and Hospital in the Home.

Primary Healthcare Service Reform

The COAG agreements relating to primary healthcare reform lack specific detail regarding the implementation, function and governance structure of primary healthcare services. Clarification of these details that constitute primary healthcare services is needed. The VHA reaffirm that primary healthcare services are fundamental to the Australian healthcare system and the COAG reforms are heavily weighted towards acute services.

Primary healthcare services could benefit from the creation of PHCO. PHCO need to be able to identify and respond to service gaps and build on existing infrastructure and service provision and not develop competing duplicate models of service provision.

The VHA supports increased funding to mental health services, and recommends further investment in services delivered within community settings outside of hospitals.

Preventative Health

High-quality hospitals and health services will remain a fundamental component of Australia's healthcare system. Despite this fact, the federal health reform process has earmarked increased funding for illness prevention and health promotion. The VHA welcomes the Commonwealth Government's focus on prevention but calls for yet more investment in the future.

The VHA has long contested the small proportion of the total health budget spent on illness prevention and health promotion by Federal Governments over recent decades. Despite some increased preventative health funding, and the focus shown by COAG through the National Partnership on Preventative Health, the proportionately larger increases in spending on acute care will ensure that funding for prevention remains constrained.

To achieve optimal health outcomes and a health system truly focused on prevention and wellbeing, the proportion of the health budget spent on prevention must continue to rise. This needs to be matched by further policy support and recognition of the



fundamental role health services can play in illness prevention and health promotion for their communities. The VHA encourages the Government to commit to rigorous implementation and evaluation in prevention that includes community-based health promotion and not just expensive mass media campaigns.

Health promotion and preventive health programs will be delivered by PHCO and targeted to risk factors in their communities. These programs will be based on cooperation with the National Preventive Health Agency. What is lacking is any detail about how health promotion and illness prevention can be incorporated into multidisciplinary primary healthcare, or into the core business of hospitals and primary healthcare services. The proposals listed are heavily centralised around GPs, health education and behaviour change, rather than considering communities within the social model of health.

2.4 Population Health

The VHA notes the National Health and Hospitals Network Agreement states that PHCO will undertake population level planning. However, it is unclear what this means within the confines of the agreement. The VHA affirms that health agencies can no longer work in isolation and population health approaches, which engage and involve a broad range of stakeholders in planning, must be adopted by services and enabled by government.

The VHA believes that population health planning will be a vital component of health service planning in the future and will enable multi-sectoral approaches to reducing health inequities. The VHA position paper – *Population Health Approaches to Planning: Definitions* - establishes for the first time, a set of industry-endorsed definitions of population health and population health planning. This includes a guide to the four core components and eight best-practice principles to best practice population health approaches to planning. The VHA is also developing an online toolbox that assists services in population health planning to complement this definition.

The VHA recommends that federal, state, local government and health and community sector agencies adopt the VHA's working definition of population health and the VHA's working definition of population health planning, including the four core components and eight best-practice principles. This definition represents current best-practice, and recognises that population health theory is evolving and may require further refinement.

This research can inform healthcare governance into the future as it targets a key governance responsibility. That responsibility is to formulate strategy appropriate to the population health needs of the community being served by the organisation.

Traditionally, health services have reported on the basis of productivity and in recent years, this was extended to include quality and safety requirements. The next step is to mandate population health reporting and require health services to be accountable for the population health needs of their community. This current federal reform process could enable this by supporting better data collection to inform health service planning. This will require investment to support health agency boards to develop service priorities based on a population health perspective and to effectively partner with other providers to address priority areas.



2.5 Workforce

Australia can ill afford to neglect its workforce challenges. Workforce limitations remain a key impediment to health sector reform. There is a worldwide shortage of healthcare professionals and Australia is not immune from this shortage, with many rural areas experiencing significant recruitment difficulties.

The VHA welcomes the new federal funding to increase the number of health service providers and training opportunities for current workers. An experienced workforce is essential to maintain the capacity of the health system to meet increased service demand. The recruitment and retention of all employment categories is essential to the long-term viability and success of Victoria's health industry.

A neglected area in the current reform process is that of workforce redesign. By this, the VHA means the creation of new categories of healthcare workers. These workers would complement our trained professionals, by relieving them of routine and time-consuming elements of their professions.

Workforce reform must also look at "scope of practice" issues to better use the skills of scarce medical professionals, particularly in rural areas. This may mean widening the use of nurse practitioners and physician assistants to reduce workload pressures on medical practitioners, where it is safe to do so.

The COAG reforms do not adequately address the significant problem of funding following the provider. It is this that leads to inequity of funding distribution and workforce shortages. The VHA recommends a review of the Medical Benefit's Schedule (MBS) to address geographical and social inequities in workforce distribution, with reforms to the funding methodology to account for socio-economic and health need.

2.6 Information Management

The COAG agreement for a new Performance and Accountability Framework is welcomed by the VHA. Clear and transparent reporting on all health services, public and private, is vital.

To support a process of quality improvement, the VHA recommends that data on safety and quality should be collated, compared and fed back to hospitals, clinical units and clinicians in a timely fashion to expedite quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care, including actions taken in response to identified safety issues. This information must also be publicly available.

A set of industry-agreed key performance indicators (KPIs) is necessary to provide a shared focus as the healthcare system moves from the provision of acute services to early intervention, prevention and health promotion. This data would facilitate the important task of benchmarking between health services to allow service providers to adjust their processes towards best practice.

The VHA-commissioned 2009 Access Economics *Victorian funding and productivity study* recommends the use of this as an important step to deliver further productivity improvements within the constraints of an overstretched public healthcare system.



However, health services must receive adequate funding to collect and analyse the data, and to implement any necessary changes.

The VHA believes there is the potential to vastly improve health service planning via the establishment of a national health data site overseen by a single, major academic institution. This site would align key health data from a range of sources and make it publicly available via Geographic Information System (GIS) mapping. The site would help individual health services to access data to inform population health service planning and innovation. It is a simple yet cost-effective solution that would yield significant productivity dividends.

Further potential exists within the health system to capture and analyse data that is not currently utilised. For example, access to and analysis of Health Insurance Commission data by health planners has the potential to significantly improve health system performance, providing the input methodology is changed to identify morbidity demand.

The VHA applauds the development of consumer-controlled electronic health records, however is disappointed in the lack of fiscal support for e-health. The opportunity exists to standardise health records and clinical communications in a way that accommodates all stakeholders, consumers and clinicians. To improve patient outcomes, the VHA supports the development of e-Health records to streamline patient data across the acute and non-acute sectors to ensure health professionals have access to vital patient information. Information technology can play an important role in ensuring continuity of care.

There is also an urgent need to ensure that the underlying building blocks - broadband infrastructure and computer systems - are in place to facilitate such endeavours. The VHA calls on both Federal and State governments to ensure the success of all health IT projects are measured against the e-health goals of better patient outcomes and productivity improvements, not simply project and product implementation.

3. Conclusions

The key message from the COAG outcomes is that there needs to be improved partnerships and communication between the Commonwealth and State/Territory governments to form "one health system". It highlights the need for improved indicators to measure access and performance; improved data collection and information technology to share and compare information; a single stream of funding and policy with greater flexibility to tailor services to need; and a focus on primary and preventative health, including post-acute care.

It is vitally important that in constructing a new National Health and Hospitals Network that we do not create new cracks in the system. The acute sector cannot be sectioned off in isolation from the continuum of care. Health services cannot be sectioned off from other mechanisms of government, such as education, social welfare and justice.

A co-operative partnership between the Commonwealth and State governments is needed to achieve optimal health for all Australians via a "whole of health" approach.





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Please note that attached to this submission are the following documents:

- The GPV-VHA joint submission on PHCO
- The VHA Position Statement: *Population Health Approaches to Planning: Definitions*
- The VHA Position Statement: *Elective Surgery Waiting Lists*

The VHA would welcome the opportunity to appear before the Senate Finance and Public Administration Committee to discuss any of the matters outlined in this document, or any other issues associated with the COAG reforms relating to health and hospitals.

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

Trevor Carr

Chief Executive Officer

