Victorian Healthcare Association

SUBMISSION

Senate Community Affairs Legislation Committee Inquiry into the National Health and Hospitals Network Bill 2010

20 October 2010

1. Introduction

This submission paper outlines the Victorian Healthcare Association's (VHA) position regarding Australian health system reform in relation to the Senate Community Affairs Legislation Committee Inquiry into the National Health and Hospitals Network Bill 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 healthcare agencies 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 approximately 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 (RAC) services. One feature of Victorian 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 Bill

The Bill for the National Health and Hospitals Network Act 2010 (the Act) provides for the framework legislation to establish the ACSQHC. However, since the passage of the Act will mark the implementation of the NHHN, this submission will include comments on the entire NHHN and its impact on the health outcomes of all Victorians.

The COAG Reforms

The VHA acknowledges that the other COAG reforms relating to the National Health and Hospitals Network (NHHN) 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.

Despite this, true health reform should evolve the health system from its current, disproportionate emphasis on acute and episodic care to a system of interlinking

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

elements that includes aged care, emergency care, acute care, primary healthcare, 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.

The VHA applaud the establishment of a permanent Australian Commission for Safety and Quality in Health Care (ACSQHC) to set national clinical standards and strengthen clinical governance.

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 state governments. The VHA welcomes the mandate for formal bilateral agreement between the federally-administered Medicare Locals (ML) and the state-administered Local Hospital Networks (LHN).

In establishing the Independent Pricing Authority and the National Performance Authority it is important that the current fragmentation between funding and productivity is not exacerbated.

Local Hospital Networks

The VHA applauds the COAG agreements' introducing 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 model of local Boards of Governance facilitates innovative models of health service delivery to communities of interest and enables community based decision making. This decentralised health service governance model enables 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.

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

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.

Medicare Locals

The VHA welcomes the development of ML 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 ML. In particular, the VHA calls on the Victorian and Commonwealth Governments to ensure that any reform to primary healthcare delivers demonstrable benefits to those communities and people who underutilise primary healthcare services, such as those experiencing socioeconomic disadvantage and those in rural and remote areas.

In developing its model for ML, the Commonwealth Government should to agree to some variation between states while holding to the same overarching principles across all jurisdictions. This will ensure that the existing strengths of Victoria's primary healthcare infrastructure are not lost in a one-size-fits-all approach.

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

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au

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.

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

Access targets must be linked to both service capacity and funding. A system wide 10 year health plan that links service demand to both infrastructure investment and funding growth is required. While the VHA agrees timeliness of care is important, it cautions that the creation of 'access guarantees' may create perverse incentives and lead to increased service demand.

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. This appears that it will only be to cover the cost of existing asset replacement. Further long-term funding agreements for ongoing investment in new infrastructure are required. Capital investment must target priority areas and be 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 and funding.

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.

The VHA is concerned about the fund-holding role of ML. Initially, the only fund-holding that the Medicare Locals are expected to undertake is for service coordination,

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

improving the quality of care and population health. Over time, that may expand to include funds for services in the ML catchment area. When determining what funds ML hold, it will be important for the Federal Government to ensure transparency and guard against potential conflicts of interest.

2.3 Service Reform

Acute/Sub-acute Service Reform

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 also welcomed. 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.

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 ML, however they must 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.

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

Preventative Health

The 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 additional investment.

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.

The NHHN agreement states that health promotion and preventive health programs will be delivered by ML 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.

Health promotion and illness prevention programs deliver benefits to the community by promoting positive wellbeing and reducing preventable illness. Health promotion strategies rely on active engagement with the community of interest. Consequently, such programs must be community informed and owned. There are services in Victoria with significant experience and expertise in delivering these programs, including community health services.

2.4 Population Health

The VHA notes the National Health and Hospitals Network Agreement states that ML will undertake population level planning. However, it is unclear what this means within the confines of the agreement. The VHA agrees that healthcare 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 statement – *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

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

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 calls on all levels of government and health and community sector agencies to adopt the VHA's working definition of population health and 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.

The research conducted by the VHA and Monash University can inform healthcare governance into the future as it targets a key governance responsibility; the responsibility 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 national 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 not afford to neglect its health workforce challenges. Workforce limitations remain a key impediment to health sector reform. An experienced workforce is essential to maintain the capacity of the health system to meet increased service demand, therefore 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.

2.6 Information Management

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

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

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 Commonwealth 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.

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.

Benchmarking must create an environment that encourages information sharing between health services and to the public. Benchmarking is often used to punish poor performance, instead of being a flag to draw attention to health services needing help to improve. The design of Victoria's healthcare indicators for benchmarking is the key to unlocking productivity in health services.

The VHA-commissioned 2009 Access Economics *Victorian funding and productivity study* recommends the use of benchmarking 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.

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 NHHN we do not create new cracks in the system. The acute sector cannot be sectioned off in isolation from the continuum

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au
www.vha.org.au

of care. Public health services cannot be sectioned off from other mechanisms of government, such as education, social welfare and justice.

The establishment of the ACSQHC, the pricing and performance authorities must not result in further fragmentation. Collaborative partnerships between and within the Commonwealth and State governments are needed to achieve optimal health for all Australians via a "whole of health" approach.

The VHA would welcome the opportunity to appear before the Senate Community Affairs Legislation Committee to discuss any of the matters outlined in this document, or any other issues associated with the NHHN.

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

Trevor Carr
Chief Executive Officer

ABN: 54 004 228 111
Level 6, 136 Exhibition Street, Melbourne, VIC, Australia, 3000
Tel: (03) 9094 7777 **Fax:** (03) 9094 7788 **Email:** vha@vha.org.au