Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan
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May 2011
Foreword

Few things matter as much as our health. Being in good health – and getting the care we need when we need it – allows us to live long, fulfilling lives and to participate fully in our community. But we cannot stay healthy without a strong health system.

Health is important in itself, but it is also crucial for a strong economy. Healthy people mean a healthy workforce, and a healthy workforce combined with a strong health and medical research sector will increase Victoria’s long-term productivity and economic growth. The last factor is essential for the state’s stability and security, and to foster the conditions in which members of our community and leaders of our health system can plan for the future with confidence.

Although Australians, as compared to other OECD countries, generally receive very good health care services, service providers are feeling the pressure from increasing demands and constrained resources. Our hospital system is clearly facing challenges. The historical role and focus of hospitals has been acute illness, usually relatively short term.

Victoria’s health system has not been planned properly to take account of population growth and the ageing of the population. Victoria’s health system has been operating on planning that has used 2002 population projections that are long out of date and superseded by the rapid increase in Victoria’s overall population. Victoria’s health system is under pressure and Victorians are feeling it.

We have known for a long time that our population has been ageing, and growing, and that this and life style changes have contributed to chronic health conditions, such as respiratory and heart disease, type 2 diabetes and mental illness, that are increasingly affecting many Victorians. These conditions are placing unprecedented pressures on all health services, but particularly on hospitals. We have invested too little in preventing and better managing these conditions.

The health system needs more support to improve management of these long-term chronic conditions, as well as better managing health issues faced by particular communities.

Health care costs are growing steadily, and our workforce will need new skills to meet our changing needs. All Victorians must be better informed about how to stay healthy and how to make the best use of the health system when they need it. The Victorian Government is committed to more and better information for patients. Informed consumers are able to make better choices for their health care and that of their family.

The implications are clear. Without change, our health system will not be able to meet our future needs.

The Victorian health system is much more than public hospitals. Victorians have benefitted from a wide range of community health and community support services, public dental and community nursing services. Importantly, the Victorian health system also includes the private sector. However, this sector, including private hospitals and private health providers such as general practitioners, medical specialists, nursing, dental and allied health clinicians, has been treated in isolation from our major public institutions. Planning for Victoria’s health system must recognise the role and capacity of private services so that we achieve the best possible health service system for all Victorians.

The government undertook, during the 2010 election campaign, to provide the state with a health services plan to 2022, based on current and accurate demographic and population data, and on consultation with all sectors and stakeholders, to lay out a clear integrated and coordinated agenda for the future of the entire Victorian health system.
In fulfilment of this commitment, the Department of Health has consulted with the health sector, and I have appointed a Ministerial Advisory Committee, chaired by the Hon. Rob Knowles AO, to provide advice and information on the best possible approach to planning for improved health services in Victoria.

These consultations and discussions have asserted the need for long-term health planning priorities for the state that recognise the impact of chronic illness and disease, the capacity to do much to prevent and reduce these conditions, and the pressures resulting from the rapid increase in the Victorian population.

The previous planning framework for metropolitan Melbourne, *The Directions for your Health System: Metropolitan Health Strategy (2003)* was based on flawed population projections and is now long outdated. The government, through the Department of Planning and Community Development (DPCD), is preparing new population projections, available in June 2011, that will be essential information in the planning and delivery of health services.

As a result of the advice from the consultations and the Ministerial Advisory Committee, we have prepared this *Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan* (the Health Plan) to provide, for the first time ever, statewide planning principles for the Victorian health system.

The Health Plan is the first step in our ground-breaking statewide approach to the implementation of those priorities within metropolitan Melbourne. A companion *Metropolitan Health Plan – Technical Paper* provides the essential data and analysis to inform implementation of these planning priorities in metropolitan Melbourne.

The Health Plan, whilst focussed on the central role of the public sector in the provision of health services, for the first time recognises the increasingly valuable and complementary role of the private sector. Together, the public and private sectors, including health funds and the full range of private practitioners, make up Victoria’s essential health services.

The Victorian Government is committed to confronting the challenges that lie ahead, and to creating an equitable and sustainable health system with people at its heart.

The government has already committed to a strategic approach to improvement of our health system through its election campaign commitments that included, amongst other features:

- additional health infrastructure and capacity
- waiting list and emergency department reform
- improving ambulance services
- overhauling rural and regional health services
- supporting Victoria’s leadership in health and medical research
- increasing transparency and accountability.

A key election promise was to undertake comprehensive planning for the future upon coming to government.

The release of this *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan* marks the delivery of that commitment.
The Health Plan is focussed towards 2022 – a longer time span than hitherto embraced by government. This will guide the preparation of the Rural and Regional Health Plan and the Health Capital and Resources Plan 2012–2022, which will be developed over the coming months with the advice of the Ministerial Advisory Committee and in close consultation with the community and health sector – a process we have already begun.

Together, these priorities and plans will put strategic long-term health and hospital operation and development across the state on a firmer and more rational footing. This will also enable for the first time, a focus on the special place of inter-face communities – those where the metropolitan and rural communities intersect – and which have long suffered from disconnected planning.

The Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan sets out seven priority areas for metropolitan, rural and regional and health capital planning into the future:

– developing a system that is responsive to people’s needs
– improving every Victorian’s health status and experiences
– expanding service, workforce and system capacity
– increasing the system’s financial sustainability and productivity
– implementing continuous improvements and innovation
– increasing accountability and transparency
– utilising e-health and communications technology.

These priorities will help us to create the people-focussed, knowledge-focussed system Victorians deserve, laying out a path to the future.

I wish to thank the Hon. Rob Knowles AO and the Ministerial Advisory Committee, and the many health professionals who were consulted in the preparation of this document. Their advice and input shaped these priorities that will now guide our future work.

I encourage all Victorians to have your say on the priorities outlined in Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan. Your comments will help inform the implementation of the government’s vision for our state’s health service system in the future.

The Hon David Davis MP
Minister for Health
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The Victorian health system has served our community well over many decades but it is straining to meet current needs. At present, it is not designed to handle the rise of chronic and complex conditions nor to fill the growing need to provide individuals with access to information about their health and health care. The current health service configuration does not fulfil people’s desire for health services to be close by and available when they need them.

Previously, governments could be said to have run the public health system as a series of health factories in which illnesses and injuries are treated. As a result, the existing buildings and institutions, together with historical patterns of practice, still influence many decisions made within the system. Connections between publicly-funded, private, and not-for-profit health services are limited. As a consequence we do not use these expensive resources as efficiently as possible. Better connections between all parts of the system, whether public, private or not for profit would help to maximise the benefits to be gained from available resources. Furthermore, people are not fully informed of their options for care nor of the various ways in which they might engage in the management of their own health care.

Hospitals have been and largely remain central to the health system. Many of our hospitals have long histories and iconic relationships with their communities. Their contributions to the care of sick and injured people are essential. However, over many years, funding arrangements by national and state governments have obliged hospitals to become, in addition, providers of urgent health care - regardless of whether or not health conditions actually require hospitalisation.

Hospitals were generally built where the majority of people lived when they were first designed, but today many people live well away from these locations. Many were designed for the medical systems of the past and did not consider people’s experiences of going to hospital. In many cases, our hospital buildings and technology are approaching obsolescence.

Health services often channel people into traditional treatment pathways rather than assisting them to make informed choices about which treatments to take and providing people with access to the most clinically effective and most cost-effective places for obtaining those treatments.

When people are very unwell or have life-threatening conditions, they need to be in hospital. Hospitals will therefore continue to be pivotal in the health system. However, in many instances of urgent medical conditions and complex and chronic illnesses, people could receive as effective but more customised, less costly care in their homes, or in clinics in accessible community settings.

Introduction

Health is central to our lives. It underpins everything we do, from choosing the food we eat every day, to consulting a specialist about a serious life threatening illness.

The Victorian Government is committed to empowering people to maintain their health and to make informed choices about the most appropriate health care for their needs. Ensuring that Victorians have optimal health and health care outcomes is essential to Victoria’s economic and social future.
Victoria has a significant record of effective preventive health care, from the early public health focus on basic infrastructure and immunisation to the long, more recent campaign to reduce smoking rates and the poor health caused by smoking tobacco. Today, to ensure we capitalise on our strengths in health and wellbeing, Victoria needs to develop a systematic and comprehensive approach to measuring public health, to informing people about health and health care, and to helping people to maintain and improve their health.

Limitations in the availability and use of relevant information in the health system undermine accountability in the provision of health services, undercutting both health experiences and outcomes, and the system’s capacity to achieve value for taxpayers.

Whilst many people in our community use electronic technology to conduct their day-to-day business, the health system uses a ‘pens and paper’ approach for some of its most important tasks. This limit to capacity impedes the fluent flow of information, reduces efficiency, and increases the risk of error, while denying individuals and their health care providers essential information about their treatments and outcomes in an accurate and timely manner.

The provision of high-quality health care requires the provision of detailed information to the public so as to empower every individual to make healthy choices and to live healthy lives.

The Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan (the Health Plan) establishes a framework for the planning and development priorities for health services across the whole Victorian health care system by the year 2022 and then articulates the particular planning and development priorities for metropolitan and statewide health services.

Current growth in the population and the steady ageing of our population each present challenges to health care that our services are struggling to address. With the increasing growth in the population, the future acceleration of ageing within the population and the increasing prevalence of chronic and complex conditions, meeting these challenges will become more difficult and costly unless current planning develops a better designed and more effective health system.

Therefore, this Health Plan reviews Victoria’s health system, sets out the case for change, and proposes critical directions and priorities to guide detailed planning and development into the future.

The government invites the community’s feedback and comments on these priorities and directions. Consultations will be held to enable the community to comment on the identified priorities and directions of the Health Plan and contribute to the further detailed blueprints for the development of health services that the government will publish this year: The Rural and Regional Health Plan 2012–2022, and the Health Capital and Resources Plan 2012–2022.

In formulating this approach and these priorities, the government has been guided by its Ministerial Advisory Committee (the Committee). The Committee is chaired by the Hon. Rob Knowles AO, and its members, who come from throughout the health care system, are experts in public health, public and private sector health services and health research, teaching and workforce. The advice of the Committee is noted throughout the Health Plan. The priorities are also informed by advice the government has received in workshops and consultations with clinicians, managers, service providers, and other people familiar with the Victorian health system.
These consultations confirmed the pressing need for a strategic approach to system planning in Victoria, and for the development of a priorities and directions framework and health plan commencing with metropolitan Melbourne.

Together with the companion publication, Metropolitan Health Plan - Technical Paper, this Health Plan provides the first phase of a comprehensive recasting of health planning in Victoria. They reflect the government’s commitment to improving hospital capacity, developing community-based health services, promoting healthy living, providing more extensive and higher quality health care information, improving emergency services, and creating more effective health care outcomes.

The Metropolitan Health Plan - Technical Paper provides, for the first time, the best available data on metropolitan Melbourne’s health needs and existing health services. Together with the government’s new population projections, forthcoming in June 2011, the Metropolitan Health Plan - Technical Paper will become a key evidence base for planning by government and health services across metropolitan Melbourne into the future.

Companion Technical Papers for Rural and Regional Victoria and Victoria’s Health Capital and Resources, including the health workforce, will be produced later this year.

Together these will assist the government to take into account the complex economic, demographic and social factors that affect Victoria’s health system.

As well, they will position Victoria to accommodate the context in which the plans are being developed: one of significant change and uncertainty. In particular, significant recent change through the Council of Australian Governments (COAG) health reform initiatives that were agreed, in principle, in February 2011, have substantial implications for the state health system and therefore future planning. These discussions have implications for future Commonwealth funding and governance arrangements for health services.

The Commonwealth’s commitment to provide an additional $16.4 billion in additional health funding over the six years to 2020 remains subject to further negotiation. As well recent Commonwealth Grants Commission recommendations have reduced Victoria’s share of national GST revenue by the significant sum of $2.5 billion over the next four years putting additional pressure on Victoria’s ability to fund appropriate health services.

Meanwhile, national health reform discussions continue and many aspects of health system governance remain unresolved. Victoria is committed to sustaining the current strengths of the Victorian health system and building on those strengths. In order to respond to, and continue to influence, Commonwealth economic and health reform actions and to drive continuous improvements in planning and health services development, the government will review the Health Plan every four years, and revise the related blueprints for health services development accordingly.
The Victorian health system is a complex web of types and providers of services that are managed and funded by the Commonwealth, state, and local governments, and by private, and not-for-profit organisations. These organisations and governments vary in their approaches, and operate in an uncoordinated and fragmented way.

This complexity makes the system extremely difficult for patients and clinicians to navigate. It is not easy for people to work out where they should go to for information and get the right care to meet their needs.

The health system is under increasing pressure as a result of population growth, the ageing of the population, increasing levels and types of chronic disease, rapidly evolving technologies and the rising costs of services.

The publicly funded health system in Victoria comprises a range of service providers that deliver services across the continuum of care. Services include primary health care services, such as general practitioners and community health centres; acute health services, including secondary, tertiary and quaternary care provided by hospitals; and a range of services that seek to provide coordinated care services for people who need specialist medical and other clinical care for chronic and complex health conditions; and public health services that aim to improve health by reducing or removing risk factors that adversely affect the health of our communities.

These health service providers deliver high quality health care in buildings that are often outmoded in design and capacity; with financial, time and demand pressures that continue to increase; and with limited ability to innovate and implement change to historical service arrangements.

Overall, the system will face considerable challenge in the near future from increasing demand and from changing health care needs as the population grows and becomes older, and disease patterns change.

Without change, the health system will struggle to meet these future needs.

The government has a vision for the future, and a plan to get there. Important commitments, have already been made, such as increasing capacity by an additional 800 new hospital beds and increasing the ambulance services capacity, but that is just the beginning.

The Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan provides seven priority areas for the development and operation of the Victorian health system for the future:

- developing a system that is responsive to people’s needs
- improving every Victorian’s health status and experiences
- expanding service, workforce and system capacity
- increasing the system’s financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

The Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan subsequently proposes the following planning and development priorities for metropolitan and statewide health services.

To deliver a system that is responsive to people’s needs:

– The systematic development and implementation of metropolitan municipal health and wellbeing plans that will address local population health determinants and health care needs and support healthy communities. In addition, to deliver the Health Plan’s vision for services in 2022, the government will produce: The Victorian Health and Wellbeing Plan 2011-2015.¹

– The development of more sophisticated planning approaches and tools such as:
  • area-based planning
  • definitions of the role and scope of services across the care continuum
  • service capability frameworks that provide definitions for minimum standards, workforce skills, and service arrangements to ensure safe, sustainable and effective health services
  • a service-planning and asset development and management framework that establishes principles and criteria for prioritising investments
  • analysis of up-to-date and correct population statistics that is summarised and distributed to the Victorian health sector to inform planning.

– Evaluation of existing and development of new care settings to ensure services are clinically effective and cost-effective, irrespective of the funding source with a focus on building capability and capacity for out-of-hospital care and improving access to primary medical and primary health care.

– Development of the proposed statewide primary health care plan for a stronger primary health care system in consultation with the Commonwealth Government (joint planning for a Victorian General Practice and Primary Health Plan).

– Joint planning with the Commonwealth, particularly on the Medicare Locals initiative to better connect primary care with other community-based services.

– Development of opportunities for greater private sector collaboration, coordination and integration.

– Enhancement of existing plans and development of relevant new plans for the systematic improvement to care planning and management for specific patient groups requiring detailed development of systems capacity or patient pathways.
To improve every Victorian’s health status and health experiences:

- development of Victoria’s Health and Wellbeing Plan 2011–2015, a prevention strategy and cross-government, cross-sector initiative (for release in September 2011)

- a comprehensive metropolitan community engagement, development and experience plan to enable effective partnership approaches to healthy communities by supporting implementation of municipal health plans for metropolitan municipalities

- identification of population groups in metropolitan municipalities who are vulnerable to poor health, and development of interventions that address their health needs

- a metropolitan and statewide strategy for improving people’s health knowledge and supporting patient choices, focusing on high demand patient cohorts such as the elderly, targeting metropolitan areas of high levels of disadvantage, targeting at risk cohorts such as those for whom English is not their first language, and expanding models for advanced directives for end-of-life care.1

To expand service, workforce and system capacity:

- evaluation and development of existing efficient and effective service models and settings, such as Hospital In The Home and community health, and development of new care settings to ensure services are clinically effective and cost-effective, irrespective of the funder, with particular emphasis on expanding capacity in out-of-hospital care and on increasing access to primary medical and primary health care

- allocation of additional investment in workforce education, training, placements and role development towards a more interdisciplinary workforce with a more extensive range of skills, to improve clinical outcomes, and care coordination, working with the Commonwealth, the AMA, nursing and key allied health professions.

To increase the system’s financial sustainability and productivity:

- Evaluation of alternative provider setting options, such as day hospitals, super clinics and community health centres, to identify and invest in services that are clinically effective and cost-effective, irrespective of funder and funding model.

- Development of a resource allocation model supporting greater fiscal management that is sensitive to population health needs, productivity, value for money and a more sustainable system.

- Refining and expanding the Victorian casemix funding for inpatient and other health services to ensure these arrangements meet future population health needs.

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1 Refer to Metropolitan Health Plan - Technical Paper for further details of health literacy and health information in metropolitan Victoria.
– Considering new funding models such as packages of care for targeted patient groups, such as those with chronic and complex care needs. Since care for these groups of patients is provided across the continuum, funding from state, Commonwealth, private, not-for-profit and non-government sources need to be considered, coordinated and not limited by existing barriers.

– Incorporating quality and outcome performance measures into existing funding models.

– Identification of aspects of the metropolitan and statewide health system that show potential for productivity improvement through alternative models of care.

To implement continuous improvements and innovation:

– facilitating clinician leadership of evaluations, service improvements and innovation

– development of a more effective central clinical data acquisition and management system (including advanced analysis capability) that generates the evidence base for improved or innovative clinical practice and population health interventions, and supports the development of better clinical pathways and service planning.

To increase accountability and transparency:

– development of a Health Outcomes Framework that encompasses the measurement of patient experiences, health outcomes (specifically including a focus on quality and safety), efficiency and effectiveness that does not generate any unnecessary additional data reporting and provides a framework for coordinating existing reporting processes (both state and national)

– mechanisms for auditing adherence to key initiatives such as the establishment and utilisation of clinical guidelines and patient pathways (including monitoring through Clinical Networks)

– review of the existing legislative approaches that drive governance and accountability arrangements for health services such as the Health Services Act as amended by the Health Services (Governance) Act 2000, the Mental Health Act 1986 and the Mental Health Regulations 1998.

To improve utilisation of e-health and communications technology:

– Articulate the system requirements and deliverable outcomes that increase clinical time, ensure optimal health information and reduce administrative time for both the patient and system, to be developed in the Health Capital and Resources Plan.
Throughout this year, further plans for rural and regional Victoria, and health capital and resources, will be published, based on the *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan*. Together, the health plans will guide the development and operation of Victoria’s public health services and enable the public and private sector to work together to deliver improved health services for all Victorians.

Over the coming two months, the government wants to learn what the community and the health sector think about implementing the *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan*. An extensive consultation process will be undertaken, which will include open forums, focussed small group sessions, and many discussions with interested parties around the state. In addition, the government welcomes written submissions on this paper. Further information about the consultation process, including dates and other details, is available online at [http://www.health.vic.gov.au/healthplan2022](http://www.health.vic.gov.au/healthplan2022)
In the Victorian health system, there is a range of services that are funded through multiple sources and across a broad range of settings. The range and mix of services provided is typically referred to as a continuum of care (Figure 1).

**Figure 1: Victoria's health system - a representation**

**CONTINUUM OF CARE**

- **HEALTH PROMOTION AND DISEASE PREVENTION**
  - Health protection program
  - Health promotion and illness prevention programs
  - Public health and wellbeing programs
  - Other sectors, locations and mediums

**SERVICE TYPES**

- **PRIMARY HEALTH CARE**
  - Primary medical care
  - Primary health care in community settings
  - Assistance for independent living

- **SECONDARY CARE**
  - Specialised acute and subacute care in hospital and non hospital settings
  - Residential care

- **TERTIARY CARE**
  - Specialised acute and subacute care in hospital settings

**SERVICE PROVIDERS**

- **Community health services**
- **General practitioners**
- **Non-government organisations**
- **Local government**
- **Public hospitals and health services**

**Funding**

- **State government funding**
- **Private health and individual contributions**
- **Local government**
- **Commonwealth Government funding**
Services

Health services in Victoria cater for the full range of health care needs, from prevention and primary health care services typically delivered in community-based settings through to acute and emergency care services provided in hospital settings. All levels of government and a complex range of service providers, both public and private, intersect with each other in the provision of this continuum.

This continuum can be broadly described as comprising four clusters of services: public health, primary health care, secondary care and acute care.

Public health includes health promotion and disease prevention activities undertaken at both a population and individual level. At a population level these activities include infrastructure services that ensure clean water and clean air, as well as social marketing campaigns about the dangers of smoking or the importance of healthy eating. For individuals these activities can include programs that provide education to people at risk of developing a chronic condition such as diabetes.

The state government, in particular through the Department of Health and its funded agencies, plays the most significant role in meeting public health needs. Local governments, via their many services and municipal health and wellbeing plans also play important roles in promoting healthy communities. Additional providers and peak groups, such as VicHealth, a statutory authority with an independent chair and board of governance, also play a critical role in promoting healthy individuals and communities.

Primary health care is the most commonly accessed component of the health system. It is most people’s first point of contact with the health system often to treat specific and immediate illnesses. Those people with ongoing or more complex conditions will have regular and ongoing contact with various parts of the primary health care system. As the number of people with chronic and complex conditions increases, primary health care providers are developing new service models that provide more specialised and coordinated care. In particular early intervention and team care programs are being developed.

Primary health care includes general practice services, including medical and nursing services, community health including community nursing, allied health, public oral health services and child and maternal health services, and private allied health including oral health, optometry, psychology or physiotherapy services. Specialised services to meet local community needs have been developed across Victoria’s primary health care system including the Early Intervention in Chronic Disease program, refugee health nurses and sexual health clinics.

Like most parts of the health system, primary health care involves a mixture of public and private funding, with a mix of local government, public and private service providers. Funding for general practitioner services principally comes from the Commonwealth Government, but also has out-of-pocket components. Community health services are funded principally by the state government, with a minor out-of-pocket component. Private allied health services are funded by a mixture of out-of-pocket expenses and private health insurance subsidies. Many low income earners are able to access a core suite of primary health care services with no or minimal out-of-pocket expenses.

In Victoria and metropolitan Melbourne the primary health care sector works in partnership through Primary Care Partnerships. Through their activities Primary Care Partnerships aim to support primary health care providers working collaboratively to improve the health and wellbeing of their catchment’s population by better coordination of planning and service delivery in response to identified needs.
In the future, Medicare Locals will have a role in supporting coordination across the primary health care sector. The scope and function of this role is still being developed by the Commonwealth Government. The impact of this on the primary health care sector is unclear.

**Secondary care** is typically provided by specialist health professionals and for people with specific illnesses and chronic and complex conditions. Examples include radiology and pathology services or specialist services required by a general practitioner as more detailed investigations of specific and immediate illnesses. Ongoing secondary care is also provided by specialist clinicians for a chronic or complex condition. As new models of care are developed for these conditions greater integration of secondary and primary health services is occurring. Following treatment in an acute facility, secondary care will often be provided either in a hospital or through community care when the person returns to their home. These services include rehabilitation, home nursing, and attendance at a specialist cardiac clinic when recovering from cardiac surgery.

In Victoria, state government funding for secondary care includes some inpatient services and specialist ambulatory care clinics, such as those for continence, chronic pain management, dementia and memory loss. Other secondary services include Commonwealth-subsidised services by private specialist medical practitioners and diagnostic services to whom patients are referred by their general practitioner.

**Acute care**, often referred to as tertiary and quaternary care, is typically provided in a hospital setting as well as a range of same day surgical clinics and day hospitals and community-based agencies. Acute care is provided by both public and private providers.

**Acute health** care is accessed via emergency departments or outpatient clinics following a referral from a primary health care professional. In emergency departments patients with acute and immediate health needs are treated by a range of clinicians. Those requiring ongoing care are admitted to the hospital for ongoing care. Those requiring short-term care are cared for within the emergency department. In the public hospital system patients requiring either emergency or elective surgery will be prioritised based on the acuity of their condition. Surgical hospital care is provided on multi-day and, increasingly, same-day bases.

Victoria has an extensive network of public hospitals governed by health service boards, with 86 independent hospital boards operating across the state. This includes 21 public health services (major health service networks), 22 sub regional health services and 43 small rural health services. These health services are governed by the *Health Services Act 1988*, which sets out their obligations to meet the health needs of their local communities. In Victoria the private hospital sector comprises free-standing day procedure centres, private hospitals operating on a not for profit basis (34 facilities) and a commercial for profit basis (128 facilities). Private hospitals are also regulated under the *Health Services Act 1988*.

The principal source of funding for public hospitals is the state government (although the Commonwealth indirectly provides about 40 per cent of this funding through the Australian Health Care Agreement). Public hospital services are free to the community, with generally no out-of-pocket expenses. Private hospital services are funded by private health insurance, Medicare rebates, and out-of-pocket expenses.

There are two other important sub categories of services provided across Victoria, these are residential and community care.
Residential care is provided to people who can no longer be cared for in their home due to disability or the effects of ageing. Residential care is categorised as secondary care. These services are provided through care facilities that provide for the full range of day to day needs of individuals via personal care, medical and psycho social services. Facilities that provide these services are owned and run by public, private not for profit and for profit organisations. The sources of funding for these services include the Commonwealth and state government as well as out-of-pocket expenses.

Community care includes a range of services provided on an ongoing and short-term basis to people with either short or long-term health conditions or personal care needs. Community care is generally a component of primary health care but can also include some secondary services. These services include nursing, personal care such as assistance with showering and home cleaning or the provision of meals. The aim of these services is to enable individuals to be cared for in their home for as long as possible. Services are provided by a range of community-based providers. The sources of funding for these services include the Commonwealth and state government as well as out-of-pocket expenses.

People move through the continuum of care provided by these services according to their health needs. Most Victorians navigate between the various services as and when they need to. However, for some people, particularly those with long-term multiple needs, including people with chronic conditions, the aged and people with mental health problems, navigation is difficult and there is a need to ensure that these particular patient groups have care that is coordinated and integrated in order to facilitate optimal health outcomes and to minimise duplication of services and costs. Primary and secondary health care providers play a critical role in coordinating care for these groups of clients.

Victorians access services from throughout the continuum of care according to their needs. When one part of the system is not working properly, or is inadequately funded or inaccessible, the burden shifts to another part of the system – including to public hospitals, which are the most costly and possibly the most pressured parts of the health system.

The services in the metropolitan health system

All elements of the service system described previously operate within metropolitan Melbourne. Public health care is provided through a system of integrated services located in multiple campuses within broad geographical areas. It includes:

- statewide specialist centres of excellence which lead the provision of complex, high acuity health care
- specialist services in major tertiary hospitals
- a range of general acute and/or subacute care for local communities
- ambulatory services which provide same-day procedures and other ambulatory care.

Services range across acute, subacute, aged care, mental health and primary care. Integrated health services, such as Southern Health and Peninsula Health, provide all levels of care within their region through services in various locations. Specialist hospitals, such as The Royal Women’s Hospital, provide the full range of services from specialist to ambulatory, but only for a particular patient category or clinical specialty.

Each metropolitan health service collaborates with community-based providers such as general practitioners (GPs), community health services (CHS), community dental services and other health care services throughout Victoria. Metropolitan health services also play a role in teaching, training and research.
Funding

Funding and service provision structures in Victoria, and, more generally, in Australia, have evolved over time in response to contemporary economic and social policies and population health needs. The resulting system is complex and multi-layered, combining public and private service provision, Commonwealth, state and private funding, and a multiplicity of service types largely shaped by funding sources and requirements.

In 2008–2009, Australia spent $112.8 billion on health goods and services - that is, on average, $5,190 per Australian. Of the total, 94.9 per cent ($107.1 billion) comprised recurrent expenditure on health goods and services. The remaining 5.1 per cent was capital expenditure ($5.7 billion).

Spending on public hospital services in 2008-09 is estimated to have been $33.7 billion; on medical services, $19.8 billion; and on medications, $15.2 billion.

In 2008–2009 recurrent expenditure in Victoria for public acute and psychiatric hospitals totalled $8.2 billion and employed over 66,000 staff.

In 2007–2008, governments funded 69 per cent of total health expenditure, the Australian Government funded 43 per cent and state and territory governments funded 26 per cent. Private insurance contributes 7.6 per cent of total health expenditure. Since 1999, at least 30 per cent of a private health insurance premium has been paid by the Australian Government through a rebate. In mid-2010, 44.6 per cent of the population had private hospital insurance.

Out-of-pocket spending accounted for 16.8 per cent of total health expenditure in 2007-08. Most of this expenditure was for medications not covered by the PBS, dental services, aids and appliances, and co-payments on medical fees.³

Victorians have access to medical and pharmaceutical services through the Medicare and Pharmaceutical Benefits Schemes. These schemes are regulated and administered by the Commonwealth Government, and subsidise many pharmaceuticals, specialist medical and surgical care, general practitioners, and (for people who have chronic conditions) limited dental and allied health services.

Close to half of Victorians maintain private health insurance, subsidised by the Commonwealth Government. Private health insurance underpins private hospital utilisation and other private health care services such as physiotherapy, dentistry, optometry, and podiatry, as well as complementary medicine services. Approximately one-third of hospital beds are in private hospitals, complementing the public system by providing additional inpatient capacity and enabling choice.

³ Australian hospital statistics 2008-2009, AIHW 2010, Cat no. HSE 84. Canberra: AIHW.
Figure 2: Recurrent health expenditure, by area of expenditure and source of funds, current prices, 2008-2009

Notes: Public hospital services exclude certain services undertaken in hospitals. They sometimes include services provided off site such as Hospital In The Home, dialysis and other services.

‘Other health’ comprises patient transport services, administration and research
Governmental responsibilities

The Victorian Government’s primary responsibility in health is to manage the Victorian public health care system and to support the health and wellbeing of all Victorians. The government also is accountable for ensuring the most effective resource allocation decisions are made within the limitations of the overall health budget. In 2009-2010, the Victorian Government health care budget was $12.5 billion, that is, around one third of all Victorian Government expenditure.

The Victorian Government is responsible for services delivered in public hospitals. Public hospitals deliver a range of services, including emergency care, surgery, multiday medical care, sub acute and rehabilitation care, and palliative care. In addition, the Victorian Government also funds ambulatory care services through specialist clinics, some located in community settings, and community health centres throughout Victoria that provide a range of primary health care services such as community nursing, allied health, community development, chronic disease management and health promotion services. These services complement the primary health care services funded by the Commonwealth Government. The Commonwealth has committed to the establishment of Medicare Local organisations which are to plan and support the delivery of face-to-face GP services outside normal hours.

The Commonwealth and Victorian Governments fund a wide range of additional health services, including health promotion, mental health, limited dental health, rural and Aboriginal health programs, and health services for war veterans.

The Commonwealth Government provides the greater proportion of funding for residential aged care and various funders are responsible for providing services to people whose needs are met by community-based services. In Victoria, state and local government play a significant role in supporting independent living through the Home and Community Care Program.

The Council of Australian Governments (COAG) signed a new Heads of Agreement in February 2011. Although debate on national health reform continues, this agreement has confirmed and strengthened the role of the states as the managers of the public health system.

Many of the initiatives agreed by COAG remain to be decided. The roles, remits and inter-relationships of the National Health Performance Authority, Medicare Locals, the National Health Pricing Authority, the Australian Safety and Quality in Health care Commission, and the National Preventive Health Agency have not been settled. Nor are the intricacies of the workings of the national funding pool clear. Most importantly, from the perspective of the Victorian health system, the impact these changes will have on the state as system manager, and on Victoria’s health services, is as yet unclear.

The Victorian Government sees great benefit in Victoria’s unique model of Home and Community Care (HACC) service delivery, which involves a close partnership with local government. HACC services are particularly important in supporting Victorians at vulnerable points in their own homes and it is at these points that there is on many occasions close interaction with the health care system.

The support provided by HACC to patients is an important factor in avoiding hospitalisation and in supporting discharge of patients from hospital.

Current HACC arrangements remain a formal point of debate with the Commonwealth Government. The Victorian Government, together with local government, is seeking to retain the benefits of Victoria’s unique HACC model of service delivery.

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4 For details about the National Health Reform, see <http://www.health.vic.gov.au/healthreform>
The performance of the Australian health care system: a snapshot

Australians in general receive very good health care. By international comparison, the Australian health care system ranks third of seven Organisation for Economic Co-operation and Development (OECD) countries.

Australia ranks highest of the seven countries compared for living long, healthy lives, and second in efficiency, but lower in quality of care and equity, and joint lowest for access.

These rankings provide a focus for what needs to be done to improve the Victorian health care system. Additional areas for improvement include overall health status, patient outcomes and experience, the health knowledge of the Victorian community, managing accelerating demand, the over-reliance on hospitals, and a discrepancy between service and workforce structures, on the one hand, and on the other hand, the distribution of population needs.

Recent inquiries, such as the reports of the National Health and Hospitals Reform Commission, have pointed to the need to change current Australian health system arrangements.

Figure 3: Comparison and ranking of national health care systems, based on Commonwealth Fund surveys

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Canada</th>
<th>Germany</th>
<th>Netherlands</th>
<th>NZ</th>
<th>UK</th>
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<tbody>
<tr>
<td>Overall ranking</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Quality of care</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
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<tr>
<td>Efficiency</td>
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<td>6</td>
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<td>3</td>
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<td>Long healthy lives</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Health expenditure per capita (US$)</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,588</td>
<td>$3,837</td>
<td>$2,454</td>
<td>$2,992</td>
<td>$7,290</td>
</tr>
</tbody>
</table>

The case for changing the Victorian and metropolitan Melbourne health system

The Ministerial Advisory Committee (the Committee) and the preparatory health service consultations have identified a range of issues that demonstrate the need for improvement in current health services and health outcomes. These have been informed by the Metropolitan Health Plan – Technical Paper.

Many people do not have optimal health care outcomes

A number of factors increase the risk of poor health and poor health outcomes for some particular population groups. These include education, income, housing, employment status, geographical location and cultural background.

Some groups in the population are more likely to experience poor health and illness than others. For example, a higher proportion of the rural population than of metropolitan Melbourne is likely to suffer poor health, chronic conditions, and ambulatory-care sensitive conditions. Some communities have less access to primary care services, and have a higher prevalence of obesity, poor dietary choices, and unhealthy behaviours (such as smoking). A number of these area- or population-based differences are detailed within the Metropolitan Health Plan – Technical Paper.

Figure 4: Potentially avoidable hospital admissions (ambulatory-care sensitive conditions)\(^6\)

6 Note that the drop in rates of ambulatory-care sensitive conditions between 2007–08 and 2008–09 are due to changes in coding practice for diabetes and gastroenteritis.
For some groups with particular health needs, such as those with chronic or complex health conditions, poor coordination of care increases the risk of poor health outcomes.³

The capacity of the health system to deliver responsive coordinated care, and to effectively target population groups with poor health status, is currently limited. Although the health system includes the necessary health services to provide coordinated care, and to effect early intervention care for people at risk of poor health status, the complexity of funding arrangements and consequent service types make it difficult to combine multiple services effectively around the needs of any one person or particular population group.⁴

**Primary health care services**

For those people who are vulnerable to poor health, early intervention (either pre-emptive interventions or interventions made early in the progression of a chronic or complex condition) are essential. These interventions need to be timely and proximate, making the role of primary health and primary medical services of critical importance. Primary health care services based in local community settings are better placed than centralised, more difficult to access services to recognise and respond to any one individual’s need for intervention. The most effective location for a large proportion of the services needed by patients with chronic and complex conditions is therefore in community settings.

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³ Population Health Survey 2008, Department of Health.

⁴ Chronic illnesses and complex conditions include diabetes, cancer, dementia, mental illness, and heart and respiratory failure. Elderly, frail people form a distinct group within this category.
Coordination of services

The lack of sufficient coordination between the services in the system can be costly for both individuals and the health care system. People whose chronic and complex conditions are not well managed often need to make more extensive use of hospitals. In the long-term, their health outcomes may be poorer, requiring increasing levels of health care to meet their needs. The barriers to coordinating services lead many providers to focus on their immediate role in the continuum of care. Currently, even when individual services provide high standards of clinical quality, there is often insufficient coordination across settings to adequately meet individual patient needs.

Some of those most in need of the health system’s services are those for whom the system is hardest to use.

Clinical guidelines and patient pathways are two tools widely recognised as supporting better coordination and utilisation of services. Clinical guidelines help to create consistency between clinical decision-making and practice across the continuum of care and for all patients. Descriptions of the pathways patients would expect to follow through the system’s various services help individuals to understand the system and to use its services more effectively.

However, the Committee and consultations noted that few clinical guidelines or patient pathways are used consistently throughout Victoria and metropolitan Melbourne. Clinical guidelines and patient pathways are formulated at a local level, often on an ‘as needs’ basis. There is limited practice of sharing these tools between service settings, and there is a lack of structural arrangements that ensure clinicians and patients follow the guidelines and pathways with any consistency.

The inconsistencies between the guidelines and pathways formulated in various settings make it difficult for clinicians to coordinate patient care effectively and for patients to make informed decisions about how they will use services. The lack of consistency in clinical guidelines and patient pathways means that any one patient’s experiences of the system can be inconsistent and fragmented.

Sharing of information

Information sharing, for clinicians as well as for individual health care users, is made difficult by the diversity of information management systems between the state, Commonwealth and private health sectors. Provider relationships and information management system variations are more evident in metropolitan Melbourne where service providers operate under a greater number of independent agencies or practices and governance structures.

The impediments to sharing information create unnecessary risks of error, inefficiency, and potential disparities in patients’ outcomes. Limitations in the timely electronic movement of clinical information may mean that the key information about a patient whose risks have been identified in one setting may not always be transferred to other settings. It was noted that difficulties in obtaining information can mean that up-to-date evidence and best practice approaches do not always influence either clinicians’ decisions or patients’ choices about how to manage their health.

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10 For definitions of clinical guidelines and patient pathways, see the Glossary.
There are not enough services when and where they are needed

Ideally, the health system would provide services when and where they are needed. Advice from consultations and the Committee indicated that services are not always available when and where people need them with outer metropolitan (and rural areas) commonly less well supplied than inner metropolitan areas. In other words, the system’s services are not always well-allocated: their distribution does not always correlate to the distribution of the population across the state, making it difficult for some people to obtain timely, and therefore effective, primary and acute medical care.

Most services (GPs, hospitals, ambulances, and specialists) are clustered in or near the centre of metropolitan Melbourne and in well-developed regional centres. In some cases, the concentration of specialist services is necessary for the efficient, cost-effective, and safe delivery of high-quality care. The high-quality of the service hubs distributed throughout Victoria exemplifies the benefits of concentrating specialist services. But concentration of services is not always necessary and often means that patients in less well serviced areas have to travel long distances to access care that could be provided locally. The Metropolitan Health Plan – Technical Paper identifies and details the considerable variation across metropolitan Melbourne in the correlation of services to population even when allowing for the impact of the centralisation of specialist services to inner Melbourne. This is made worse in areas in which there is restricted access to and choice of transport services, including emergency transport.

At present, limited public and private hospital services are located in the areas of more recent population growth. As well, the distribution of general practices does not correlate well to where the greatest number of people live. In metropolitan Melbourne, only 20 per cent of the population live within a 10 km radius of the city, yet 40 per cent of public and private hospitals, and primary and specialist medical care services are based within this radius. In rural and regional Victoria, residents often need to travel long distances to access the type and level of health service they require, limiting their ability to obtain timely or appropriate health services.

Projections of population growth show that the population will continue to grow more rapidly in outer metropolitan Melbourne than elsewhere. These projection estimates will be updated as new detailed population data becomes available in June 2011. Without improvements in the distribution of health services for these growth areas, the discrepancies between demand and supply in these areas will worsen.
Figure 6: Population and location of hospital services

Figure 7: Population and location of general practitioners


Hospital utilisation could be better managed

Hospitals play a central role in the Victorian health system. However, pressure on the hospitals as well as the health system overall is increasing because people are living longer, the prevalence and types of illness are changing, and people have heightened expectations of the health system.

The availability and accessibility of community based general practice and primary health care has a significant impact on the utilisation of surrounding hospitals. People who cannot access appropriate primary care will often choose to use hospitals to meet their immediate (although perhaps not urgent and critical) health care needs. People with chronic and complex health conditions, such as diabetes and respiratory conditions, can become high users of hospital care in the absence of well coordinated community-based care that prevents avoidable illness and deterioration.

Access to medical care outside of the public hospital system can be unaffordable for some, with public hospitals providing trusted and affordable (free) health care.

The availability of post-acute and long-term care options for people, particularly older people, requiring support post-discharge from acute care contributes to the inappropriate utilisation of hospitals. At any one time there are a number of patients in hospital beds because of a lack of other available alternative support services at home or in supported residential settings.

Figure 8: Hospital admission rates for potentially avoidable hospital admissions, across Victoria

![Graph showing hospital admission rates across various years and regions in Victoria.](https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/ViewContent.aspx?TopicID=1)
On present trends, we can expect that, in 2022:\(^\text{12}\):

- People over 70 will use 45 per cent of hospital capacity (bed days)
- Population will grow 1.3 per cent per year but the number of times patients will seek care will increase by 3.3 per cent a year
- 70 per cent of health care costs will be associated with chronic and complex conditions
- Largest growth in demand will be for renal dialysis services, at a rate of 4.8 per cent per year

Hospital funding arrangements can act as barriers to improving the efficient and effective use of hospital services. For example, under current Victorian funding arrangements, some patients undergoing same-day procedures are admitted to a hospital facility, rather than in a clinically more appropriate community setting, as occurs elsewhere.

In Victoria, between 2004–05 and 2009–10, same-day hospital admissions increased from 137 to 148 per 1,000 population while multi-day admissions only increased from 109 to 112 per 1,000 population. This data shows hospital growth is primarily in same-day admissions and reflects shorter length of stay, changing models of care and the impact of increasing demand. However, questions remain as to whether the treatments provided through these same-day admissions all need to occur in a hospital. Comprehensive application of clinical guidelines and patient pathways should enable care to be provided in the most clinically appropriate and cost effective setting and help determine when inpatient care is clinically required.

The Committee considered that alternative community-based care delivery models and settings in operation around the world have demonstrated the capacity to reduce pressure on hospital services and to improve patient experiences. Alternative care delivery models aim to relieve pressure on hospitals by working more closely with the private health sector and primary and secondary health care provider. In addition, removing barriers between public and privately-provided services could also increase the capacity of the system to treat more people, and to treat them in the most clinically appropriate and cost-effective settings.

Even if the fundamental role of hospitals, GPs and other community-based primary and secondary care services (public or private) were better communicated and more widely understood by the community, the fact is that, without specific coordination mechanisms, hospitals will continue to be relied on for health services that are able to be provided in these less costly, clinically appropriate settings.

The statewide and metropolitan Melbourne health system is a complex web of service types and providers that are managed and funded by the Commonwealth, state, and local governments, and by private, and not-for-profit organisations. As already identified, these organisations and funders vary in their approaches, and operate in an uncoordinated and fragmented way. This complexity, particularly for metropolitan Melbourne and services across the state, makes the system extremely difficult for patients and clinicians to navigate. It is not easy for people to work out where they should go to for information and get the right care to meet their needs.
Demand for health services is increasing rapidly

Rapid population growth is expected to occur over the next decade. This population growth will compound the pressure on already over utilised hospital services.

Between 2011 and 2022 Victoria’s population is projected to grow rapidly to 6.45 million people. It is anticipated that 4.8 million people will live in metropolitan Melbourne and 1.65 million people in regional Victoria. This represents respective growth of 27 per cent and 19 per cent. Population growth will not be spread evenly: the largest increases are expected to occur in the outer fringes of Melbourne, inner Melbourne and major regional centres. These population estimates will be updated by the Department of Planning and Community Development in June 2011.

At the same time, the population is ageing. The proportion of people aged 60 years and over in 2022 will be higher than has been experienced in the past 40 years, with a greater proportion of people aged over 45 years (through to 85+ years) living in rural Victoria.

The Metropolitan Health Plan – Technical Paper shows that the aged and ageing population across metropolitan Melbourne is not equal and these variations need to be taken account of in future service planning.

As the population ages and chronic disease becomes more prevalent, demand for services will increase and more pressure will be placed on our health care and associated systems. On average, people aged over 75 years use five times as many health care services than people aged less than 75 years.

The contribution of the ageing population to family support, through ongoing paid work and through their contribution to the voluntary sector cannot be overlooked and the importance of maintaining the health of older Victorians cannot be overestimated.

Figure 9: Projected changes in Victoria’s age profile, 2009 to 2036\(^{13}\)

\(^{13}\) Department of Planning and Community Development, 2009, Victoria in the Future 2008, population projections at 2036.
The state government has recognised this and established an inquiry on successful ageing and how to maximise the social and economic contribution of the increasing number of older Victorians and their choices and options.

**Chronic and complex conditions are becoming more prevalent**

The number of Victorians with chronic and complex conditions is increasing. For example, cancer, cardiovascular disease, and mental disorders together account for more than half of the disease burden in Victoria. A number of factors including lifestyle and behaviour contribute to this situation. The *Metropolitan Health Plan – Technical Paper* confirms that the distribution of growth in these chronic and complex conditions across Metropolitan Melbourne (and Victoria) is not consistent and needs to be accounted for in service planning.

As the population ages and chronic disease becomes more prevalent, demand for services will increase and greater pressure will be placed on our health care and social systems.

Modeling suggests that if this trend continues on its current course (and nothing is done to stop or change it), there will be uneven distribution of growth in particular health conditions. Current service planning does not take into account the projected distribution of this growth. Consequently, services will not be provided where they are most needed if future planning does not take these projections into account. Figure 11 gives an indication of future demand for hospital care based on the current trends.

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**Figure 10: Changing prevalence of chronic illness across Victoria, 2008 to 2022**

- **Stroke**: Estimated prevalence in 2022: 0, Change over 2008 prevalence: -1.6%
- **Osteoporosis**: Estimated prevalence in 2022: 11.9%
- **Cancer**: Estimated prevalence in 2022: 34.3%
- **Heart disease**: Estimated prevalence in 2022: 18.7%
- **Arthritis**: Estimated prevalence in 2022: 21.8%

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Figure 11: Modelled hospital episodes of care for the highest growth treatment stream 2008–09 to 2021–22

<table>
<thead>
<tr>
<th>MODELLED BED ESTIMATES</th>
<th>FINANCIAL YEAR</th>
<th>GROWTH 2008–09 TO 2021–22</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROGRAM/TREATMENT</strong></td>
<td><strong>2008–09</strong></td>
<td><strong>2021–22</strong></td>
</tr>
<tr>
<td>Emergency multi-day medical</td>
<td>3,365</td>
<td>4,814</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>277</td>
<td>461</td>
</tr>
<tr>
<td>Renal &amp; peritoneal dialysis</td>
<td>485</td>
<td>894</td>
</tr>
<tr>
<td>Mental health (MH funded)</td>
<td>938</td>
<td>1,207</td>
</tr>
<tr>
<td>Geriatric evaluation and management</td>
<td>904</td>
<td>1,212</td>
</tr>
<tr>
<td>Palliative care</td>
<td>249</td>
<td>354</td>
</tr>
</tbody>
</table>

The use of services is also intensifying. The population is forecast to grow at 1.3 per cent per year while the number of times people see a doctor or other health care provider is expected to increase by 3.3 per cent per year. As the ageing of the population accelerates and, longevity for Victorians extends, this utilisation will be intensified as the proportion and number of people with the highest health care needs grows.
The demand for mental health services will also continue to rise over the next decade. In the 10 years to 2019, on demographic growth alone, there will be some 100,000 more Victorians each year with a diagnosable mental illness. Around 30,000 of these will have a moderate to severe condition likely to need extended treatment and support.

These factors combined will lead to substantial increases in demand for and use of services across the continuum of care.

Source: Australian Bureau of Statistics, 2006 Census of Population and Housing
Cells in this table have been randomly adjusted to avoid the release of confidential data. No reliance should be placed on small cells. For details on a classification and associated data quality information click on the blue i-links in the table.

Table generated using ABS TableBuilder
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Rising health costs need to be well managed

The cost of delivering health services is rising. Two key factors are widely accepted as contributing most to the rise: more services are being provided and the cost of each individual service is increasing. Individual service costs are rising as a result of a number of factors such as advances in medical technology, rising wage costs and the increasing cost supplying essential goods and services. Any inefficient use of resources, poor fiscal management or system waste will exacerbate the rise in costs and undermine the sustainability of the health system.

Across Australia it is anticipated that the cost of health care and aged care will grow significantly as can be seen in Figure 13.

Figure 13: Projected Australian Government spending on payments to individuals, health and aged care, 2009-10 to 2049-50

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Evidence from the United Kingdom National Health Service over the past decade indicates productivity of the health sector as a whole has remained static and in the hospital sector has been declining. Any failure in the Victorian system to address productivity will compound the rising costs and further impact sustainability.

Productivity opportunities exist to improve the way we establish, provide and maintain health service infrastructure, information and communication technology (ICT), workforce and effective use of resources.

The health care system, if maintained in its current form, is not easily affordable and will be a challenge for the community to support in the long term. Change is required in community expectations and the way people access and use the system, particularly the default use of acute hospitals. Our acute hospital over-reliance needs to be replaced by increased capacity and coordination of the primary and community care sectors and greater personal responsibility and management of health care needs.

The increasing out-of-pocket cost of health services impacts upon the community. The affordability of services impacts on patient choice.

To become financially sustainable, the system will have to increase in efficiency. Its use of resources, fiscal management, coordination of services, and the use of its services must all be as efficient and effective as possible. Many of these requirements have already been discussed.

Nonetheless, it is evident from the advice of the Committee and consultations, that making improvements to health service infrastructure, information and communication technology (ICT), the nature of the workforce’s skills, and the utilisation of resources would improve the productivity of existing investments.
The health workforce is not prepared for future needs

The workforce underpins the ability to provide care.

The workforce needs to support clinically effective care delivery. The workforce needs to have the appropriate skills and levels of expertise to provide patients with the most clinically effective care. The workforce needs to be located or able to work in areas of need and to be able to use the full extent of their skills.

Australia has been slow to adopt new workforce models that operate successfully in other industrialised countries. Examples include generalist medical practitioners and physicians, independent midwives, nurse practitioners, nurse anaesthetists or assistants and nurse endoscopists. In many cases, slow adoption of new workforce models and roles has been due to industrial issues and professional boundaries.

Recent workforce planning has focussed on an outdated professional silo approach. Consultation advised that the number of rules, guidelines, regulations and agreements have exacerbated the silos and slowed adoption of international trends towards adaptive training and role definitions. This has limited the scope of workforce roles, skills development and role evolution. The silo approach makes it difficult to facilitate the coordinated and interdisciplinary care that clinicians want to provide and that are needed in a people-focused health care system.

Training lead-times to develop the workforce are long, and targeted and sophisticated planning is necessary.

Across a range of clinical professional groups, there is uneven distribution with fewer health professionals available in outer metropolitan Melbourne and Victorian regional or remote areas. This is highlighted in more detail in the Metropolitan Health Plan - Technical Paper. The options and supports for health professionals to work in these areas are inadequate and this results in fewer services in geographic areas.

There are increasing requirements placed on health service providers to plan for, and manage change, as a result of the need to deliver more care in the community. There is a need to plan effectively to address workforce supply and utilisation issues including team-based care, the implementation of new clinical practices and models of care, and the increasing need for greater productivity.
People need to be better informed about their health

Knowledge and information is central to people making good decisions about health care. Without it, people cannot take responsibility for their health - keeping healthy, preventing illness, and seeking care from the most appropriate provider or clinician when they need it.

The ability to understand and apply health-related information is known as health literacy. Health literacy is more than just the ability to read, it includes the ability to understand and interpret health-related information and apply it to a particular situation. Health literacy skills are used every day and are necessary to be able to make decisions about, for example, when to seek treatment, which over the counter medicine might be appropriate or what to do in a first aid emergency.

In 2006, only 41 per cent of Australian adults were assessed as having adequate (or better) health literacy skills. This indicates a large proportion of Victorians are unlikely to be well-informed or optimally informed about their health.

The lack of overall health literacy in the community has lead to some misconceptions or inappropriate expectations about how individuals can look after their health, how health services should be accessed and in what form health services should be provided.

Improving the level of health literacy of Victorians will support people to better understand and manage their own health, enable them to be active participants in decision making about their own care and help them to make appropriate decisions about the consumption of health care resources. The ability of people to be involved in their care decisions needs to be improved to enable them to make informed choices when options are available. This is particularly so for older people as identified in the Metropolitan Health Plan – Technical Paper. For example, this is essential for sensitive individual health planning decisions such as organ donation and end-of-life care.

Figure 14: Health literacy skill level

NOTE: Skill levels 3, 4 and 5 represent adequate or better health literacy.
Setting directions for change

There is a clear case for significant improvements in the current health system in Victoria to ensure that health services become more responsive to people’s needs, better coordinated, more efficient, and more rigorously-informed and informative.

Among other points, the system needs greater capacity to deliver prevention, primary care, and early intervention.

The obstacles to sharing information within the system need to be reduced as much as possible.

The system needs to provide health care users with clearer information about their health care needs, options and choices. Individuals and community groups also need to be engaged and supported in health improvement and better health management of their own health.

Services in the system need to be coordinated efficiently and consistently, in ways that enable the public to use the combination of services required for their specific needs to optimal effect.

Services need to be located where they are needed, and the allocation of services needs to anticipate future levels and distribution of demand, in particular with regard to the ageing population, population growth, and increases in the prevalence of chronic and complex conditions.

Productivity, measurement of performance, health literacy, efficiency (in the use of resources and the configuration of services) need to be increased to ensure the system’s services are and remain affordable.

Workforce planning and the definitions of workforce roles and responsibilities need to depart from the traditional silo approach to a more flexible approach. Workforce training needs an increased focus on interdisciplinary expertise and skills, and to better model anticipated future workforce needs to ensure that our health system is capable of responding to the future specific needs of our community.

The Victorian Government has already committed to a number of actions that will initiate some of the changes outlined above. These actions are described in the next section, entitled, ‘Immediate action.’

To ensure that future planning maintains the current strengths of the Victorian health system, and facilitates improvements to the current barriers and limitations outlined above, this Health Plan proposes seven health system priorities for the development of health services in Victoria over the next decade.
Immediate action

The Victorian Government has already made commitments to take action and address areas of immediate concern in both metropolitan Melbourne, and rural and regional Victoria. These commitments include a series of infrastructure investments that aim to diminish the excessive burden of demands currently placed on the hospital system, improve workforce capacity, stimulate innovation and improvements, and implement measures to increase accountability and transparency.

These commitments are aligned with the priorities outlined in this Health Plan and provide a basis on which to build future improvements.

Government commitments include:

- Increasing capacity by 800 new beds over the next four years to ensure that Victorians receive the hospital care they need. Allocation of new capacity will be based on analysis contained in the Metropolitan Health Plan – Technical Paper and subsequent Rural and Regional Health Plan and guided by the Health Capital and Resources Plan 2012–2022.

- The establishment of a $1 billion Health Infrastructure Fund to provide for the planned and strategic investment in Victoria's public hospital infrastructure and hospital equipment for both metropolitan and rural hospitals, mental health facilities, primary health care facilities and health support services.

- A range of capital infrastructure projects that will be detailed in the Health Capital and Resources Plan 2012-22, including:
  • Box Hill Hospital
  • Bendigo Hospital
  • Geelong Hospital
  • Royal Victorian Eye and Ear Hospital
  • Echuca Hospital
  • Ballarat Health Service
  • Monash Children’s
  • and a range of others.

- Waiting List and Emergency Department Reform Initiatives to enable health services to provide Victorians with improved and more coordinated services. Patient treatment coordinators, for example, will help case-manage and coordinate patients’ journeys through health care and treatment, thereby improving their experiences and health outcomes.

- Safety and security in our hospitals, particularly in emergency departments, is an important issue and the Victorian Government will work with hospitals to ensure levels of safety for health professionals and the general public. Consultation will be important to ensure that it is implemented appropriately and doesn’t compromise patient care. There are ongoing security issues at hospital emergency departments. The Government has proposed to fund additional protective service officers in hospital emergency departments. The Parliamentary Drugs and Crime Prevention Committee will be referenced to review and make recommendations regarding all contributing factors relating to safety and security at our hospitals. The Government’s proposal will be considered as an element of that review.

- Improving ambulance services through a range of initiatives that include building new and developing existing ambulance stations, recruiting 340 additional ambulance paramedics and patient transport officers, and halving the cost of Ambulance Victoria membership fees to support Victorian families.
– Improving rural and regional health services, to be detailed in the Rural and Regional Health Plan and the Health Capital and Resources Plan 2012–2022. Actions will include support for the recruitment and retention of a skilled workforce in rural and regional Victoria as well as improved infrastructure and services. Support will be provided to rural doctors undertaking continuing professional education and there will be increased assistance for training registered midwives in rural locations.

– Increasing transparency and accountability, supported by accurate and relevant information about the health system’s performance, enabling Victorians to judge the effectiveness of the health care system.

The government will:
- Establish a hospital performance website to provide information about the performance of major metropolitan and regional hospitals. This website will be launched in June 2011 and will publish data including:
  - emergency department attendances by urgency category, median wait times, admissions, and activity
  - ambulance diversions, including ambulance bypass and Hospital Early Warning System (HEWS) incidences
  - the number of ambulance patient transfer occasions and hours.
  (The data reported on the website is likely to expand over time to include new indicators as they are developed).

- Provide, by the end of 2011, public reporting of outpatient waiting lists for public hospital specialist clinics, including the time patients wait to get an appointment.

– Establishing the Health Innovation and Reform Council to lead continuing improvements to our health system. The Council will advise key directions for improvement in areas such as:
  - improving patient flow through the health system
  - improving hospital service quality and safety
  - clinical and hospital administration and best practice.

The Council will draw on the existing review, advice, and consultative bodies that operate on a statewide and regional level to improve Victoria’s health system.

– Supporting Victoria’s leadership in health and medical research by creating and extending health and medical research capacity in universities and health services. This will include establishment of a health and medical research precinct at Deakin University, and it will designate the Alfred Health precinct an academic health science centre and supporting other teaching training and research facilities.

– Delivering effective improvements (and where necessary, changes) to services in mental health to ensure that Victorians with mental health illnesses can access earlier effective treatment, timely acute care, and targeted support to assist in long-term recovery. This effort will include new measures to strengthen delivery of evidence-based practice, ensure better access to community-based treatment and recovery services, and improve housing and employment outcomes. Particular priorities include:
  - Boosting mental health bed capacity through a range of initiatives including expanding step up/step down services, and establishing a new secure step-down model, fifteen new mother and baby beds, and additional mental health inpatient beds. A central bed coordination role will also be established to assist clinicians to locate mental health beds for their patients more effectively.
  - Meeting growing demand for community clinical mental health services, particularly in outer suburban growth areas, to assist up to 800 more adults to access treatment.
  - Providing pathways to economic participation for people with severe mental illness. The pathways will include a pilot program that assists up to 600 people to access open employment and education and training opportunities.
• Initially supporting the expansion of local Headspace youth mental health services. New programs to address eating disorders and youth suicide prevention will also be implemented.

• Improving the psychiatric disability rehabilitation and support service sector to meet growth in demand for Home-Based Outreach Support services.

• Improving housing outcomes for people with a severe mental illness through a range of initiatives in collaboration with clinical and community support agencies.

• Establishing a Mental Illness Research Fund with emphasis on translating research into evidence-based treatment and clinical practice.

— Finalising a new Mental Health Act, developing a Victorian Suicide Prevention Strategy, tackling workplace stress, better involving carers of those with mental illness, deliver an eating-disorders plan, developing a comprehensive mental health workforce strategy, and a range of other system development improvements to the way mental health services are provided in Victoria.

— Developing a reform action plan for the alcohol and other drug treatment system to better provide a well planned, responsive and comprehensive suite of evidence-based treatment and recovery services.

In order to discharge its responsibilities, the Victorian Government has already established inquiries into a number of whole-of-government issues relevant to supporting and promoting healthy individuals, families and communities. These inquiries include:

— the measurement, including budget measures, of primary health and aged-care services and outcomes

— the contribution of environmental design to prevention and public health in Victoria

— liveability options in outer suburban Melbourne.

— successful ageing to maximise the social and economic contribution of the increasing number of older Victorians.

The 2011–12 Victorian State Budget funds many of these initiatives and, as such, provides the first series of investments towards delivery of an improved Victorian health system.
The Victorian health system in 2022

By 2022, Victoria’s health system should be:

Responsive to people’s needs

With the following outcomes:

- People are as healthy as they can be (optimal health status).
- People are managing their own health better.
- People enjoy the best possible health care service outcomes.

These outcomes will be achieved by:

- ensuring that health care is clinically effective and provided in the most clinically effective and cost-effective environments
- providing primary and community-based health services that reduce and prevent misplaced hospital admissions and that manage chronic and complex health conditions to optimal effect
- individuals and families consistently receiving the information and skills-training that are necessary for health literacy, and thus gaining an enhanced ability to maintain their health and to make decisions that improve their health status and reduce their risk of ill health
- providing health advice and information that is readily accessible and relevant and that enables individuals and families to:
  - locate and access clinically effective health services in a timely way
  - make choices about their health care and manage their health care requirements with their health providers.

Rigorously informed and informative

With the following outcomes:

- Care is clinically effective and cost-effective and delivered in the most clinically effective and cost-effective service settings.
- The health system is highly productive and health services are cost-effective and affordable.

These outcomes will be achieved by:

- planning prevention and early intervention services to achieve comprehensive access throughout the state based on population health data and with particular provision for people with high-risk and specific health needs
- using up-to-date research and evidence to determine and implement the most effective use of all resources, minimising waste and unnecessary care
- making health education, advice and information readily available and easy to understand and use for health service users
- using up-to-date research and evidence to design service and care provision models that target the needs (for care and health literacy) of those who are most vulnerable to poor health
- working in partnership with communities to better understand local community needs, and the differences between communities
- ensuring health care delivery is guided by patient pathways and clinical guidelines that are based on contemporary evidence and best practice information

- providing information sharing technologies and systems and care planning arrangements that promote shared decision making between clinicians and patients and their families, so as to deliver effective care

- ensuring care is of a high standard and safe, and that risks and errors are minimised

- continuously improving clinical care by using and supporting research, innovation and strong clinical leadership

- developing a highly capable workforce whose skills answer the health needs of the population, and correlate to trends in the needs of the population, and to health service provision based on patient pathway and clinical guidelines

- providing comprehensive information about the performance of the health care system and being publicly accountable for the quality, safety and cost effectiveness of services

- developing funding models that promote the provision of clinically effective services in the most clinically effective and cost-effective service environments to deliver optimal health outcomes for health service users

- delivering funding and services in partnership with the Commonwealth government, the private and not for profit health service sector and with health professionals, using agreed patient pathways and clinical guidelines. Service delivery and funding arrangements should remove barriers to, and develop capacity for, coordinated service delivery and shared responsibility across the continuum of care, particularly for people with chronic and complex conditions

- looking to, wherever possible, shift the balance of care in the long term from hospital settings to community-based settings. A framework to support this objective should be developed that meets growth demands, ensures effective service delivery and increases the utilisation and capacity of general practice and allied health settings and Victoria’s community health sector, where appropriate.

What this means for people using Victoria’s health system in 2022.

The following table compares how some key aspects of information about health, and health services, will be different in 2022.
### Figure 15: Changes in experiences of the Victorian Health System, 2011 to 2022

<table>
<thead>
<tr>
<th>NOW</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When you are well</strong></td>
<td><strong>You will be more health literate</strong></td>
</tr>
<tr>
<td>Limited range of whole-of-population health promotion and risk reduction initiatives</td>
<td>You will have ready access to a range of programs for health and wellbeing.</td>
</tr>
<tr>
<td>Health information and promotion programs will be locally provided and focussed on high risk groups in your community, such as people who are overweight, and migrant populations with genetic predispositions to illness.</td>
<td>All local governments will have Municipal ‘Healthy Communities’ Public Health and Wellbeing Plans that are well known to their local communities and that promote healthy living.</td>
</tr>
<tr>
<td>Your community will have a better diet and reduced risky behaviours such as smoking and excessive consumption of alcohol.</td>
<td>Your community will have a better diet and reduced risky behaviours such as smoking and excessive consumption of alcohol.</td>
</tr>
<tr>
<td><strong>If you become unwell</strong></td>
<td><strong>Readily accessible e-health information and telephone advice to provide first point of call information and advice for most health concerns.</strong></td>
</tr>
<tr>
<td>Limited choices about where and how to receive care</td>
<td>Local access to first point of call information, advice and referral, including extended hours service provision.</td>
</tr>
<tr>
<td>Hard for individuals and families to get the complete information they need about care options</td>
<td>Clearly defined and well-distributed points of access to the health care you need - you will know where to go for the care you need.</td>
</tr>
<tr>
<td>Only a small proportion of individuals and families feel fully involved in decisions about their care</td>
<td>Your health care will be clearly described to you based on the clinical guidelines used by your clinician or clinical team.</td>
</tr>
<tr>
<td>Information about your health needs will be readily available to your primary, specialist and hospital clinicians so that important diagnostic and treatment information is easily transferrable.</td>
<td>Information that is easy to understand and use will be available to you and your family so that you can participate fully in decision making about your health and health care and your expectation will be aligned with real care options.</td>
</tr>
<tr>
<td>Options for receiving care at your home or closer to home will be available when safe and appropriate: you will have access to the right care at the right time and place.</td>
<td>In rural Victoria - you will have greater access to primary medical care, defined and improved patient pathways to central specialist services, greater local service self-sufficiency for appropriate, localised care, and a lower chance of your needing a hospital admission.</td>
</tr>
<tr>
<td>NOW</td>
<td>2022</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have a chronic or complex condition</strong></td>
<td>Options for you to receive care at home or close to home will be available when safe and appropriate, and funding will support these options.</td>
</tr>
<tr>
<td>Hospital-centric model of care (most roads lead to Hospital)</td>
<td>Information will flow easily between you and your clinician.</td>
</tr>
<tr>
<td>No central service takes responsibility for the patient</td>
<td>The coordination of your care will be a central part of the system based on agreed patient pathways, so as to ensure that you receive the right care at the right time and place.</td>
</tr>
<tr>
<td>Ad hoc connection and information sharing between care provider settings</td>
<td>Information that is easy to understand and use will be available to you and your family so that you can participate fully in decision making about your health and health care and take greater responsibility for managing your health care.</td>
</tr>
<tr>
<td>Services and care are hard for individuals and clinicians to navigate and coordinate</td>
<td>Care will be available from a range of different providers working in collaboration with each other throughout the continuum of care, with one taking primary responsibility for your care.</td>
</tr>
<tr>
<td>Funding models drive care to unnecessary admission to hospital</td>
<td>You will be supported in being very confident about how you can manage your own health independently, where appropriate.</td>
</tr>
<tr>
<td></td>
<td>Your family, supporter or carer will be supported with information and respite to be better able to maintain their caring role.</td>
</tr>
<tr>
<td></td>
<td>In rural Victoria earlier and more effective intervention for your chronic or complex condition will be available within your local area. Your admission to hospital should only occur when the treatment you require cannot be provided out of hospital.</td>
</tr>
<tr>
<td><strong>When you are elderly</strong></td>
<td>Health care environments and services will be age-appropriate, and will focus on minimising your functional decline.</td>
</tr>
<tr>
<td>Lack of clarity on services available</td>
<td>You and your family will have easy to understand and use information available to you all so that you and your carer can participate fully in decision making about your health and health care.</td>
</tr>
<tr>
<td></td>
<td>Your treatment or care will be available at the most clinically effective and cost-effective location according to your clinical care needs, your decisions, and your preferences.</td>
</tr>
<tr>
<td></td>
<td>Your family, supporter or carer will be provided with information and respite to be better able to maintain their caring role.</td>
</tr>
<tr>
<td><strong>End of life care</strong></td>
<td>You and your family, supporter or carer have actively participated in deciding your care pathway options, and your and their control over your care and outcome and your choice is respected.</td>
</tr>
<tr>
<td>Often very limited engagement in decisions about care (including carer)</td>
<td>Care is available at the most clinically effective and cost-effective location based on your and your carer’s decision making and preferences.</td>
</tr>
<tr>
<td></td>
<td>In outer metropolitan suburbs or interface communities as well as rural Victoria, there will be expanded options for your palliative care at home or in the local community.</td>
</tr>
<tr>
<td></td>
<td>Your family, supporter or carer will be supported with information and respite to be better able to maintain their caring role.</td>
</tr>
</tbody>
</table>
Pathways that are responsive to people’s needs

By ensuring that its services are responsive to people’s reasonable needs, the system will provide the best health outcomes possible for people needing treatment and management of illness or chronic conditions, and ensure that people are as healthy as they can be.

To enable individual participation in informed health care planning, management and decision making, and to provide the best care possible, health information that is based on up-to-date information and best clinical practice will be readily available from and accessible in local and web-based services.

Health diagnosis, treatment and management information will be, where patients consent, shared electronically (securely and with appropriate privacy) and best practice patient and clinical pathways will be developed for a comprehensive range of conditions that span the continuum of health care and the range of relevant health service providers. This will remove current information barriers between providers, in public, private and not-for-profit sector services and between health professional groups, and will facilitate shared planning and management of an individual’s treatment, enabling care to respond to the needs of people without being restricted by the health service structures.

For frequent users of the health care system and particularly those with chronic and complex conditions, this will mean a greater focus on improved care planning and coordination of care and will promote the provision of more care in community settings.
A personal health care experience: 
a current journey

The complexities, confusions and inefficiencies 
of present health service arrangements and 
provision are best shown through the experience 
of a person needing treatment. This example maps 
the current journey through the health system of 
a person with a heart condition.

The current experience for most people with 
a heart condition will include:

– repeatedly returning to their GP to help 
  them navigate their way through the health 
  care system
– limited or inadequate information 
  provided to their GP if they have a required 
  hospital admission
– seeing, and repeating their story to, multiple 
  service providers whose involvement with the 
  person may be quite disjointed from each other 
– not having the opportunity or knowledge to be 
  involved in planning or coordinating their care 
– multiple separate medical or health records, 
  all held by individual service providers

The people’s cardiac disease journey in 2022

In 2022, the journey for people with a heart 
condition through the system will be well-defined 
and responsive to the needs of the person, 
and consequently, it will be easier to coordinate 
and to navigate. Health literate people will be 
able to make choices about their care when it is 
appropriate to do so.

The future experience for most people with a heart 
condition will include:

– single point of care coordination, either GP 
or most clinically and geographically effective 
health provider, for cost effective and efficient 
care management

– well-defined and personalised cardiac pathway 
including roles of health service providers to 
make care planning easier

– access to personal information and knowledge 
development to facilitate high levels of 
person’s involvement in care, whether it is 
planning, coordination, or decision making

– information within the person’s control and 
with consent, easily transferred between 
providers resulting in improved 
communication, safety of care and optimal 
health care choices and decisions

– single electronic medical health record shared 
between the person and providers of care

– clinicians who have access to up-to-date 
evidence and who receive support for real time 
decision making

– clinicians who know which treatment regime, 
based on the cardiac care pathway, is in place.
Priorities Framework

The Victorian Health Priorities Framework 2012-2022. The Health Plan establishes the key outcomes, attributes and improvement priorities for the health care system based on the advice received from the Committee and other preparatory consultations. It provides a framework for planning and delivering an innovative, informed and effective health care system that is responsive to people’s needs, now and in the future.

Seven priorities are proposed to create a health system that is underpinned by expertise among health professions and health literacy among the public, so that people can live healthy and productive lives. Patients should have the option to make choices about their care, in partnership with their clinician.
These seven priorities will address, now and in the future, the key issues in the health system. The first four of these priorities target specific changes and improvements to our health system and the other three are essential underlying changes to allow our health system to work more effectively.
Metropolitan Melbourne and statewide service priorities

The Ministerial Advisory Committee and the preparatory consultations indicated the health system must be better planned and identified a range of priorities with associated future actions to better meet the population and individual health needs of Victorians.

This chapter presents the application of the Victorian Health Priorities Framework 2012-2022 for the metropolitan Melbourne and statewide health services.
Developing a system that is responsive to people’s needs

For the metropolitan Melbourne and statewide health system to become more responsive to people’s needs, people need to be able to obtain the most effective form of care for their needs; they need to be able to make informed decisions about that care; their care needs to be coordinated; and the system needs to be easy to navigate. In addition, the health system needs to anticipate people’s needs by promoting health and managing the risks for specific population groups.

For the metropolitan Melbourne and statewide health system to provide these services, planning must consider specific local needs and pay attention to all aspects of health service operation, including clinical-effectiveness, cost-effectiveness and fiscal management.

Community groups and local governments should play a strong role in identifying the needs of their local communities and planning for health services. This will ensure care is targeted to meet local needs and to promote healthy communities. Developing community-based municipal public health plans is one means of supporting these objectives. Community Advisory Committees of metropolitan health services are another means of supporting these goals.

Instituting a system that is responsive to people’s needs requires capacity planning along the continuum of care. Identified capacity gaps in primary care, based in the community, and ways to address these gaps needs to be addressed through comprehensive planning. Increased capacity in primary care to provide more and improved services will relieve misplaced demands on metropolitan hospitals and improve access to care in non-hospital based settings whenever appropriate.

Not all people will require care to be coordinated for them. But those individuals who need frequent care or management of their illness, such as those with chronic and complex conditions, and the frail aged, will benefit from better coordination of care between service providers. People with chronic and complex conditions create around 70 per cent of current demand on the metropolitan health care system. Improving care for these individuals will require a smoother flow of information within the metropolitan system, and greater coordination between general practitioners, specialists, rehabilitation and other social services.

The use of local planning was identified through consultations as vital. Due to large differences in population density and forecast growth, needs, and existing service access, detailed metropolitan data analysis is required to ensure planning is responsive to the needs of the local community. The companion Metropolitan Health Plan – Technical Paper and forthcoming Rural and Regional Health Plan provides this data analysis.

The coordination of care needs to occur based on clinical evidence and best-practice clinical guidelines and patient pathways. The development of clinical guidelines and patient pathways will require a concerted and ongoing development process, starting immediately. The guidelines and pathways will provide the basis for future service and workforce planning. Clinical networks have a valuable role to play developing and applying clinical guidelines and patient pathways.

There are people within the community who have specific needs that require particular attention when planning for the health system. Some of the key areas of need identified by the Committee that need targeted intervention and better planning include:

– Chronic and complex conditions. As already outlined, there is an increasing rate of chronic and complex conditions and people with these conditions have specific needs and require a high level of coordinated care. Planning is required to identify targeted interventions for these people at a population and local level to ensure care is coordinated around their needs. For example, the outer west area of metropolitan Melbourne has the largest proportion of people in metropolitan Melbourne with type 2 diabetes.
— Child health. The health of metropolitan children and youth is vital. The evidence shows there is an increase in the rate of overweight and obese children. This makes them more susceptible to developing chronic health problems such as diabetes and cardiovascular disease. More children and youth are reporting mental health problems, contracting sexually transmitted infections and undertaking risky behaviours such as binge drinking.

— Oral health. Oral health is vital for good health. The mouth and its structures are susceptible to infection, disease, injury and decay which can lead to serious illness, such as throat cancers and blood stream infections. Poor oral health, prevention and maintenance, is resulting in high rates of avoidable hospital admissions.

— Aboriginal health. Progressing the Strategic Directions in Aboriginal health as part of Victoria’s response to Closing the Gap, with a particular focus on increasing life expectancy and reducing child mortality rates for children under five must be a critical focus of our future health planning.

— Aged health. In response to the Productivity Commission findings in aged care, the Victorian Government will review its approach to models of assessment, promoting independence and wellness of older people receiving aged care services, providing information about available services and performance, providing support for choice, improving care coordination and promoting early engagement.

— Women’s health. To improve the health and wellbeing of all metropolitan women (with an emphasis on those most at risk), the development and dissemination of health information and research, and the provision of community and professional education is required. These activities should take place directly with women and in partnership with the health and community sectors.

— Men’s health. In a range of areas, such as life expectancy, avoidable mortality and health risk behaviours, more attention is needed to improve men’s health. Men can be better supported to create healthier lifestyles and increase their engagement with health services. Health services can be supported to better understand and meet the needs of men.

— Gay, lesbian, bisexual, transgender and intersex health. We will further develop the Health and Wellbeing Plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) community.

— Cultural and linguistic diversity. A culturally competent health care system will support efforts to increase the capacity of the health care system to design, implement, and evaluate culturally and linguistically competent services to address health disparities among populations from culturally and linguistically diverse (CALD) backgrounds and to promote health and mental health equity, including the development of a Refugee Health and Wellbeing Plan.

— Alcohol and drug prevention and treatment. The Victorian Auditor General noted that the alcohol and drug treatment system had changed little since its introduction in 1997 and that it had not kept pace with community needs. In response to these findings the government is shaping an agenda for sector reform that will address longstanding issues with treatment models, system performance and workforce, and equity in the distribution of alcohol and drug treatment resources. In addressing the distribution of alcohol and drug treatment resources, current and forecast prevalence and incidence will be taken into account. For example, current data indicates that the highest risk populations in metropolitan Victorian for alcohol consumption are in the areas of the Mornington Peninsula, the Inner North, Inner Southeast and Northeast areas.\(^{21}\)
Current planning approaches are not designed to deliver a health system that can easily use, and is responsive to, the most current information and knowledge for effective and efficient service delivery. Planning approaches are disparate and disconnected. If planning is to occur across the continuum, arbitrary funding and governance barriers will need to be overcome. In addition, greater collaboration and planning with the private sector and Commonwealth will need to occur.

The Committee expressed a view that more sophisticated planning tools, based on up-to-date evidence and knowledge, and designed to recognise and anticipate the influence of changes in one part of the system on the other parts, must be developed and implemented. For example, if the primary health care sector is strengthened and more early interventions are provided to at-risk population groups, there may be a reduction in avoidable and unnecessary hospital admissions, reducing some of the demand for hospital inpatient beds. The impact will be most pronounced in areas of high current and forecast demand and where there are limitations in capacity. For example, in metropolitan Victoria, the inner west area has the highest percentage of primary care type presentations to emergency departments at 60 per cent.

By ensuring the application of up-to-date evidence and best practice in planning a system designed to respond to people’s needs, planning tools will prompt evaluation of existing service settings. This will guide care into the most clinically effective and cost-effective service settings and drive a highly productive and sustainable system. For example, this may include future collaboration with the private health care sector.

Delivering a system that is responsive to people’s needs:

The government has committed to a range of initiatives to begin the redevelopment of the health system into one that is more responsive to people’s needs, including:

1. The Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan (the Health Plan), which, together with its companion Metropolitan Health Plan – Technical Paper and supporting plans, provides directions and guidance for the development of Victoria’s health system and specifically metropolitan Melbourne and statewide health services throughout the next decade. The further supporting plans include:
   a. The Rural and Regional Health Plan, which will provide a detailed plan for the development of rural and regional services between 2012 and 2022.
   b. The Health Capital and Resources Plan 2012–22, which will provide a detailed plan for:
      i. infrastructure and assets
      ii. health professional workforce
      iii. ICT
      iv. health and medical research.
Planning and development priorities for metropolitan health services will include:

1. The systematic development and implementation of metropolitan municipal health and wellbeing plans that will address local population health determinants and health care needs and support healthy communities. In addition, to deliver the Health Plan’s vision for services in 2022, the Government will produce: The Victorian Health and Wellbeing Plan 2011–2015.  

2. The development of more sophisticated planning approaches and tools such as:
   a. Area-based planning: That is, planning services based on geographic boundaries and local population health needs. This approach has the benefit of addressing local service gaps by matching services to local needs and specific population groups and/or people types. In metropolitan Melbourne, area profiles have been developed and used in the Metropolitan Health Plan – Technical Paper for the purposes of analysis.
   b. Guidelines and principles for all levels of planning, from statewide to regional to sub-regional to local level, across the care continuum.
   c. Definitions of the role and scope of services across the care continuum.
   d. Service capability frameworks that provide definitions for minimum standards, workforce skills, and service arrangements to ensure safe, sustainable and effective health services. This will include, for example, statewide services such as trauma and paediatrics, and the capability requirements of local hospitals to undertake advanced procedures and surgery, and routine investigations. Service capability frameworks will also guide planning for new services or growth in existing services.
   e. A service-planning and asset development management framework that establishes principles and criteria for prioritising investments.
   f. Analysis of up-to-date and correct population statistics that is summarised and distributed to the Victorian health sector to inform planning.

3. Evaluating existing and developing new care settings to ensure services are clinically effective and cost-effective, irrespective the funding source. There will be a focus on building capability and capacity for out-of-hospital care and improving access to primary medical and primary health care. This may occur through, for example, role evaluations of existing day hospitals.

4. Development of the proposed statewide primary health care plan for a stronger primary health care system in consultation with the Commonwealth (joint planning for a Victorian General Practice and Primary Health Plan).

5. Joint-planning with the Commonwealth, particularly on the Medicare Locals initiative to better connect primary care with other community based services (beyond primary medical health care and specifically including housing, disability services etc).

6. Development of opportunities for greater private sector collaboration, coordination and integration. This includes initiatives to strengthen health promotion and health prevention initiatives, particularly in partnership with VicHealth. This will be part of strengthening the already significant role of VicHealth for the future.

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23 Section 49 of the Public Health and Wellbeing Act (2008) stipulates that a State Public Health and Wellbeing Plan must be developed no later than 1 September 2011, and subsequently every four years after that date.
7. Enhancement of existing plans and development of relevant new plans for the systematic improvement to care planning and management for specific patient groups requiring detailed development of systems capacity or patient pathways. These will include new plans for:
   a. cardiac
   b. renal
   c. ambulance
   d. chronic and complex
   e. child and paediatric
   f. alcohol and drug.

Reviews of the following existing plans should be a priority:

   g. care for older people (considering 2011 productivity commission review findings)
   h. cancer
   i. oral health
   j. Aboriginal health
   k. women’s and men’s health
   l. GLBTI health.
Ensuring that the diverse communities of metropolitan Melbourne receive high-quality, safe and culturally sensitive health care was identified as an important priority.

Improving the health status of residents of Melbourne requires action to improve health literacy among the whole community, thereby engaging them in maintaining optimal health status for themselves and their families. This involves ensuring that support services, such as interpreters, are available where needed.

It also requires that information about health and early health promotion interventions reach and engage all vulnerable people and patients.

The need for efficacious and cost-effective preventative health intervention, whether in health promotion or other preventative interventions has been reinforced by the VicHealth and Queensland University ACE study. This, and other similar research findings, should guide future policy and funding decisions regarding health promotion and prevention interventions.

Ensuring that services are more responsive to the needs of vulnerable groups in the population is another key part of fulfilling this priority. For example, the data provided in the Metropolitan Health Plan - Technical Paper suggests that in metropolitan Melbourne, lone parents and the Aboriginal and Torres Strait Islander populations have the highest risk factors for chronic heart disease and diabetes.

People and families need to receive accurate, up-to-date information so they know how to be as healthy as possible. Health-literate people, families and communities will be healthier and empowered to make more informed decisions and choices about their care and take greater responsibility for their health.

Fulfilling these objectives may mean more people will take greater time and care to maintain better oral health, exercise more and eat better and reduce the amount of alcohol they drink. Schools can teach children how to grow fruit and vegetables to encourage them to eat well. Opportunities exist to improve the health literacy and experience for patients. Consultation advice indicated more work needs to be undertaken to better understand patients’ current experience and where there are opportunities for improvement.

The Victorian Government is aware of the significant amounts of health data available that are not accessible to consumers or health practitioners advising patients. Such data when properly analysed and made accessible has the potential to empower consumers to make more informed and better choices about their health and health care needs.

A recent example of such data being analysed and made accessible to community and health practitioners is the Arthritis Foundation’s website. The Department of Health worked with the Arthritis Foundation to provide a range of useful information and the Arthritis Foundation produced the first rate website that makes publicly available a large amount of information previously unavailable to the community.

The government will work with other groups to ensure available information is made accessible to health consumers and patients to strengthen the basis of their choices and empower their decision making.

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25 Refer to Metropolitan Health Plan - Technical Paper for further details of vulnerable population groups, health status and experiences.
Delivering improved health status and experiences:

1. The government will work with hospitals, health services, clinicians, and other key stakeholders to develop best practice discharge and follow-up parameters that include:
   a. providing more easy to use and understand information and advice to patients, carers and family members when they are discharged, regarding medications and symptoms of complications;
   b. introducing regular follow-up contact by local general practitioners and community nurses as the basis of better post-discharge care procedures.

2. The government has established inquiries into whole-of-government responses and actions to support healthy individuals, families and communities in the following three areas:
   a. contribution of environmental design to prevention and public health in Victoria;26
   b. liveability options in outer suburban Melbourne;27 infrastructure and business development in outer suburban Melbourne;28
   c. successful ageing to maximise the social and economic contribution of the increasing number of older Victorians.

Planning and development priorities for metropolitan health services will include:


2. Developing a comprehensive metropolitan community engagement, development and experience plan to enable effective partnership approaches to healthy communities by supporting implementation of municipal health plans for metropolitan municipalities.

3. Identifying population groups in metropolitan municipalities who are vulnerable to poor health, and developing interventions that address their health needs. As identified in the Metropolitan Health Plan – Technical Paper, vulnerable groups include lone parents, the unemployed, Aboriginal and Torres Strait Islanders, people with chronic and complex conditions and the elderly.29 These strategies will be carried out in conjunction with local government and community health services.

4. Developing and implementing a metropolitan wide strategy for improving people’s health knowledge and supporting patient choices. As identified in the Metropolitan Health Plan – Technical Paper, the strategy will focus on high demand patient cohorts such as the elderly, targeting metropolitan areas of high levels of disadvantage, targeting at risk cohorts such as those for whom English is not their first language, and include expanding models for advanced directives for end-of-life care.30

5. Collaborating with key groups including the Cancer Council and VicHealth as well as the community to continue the work on tobacco control with the clear objective of reducing the harm caused by smoking and reducing the rate of smoking in the community.

29 Refer to Metropolitan Health Plan Technical Paper for further details of vulnerable population groups and area profiles.
30 Refer to Metropolitan Health Plan Technical Paper for further details of health literacy and health information in metropolitan Victoria.
Expanding service, workforce and system capacity

As the metropolitan population continues to grow and age, and illnesses change, the capacity of health services needs to expand and change to respond to the specific needs of the metropolitan population.

In the past, expansions in capacity have often focused on increasing inpatient capacity, for example, by investing in hospital beds. In the future, hospital capacity will need to expand further, and accordingly, the Victorian Government will continue to build new beds. But it will also shift the focus of expansions in capacity from acute care to primary health care, and the distribution of care, in order to ensure that these expansions respond to peoples’ needs. This approach will involve:

- increasing the availability of services that meet peoples’ needs
- expanding capacity in community settings and homes, in particular, in relation to primary medical care, early intervention and disease prevention, and chronic and complex disease management
- investing across the continuum of care in improvements to the distribution of services
- rigorous management and investment decisions to ensure that care is clinically effective and cost-effective and delivered in the most clinically and cost-effective service settings
- maintaining existing hospitals, and expanding their capacity.

The Victorian health system, like other states, is more fragmented than it should be. Patients therefore often find it difficult to navigate their way through the system to obtain the best and most coordinated care.

Smart decisions about the allocation of resources will ensure the system has the necessary types of capacity and that it uses resources cost-effectively. These decisions will capitalise on the current opportunities to increase capacity by working differently with the private sector, not-for-profit sector, local government, and the Commonwealth Government.

General Practitioners remain the lynchpin of early diagnosis and develop long term relationships with individual patients and their families. As such they are best placed to assist patients to work through the system.

A number of chronic disease management strategies may be best coordinated through general practice and with the involvement of specialist medical practitioners for the coordination of patient treatment in both primary care and hospital settings. Consideration should be given to what services could be delivered in strategically located community practices and with appropriate shared information.

The management of patients with complex and chronic conditions within local general practices would help avoid unnecessary and avoidable hospital admissions and provide services that are more clinically appropriate and cost effective. These community practices would also be well placed to assist in the post discharge management of patients after hospital based procedures or other hospitalisation.

To ensure the expansions in capacity are affordable, it is essential that both patients and the health workforce use resources in a cost-effective manner. Health services and government will need to work together to ensure effective and appropriate decisions are made about how resources are allocated and performance is measured. Performance will be measured in the light of the allocation of resources.

A fundamental aspect of expanding capacity is increasing and diversifying the skills and expertise of the health workforce. Industry and professional bodies will play an important role in developing the workforce and providing leadership.
Improved workforce planning will ensure that future demands for health care are anticipated in detail, actions are taken early to train the workforce in the requisite skills, and role requirements change in response to the needs of the metropolitan population. Workforce planning will also need to identify where skills are needed and develop strategies to make sure the workforce supply meets demand. For example, as outlined in the Metropolitan Health Plan – Technical Paper the health workforce is distributed around the key service delivery nodes, which are clustered in the centre of Melbourne and well established communities, whereas population growth and demand will be prominent in the outer west and outer northwest.31

Clinical networks provide a valuable tool that can be harnessed to promote a capable workforce through leadership, developing guidelines, advising on standards and promoting innovation, research and learning.

Opportunities exist for Victoria to develop and expand the role and scope of many professional groups and adopt international best practice where appropriate.

Nurses are a crucial lynchpin in our health workforce. The nursing profession has great capacity to contribute further in the years towards 2022. Many of the challenges with an ageing nursing workforce are outlined in the accompanying Metropolitan Health Plan – Technical Paper and will be subject to work and consultation in the development of the Health Capital and Resources Plan 2012-2022 to be released later this year.

Input from nursing and allied health professional groups in the development of the Health Capital and Resources Plan 2012-2022 to be released later this year will be critical. This could include advice on trials of new models of health care delivery.

Better planning will inform the distribution and types of additional services that the metropolitan health system requires both today and through the coming decade.

The Metropolitan Health Plan – Technical Paper lays out many of the challenges for the metropolitan health system where demand growth continues unabated. On these projections there will be increasing costs and this will require a considered long-term response from government, the community and the health care sector.

The increase in hospital demand – driven by both population growth and ageing of the population, for example, will require more hospital beds and this is why the Victorian Government has committed to an additional 800 beds in the first term and a further 800 beds in the second term if re-elected. These new beds will be essential.

But the provision of new beds is not the only solution to address the growth in demand.

The Victorian Government understands that increased community-based services will also be important. Addressing demand will also require the management of unnecessary and avoidable hospital admissions as will a reduction in unnecessary or avoidable readmissions to hospital.

The Victorian Government also understands that higher quality health care and safer health care are important factors in achieving better clinical and cost outcomes.

Improving patient experience and outcomes can be achieved by lowering infection rates in our public hospitals and health facilities. This also addresses unnecessary costs.

The establishment of the Health Innovation and Reform Council will drive these improvements in quality and the innovation required helping meet the challenges ahead.

Innovation should include not only clinical and practice innovation but also process and management improvements.

31 Refer to Metropolitan Health Plan – Technical Paper for further details on workforce skills.
Delivering additional capacity:

The government has committed to a range of initiatives to begin the much-needed expansions in Victoria's health service capacity, including:

1. Providing 800 new beds to ensure Victorians receive the health and hospital care they deserve. Allocation of new capacity will be based on analysis contained in the Metropolitan Health Plan – Technical Paper and subsequent Rural and Regional Health Plan and guided by the Health Capital and Resources Plan 2012-2022.

2. Establishing a $1 billion Health Infrastructure Fund to provide for the planned and strategic investment in Victoria's public hospital infrastructure and hospital equipment for both metropolitan and rural hospitals, mental health facilities, primary care facilities and health support services.

3. The range of capital infrastructure projects that will be detailed in the Health Capital and Resources Plan 2012-2022.

4. Improving ambulance services through a range of initiatives that include building new and developing existing ambulance stations, recruiting 340 additional ambulance paramedics and patient transport officers across the state, and halving the cost of Ambulance Victoria membership fees to support Victorian families.

5. Improving service effectiveness and system capacity by implementing the Government's Waiting List and Emergency Department Reform initiatives. These initiatives will enable health services to provide improved and more coordinated services to Victorians. Patient-treatment coordinators, for example, will case-manage and coordinate patients' journeys through health care and treatment to improve their experience and health outcomes.

6. Deliver better mental health care, including:
   a. enhanced community-based support services
   b. extra Prevention And Recovery Care (PARC) facilities.

7. An expansion of services to assist people who require palliative care.
Planning and development priorities for metropolitan health services will include:

1. Evaluating and developing existing efficient and effective service models and settings, such as Hospital In The Home and other community-based health care services, and developing new care settings to ensure services are clinically effective and cost-effective, irrespective of the funder. Emphasis will be placed on expanding capacity in out-of-hospital care and on increasing access to primary medical and primary health care so as to provide effective alternatives to making misplaced demands on hospitals. Expanding capacity in out-of-hospital care and increasing access to primary medical and primary health care will be targeted to geographic areas of need (as identified in the Metropolitan Health Plan – Technical Paper) such as areas with low general practitioner to population ratios and areas with above average rates of primary care type presentations to emergency departments.\(^{32}\)

2. Allocation of additional investment in workforce education, training, placements and role development. This investment will lead to a more interdisciplinary workforce with a more extensive range of skills, ensuring the workforce has the capacity to answer the needs of the community, and the workforce is distributed according to where its skills are needed.

3. Investigate, in conjunction with the Australian Medical Association (Victorian Branch) (AMA), what state-funded services could be provided through selected general practices across key metropolitan Melbourne locations. Through this work a number of pilot programs, where such a model could effectively be trialed, could be established. The aim of these programs will be to improve clinical outcomes, and care coordination, providing clinically appropriate and cost-effective services. The Victorian Government will undertake a dialogue with the Commonwealth Government to ensure that these services do not duplicate existing Commonwealth programs and that Commonwealth support is maintained as a base from which to provide additional services.

4. Investigate, in collaboration with key nursing and allied health groups, potential to establish new models of health care delivery that will maintain or enhance patient outcomes as well as improved safety and quality health care delivery.

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\(^{32}\) Refer to Metropolitan Health Plan – Technical Paper for further metropolitan population growth, location of services and hospital demands.
Increasing the system’s financial sustainability and productivity

Sustainable and cost-effective organisation of care

“Evidence indicates that reorganising care around the patient, with teams that are accountable to each other and to patients and are supported by information systems that guide and drive improvement, has the potential to eliminate waste, reduce medical errors, and improve outcomes – at lower total cost.”

Accomplishing this requires changing the incentives upon which the health care system is built. The fee-for-service payment that currently typifies the health system emphasises the provision of health services by individual providers rather than coordinated teams of providers who collaborate to address patients’ needs.

The Committee advised that delivering care in the most clinically and cost-effective service settings, regardless of the funder and provider type, is critical to ensuring the system’s affordability. This task will require improvements in the funding arrangements between governments, greater flexibility in funding models, and more rigorous fiscal management.

Resource allocation

Governments are accountable for making investment decisions on behalf of all Victorians to maintain a health system and support people so they can live healthy lives. Deciding what to fund and by how much is difficult and requires tough decisions. Many health services and service resources require large up-front spending, and often the return on investment is hard to quantify. These services and resources include health prevention activities, health promotion, information communication technology back-end systems, and upgrading capital.

There should be a focus on ensuring transparent evidence-based and best value resource allocation decisions.

Productivity

Rising costs, rising demands and intensifying utilisation of services all place pressures on the system. Inefficiencies in resource utilisation contribute to these. These pressures reaffirm the need to review current approaches and identify opportunities for improvements in productivity, bearing in mind that a productive health care system provides high-quality services and care and makes effective and efficient use of resources.

Specific areas for investigation and potential productivity improvement include:

- ensuring the workforce is appropriately skilled and capable of responding to and meeting current and future health needs
- the use and application of data and performance information to review and drive system improvements
- promotion and support of service providers to increase evidence-based consistency in clinical practice, without discouraging innovation
- effective management and utilisation of clinical technology (such as MRI, CT, prosthesis) and information communication technology
- clinically effective and cost-effective configuration and delivery of services.

References:

Delivering a sustainable and productive health system:

1. Adopting appropriate mobile technology as well as supporting the e-health identifiers, with appropriate privacy protections, proposed by the Commonwealth to increase clinical time and reduce administrative time.

2. Establishing an inquiry into the measurement, including budget measures, of primary health and aged-care services and outcomes. The inquiry will investigate whole-of-government responses and actions to support healthy individuals, families and communities.

3. Establishing the Health Innovation and Reform Council to lead continuing improvements to the health system. It will advise key directions for improvement in areas such as:
   a. improvement options to drive innovation
   b. improving patient flow through the health system
   c. improving hospital service quality and safety
   d. clinical and hospital administration and best practice.

This Council will build on the existing review, advice and consultative bodies that operate at a statewide, metropolitan and local level to improve Victoria’s health system.

Planning and development priorities for metropolitan health services will include:

1. Evaluating alternative provider setting options, such as day hospitals, super clinics and community health centres, to identify and invest in services that are clinically effective and cost effective, irrespective of funder and funding model. This evaluation may also result in the consolidation of some specialised services and the expansion of others across metropolitan Victoria.

2. Developing a resource allocation model that is sensitive to population health needs, promotes productivity improvements and provides value for money and a more sustainable system.

3. Refining and expanding the Victorian casemix funding for inpatient and other health services to ensure these arrangements meet future population health needs
   a. Considering new funding models such as packages of care for targeted patient groups, such as those with chronic and complex care needs. Since care for these groups of patients is provided across the continuum, funding from state, Commonwealth, private, not-for-profit and non-government sources need to considered, coordinated and not limited by existing barriers
   b. Incorporating quality and outcome performance measures into existing funding models.

4. Identifying aspects of the metropolitan health system that show potential for productivity improvement through alternative models of care and expanding and building on them where appropriate.
Implementing continuous improvements and innovation

The Victorian health system has an established record of leadership in research and innovation, and in ongoing improvements to health services through strong clinical leadership.

Maintenance of high standards of leadership, improvements and innovation relies on ongoing targeted translational research, development of new evidence and the sharing of knowledge. Up-to-date research outcomes, evidence and information need to be shared between health professions and throughout the health workforce.

Clinicians should be encouraged to take on leadership roles in developing, disseminating and adopting new evidence for clinical practice, driving local innovation, service delivery improvements and research in a systematic way.

Opportunities exist for Victoria to extend its role as a leader in health and medical research through strong partnerships between academics and the Universities, and health providers. This will increase health and medical expertise, and expand our capacity to:

- fully utilise current information about health treatments, health services and health outcomes
- review and evaluate current practice
- review and develop clinical guidelines; and
- to inform present and future research questions and activities.

Increased health and medical expertise will ensure that Victoria maintains a high level of commitment to leadership in research and innovation in health care.

Figure 17: Desirable flows of information within the system
Delivering continuous, evidence-based improvements and innovation:

1. Establishing the Health Innovation and Reform Council to lead continuing improvements to the metropolitan health system. It will advise key directions for improvement in areas such as:
   a. improvement options to drive innovation
   b. improving patient flow through the health system
   c. improving hospital service quality and safety
   d. clinical and hospital administration and best practice.
   This Council will build on the existing review, advice and consultative bodies that operate on a statewide and regional level to improve Victoria's health system.

2. Establishing measures to improve the operation of outpatient treatment through the outpatient improvement fund, patient treatment coordinators and the development of clear business rules for the operation of these services.

3. Supporting Victoria's leading role in health and medical research by creating and developing further health and medical research capacity within metropolitan universities and health services. This will support health professionals and clinicians to drive improvements and innovation. The Victorian Government has committed to strengthening the health and medical research focus by establishing a health and medical research precinct at Deakin University, and designated the Alfred Health precinct to become an academic health science centre and the government has supported other teaching, training and research facilities including the Olivia Newton John Health and Wellbeing Centre.

4. Creating the Mental Illness Research Fund to support collaborative research to improve evidence-based mental health practice.

Planning and development priorities for metropolitan health services will include:

1. Facilitating clinician leadership of evaluations, service improvements and innovation. This will enable clinicians to champion and lead the required changes in clinical practice that are based on evidence of improved and/or innovative practices. It does not happen by itself.

2. Developing a more effective central clinical data acquisition and management system (including advanced analysis capability) that generates the evidence base for improved and innovative clinical practice and population health interventions as well as supporting the development of better clinical pathways and service planning.
Increasing accountability and transparency

High performing health systems are accountable to their communities for the delivery of health services. Greater transparency in information about the performance of the health system will lead to choices, responsibility and accountability, in terms of health outcomes including improved quality of health care and taxpayer value.

Transparent reporting of accurate and relevant information about the health system’s performance will help to drive improvements throughout the metropolitan health system and to direct the allocation of resources.

Health outcomes framework

Existing performance reporting has gaps, in particular in the ability to measure and report health outcomes, patient experience, efficiency and effectiveness.

A comprehensive Health Outcomes Framework (widely supported by the Committee and through the consultations) that uses a set of indicators that reflect the quality of care delivered across all dimensions and domains is proposed, with a focus on measuring and improving patient health outcomes. Development and implementation of a Health Outcomes Framework will need to ensure there is minimal or no duplication of existing reporting requirements and that new requirements are not overly burdensome for providers.

A Health Outcomes Framework would be used:

- by health sector providers to review and monitor their performance and determine areas for improvement
- by the department to monitor and evaluate health outcomes and inform resource allocation and improvement initiatives, such as those to be led through the Health Innovation and Reform Council.

The Health Outcomes Framework would be developed in consultation with the sector and other key stakeholders.

Indicators that comprise the Health Outcomes Framework should be developed to reflect high-quality health outcomes and work in concert with clinical guidelines and patient pathways.

Governance

The Committee indicated the roles of all providers and players in the health system need to be clearly defined so that throughout the continuum of care, they can take greater responsibility for health service provision.

To enable providers to implement changes, effective governance arrangements are needed. Current barriers to action must be removed and permission for action given where required. Through better designed stewardship obligations and transparent reporting, health services’ accountability and financial monitoring can be improved.

The governance of hospitals and health services is a central task in the safe, efficient and cost effective delivery of high quality health care. This governance is regulated by the appropriate acts of parliament. Board members, a strength of the Victorian health care system, are required to act within the terms of relevant legislation and as trustees of health services.
There is also a need for sufficient input into clinical governance and health service governance from clinicians - doctors, nurses and allied health professionals. This will ensure that their voices and experience input into the governance and decision making by health services.

Delivering greater transparency and accountability:

To be truly transparent, the health system must provide the Victorian community with full reports on outcomes and performance. These reports should include accurate and relevant information about the state of our hospitals and health system, for example, by reporting openly on waiting lists.

Increasing transparency and accountability in reporting of accurate and relevant information about the health system’s performance will empower people of metropolitan Melbourne to judge the effectiveness of the health care system.

The government will:

1. Establish a hospital performance website to provide transparent information regarding the performance of major metropolitan and regional hospitals. This website will be launched in June 2011 and will publish data including:
   a. ED attendances by urgency category, median wait times, admissions, and activity
   b. ambulance diversions, including ambulance bypass and Hospital Early Warning System (HEWS) incidences
   c. the number of ambulance patient transfer occasions and hours
   d. the data reported on the website is likely to increase over time to include new indicators as they are developed.

2. By the end of 2011, publish outpatient waiting lists for public hospital specialist clinics, including the time patients wait to get an appointment.

The Victorian Government will require each metropolitan health service to formally report as part of their annual report, on the mechanisms they have employed and the actual consultation that has taken place to engage with their staff and relevant clinicians. These new reporting requirements will be implemented in the 2011-12 financial year.

Planning and development priorities for metropolitan health services will include:

1. Developing a Health Outcomes Framework that encompasses the measurement of patient experiences, health outcomes (specifically including a focus on quality and safety), efficiency and effectiveness that does not generate any unnecessary additional data reporting and better coordinates and rationalises existing reporting processes (both state and national).

2. Auditing adherence to key initiatives such as the establishment and utilisation of clinical guidelines and patient pathways (including monitoring through Clinical Networks).

3. Reviewing the existing legislative approaches that drive governance and accountability arrangements for health services such as the Health Services Act as amended by the Health Services (Governance) Act 2000, the Mental Health Act 1986 and the Mental Health Regulations 1998.
Utilising e-health and communications technology

Obtaining the best possible health care and outcomes relies on clinicians making informed and judicious decisions. For people and clinicians to make informed decisions, the knowledge held by various people in the system must be managed well at a systemic level. An obvious and essential means to improve knowledge management within and across the health system – and one of our richest opportunities to address the metropolitan health care system priorities – is the use of the most sophisticated e-health and communications technology available.

Consultation indicated that the routine and comprehensive use of e-health and communications technology should be integral to the metropolitan health system. E-health technology includes electronic medical records, remote monitoring, tele-health and bedside clinical decision support.

The benefits of sophisticated and comprehensive knowledge management will include increased information for the metropolitan communities about the benefits and expected outcomes of care, the performance of the system, health status, the location of services and how to access them. For clinicians and system managers, increased information will facilitate more robust analyses of patient health outcomes, and of systems, as well as stimulating innovation and improvements (such as the need to make the system more responsive to people’s needs) where they are required.

E-health and communications technologies need to be common to and shared by all metropolitan health services across the continuum of care, to ensure timely and appropriate access to essential health information for providers, patients and the community. Access to relevant information, when it is needed and in an understandable and usable form, will have a range of benefits for metropolitan health services, for individuals, for clinicians and for communities.

Improved knowledge management will also foster accountability and greater transparency of knowledge and information and will directly contribute to increased efficiency and effectiveness of health service provision.
For patients

- Electronic access to information about their condition, health and treatment options, creates more opportunities to be involved in their care, and make decisions and better informed choices.

- Improved access to services, particularly for those in rural and remote areas, including via remote monitoring, correspondence and diagnosis.

For clinicians

- Timely access to critical patient information and the clinical evidence base, such as the best-practice patient pathway and local clinical guidelines will support a reduction in medical errors.

- The capacity to analyse, report, and interpret information supports better clinical decision-making and improved patient health outcomes.

For the community

- Increased health knowledge, including health promotion activities.

To get there further work is required:

1. Articulating the system requirements and deliverable outcomes to increase clinical time, ensure optimal health information and reduce administrative time for both the patient and system. Details, including the following, will be outlined in the Health Capital and Resources Plan 2012-2022:
   a. The development of ICT design principles such as planning for people as well as for workflow practices and institutions.
   b. Priority strategies such as: electronic clinical records (possibly patient controlled), unique patient identifier, wireless technologies, and tele-health. Principles to guide prioritisation will also be developed.
   c. Outline of proposed stages for development, delivery and return on investment over a specified time horizon.
   d. Clinical and consumer participation in governance and a review of legislative arrangements for ICT implementation and operation.
   e. Information security, privacy and access.
   f. Alignment of ICT and capital and other infrastructure planning, development and operation.
   g. Consistency with state and national policy to ensure that future investment is strategic, efficient and effective.
Next steps

There is much work to be done to realise the government’s vision of a high-performing, people-focused, knowledge-focused health system in 2022. Concrete steps towards this will be implemented through measures announced in the 2011-2012 Budget and outlined in this document. But all the changes we need will not happen overnight.

Over the coming two months, the government wants to learn what the community and the health sector think about implementing the Victorian Health Priorities Framework 2012-22: Metropolitan Health Plan. An extensive consultation process will be undertaken, which will include open forums, focussed small group sessions, and many discussions with interested parties around the state. In addition, the government welcomes written submissions on this paper. Further information about the consultation process, including dates and other details, is available online at http://www.health.vic.gov.au/healthplan2022

The government looks forward to working closely with the community, and with all those who contribute to and work in our health system. The energy, ideas, and enthusiasm for change that is evident in the health sector provide an excellent basis for the work that lies ahead. We look forward to building a health system that all Victorians can rely on, and be proud of.
## Appendix

### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Allied Health</strong></td>
<td>a range of health professionals including but not limited to; Audiologists, Chiropractors, Dietitians, Exercise Physiologists, Occupational Therapists, Orthoptists, Orthotists and Prosthetists, Osteopaths, Pharmacists, Podiatrists, Psychologists, Radiographers, Radiation Therapists and Sonographers, Social Workers and Speech Pathologists and Diabetes Educators.</td>
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<tr>
<td><strong>Allocation, as in resource allocation within the health system</strong></td>
<td>denotes decisions we make about how and where and for whom we spend our resources.</td>
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<td><strong>Ambulatory-care sensitive conditions</strong></td>
<td>conditions for which hospitalisation is thought to be avoidable with the application of preventive care and early disease management.[^35]</td>
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<tr>
<td><strong>Capacity</strong></td>
<td>refers to the amount of services able to be offered, or the number of patients able to be cared for, by the system or a service provider. Common capacity constraints include too few beds or too few staff.</td>
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<tr>
<td><strong>Clinically effective</strong></td>
<td>describes care that from a medical perspective (as opposed to, for example, a financial perspective) is deemed fitting, and is ideally considered best practice.</td>
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<tr>
<td><strong>Clinical guidelines</strong></td>
<td>guidelines for clinical practice (clinical guidelines) are statements developed systematically in order to assist practitioners and patients to make decisions about appropriate health care for specific circumstances.</td>
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<tr>
<td><strong>Clinician</strong></td>
<td>denotes any health professional.</td>
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<tr>
<td><strong>Chronic and complex conditions</strong></td>
<td>Chronic condition a condition of at least six months duration that can have a significant impact on a person’s life and requires ongoing supervision by a health professional. For example: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions. Complex care needs people with complex care needs have multiple health, functional and/or social issues and are at risk of functional decline and/or hospital admission.</td>
</tr>
<tr>
<td><strong>Community-based services and settings</strong></td>
<td>health and wellbeing services and service locations (which may include care in the home) that are designed to meet a community’s needs locally, that is, close to where people live.</td>
</tr>
<tr>
<td><strong>Configuration of the health system</strong></td>
<td>denotes how we organise health services to deliver the outcomes we want.</td>
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[^35]: Ansari Z. Concepts and Usefulness of Ambulatory Care Sensitive Conditions as Indicators of Quality and Access to Primary Health Care, Volume 13–No 3 Australian Journal of Primary Health; Dec 2007.
Continuum of care

the collective term for all components of care in the health system. The components are:

1. Protection
   actions by the state to help the whole state’s population (as opposed to individuals, to whom the remaining seven components pertain); for example, in relation to preparing the community for emergencies, protection against communicable diseases, and the protection of environmental health.

2. Health promotion
   services that help you make decisions about actions and behaviour that lead to good health.

3. Illness prevention
   services that help you make decisions about actions and behaviour that help prevent you from becoming ill.

4. Primary care
   Primary care occurs at a patient’s first point of contact with the medical or health care system. There are two types of primary care:
   i. Primary medical care is the care you receive at your first point of contact with the medical system, most often, your GP.
   ii. Primary health care is the care you receive at your first point of contact with the health care system, for example, when you see a physiotherapist because you have a sore back. It is traditionally delivered in community health centres or through private allied health providers.

5. Secondary care
   The care you receive when primary care is not enough. Secondary care is more technical, intensive, or complex than primary care.

6. Tertiary care
   Tertiary care is more technical, intensive, and/or complex than secondary care.

7. Quaternary care
   Quaternary care is the next step up again in technicality, intensiveness and/or complexity of care; it is highly specialised and operates at a statewide level; for example, trauma care and some organ transplants.

8. Rehabilitation
   The service you need to get back on your feet - to function - after ill health.

9. End of life
   The care you receive when you are dying.
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<tr>
<td>Coordinated care</td>
<td>Care coordination is “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organising care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.”</td>
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<tr>
<td>Early Intervention</td>
<td>denotes an act of intervening, interfering or interceding with the intent of modifying the outcome either early in a person’s life course or early in the progression of a disease.</td>
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<tr>
<td>E-Health technology</td>
<td>E-health technology denotes electronic tools and resources used in health care; these include electronic medical records, remote monitoring, tele-health and bedside clinical decision support.</td>
</tr>
<tr>
<td>Evidence, as in ‘evidence-based’ and ‘evidence-informed’</td>
<td>accumulated knowledge from medical practices, experience, and research. Often used in the context of decision making - decisions wherever possible should be based on evidence and not primarily motivated by other considerations (such as past practice, or political expediency).</td>
</tr>
<tr>
<td>Fiscal responsibility</td>
<td>the responsible collection (taxation) and use (expenditure) of government revenues. Often connotes transparency and accountability.</td>
</tr>
<tr>
<td>Health care</td>
<td>the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments. The health care system is focussed on the wellbeing of individuals – in contrast, the field of public health (see ‘Public Health’) focuses on the wellbeing of populations.</td>
</tr>
<tr>
<td>Health literacy</td>
<td>an individual’s ability to read (or otherwise apprehend), understand, and use health care information to make decisions about their health and follow instructions for treatment.</td>
</tr>
<tr>
<td>Knowledge-focussed</td>
<td>an emphasis on knowledge and information (see also ‘Evidence’)</td>
</tr>
<tr>
<td>Knowledge management</td>
<td>how information and knowledge is managed - that is, collected, stored, analysed, shared, and used.</td>
</tr>
<tr>
<td>Palliative care</td>
<td>specialised health care provided by experts with training and experience in supporting people living with a terminal illness and their families</td>
</tr>
<tr>
<td>Patient pathway</td>
<td>a picture or model of the procedures and administrative processes that a patient experiences when moving through the health care system.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>People-focussed or people-centred</td>
<td>an emphasis on individuals (patients, carers, and their family members). Often contrasted with ‘system-focussed’ or ‘service-focussed’, and used to denote the importance of designing care and delivery of care primarily around the needs and experiences of people, not of the system or services.</td>
</tr>
<tr>
<td>Provider, as in health provider or service provider</td>
<td>an individual who or organisation that provides services related to health and wellbeing.</td>
</tr>
<tr>
<td>Primary health care</td>
<td>Primary health care is the care you receive at your first point of contact with the health care system, for example, when you see a physiotherapist because you have a sore back. It is traditionally delivered in community health centres or through private allied health providers.</td>
</tr>
<tr>
<td>Primary medical care</td>
<td>Primary medical care is the care you receive at your first point of contact with the medical system, most often, your GP.</td>
</tr>
<tr>
<td>Private health sector</td>
<td>comprises health and wellbeing services primarily funded by individuals through insurance payments, and managed by organisations that are independent of government (for example, churches and for-profit companies).</td>
</tr>
<tr>
<td>Public health sector</td>
<td>comprises health and wellbeing services primarily funded by citizens through the taxation system, and managed by or on behalf of, government.</td>
</tr>
<tr>
<td>Public health</td>
<td>what we, as a society, do collectively to assure the conditions in which people can be healthy. Public health focuses on prevention, promotion and protection rather than on treatment (see ‘Health care’), on populations rather than individuals, and on the factors and behaviour that cause illness and injury.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>rehabilitation is care in which the clinical purpose or treatment goal is to improve the functional status of a patient with an impairment, activity limitation or participation restriction.</td>
</tr>
<tr>
<td>Subacute</td>
<td>Care for patients requiring short-term, complex medical and or rehabilitation interventions. Typically used as an alternative to acute hospital admission or continued hospitalisation.</td>
</tr>
</tbody>
</table>

Consultation

In line with the government’s pre-election commitment extensive consultation was undertaken with clinicians and health sector members regarding the development of this Health Plan.

The formal consultations were conducted through:

- a series of individual formal interviews
- a direction setting forum
- a formal meeting of the Council of Board Chairs, comprising the chairs of the 21 public health services
- the Australian Medical Association at forums with regional representatives
- a forum of clinical network leaders
- an internal Department of Health Executive Officers Forum

The Ministerial Advisory Committee Chaired by the Hon. Rob Knowles AO was in particular a very productive source of advice. Their generous contribution and specifically Rob Knowles’ wise counsel is much appreciated. The meetings of the Committee were invaluable in their input. The Committee will provide further important support to assist the production of the Rural and Regional Plan and Health Capital and Resources Plan in forthcoming months.

In addition many individuals both within the health sector and outside have made their views known which have provided constructive and important input.

The depth of the input has in fact been quite remarkable and many of these people have been extremely giving with their time and thoughts. The government wishes to formally record its appreciation of that generosity.