Family and Community Development Committee Inquiry into Perinatal Services

14 July 2017

Introduction

The Victorian Healthcare Association (VHA) welcomes the opportunity to submit to the Family and Community Development Committee’s Inquiry into Perinatal Services (the Inquiry).

The VHA is the not-for-profit peak body supporting Victoria’s public health and community services to deliver high quality care. We represent public sector health services, hospitals, registered community health services, multi-purpose services, and bush nursing services.

The VHA’s members provide maternity services ranging from community-based child and maternal health services, regional and rural maternity services, through to specialist metropolitan hospitals offering international clinical leadership and research.

We consider the delivery of accessible, safe and high quality maternity services to be a cornerstone of the Victorian public health system and want to ensure that access to these services is maintained across Victoria.

We note the breadth of the Inquiry’s terms of reference, and have focused our submission on issues related to access, service and capital planning, funding and workforce.

While this submission is informed by consultation and input from our membership, it does not supersede any individual submission made by our members.

1. Submission

2.1. Access to maternity services

Maternity services are a foundation of the Victorian health system and access to them is often intrinsically linked to the wellbeing and viability of communities, particularly those in rural Victoria. There is an expectation that children can be safely delivered in or close to the community in which the parents reside.

Following the Andrews Government’s in-principle acceptance of the recommendations of the Targeting Zero report,¹ the Department of Health and Human Services (the

Department) has undertaken a process to revise the planning, delivery and governance processes of clinical health services across Victoria, including maternity services.

The common logic underpinning these plans is that clinical services that are of a higher risk to the patient should be undertaken in hospitals whose clinicians, staff and governance processes are more experienced in delivering those services. In many cases a relationship between volume and risk can be demonstrated, where clinical services that are undertaken less frequently can carry a higher risk of complications to the patient.

In the case of maternity services and the planning processes that underpin them, risk management is stratified and each of Victoria’s hospitals that deliver planned birthing services operate within a capability framework that allocates an upper limit to the level of risk that they assume when delivering a birth.

Under the existing capability framework for Victorian maternity and newborn services, a small rural hospital may be credentialled to deliver births within a set risk framework. For example, a level three maternity service is equipped to manage normal risk pregnancies, including management of labour, birth and puerperium at 37 weeks gestation or more, including performing elective and emergency caesarian sections.

A consultation process has been undertaken to update the existing maternity and newborn services capability framework, and that it may result in changes to health services’ maternity capability levels, including downgrading some health services’ capability level.

While the main driver for this change is to ensure that public hospitals work to an appropriate capability that reflects a safe and high quality service, we note that potential reductions to service delivery in rural Victoria will have dual impacts; local residents will have the burden of travelling to access healthcare placed on them, and larger health services in regional and metropolitan Victoria will likely experience a growth in demand.

The VHA supports the need to introduce greater clarity to the planning of acute healthcare across Victoria but suggests that maintaining appropriate access to maternity services in rural areas must be a priority.

2.2. Planning for the future

Victoria’s population is projected to reach 10.1 million people by 2051, with much of that growth centering on Melbourne’s outer-northern and western suburbs.

This growth will result in commensurate demands on the state’s public hospitals, including their maternity units. Recently the Victorian Government has responded with significant capital investments into the public health services operating in Melbourne’s suburban areas experiencing significant growth, including the Joan Kirner Women’s and

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Children’s Hospital in Sunshine and the Monash Children’s Hospital project at the Monash Health network in Melbourne’s south east.

The VHA welcomes this investment but submits that the process by which capital and growth funding are allocated must be part of an overarching strategy that responds to population health demands, demographic change and the movement of people within Victoria.

We are hopeful that a policy driving capital and service planning that reflects these priorities is possible, and anticipate the finalisation of the Health system design, service and infrastructure plan as a means of delivering this transparency.

2.3. Funding for quality

Victoria’s hospitals are funded using two different methodologies; activity-based funding (ABF) for metropolitan, regional and sub-regional hospitals\(^4\) and block funding for small rural health services and multipurpose services.\(^5\) The use of each methodology is to a large degree based on the historic and expected volume of care delivered by the health service; ABF delivers revenue to health services based on the number of services provided to patients, set at a certain price for delivering those services, while the block funding methodology allocates a set amount to each health service, which is then used to resource the various types of care delivered. Block funding is used in rural health services with lower patient numbers, in an acknowledgement that an ABF model would not result in enough revenue to maintain a viable health service.

In recent years the VHA has expressed concerns that the degree to which health services’ revenue growth has regularly been outstripped by the growth in demand for care, the cost of meeting wages and EBA requirements, and the impact of inflation. While the VHA strongly supports efficient delivery of health services and an effective expenditure of resources, we are concerned that the ongoing drive for financial efficiencies is placing health service budgets under increasing pressure.

This is commonplace in maternity services, where the costs of maintaining a viable service – particularly in rural areas – regularly exceed the funding for delivering this care. As noted, the existing maternal and newborn services capability framework sets out workforce arrangements that are necessary to maintain a safe service. For example, a hospital with a level three maternity capability is required to have in place the following arrangements:

- established consultation and referral pathways to specialist obstetricians in higher acuity hospitals
- general practitioners credentialled for obstetric care
- one of a specialist obstetrician, a GP or a general surgeon credentialled to perform caesarian sections, on call 24 hours a day
- a GP anaesthetist or specialist anaesthetist, on call 24 hours a day and able to perform spinal and general anaesthesia
- a paediatrician or GP with paediatric skills/ neonatal ALS accreditation, available 24 hours a day, and established referral and consultation pathways to a specialist paediatrician

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\(^4\) Health Services Act 1988 (Vic) sch 1
\(^5\) Health Services Act 1988 (Vic) schs 3 and 5
- midwives and nurses according to ratios set out in the industrial agreement
- allied health referral pathways.

To illustrate how these arrangements are funded, the VHA submits a de-identified case study outlining the scenario for maintaining a rural maternity service over the course of a financial year.

**Case study: small rural health service**

| Revenue - based on 250 births per annum, 67% vaginal and 33% caesarian section |
|-----------------------------------|--------------------------|
| Number of vaginal births          | 167                      |
| Average WIES cost weight          | 1.16                     |
| WIES23 price, small rural, public | $ 4,724                  |
| Revenue                           | $ 915,133                |
| Number of c-section births        | 83                       |
| Average WIES cost weight          | 2.022                    |
| WIES23 price, small rural, public | $ 4,724                  |
| Revenue                           | $ 792,810                |

Total WIES revenue: $1,707,943

| Expenditure - mixed medical model  |
|-----------------------------------|--------------------------|
| Midwives 7.5 base EFT             | $ 922,000                |
| Nurse Unit Manager                | $ 103,000                |
| Antenatal clinics                 | $ 95,000                 |
| On-call/Recall Cover - midwives   | $ 145,216                |
| On-call/Recall Cover - theatre    | $ 74,592                 |
| On-call Cover - anaesthetics, obstetrics | $ 416,429 |
| Visiting Medical Officer - fee for service | $ 275,285 |
| **Workforce expenditure**         | $ 2,031,522              |
| Allied health services            | $ 55,100                 |
| Overhead bed day cost             | $ 620,000                |
| **Other expenditure**             | $ 675,100                |

Total expenditure: $2,706,622

The VHA strongly supports the drive to improve the quality and safety of hospital services, however we assert that it must be supported by a funding model that adequately resources hospitals to deliver care in-line with both community expectations and the staffing required by the relevant capability framework.
If the Victorian Government is to ensure that maternity services continue to be viable across Victoria, the VHA recommends that transparent and equitable funding is delivered so that such funding shortfalls are avoided.

2.4. Workforce

The VHA membership reports concerns regarding the existing and future workforce, namely that the current nursing and midwifery workforce is ageing as many reach retirement; and recruitment to fill key positions in rural hospitals can be extremely challenging.

Many rural hospitals sustain lower volumes of clinical activity, including births, which places competing strains on the workforce. Staff are required to maintain their clinical accreditation through professional development and training, however their day-to-day exposure to emergency and high risk scenarios is limited due to the existing referral pathways that ensure higher risk births are managed in larger regional and metropolitan health services.

There are a number of schemes and incentives in place to train graduate staff in rural settings, many of which result in longer term employment and ensure that the workforce is exposed to clinical environments in a range of settings. One such program – Maternity Connect – is funded by the Department of Health and Human Services and allows rural health services’ nurses and midwives to work for another hospital in order to develop and maintain their skill, competencies and understanding of contemporary clinical governance requirements.

The VHA holds broad concerns about the long-term access to a skilled workforce in rural Victoria, with a range of barriers impacting on the ability of rural and regional health services to attract and retain key staff. Many rural hospitals base their medical model of care on general surgeons, clinicians and GPs, recognizing that the acuity and volume of care in many locations does not justify the recruitment of specialists.

The reliance on generalists and GPs exposes Victorian health services to potential workforce shortages, particularly when hospitals are not situated in an area classified as a district of workforce shortage (DWS), where overseas-trained doctors must practice if they are to access a Medicare provider number. Hospitals not situated in a DWS experiencing difficulties in attracting Australian-trained doctors are left with few options to support recruitment.

Maintaining a sustainable medical and surgical workforce can be challenging, particularly as 24-hour on call shifts are required to ensure hospitals are operating in-line with their assigned capability level. When these capability levels cannot be met – for example as a result of annual leave, sick leave or recruitment issues – hospitals have to defer non-urgent surgery and effectively go on bypass, requiring some patients to be transported to alternative facilities. There is a significant clinical risk associated with these episodes, as many of these presentations and transfers are necessary at times of reduced medical capability. Further complicating matters is the lack of formal and agreed statewide referral pathways (excluding referrals to specialist hospitals such as the Royal Women’s Hospital), meaning lower scope rural hospitals are required to identify and negotiate with...
alternative hospitals that can accept a patient transfer. The piecemeal approach and the subsequent delays increase maternal, foetal and neonatal risk.

Rural-based training for medical, surgical, nursing and allied health graduates is a reliable and successful option for improving the pipeline of staff who are exposed to and happy to commit to rural healthcare. For example, the Victorian Government supports five programs to train medical and surgical interns in rural settings, playing a key role in bolstering access to a skilled workforce.

Each intern-training program is managed by local hospitals and delivers rural-based opportunities, often focusing on rotations through several acute and primary care settings. These programs are essential and place surgeons and clinicians into rural health services, and have resulted in good retention rates and a multi-disciplinary medical workforce in rural Victoria, including generalists credentialled to perform caesarian sections.

The importance in supplying a pipeline of trained doctors familiar with rural practice with the experience to cover a broad range of responsibilities cannot be overstated. The success of this model is integral to the sustainability of the health workforce in rural Victoria.

2. Contact

Tom Symondson  
Chief Executive Officer

Chris Templin  
Senior Policy Advisor

03 9094 7777

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6 The VHA notes that codifying formal referral pathways across Victoria is a planned policy of the Department of Health and Human Services and supports this measure.