Legislative Council Standing Committee on Finance and Public Administration -
Inquiry into Public Hospitals
Submission from the Victorian Government
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Preface

On 12 November 2008, the Legislative Council Standing Committee on Finance and Public Administration announced the establishment of an Inquiry into Public Hospital Performance Data. The terms of reference for the inquiry are:

*To inquire into and report on the capacity of hospitals to meet demand, standards and quality of care, resourcing and access levels, and the accuracy and completeness of performance data for Victorian public hospitals.*

This document forms the Victorian Government’s submission to the inquiry. The submission provides a summary of public hospital operations in Victoria, including issues relating to accessibility, resourcing and performance reporting. In doing so, the submission will demonstrate the breadth and complexity of the public hospital system, and the comprehensive range of services delivered by the Victorian Government in order to provide the Victorian community with a high-quality health system.

The submission draws upon a number of publicly available documents, which can be accessed to obtain further information. A list of key health policy documents can be found at Appendix A.
1. The Victorian health care system: an overview

Introduction

Giving citizens access to quality health care and supporting them to maintain good health throughout their life is a key goal of society. Governments play a vital role in population health outcomes and provide hospital and health care services to ensure citizens, regardless of location or income, receive the necessary care.

While Victorians enjoy health outcomes that are among the best in the world, new and existing pressures are challenging the public hospital system, including the ageing population and the increasing prevalence of complex and chronic diseases, such as heart disease, diabetes and cancers.

The Victorian Government is committed to meeting these challenges and ensuring it continues to deliver a world-class hospital system. In doing so, the public hospital system in Victoria is able to deliver quality health services which meet the demand, standards and quality of care, resourcing and access levels required, and is able to provide accurate and reliable performance data for reporting, funding and planning.

Victoria has played a strong leadership role in the national health reform agenda, driving a number of reforms and initiatives to improve the national health system, in collaboration with the Commonwealth and other state and territory governments, in order to deliver better health outcomes. Overall, the Victorian Government has a proven track record in delivering a high-performing health system and running an effective and efficient system relative to the performance of other Australian jurisdictions.

The Australian health care system

The health care system in Australia is complex, with interdependent roles and responsibilities between the Commonwealth and state and territory governments. Other parts of the community, including the local government, private sector, communities, families and individuals also have a role to play in achieving good health outcomes.

Individuals travel along a continuum of care which reflects their individual need for health services. The health care system provides a whole-of-system response, providing care at the most appropriate stage for individual needs. Key stages are:

1. The ‘well’ population includes individuals in the community with no or minimal burden of disease who do not require extensive health care services. This category is the focus of health promotion and prevention which seek to preserve good health, and reduce or eliminate the causes of ill health. Preventative health care includes promoting healthy lifestyles through such strategies as smoking reduction programs, and population health measures such as immunisation programs.
2. The ‘at risk/low acuity’ group with high-risk factors (genetic, lifestyle, history) or early onset conditions which require screening and early intervention through the primary health care system. These services are generally provided by general practitioners and community health care workers. Primary care includes treatment for chronic diseases and conditions, and minor acute health episodes. Primary care providers will often recognise the early symptoms of more severe illnesses, and refer patients to specialists for further care.

3. Individuals with ‘acute conditions’ requiring emergency care and/or hospital-based surgical or medical services. Individuals generally require high-level, highly specialised care, undertaken in highly specialised facilities. Care may be provided by specialists in a particular field.

4. Individuals with ‘chronic conditions’ requiring ongoing care for chronic or complex needs. For example, an older person with chronic heart disease will sometimes require admission to hospital to treat their condition or may receive treatment through continuing care programs such as Hospital in the Home.

Funding, capital, information and communication technology and the workforce underpin the provision of health services to the community.

Australia operates under a universal health care system. Health care coverage is extended to all eligible Australian residents, ensuring that all Australians are able to access free treatment as a public patient in a public hospital. Under current health care arrangements:
- public hospitals are co-funded by the states and territories and the Commonwealth under the National Healthcare Agreement
- states and territories are responsible for the operation and regulation of public hospitals within their jurisdictions.

In 2006-07, $94 billion dollars was spent on health care across Australia accounting for approximately nine per cent of Gross Domestic Product (Australian Institute of Health and Welfare, 2008). Of this, $24.3 billion was spent on public hospital services in Australia, with the Commonwealth Government provided $10.1 billion (42 per cent), the state and territory governments provided $12.4 billion (51 per cent) and private sources contributed $1.8 billion (seven per cent) (Department of Health and Ageing, 2008).

In November 2008, the Council of Australian Governments agreed to the new National Healthcare Agreements which will see the Commonwealth provide $60.5 billion over five years to the states and territories for the provision of public hospital services, of which Victoria will receive over $14 billion. Victoria played a key leadership role in the development of the new Specific Purpose Payments framework and obtaining increased funding from the Commonwealth for public hospitals.

Importantly, the public hospital system forms only one component of the entire health system, and the delivery of hospital services are impacted and interdependent on other areas of the health system including, primary care, community care and health prevention and promotion.
The Victorian Government’s role in health care

The Victorian Government is responsible for delivering a wide range of health services to the community including:

- health care services through the public hospital system, community health services, ambulance services, dental services and public mental health services
- health promotion and protection through emergency management, public health and related preventative services, education and regulation
- residential and rehabilitation care for older people, along with support and assistance to enable them to function independently in their own homes.

While the Victorian Government undertakes some activity within primary health and in aged care, these areas are the responsibility of the Commonwealth Government. The role of the states and territories focuses on the delivery of public secondary and tertiary health services. A summary of the different roles and responsibilities of the Commonwealth and state and territory governments can be found in Appendix B.

Health services in Victoria are delivered in line with the Victorian Government’s economic, environmental and social policy goals for Victoria. These goals are outlined in a number of government policies, including *Growing Victoria Together, A Fairer Victoria* and *Governments working together: Third Wave of National Reform*.

In 2008-09, the Victorian Government will spend over $10 billion on health services, of which over $7 billion is allocated towards acute services within the public hospital system (Table 1).

### Table 1: State Government appropriations for health services ($ million)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Hospitals (acute)</td>
<td>3,425</td>
<td>3,670</td>
<td>4,130</td>
<td>4,467</td>
<td>4,857</td>
<td>5,350</td>
<td>5,845</td>
<td>6,284</td>
<td>6,710</td>
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<td>Mental health</td>
<td>453</td>
<td>494</td>
<td>527</td>
<td>589</td>
<td>616</td>
<td>652</td>
<td>733</td>
<td>783</td>
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<td>884</td>
</tr>
<tr>
<td>Ambulance</td>
<td>198</td>
<td>221</td>
<td>225</td>
<td>249</td>
<td>288</td>
<td>319</td>
<td>364</td>
<td>387</td>
<td>417</td>
<td>494</td>
</tr>
<tr>
<td>Dental</td>
<td>75</td>
<td>79</td>
<td>83</td>
<td>84</td>
<td>89</td>
<td>118</td>
<td>125</td>
<td>130</td>
<td>138</td>
<td>139</td>
</tr>
<tr>
<td>Aged care, primary health and public health</td>
<td>856</td>
<td>919</td>
<td>990</td>
<td>1,082</td>
<td>1,160</td>
<td>1,255</td>
<td>1,317</td>
<td>1,479</td>
<td>1,645</td>
<td>1,702</td>
</tr>
<tr>
<td><strong>Total funding</strong></td>
<td>5,008</td>
<td>5,382</td>
<td>5,956</td>
<td>6,470</td>
<td>7,010</td>
<td>7,693</td>
<td>8,383</td>
<td>9,063</td>
<td>9,729</td>
<td>10,487</td>
</tr>
</tbody>
</table>

(Source: Department of Treasury and Finance, 2008)

The Victorian public hospital system

Victorian hospitals are managed by public health services, which are responsible for managing hospital and health services delivered within a geographic region or for a particular medical specialty.
Major health services are incorporated public statutory authorities established under the Health Services Act 1988. They are at arms-length from government, have separate legal status and are not part of the Crown. The objectives of health services are specified in by-laws and include ensuring the provision of high-quality health care, and that services are efficiently managed and meet community needs. The Health Services Act contains powers that have the intent of ensuring health services are accountable to government and the community ‘for their overall performance and the prudent expenditure of public funds’.

Victoria has 144 public hospitals – Appendix C and D provide maps of the location of public hospitals in metropolitan Melbourne and rural and regional Victoria.

Public hospitals provide inpatient and ambulatory care, as well as teaching and research facilities. Treatment is provided on the basis of clinical need and urgency. Services provided differ at each public hospital, depending on the skill set of the available medical staff and the variations in physical facilities at each campus. Various hospitals have developed a critical mass of highly-trained specialists in a range of facilities, ensuring exceptionally high levels of care and allowing complex cases to be effectively managed at one location. Other hospitals provide a broader range of services, referring more complex cases to specialised facilities.

In addition to the major generalist hospitals, Victoria also has a number of specialist hospitals, which focus on particular types of care. These hospitals include the Royal Women’s Hospital, the Royal Victorian Eye and Ear Hospital, the Royal Dental Hospital and the Royal Children’s Hospital.

**Funding for public hospitals**

The Victorian Government provides funding to public hospitals and health services on an output and input basis. This includes funding for a range of acute and non-acute health services (including residential aged care, mental health, primary care, and home and community care services). Funding models aim to ensure that hospitals receive funding for the different types of services which are provided. At the same time, funding models seek to promote efficient and effective use of resources by the hospitals.

Victorian acute hospital services are primarily funded on an output basis through the casemix system. Casemix funding is a financial model that reimburses the cost of patient care based on the type and mix of the patients treated by a hospital. Casemix aligns a hospital’s funding with its output and provides a more equitable method of funding than historical or block funding. Casemix funding encourages efficiency as hospitals are funded according to industry standards and for similar services.

Funding is also provided to hospitals for services outside the scope of the casemix system. This funding covers activities such as training and development and specified grants for selected services, and helps to strengthen the availability of specialist services. Health services remain responsible for the allocation of funding within the hospital itself.

The 44 smallest health services in rural Victoria are funded under the Small Rural Health Services funding approach. These 44 services are not casemix-funded and have a quarantined flexible funding pool that they can apply to meet local needs, in line with local service planning and as agreed with the Department of Human Services.
Further information on funding of public hospitals can be found in the *Victoria—public hospitals and mental health services: Policy and funding guidelines 2008–09*, June 2008
2. Challenges facing the public hospital system

A number of environmental factors influence the operation and performance of the public hospital system. Broadly, these factors can be grouped as either ‘demand’ or ‘supply’, and include the following:

- **Demand factors**
  - social and demographic characteristics of the population
  - health status of individuals
  - other health services
  - medical technology

- **Supply factors**
  - health workforce
  - resourcing and funding.

The Victorian public hospital system, as with other hospital systems world-wide, faces challenges in the context of increasing demand and community expectations. The Victorian Government is working to meet these challenges through a range of reforms and initiatives, including a significant increase in funding and capital investment, innovative models of care and working co-operatively with the Commonwealth Government.

Increasing hospital demand

Since 1999, demand for hospital services in Victoria has grown substantially, with 43 per cent growth (an extra 403,709 presentations per year) in emergency department presentations, 34 per cent (351,345) more admissions, and 20 per cent (210,776) more specialist clinic treatments. In 2006-07, Victorian hospitals had a significantly higher portion of admissions, with 247 per 1,000 people compared with the Australian average of 219 per 1,000 people (Figure 1).

In 2007-08, demand for hospital services increased across all categories:

- 1,393,180 million patients were admitted to Victorian public hospitals, an increase of 36,901 patients from 2006-07
- 1,350,046 patients attended 38 Victorian public hospitals with 24-hour emergency departments, an increase of 47,316 (3.6 per cent) patients on the previous year
- 23 per cent of all patients who attended emergency departments were transferred to a hospital bed, rising 4.6 per cent from 2006-07
- 1,249,777 specialist clinics appointments in Victorian Ambulatory Classification System hospitals and 337,587 specialist clinics appointments in non-Victorian Ambulatory Classification System hospitals
- 588,382 allied health encounters.

The increasing demand for public hospital services is driven by a wide range of factors, including population growth, ageing population, increases in chronic and complex disease, access to primary care, new technologies and community expectations.
At 30 June 2008, the estimated resident population for Victoria was 5,298,000 people (Figure 2). This represented a 1.78 per cent increase on the previous year, a rate of growth which has not occurred since the early 1970’s (Australian Bureau of Statistics, 2008b).

Victoria’s population growth is driven, in part, by an increase in the birth rate. Victoria is experiencing a once-in-a-generation baby boom. In 2007, there were 73,737 births recorded across the state – the largest number since 1971.

The recent increase in fertility rates can largely be attributed to younger women having postponed childbirth during the past few decades. This has accounted for the higher fertility rates among older women and the increase in birth rates in recent times. The availability of Assisted Reproductive Technologies is another factor that impacts slightly on increased fertility rates.

The increase in the number of women having babies over the age of 30 will have an impact on health services, with an increase in complex births. As maternal age increases, there is an increased risk of some birth complications, as well as an increased risk of miscarriage, premature birth and low birth weight, which require specialist maternity care.

There has been a steady increase in the number of premature births and low birth weight babies in Victoria. In 2006, 8.2 per cent of births in Victoria were premature, an increase on the percentage of premature babies both in 1985 (6 per cent) and 1995 (7.1 per cent). There was also an increase in the
number of low birth weight babies, from 3387 (5.5 per cent) babies in 1985 to 4,969 (7.1 per cent) in 2006. In 2008, the Victorian Government provided $100.3 million in order to meet the increasing demand for hospital, maternity and child health services (Box 1).

Figure 2: Population growth across Australian states

![Population growth across Australian states](image)

(Source: Australian Bureau of Statistics, 2008b)

The ageing population

The ageing of the population is one of the major transformations being experienced by Australia’s population. With the first of Australia’s baby boomers born in 1946 about to turn 65 years of age in 2011, the changing age structure of the community is expected to have a significant influence on the demand for many goods and services, including health.

Over the last two decades, the median age of the Australian population has increased by 5.3 years, from 31.6 years at 30 June 1988 to 36.9 years at 30 June 2008. The median age of the Victorian population is set to rise and is projected to reach 39.5 in June 2026 and 42.5 by 2056.

The population aged 65-84 is predicted to continue increasing, as is the population of people aged 85 and over. In 2006, the number of individuals aged between 50-64 years of age was 882,784, whilst the number of people in the 65-79-year cohort was 497,397 (Australian Bureau of Statistics, 2008c). By 2016, this is expected to increase to 1,063,024 and 681,845 people respectively (Table 2).
Box 1: Victorian Government baby boom budget boost

Following the recent increase in births in Victoria, the Victorian Government has developed a clear plan for managing the increasing demand for maternity and child health services.

In 2008, a total of $100.3 million was provided to deliver expanded hospital, maternal and child health services, including capacity for 2800 extra births every year.

$30.5 million has been allocated for 14 new maternity beds and 18 additional special care nursery cots at suburban hospitals, giving more mothers the opportunity to deliver their babies closer to their homes, families and friends. The maternity health building projects are:

- $14 million for Stage 1 of the Werribee Mercy Hospital expansion, to provide an extra eight obstetric beds and an additional four special care nursery cots, giving capacity for an extra 800 births a year
- $5 million for the Frankston Hospital maternity service expansion, to enable an extra 300 births each year
- $4.8 million for a pregnancy assessment unit at Monash Medical Centre Clayton, enabling an extra 200 births per year, improving antenatal management and increasing the capacity of the postnatal wards and birthing suites
- $4.2 million to expand the special care nursery at Casey Hospital from six to 20 cots enabling up to 1000 additional births annually
- $2.5 million to expand maternity services at Northern Hospital, adding six new beds to the maternity unit, providing for an extra 500 births.

$54.9 million has been provided for expanded maternal and child health services to help mothers, babies, pregnant women and families across the state, including:

- $42.7 million over four years to ensure all babies and young children receive check-ups and health support at key developmental stages up to the age of five
- $12.2 million to enhance maternal and child health services for babies and vulnerable families.

Other initiatives include:

- $8.4 million over five years, matching Commonwealth funding for new screening initiatives for mothers at risk of postnatal depression
- $8.3 million for antenatal care initiatives, such as community health services in outer metropolitan growth areas delivering programs on quitting smoking, promoting healthy eating and information on support services.

This funding aims to ensure young families can access the maternal health services and support they need as close to home as possible, and provide public hospitals with the extra funding needed to help them deal with the state’s booming population.
The ageing population is expected to increase consumption of health services. Between 1999-2000 and 2007-08, the proportion of the Victorian population aged 65 and over had the biggest increase in hospital separations (Table 3). Separations in the 75-84 years age group increased by 78.3 per cent over this period, compared with 2.1 per cent for the 25-34 age bracket. As the over-65 age group continues to grow as a proportion of the entire population, the hospital system will in turn face increasing demand for services from this group.

### Table 3: Number of separations by age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1999-2000</th>
<th>2007-2008</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>100,574</td>
<td>111,497</td>
<td>10.9</td>
</tr>
<tr>
<td>5-14</td>
<td>39,899</td>
<td>44,526</td>
<td>11.6</td>
</tr>
<tr>
<td>15-24</td>
<td>78,073</td>
<td>90,873</td>
<td>16.4</td>
</tr>
<tr>
<td>25-34</td>
<td>138,937</td>
<td>141,909</td>
<td>2.1</td>
</tr>
<tr>
<td>35-44</td>
<td>115,767</td>
<td>145,422</td>
<td>25.6</td>
</tr>
<tr>
<td>45-54</td>
<td>114,787</td>
<td>154,797</td>
<td>34.9</td>
</tr>
<tr>
<td>55-64</td>
<td>127,077</td>
<td>195,783</td>
<td>54.1</td>
</tr>
<tr>
<td>65-74</td>
<td>165,382</td>
<td>223,668</td>
<td>35.2</td>
</tr>
<tr>
<td>75-84</td>
<td>119,332</td>
<td>212,747</td>
<td>78.3</td>
</tr>
<tr>
<td>85+</td>
<td>42,007</td>
<td>71,958</td>
<td>71.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,041,835</strong></td>
<td><strong>1,393,180</strong></td>
<td><strong>33.7</strong></td>
</tr>
</tbody>
</table>

### Increase in chronic and complex diseases

A large portion of the burden of disease for Australians is due to chronic and complex diseases, and its prevalence is rising. The Australian Institute of Health and Welfare (2004) estimates that chronic disease accounts for over 22 per cent of total health care expenditure. Chronic diseases include lung cancer, osteoporosis, colorectal cancer, rheumatoid arthritis, chronic obstructive pulmonary disease, kidney disease, asthma, diabetes, stroke, depression, osteoarthritis, coronary heart disease and oral health. Up
to one third of all health problems in Victoria can be attributed to chronic and complex disease. Complex and chronic diseases not only account for thousands of deaths in Australia each year, but also a significant amount of disability and indirect costs to the community.

The increasing prevalence of chronic and complex disease is being driven by the ageing population and the impact of lifestyle choices and risk factors such as smoking, physical inactivity, obesity, poor nutrition and high blood pressure. Where chronic diseases are related to lifestyle factors, much of this illness could be prevented. The Victorian Government has made a significant investment in health promotion programs to educate and empower individuals to take steps to reduce risk factors, prevent disease and lead healthier lives. This includes initiatives such as Go for Your Life, WorkHealth, the Quit campaign and sports participation activities.

**Access to primary care**

Individuals are finding it increasingly difficult to access primary care services in the community. A shortage of general practitioners has been identified - particularly in many outer suburban, regional and rural areas. This has placed significant pressure on public hospitals to treat patients who could otherwise be more appropriately managed by a general practitioner. The Commonwealth Government is responsible for primary health care, including general practitioner numbers.

The inability of patients to obtain primary care services in the community impacts on public hospitals in two ways:

- Patients who could have otherwise sought primary care intervention in the community are required to seek alternative treatment in the emergency department
- There are lower levels of early detection and management of diseases, particularly for vulnerable groups of individuals. Such patients end up requiring emergency care due to their condition deteriorating because they were unable to access earlier primary care services in the community. Patients in residential care settings are a key group in this category.

Demand for emergency department services has been impacted in recent years by ‘primary care-type’ patients presenting at emergency departments for treatment. These types of patients are generally defined as:

- not referred to hospital by a general practitioner
- required treatment in triage categories four or five
- did not arrive by emergency vehicle
- did not require admission to hospital
- had an emergency department stay of less than 12 hours.

The Victorian Government has introduced a number of initiatives which seek to manage the number of primary care-type patients presenting at emergency departments. These include:

- Co-located after hours general practice clinics: an after hours general practice clinic is located within a public hospital, near or adjacent to the emergency department to enable patients attending the emergency department for primary medical care to elect to be treated at the clinic rather than in the emergency department.
- Fast track services: a treatment service designated for the timely assessment, treatment and discharge of patients seeking primary care-type services for less serious illnesses and injuries.
New technologies and changing community expectations

The introduction of new medical technology is one of the major drivers of increasing health expenditure in many developed countries.

The introduction of new and sophisticated technologies and changing clinical practices can have paradoxical consequences. One the one hand, new technology can make existing treatments more accessible or result in the introduction of new procedures which supersede more expensive and time-consuming procedures. However, technology may also increase the cost of health care. By delivering more specialised and effective care and providing treatment options for previously untreatable conditions, new technology contributes to an increase in demand for these health services, thereby pushing up costs.

Despite these costs, advances in medical technology have delivered substantial benefits across a range of areas in the past decade. Improved health status, observed increases in longevity and improved well-being within Australia can be attributed to advances in medical technology and practices.

The increasing cost of health technology is estimated to account for approximately two per cent of the annual growth in real health care expenditure. Modelling undertaken by the Productivity Commission (2005) suggests that medical technology contributed more than one-third of the increase in real total health care expenditure between 1992-93 and 2002-03.

Supply of hospital services

The Victorian hospital system also faces challenges in the supply of health services. Addressing workforce shortages and capital planning are critical issues to ensure the hospital system continues to deliver quality health services.

Workforce challenges

Australians depend on the availability of a well-trained health care workforce in order to provide them with appropriate care for their needs. While there has been success in increasing numbers, there remains a growing workforce challenge across medical professions. This is due to a number of factors, including:

- the health workforce declining as a percentage of the total population. This is due to a number of factors including Victoria’s increasing population
- the need for more undergraduate and vocational and education training places
- increased workforce mobility, driven in part by more aggressive national and international campaigns to attract trained health workers in the face of similar issues world-wide.

These workforce issues face additional challenges in rural and remote areas and in Aboriginal communities, reflecting the concentration of many highly-trained professionals in major cities.

These issues are not localised within Victoria. The recent Council of Australian Governments announcement of a $1.1 billion funding injection to support health workforce reform across jurisdictions indicates a widespread need to address the barriers impeding optimal health care delivery across Australia.
The Victorian Government has developed strategies to meet the challenge which is described further in this submission.

**Infrastructure**

The increasing demand for hospital services has a flow-on impact on the hospital system’s physical capacity to meet this demand. The hospital system’s infrastructure is important in maintaining and improving patient care, managing service delivery, improving efficiency and working conditions for health care providers, and provides a basis for innovation. Investment in infrastructure needs to be a balanced combination of maintaining existing essential infrastructure and building or purchasing new infrastructure, consistent with current requirements and service demand.

The Victorian Government is focused on planning for the future capital needs of the hospital system in order to:

- ensure the hospital system maintains sufficient service capacity required for current and expected demand growth
- maintain existing building infrastructure to ensure it remains fit-for-purpose, meets service and occupational health and safety standards and efficiency requirements
- ensure it remains fit-for-purpose with regards to technology (equipment and information technology) in the hospital system.

Investment and asset-based decisions will be made over the next decade to ensure hospital infrastructure is provided which meets the needs of the Victorian community. The Victorian Government is committed to ensuring improvements in the health asset base in order to maintain current performance standards and enable improved health outcomes.
3. Victorian public hospital achievements

The Victorian Government has introduced a large range of policies, programs and initiatives in order to meet the challenges and ensure Victoria has a world-class hospital system. As a result, the Victorian public hospital system is considered, and has consistently ranked, as one of the best in Australia and has been a national leader in the development of new and innovative health reforms.

Victorians are among the healthiest people in the world

Victorians, like most Australians, enjoy long and healthy lives compared to world and historical standards. Life expectancy for Victorians is among the highest in Australia, and higher than most other countries in the world. Figure 3 shows that for Victorians born in 2006, their life expectancy is 79.3 years for males, and 83.7 years for females. This compares extremely well against the average Australian life expectancy, as well as against other Organisation for Economic Co-Operation and Development (OECD) countries.

Figure 3: Life expectancy outcomes for Victorian men and selected OECD nations

(Source: OECD, 2008, ABS, 2007)
The Victorian Government is committed to improving health outcomes for the community through strong investment in preventative health programs. As a result, there has been a significant reduction in smoking rates in the community, high rates of immunisation, and timely access to screening services for breast and cervical cancers.

**National leadership in health reform**

Victoria has played a strong and significant role in advancing health care and hospital reform across Australia. During 2005, Victoria initiated the National Reform Agenda at the Council of Australian Governments, seeking to improve Australia’s investment and reform in community well-being, with a particular focus on investing in preventative health care. All states and territories, as well as the Commonwealth, worked with Victoria to further develop the agenda, which has resulted in major investments in healthy lifestyles promotion and preventative health care, as well as improving the sharing of information around policies and programs and co-operation between jurisdictions.

In June 2008, the Premier launched the Victorian Government’s *Next Steps in Australian Health Reform* policy, which provides a comprehensive strategy for reforming the national health system. The policy details a ten-point plan to focus on patients and their health needs, as well as disease prevention and helping people to maintain good health. In November 2008, the Council of Australian Governments agreed that a number of these proposals will be implemented through the National Partnership on Preventative Health.

Victoria continues to lead Australia in setting the policy agenda in health care, ensuring better access to health care services for all Australians. Victoria was the first jurisdiction in Australia to introduce activity-based funding for public hospitals, with the introduction of the Casemix system in 1993. Victoria has also
led reforms in models of care. A range of innovative programs to provide patients with the ‘right care in the right place’ has also been introduced in Victoria.

Victoria’s hospital performance is among the best in Australia

Victoria has a proven track record in delivering a high-performing health system, with a key focus on the delivery of quality health services through its public hospitals. Recent Commonwealth Government reports highlight the strong performance of the Victorian public hospital system compared with Australia as a whole. In 2007-08, Victoria compared favourably across all areas of public hospital activity including emergency department treatment times, median waiting times for elective surgery and treatment of admitted patients in public hospitals.

In 2007-08, the Victorian hospital system treated an additional 600,000 patients compared to the same period in 1999-2000.

The number of hospital services provided in Victoria is increasing and at rates much higher than the national average. In 1999–2000, public hospitals provided 203 admissions per 1,000 people compared with the Australian average of 197 per 1,000 people. In 2006-07, this had grown to 247 admissions per 1,000 people compared with the national average of 219 per 1,000 people.

Despite having one of the highest rates of emergency department attendance in Australia and continued growth in presentations across all triage categories, Victoria continues to perform above the national average for the percentage of patients seen within recommended wait times, with 74 per cent of patients seen on time compared with 70 per cent nationally (Figure 5).

Median waiting times to treatment for people attending emergency departments in Victoria were also better than the national average in 2006–07, with Victoria’s overall median wait time of 22 minutes being two minutes faster than the national median (Figure 6).
**Figure 5:** Proportion of emergency department patients seen within desirable treatment times, 2006-07

**Figure 6:** Median waiting time to treatment for emergency patients, 2006-07
Victoria continues to perform well with regards to elective surgery waiting times in comparison with other jurisdictions. In 2006–07, half of all patients admitted to Victorian public hospitals for elective surgery waited 30 days or less (Figure 7). This is two days less than the national median of 32 days. Since 1999-2000, the Victorian hospital system has treated over 1,000,000 elective surgery patients.

**Figure 7: Median waiting time for patients admitted from the waiting list, Victoria and Australia**

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Resourcing for hospitals has increased

Between 1999–00 and 2008–09, funding for public hospitals has more than doubled (Figure 8). In addition to meeting the increased demand for services, growth in funding has also met increases in the cost of care due to advancements in medical technology, higher wages and other input prices, as well as increased consumer expectations with regards to quality of care.
Significant funding has also been provided to re-build and maintain Victoria’s hospital infrastructure. Since 1999, the Victorian Government has committed to invest over $4.7 billion in new, upgraded or refurbished health care facilities, including over $780 million in rural Victoria (Figure 9).

**Figure 8: Funding for health and aged care services in Victoria**

**Figure 9: Capital funding in Victoria**
Significant capital works undertaken during this period include:

- completing the new $250 million Royal Women’s Hospital, which will cater for the delivery of more than 5,000 babies each year and care for more than 2,000 premature and ill babies
- completing the new $80 million Casey Hospital, providing greater access and services to the south-east growth corridor
- investing $60 million to build The Alfred Centre, a dedicated elective surgery centre designed to treat 20,000 inpatients and provide 28,000 specialist clinic sessions each year
- completing the new $52 million Royal Dental Hospital facilities, which provides a better environment for patients and allows for the use of new and developing technologies
- investing $42 million to build three new super clinics in Melton, Craigieburn and Yarra Ranges. Super clinics bring together general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers in one location, allowing patients to receive a range of health services for conditions that require specialist medical care
- re-developing The Austin Hospital and expanding its facilities to include 400 acute beds, a new 30-bed intensive care unit, one of the state’s largest adult emergency units, a specialist six-bed facility for children, a state-of-the-art spinal unit with 26 beds servicing Victoria and Tasmania, and an infectious diseases isolation room in each ward.

**Box 2: Construction underway on the new Royal Children’s Hospital**

Victoria’s sick children will benefit from a brand new Royal Children’s Hospital in 2011. Construction is now well underway on the $1 billion project that will see a new facility built immediately west of the current hospital in Flemington Road. The project is the largest hospital re-development to be undertaken by the state, with the capacity to treat an extra 35,000 patients a year. The family-centred design will comprise mostly single rooms, providing more privacy for patients and their families. Parents will be able to stay with their children in more comfortable accommodation with access to a pull-out bed, state-of-the-art entertainment system and an internet terminal. Courtyards and gardens will provide children with easy access to the park’s healing environment, with 80 per cent of rooms featuring direct park views. The new Royal Children’s will be an internationally-acclaimed ‘green hospital’, meeting key sustainability targets such as greenhouse gas and peak energy reduction, water conservation and waste minimisation.

**Progress at the site**

Earthworks have now been completed, including the excavation and removal of 290,000 cubic metres of soil, There are now seven cranes and 300 workers operating on the site, with the structure of the five-level inpatient building having been completed at the rear of the site. Detailed internal design work is continuing to take place, involving more than 70 hospital user groups. These groups – consisting of a broad range of hospital experts – meet regularly with architects and engineers to help shape the new facility. Once the new hospital is complete, much of the existing facility will be demolished and the site restored to parkland, providing a green gateway to Royal Park.
Capital projects currently underway or planned include:
- the new $1 billion Royal Children’s Hospital, one of the biggest hospital re-developments in Australia (Box 2)
- over $160 million towards aged care services in regional Victoria
- $86 million for Stage 1 of the major re-development of South West Health Care in Warrnambool
- $80 million for community health services
- $45 million for re-development of the Frankston Hospital, providing a significant expansion in capacity across a range of health services
- $15 million for new, stand alone elective surgery centres at Austin and St Vincent's hospitals.

A growing workforce

Significant investment has occurred in expanding the public hospital workforce. At 30 June 2008, on a full-time equivalent basis there were 6,778 doctors and 29,981 nurses employed in Victorian public hospitals. This represents an increase of 2,585 doctors and 8,827 nurses in the system since 1999 (Figure 10 and Figure 11).

Figure 10: Number of doctors working wholly in the Victorian public hospital system
The Victorian Government, in collaboration with the Commonwealth Government, has already begun to implement a number of measures to support and strengthen the health care workforce through targeted recruitment, retention, education and workforce re-design initiatives. With a focus on long-term solutions to complex problems, the Victorian Government’s health workforce strategy aims to create a strong foundation from which to support a flexible and responsive workforce into the future. Victoria’s health care workforce strategy places significant emphasis on developing solutions to ensure that the workforce remains efficient and responsive to client needs and the changing face of health care delivery.

Key initiatives include the following:

**Improving workforce supply**

The Victorian Government has implemented a number of initiatives to recruit and re-distribute health professionals across areas of need. Some current programs include:

- Health Careers for a Healthy Future program to attract highly qualified international medical graduates to the Victorian workforce
- overseas/interstate allied health professional incentive packages
- Region of Choice program to improve the recruitment and retention of allied health professionals in rural Victoria
- Rural Medical Family Network to recruit and retain doctors to rural practice.

**Education and training**

The Commonwealth Government has allocated the following additional tertiary education places to Victoria:

- 220 extra medical places from 2008
- 956 extra division 1 nursing places (since 2005, including 280 places beginning 2009)
- 410 extra allied health places since 2005.
The Victorian Government has committed funding over four years (from 2006) to create additional vocational education and training places, specifically for 1500 division 2 nurses and 420 allied health assistants/other health technicians. Training to assist an ongoing workforce in rural areas will be supported through the expansion and continuing development of rural clinical schools.

The Victorian Government has also implemented a number of additional projects and programs to support the training and up skilling of health professionals in the state. Some of these include:

- extended skills training for general practitioners
- strengthening Medical Specialist Training program
- expanded Specialist Training Program
- rural Allied Health Undergraduate Scholarship program.

**Retention**

The Victorian Government has implemented a number of initiatives designed to improve retention rates amongst the existing workforce by improving employee satisfaction, reducing the risk of burn-out and dislocation/disorientation within the workplace, and by better supporting career pathways for health professionals through enhanced opportunities for further training and up skilling. Some of these retention initiatives include:

- international medical graduates assessment program
- allied health early graduate stream
- support for new nursing graduates
- additional support for medical interns
- support for nurses’ professional development.

**Improving workforce flexibility**

The *Better Skills Best Care* strategy articulates the Victorian Government’s approach to health workforce reform in terms of exploring new and re-designed work roles in health services. The aim is to ensure the most appropriate combined set of skills are available and used effectively to provide the best level of care to meet community health care needs. Work includes initiatives such as the division 2 nursing strategy to increase division 2 nurses as a percentage of the total nursing workforce.

**Regulation**

In March 2008, the Council of Australian Governments signed an Intergovernmental Agreement to establish a national regulation and accreditation scheme for the health workforce. This will create a single national registration and accreditation system for health professions. The scheme is due to be operational by 1 July 2010.

The new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce, especially where health practitioners work across or move between different states and territories. The Victorian and New South Wales governments are leading the consultations for this process.
Improved models of care

The following new models of care have been developed to increase hospital efficiency and improve patient outcomes. They include:

- **Hospital Admissions Risk Program**: a preventative/early intervention approach to patient management, assisting people with chronic diseases to better manage their conditions in order to improve outcomes for the patient and prevent avoidable hospitalisations.
- **Hospital in the Home**: a program which enables the provision of hospital care in the comfort of the patient’s own home, or other suitable environment.
- **Nurse on Call**: a new phone service that provides access to health advice from a registered nurse, 24 hours a day, seven days a week.
- **Short-stay units**: dedicated areas to enable admission for emergency department patients who, with proper assessment and treatment, are likely to be discharged within 24 hours.
- **Medical assessment and planning units**: a model which allows patients to be managed by medical physicians with collaborative multi-disciplinary input for up to 48 hours in order to facilitate intensive treatment, the engagement of appropriate allied health services and the streamlining of care planning processes.
- **Medihotels**: dedicated facilities to meet the needs of self-caring guests, who either require overnight accommodation in anticipation of a next-day admission or day procedure, no longer need acute nursing care or cannot return to their usual residence or travel considerable distance to the health facility for extensive investigations.

Improving the patient experience

Patients continue to express a high level of satisfaction with the treatment they receive at public hospitals through the Victorian Patient Satisfaction Monitor. The survey is conducted by an independent organisation and considers key areas of service delivery, such as access and admission, general patient treatment and related information, complaints management, physical environment, and discharge and follow-up.

The scoring system for the Overall Care Index for the Victorian Patient Satisfaction Monitor ranges from 20 (poor) to 100 (excellent). The Overall Care Index acts as the global indicator for the respondent’s hospital experience, and is derived from relevant questions from the six key areas of satisfaction. The 2007-08 results are identical to the results for 2006-07 but show a small decline from 2001 (Figure 12). At 78.1, the 2007-08 Overall Care Index result translates to a ‘very good’ rating. Trend data shows minimal variation over time and indicates a consistently high level of patient satisfaction with the care and services provided. The vast majority of respondents (93 per cent of the Victorian Patient Satisfaction Monitor sample) stated they had no reason to make a complaint about their hospital stay.
New medical technologies, such as improved anaesthetic procedures and laparoscopic surgery means many procedures can now be performed more safely, with patients spending less time in hospital. This has seen a significant increase in the number of patients being admitted for same-day treatment (Figure 13). In 2007-08, 768,581 people were admitted for same-day treatment in public hospitals - an increase of 29,468 patients or four per cent compared with the same period the previous year.
New programs have also been established in order to better meet the needs of older patients who may require more time in a non-hospital setting to complete their restorative process, and to finalise and access long-term care arrangements. Quite often, admission to a residential aged care facility is recommended in support of their ongoing care needs, such as a nursing home or hostel, and they wait in hospital until a suitable place becomes available.

The Transition Care Program, a jointly funded Commonwealth/state initiative is providing these older people with more appropriate care when their public hospital treatment is completed and they no longer need to be in hospital. This transition period safeguards against older people prematurely entering residential care placements, assists in optimising their functional capacity and aids their navigation and access to suitable health care services.

In 2007-08, over $19.6 million was invested in the Transition Care Program implemented across all major metropolitan and major regional health services. The program identifies and minimises the number of older people inappropriately experiencing extended lengths of stay in hospital, enabling improved care and outcomes for older Victorians.
4. Acute hospital services

Acute care involves the treatment of a patient for a time limited but severe episode of illness or injury or to give birth, usually within the hospital system. An episode of acute care for an admitted patient is one in which the principal clinical intent is one or more of the following:

- to manage labour (obstetrics)
- to cure illness or provide definitive treatment of injury
- to perform surgery
- to relieve symptoms of illness or injury (excluding palliative care)
- to reduce severity of an illness or injury
- to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- to perform diagnostic or therapeutic procedures.

(Australian Institute of Health and Welfare, 2008a)

Patients within the acute care system tend to require ‘active’ care, and are resource intensive in terms of staff time, effort and medical and surgical needs. Acute care is, in many ways, the core business of the hospital system.

Hospitals most often provide acute care:

- in emergency departments
- through the provision of elective and emergency surgery
- through the provision of medical inpatient care
- for planned treatment of existing illness, such as chemotherapy or renal dialysis.

Emergency department services

In Victoria, emergency departments are designed to deliver short episodes of time critical care and treat people who are experiencing a medical emergency that is life threatening or could cause serious or ongoing disability. Some emergency departments in Victorian hospitals specialise in treating particular groups such as children or trauma patients in addition to the usual emergency department case mix. There are a small number of emergency departments which provide only specialist care such as the Royal Victorian Eye and Ear Hospital, and the Royal Women’s Hospital.

There are currently 38 metropolitan and rural hospitals in Victoria with a designated emergency department providing care 24 hours a day.

The first priority in an emergency department is to treat patients with the most urgent medical needs. All Victorians who present at emergency departments are ‘triaged’ or assessed for urgency. The triage system relates to urgency rather than severity. Following assessment, stabilisation and management of their condition, patients may be discharged to their place of residence, be referred to another service or be admitted to hospital as an inpatient for further treatment.

The emergency department is one of multiple points of entry to the hospital. A patient’s journey through the emergency department can become blocked because of delays in accessing inpatient hospital beds or community-based services. The protocols and linkages between emergency departments and other parts
of the hospital and the broader health system are critical to ensuring effective patient flow and a continuum of care for patients who require emergency treatment.

The number of patients attending emergency departments has steadily increased since 1999. In 2007–08, 1,350,046 patients attended emergency departments – 403,709 more people than in 1999–00, which represents an increase of 43 per cent (Figure 14).

**Figure 14: Number of patients attending emergency departments**

As well as an overall increase in demand, the complexity of patients attending the emergency department is also increasing. Since 1999-2000, the complexity of patients presenting at emergency departments has also intensified, with an 84 per cent growth in triage categories one to three, compared with a 42 per cent increase for less urgent patients (triage four to five).

The increasing complexity of patients is reflected in those being admitted to hospital. Since 1999, there has been a 96 per cent increase in the number of triage category one to three patients being admitted to hospitals, compared with a 28 per cent increase in the number of triage category four to five presentations being admitted. The increasing complexity of patients can lead to delays in patients accessing appropriate acute care settings.

Factors impacting emergency services are complex and include: increased attendance by an ageing population, increased demand for emergency transportation, presentations by primary care-type patients, increased demand for mental health services and adequate staffing. These challenges are particularly pronounced in regional and rural communities, where there are additional challenges in maintaining 24/7 access to medical practitioners.
In 2006-07 the Victorian Government released the *Better Faster Emergency Care* policy which provides a five-year strategy to meet demand for emergency care, and further improve emergency care and access in Victoria’s public hospitals. The strategy identifies ten key priority areas to be undertaken by the Department of Human Services:

1. develop new service options
2. improve co-ordination between emergency departments and ambulance services
3. improve the patient experience
4. mainstream new models of care
5. explore new ways of working
6. enhance safety and quality of care
7. promote better systems of care
8. promote better management of care for people with mental health problems
9. promote better management of care for older people
10. promote better management and care of children.

**Key initiatives in emergency services**

A range of initiatives have been implemented to improve the capacity of the health system to meet the emergency care needs of the community. They include:

- Improving the ambulance/emergency interface: includes guidelines for ambulance presentations in the emergency department and guidelines for Hospital Early Warning Systems, and modifications to hospital bypass guidelines.
- Improving the patient experience: responding to the needs of patients in the emergency department, and support for the delivery of patient-centred care. Key initiatives to achieve this include upgrading physical amenities and signage, new consumer information and condition specific fact sheets, and an emergency department module for the Victorian Patient Satisfaction Monitor.
- Mainstreaming new models of care: development and implementation of best practice models of care, including observation medicine (such as short-stay observation units and medical assessment planning units), emergency department care co-ordination, medical day treatment centres, fast track and medihotels.
- Enhance quality and safety: enhancing safety and quality of care in emergency departments, including providing staff with access to up-to-date evidence-based clinical guidelines, establishment of an emergency services clinical network and the development of emergency care quality and clinical effectiveness performance indicators.
- Promoting better systems for care: the implementation of the bed board electronic bed management tool, and development of systems and practices through the primary care partnerships to allow the effective implementation of electronic referral between the emergency department and other health care providers.
- Promoting better management of care for people with mental health problems: ensuring the long-term sustainability of the mental health system by enhancing capacity to manage unavoidable demand and more effectively manage patients to prevent incidences of relapse.
- Promoting better management of care for older people: undertaking the sub-acute and residential aged care access indicators project to identify processes, practices and other factors that impact on patients’ access to sub-acute and residential aged care facilities. In addition, auditing emergency departments’ physical environments, priority funding for submissions to improve patient experiences for older people, and piloting a Clinical Assessment and Treatment In-reach
service to residential aged care facilities in ten health services as part of the Winter Strategy 2008.

- Develop new service options: in order to support continued reform of the emergency care system, the Victorian Government has implemented a review of co-located clinics and application of recommendations include development of a governance framework and guidelines. This is in addition to the continued development of new service options including emergency primary care centres, Nurse on Call and the Hospital Admission Risk Program.

The key priorities in emergency services for 2008-09 include:

- providing assistance to health services to help them improve performance and respond to changes in demand
- implementing and evaluating initiatives undertaken as part of the Winter Demand Strategy 2008
- improving the interface between ambulances and emergency departments, including better distribution of ambulance patients
- supporting programs and services to improve access to emergency departments, including re-design and alternatives care options to reduce avoidable emergency department presentations
- facilitating strategies to improve patient flow, including implementation of the bed board project and new and updated guidelines for models of care
- improving the equity and sustainability of initiatives to improve patient experiences.

Surgery

Victorian public health services provide comprehensive emergency and elective surgical services, including more than 15 separate surgical specialties and many more sub-specialties. Emergency surgery is the provision of surgical care to patients who present with an acute surgical condition. Elective surgery is defined as surgical care for which admission can be delayed for more than 24 hours, and the procedure is planned for a later date.

In 2007–08, public hospitals in Victoria treated: 54,466 emergency surgery patients, 186,850 elective surgery patients and 15,264 other surgical patients.

In most instances, emergency admissions have priority over elective admissions, since the acutely ill and injured have a higher risk of morbidity or mortality if treatment is delayed. Effective management of surgical services requires a balance between emergency admissions and those requiring elective care. Elective surgery patients are assigned to one of three urgency categories. The categories and their clinically recommended waiting time targets are:

- category one—urgent (admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency)
- category two—semi-urgent (admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency)
- category three—non-urgent (admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly, and does not have the potential to become an emergency).
Access to surgery

A range of factors affect access to surgery, including when and where it is performed. The patient’s needs relative to others who may need surgery more urgently is a key factor. In most surgical centres, theatre use is influenced by the presentation of emergency cases resulting in unplanned surgery. Maintaining an appropriate focus on elective surgery, and avoiding cancellations of scheduled elective surgery, in the context of a growing demand for emergency surgery and other hospital services, is a constant challenge for health services.

Victoria has a well-developed private hospital system, which provided elective surgery to over 270,000 privately-insured patients in 2007-08. There are significant differences between the public and private systems in terms of case mix, and the capacity to access various forms of treatment. For example, most emergency surgery is performed in the public sector.

Public hospital surgical services are accessible through a number of different avenues. While emergency surgery is always accessed via an emergency department or hospital ward, there are variable pathways to an elective surgery admission in the public system. Most patient journeys begin when a general practitioner or medical specialist refers the patient to either an individual specialist or a hospital specialist clinic, where the patient is assessed and prioritised for surgery utilising one of the three categories described above. Waiting times for specialist clinics and appointments can have a significant impact on overall waiting times for elective surgery, as clinical information identified during specialist clinic appointments is used to determine a patient’s elective surgery category.

The Elective Surgery Waiting List is a register of patients who are ready to be admitted for a defined group of specific procedures provided at 20 of Victoria’s busiest health services. These procedures are commonly referred to as ‘included procedures’ and are reported through the Elective Surgery Information System. The specified procedures conform to nationally-endorsed definitions. These definitions have been in place since 1998 and are consistent across all states and territories.

The number of patients on the waiting list is impacted by many factors, including demand for services (additions to the waiting list) and the capacity of hospitals to meet this demand.

Once a patient is admitted for treatment they are removed from the waiting list. A patient may be removed from the waiting list for other reasons including refusing treatment, or if treatment is no longer required. In 2006-07, 14.5 per cent of patients were removed from waiting lists for reasons other than receiving elective surgery (Department of Health and Ageing, 2008). The most common reasons were that surgery was no longer required or that the patient had decided not to have the surgery.

While waiting for surgery, a patient may be identified as not being ready for care due to health, social or personal reasons. This includes patients identified by clinicians as not currently fit for surgery, patients who require other procedures before surgery takes place or patients who have chosen to delay their elective surgery (for example, due to the patient being away from home for an extended period of time).

The Elective Surgery Waiting List definitions are consistent with those prescribed by the National Health Data Dictionary and excludes medical procedures such as scopes and transplants.

The Victorian Elective Surgery Access Policy provides health services with a policy framework and guidelines for managing elective surgery patients. The objectives of the policy are to:
• improve access to elective surgery through active management of waiting lists
• promote best practice models for elective surgery waiting list management
• provide transparent processes for determining access to elective surgery
• identify the rights and responsibilities of health services and patients
• improve communication between health services, general practitioners and relevant community agencies
• provide authority for the development of local policies and protocols

Improving access to surgery, particularly to elective surgery, is a key focus of planned health reforms. The Commonwealth and state and territory governments are working collaboratively to tackle the many challenges facing the health system.

Key initiatives

Current key initiatives in relation to elective surgery in Victorian public hospitals include:

• Targeted additional funding for elective surgery: $60 million Elective Surgery Waiting List Reduction Plan, jointly funded by the Commonwealth and Victorian governments, aims to reduce the number of patients waiting longer than clinically recommended for elective surgery. The additional funding in 2008 enabled Victorian hospitals to provide elective surgery to over 13,000 additional patients than in 2007, and to help hospitals increase their elective surgery capacity through capital works and equipment improvements (Box 3).
• To support implementation of the additional activity, the Victorian Government has provided a total of $10.8 million for equipment and minor capital works.
• In the 2008-09 Budget, the Victorian Government announced additional recurrent funding of $15 million over five years to meet demand for elective surgery.

Box 3: Reducing the number of long-waiting elective surgery patients

Long-waiting elective surgery patients are benefiting from faster access to treatment thanks to $60 million from the Commonwealth and Victorian governments for elective surgery services.

The additional funding for 2008 has been targeted at patients who have been waiting for longer than the clinically-recommended time for their surgery and has resulted in over 13,000 additional patients receiving their elective surgery than in 2007.

To continue meeting the demand in 2008–09, the Victorian Government has allocated an additional $15 million of recurrent funding to elective surgery.

Building new facilities

New dedicated elective surgery centres throughout Melbourne are also improving access for long-waiting patients across the state. The Alfred Centre (a new dedicated elective surgery centre) and other designated hospitals have been allocated additional funding through the Elective Surgery Access Service to perform more elective surgery.

In Melbourne’s north-east, The Austin Centre opened in July 2008 to provide Victoria with a second dedicated elective surgery centre. A third centre will open at St Vincent’s Hospital in 2009.
The Commonwealth Government has committed a further $36.8 million over the next two years to fund projects in stage two of the three-stage Commonwealth Elective Surgery Waiting List Reduction Plan. Over $20 million has been allocated to re-develop elective surgery facilities at the Royal Melbourne Hospital, Monash Medical Centre (Clayton), Sunshine Hospital, Geelong Hospital and Frankston Hospital. Over the next two years, $10.6 million will be used to purchase surgical equipment and $6 million will help develop innovative solutions to manage elective surgery.

Planning for the future

The Department of Human Services is working with the health sector and the community to develop a clear vision and plan for the future of surgical services in Victoria's public hospitals. This plan will contribute to the broader health reforms being undertaken collaboratively between the Commonwealth and the states and territories.

Access and prioritisation initiatives

Access to surgical services has been improved through the Victorian Government’s investment in new infrastructure, equipment and the re-configuration of existing facilities. Major current capital developments include:

- a purpose-built freestanding state-wide elective surgery centre at The Alfred
- two designated surgery centres at St Vincent's Health and Austin Health
- new day surgery theatres at the Yarra Ranges Day Hospital
- theatre re-development at Peninsula Health, including two new theatres
- additional theatres at Ballarat Health
- new day-surgery theatre at Echuca Regional Health.

A number of waiting list management and prioritisation initiatives aim to increase access to elective surgery. These initiatives include:

- The Elective Surgery Access Service, which assists semi-urgent (category two) and non-urgent (category three) elective surgery patients by arranging surgery at another hospital that has the capacity to treat their condition. Five metropolitan hospitals have received extra funding to treat additional patients referred to them as part of this service.
- Dedicated clinical resources to manage patients waiting for surgery. Funding has been provided to create elective surgery access co-ordinator positions at all major metropolitan health services and large regional health services.
- Specialty-specific prioritisation models. For example, the Osteoarthritis Hip and Knee Service, now implemented in 14 health services, aims to improve the management of patients referred for joint replacement surgery and prioritise the waiting list according to clinical need.
- The Elective Surgery Waiting Time website is targeted at patients and referring practitioners and provides information about waiting times for individual procedures at health services.
- Reviews of the range of surgery that will be offered to public patients - for example, aesthetic surgery and non-medical circumcision - to ensure that priority is given to the most appropriate and necessary surgical procedures.
- A re-design of the Surgical Patient Journey demonstration project will be undertaken at three health services in 2009 and will identify inefficiencies and provide solutions to maximise operating resources.
- The Emergency Surgery Working Group will be convened in 2009 to develop performance indicators and pilot innovative models of care for emergency surgery.
New models of care

A range of work has been undertaken in Victoria to introduce or encourage new approaches to the care of surgery patients. These include:

- Establishing new models of surgical care, such as the 23-hour procedure units which have been developed for surgical patients whose expected episode of care can be delivered within 23 hours. Beds in 23-hour units are quarantined for this purpose and patient care is delivered according to a set clinical pathway.
- Developing streamlined models of care for particular conditions. For example, the Cranbourne cataract model has streamlined the patient journey, tailoring care to individual patients and reducing unnecessary follow-up appointments.
- Developing guidelines to support best practice in caring for particular patient groups, such as the Surgery for morbid obesity: Framework for bariatric surgery in Victoria’s public hospitals guidelines
- Using private sector capacity. Since 2005, the Department of Human Services has procured a limited number of elective surgery procedures from the private sector under the Private Patient Initiative. The initiative, which targets patients from particular specialties who have waited longer than the clinically-recommended time.
- In rural Victoria, collaborative arrangements between health services are being encouraged as a way of improving access to elective surgery. This includes development of procedural networks, including regional or sub-regional health services working with surrounding local services to share service provision. Benefits include increased capacity within the area, improved patient management and flow, and improved capacity of local hospitals to maintain skills, procedural capacity and ability to service their local communities.
- The Victorian Government is supporting projects that utilise task substitution to address chronic shortages in the surgical workforce. In 2009, two health services will pilot nurse-led cystoscopy, while a further five will pilot a nurse-led pre-admission service.

Critical care services

Critical care services provide the expertise and equipment for treating patients with life-threatening or potentially life-threatening conditions. These services include beds in intensive care units, high dependency units, neonatal intensive care units and special care nurseries. The critical care system in Victoria provides comprehensive support and care for patients within the full range of medical and surgical services and specialties.

The availability of beds in intensive care and high dependency units can have a significant impact on emergency and elective patient flow. Intensive care services also have an important national role, providing care for patients from other states and territories who need very complex treatments such as paediatric heart transplants.

Since 2001–02, intensive care high dependency beds have increased from 134.5 to 167.0 in 2007–08. In 2008–09, a further six additional intensive care unit beds have been opened, with adult beds at The Alfred, Dandenong, Frankston and Geelong hospitals and two paediatric beds at the Royal Children’s
Hospital and Monash Medical Centre (Clayton). A further four beds will be opened as part of the Governments $321.5 million beds package announced in December 2008.

Neonatal intensive care units and special care nurseries provide care for premature and low birth weight babies, and babies born with congenital or other conditions that affect their health or survival.

In 2007–08, there were 10,833 admissions to either neonatal intensive care units or special care nurseries – an increase of 369 admissions or 3.5 per cent compared with the previous year. Demand for tertiary-level special care nurseries and neonatal intensive care units care increased significantly from January to June 2008.

Maternity services

There are currently 59 hospitals in Victoria that provide maternity care – 43 in rural Victoria (including five regional hospitals) and 16 in metropolitan Victoria. The level of maternity care provided in these settings ranges from antenatal and postnatal (including domiciliary) care only, through to full maternity care providing birthing services. There are three tertiary maternity services – Mercy Hospital for Women, Monash Medical Centre and The Royal Women’s Hospital. These services provide all elements of maternity care for their local community and provide specialised care for women experiencing high-risk pregnancies. Eleven maternity services also offer publicly-funded antenatal care through specialist clinic services. In 2007, there were 73,737 births in Victoria of which the majority were in public hospitals.

Maternity services in rural Victoria provide levels of service delivery in accordance with the Rural Birthing Services Capability Based Planning Framework. This provides guidelines to assist rural health services to assess their maternity service provision based on safety standards for mother and child. Many rural health services without a defined maternity service still provide postnatal domiciliary services to women from their area following birth elsewhere.

Specialist clinics

Victorian public health services have responsibility for providing inpatient and ambulatory care services in hospital and community-based settings. Specialist clinics\(^1\) are part of the continuum of care for many patients, and are an important interface in the health system between acute inpatient and primary care.

Specialist clinics provide planned non-admitted services that require the focus of an acute setting to ensure the best outcome for a patient. Services tend to be characterised by the need for:

- strong links to research, infrastructure and innovative practice in terms of technology-dependent interventions and drug therapy
- specialised workforce and training needs
- complex interdependencies, often with other specialised services.

\(^1\) Previously known as outpatient services.
In 2007-08, there was over 2.2 million outpatient occasions of service, this included 1,249,777 specialist appointments were provided in Victorian Ambulatory Classification System-funded public hospitals and 337,587 appointments were provided in non-Victorian Ambulatory Classification System-funded public hospitals. 588,382 allied health encounters were also provided in hospitals in 2007-08.

The majority of specialist clinic services delivered by public health services are provided in the hospital setting or community-based health care facility such as a day hospital, and provide access to:
- medical, nursing and allied health professionals for assessment, diagnosis and treatment
- ongoing specialist management of chronic and complex conditions in collaboration with community providers
- pre and post hospital care
- maternity care
- related diagnostic services such as pathology and imaging.

A range of health professionals are involved in organising and providing care at specialist clinics including medical practitioners, nurses, dentists, allied health professionals and clerical staff.

Patients are referred to specialist clinics by general practitioners, specialists and clinicians in emergency departments, inpatient units and other areas of the hospital. Patients may also access services through self-referral for clinical specialties such as maternity services.

A set of principles governing the delivery of specialist clinics has been developed. The principles aim to:
- ensure timely and equitable access
- respond to community health needs
- utilise evidence-based practice that integrates best research evidence with clinical expertise and patient values
- provide patient-centred care and support patient participation in health care
- utilise protocol-based care including use of patient pathways
- support continuum of care for patients and integration of specialist clinics with other parts of the health system
- ensure accountability, efficiency and optimal utilisation of resources
- ensure availability of appropriately trained health professionals
- support innovation, continuous improvement and dissemination of good practice.

**Key initiatives and reform**

The need to address long-standing issues in relation to the delivery of specialist clinic services is widely acknowledged by all stakeholders and it is recognised that health services require adequate capacity to meet demand pressures. In response, the Victorian Government has provided $44 million over four years from 2007-08 for reform and to improve work practices in specialist clinics, including the provision of additional services.

To date, specialist clinic reform has focussed on five key areas:
- implementing the Improving the Outpatient Experience Program, including physical amenity upgrades, development of a communications training package, and signage and way finding recommendations
- developing a generic specialist clinic care pathway template to support standardised care and streamline the patient journey
- improving the interface with primary care, including further development of the Victorian State-
wide Referral Form

- supporting innovation and good practice through funding improvement projects in metropolitan and rural hospitals
- supporting key enablers to reform through development of a resource kit *Specialist clinics in public hospitals: A resource kit for the Medicare benefits schedule-billed services*, development and pilot of a minimum dataset, review of the Victorian Ambulatory Classification System, scoping the information and communication technology interface and supporting new workforce models of care.
5. Continuing care services

Continuing care services ensure the provision of care for older people and people with chronic conditions and complex care needs in a seamless continuum, allowing patients to be treated in a more appropriate setting for their illness than in an acute environment. These services improve patient flow through the hospital system by enabling hospitals to transfer longer-stay patients into more appropriate care settings, freeing up more expensive acute beds for seriously ill patients and patients being admitted from the emergency department.

Continuing care services include chronic and complex care services, sub-acute services and post-acute care.

Chronic and complex care services

To ensure that each person receives appropriate health care, service provision must be responsive, integrated and flexible, ensuring patients with high-acuity chronic and complex care needs receive the right care in the right place at the right time.

Chronic and complex care services focus on people with these conditions in order to improve identification and management of their condition. In doing so, services seek to improve patient health outcomes and provide patients with the opportunity to stay at home for longer.

Key programs in this area include the following:

- **Hospital Admission Risk Program**: this program supports people with chronic diseases and complex needs who frequently use hospitals or are at risk of hospitalisation. Hospital Admission Risk Program services are person-centred, based on meeting a client’s individual needs, which can include physical or mental health, psychosocial, and environmental needs and include hospital-based and community-based services.

- **Residential In-Reach**: ten health services were selected to pilot clinical assessment and treatment in-reach services to residential aged care facilities. Each health service has piloted models of care to help prevent avoidable emergency department presentations by residents of aged care services.

- **Family Choice Program**: the Family Choice Program was established in 1997 at the Royal Children’s Hospital. The program supports children with medically-complex care needs to live with their families in the community, reflecting the Family Choice Program’s mandate to decrease or avoid hospitalisation of children.

- **Victorian Respiratory Support Service**: the Victorian Respiratory Support Service is a state-wide specialist service to provide ventilator equipment and support adults who are chronically ventilator-dependent. In 2007-08, 769 clients utilised the Victorian Respiratory Support Service.

Sub-acute services

Sub-acute services play an integral role in the health care system, supporting patients to maximise their independence. The sub-acute service system is characterised by links with other parts of the health care system in order to promote effective and seamless services across the care continuum. There are
important interfaces between sub-acute services and other continuing care services including the Hospital Admission Risk Program, post acute care and home and community care services.

Sub-acute care has many definitions, depending on the context in which it is considered. At its simplest, sub-acute care is about goal-oriented (and in many instances time-limited) interventions aimed at assessing and managing often complex conditions to maximise independence and quality of life for people with disabling conditions.

Key sub-acute services provided in Victoria include:

**Rehabilitation**

Rehabilitation, whether provided on an inpatient or an ambulatory basis, is targeted at achieving improvements in functioning and independence. It is provided to people with loss of function or disability from any cause, either congenital or acquired, and all age groups. There are two levels of services:

- **Level 1 Rehabilitation** - Provides rehabilitation for low volume, high complexity conditions: Acquired Brain Injury, spinal, amputee and paediatric, where the rehabilitation episode directly follows the acute care episode.
- **Level 2 Rehabilitation** - Provides high volume, lower complexity rehabilitation following stroke, orthopaedic, cardiac, pulmonary, musculoskeletal, and neurological and any other rehabilitation.

**Geriatric evaluation and management**

Geriatric evaluation and management involves the sub-acute care of chronic or complex conditions associated with ageing, cognitive dysfunction, chronic illness or disability. These conditions require patients to be admitted for review, treatment and management by a geriatrician and a multi-disciplinary team for a defined episode of care. The patient group is usually older people with complex, chronic or multiple health care conditions requiring treatment and stabilisation of those conditions and/or medical review for future treatment options or service planning.

**Sub-acute ambulatory care services**

Sub-acute ambulatory care services include a diverse array of services, comprising community rehabilitation services (centre-based and home-based) and specialist clinics. Community rehabilitation services provide a multi-disciplinary rehabilitation service targeted towards similar patients as managed by inpatient rehabilitation services. Community rehabilitation is time-limited and delivered according to a care plan that is based on goals negotiated with the client and their carer(s). Sub-acute ambulatory care services also encompass a range of specialist clinics which provide specialist assessment, diagnosis, intervention, management, education, advice and support to patients with specific medical conditions. The range of specialist clinics include falls and mobility, cognitive dementia and memory services, movement disorders, continence, polio, chronic wound management and chronic pain management.

**Victorian Paediatric Rehabilitation Services**

The Victorian Paediatric Rehabilitation Service is a state-wide specialist service that caters specifically for children and adolescents who, as a result of injury, medical/surgical intervention, or functional impairment, will benefit from a program of developmentally-appropriate, time-limited, goal-focused multi-disciplinary rehabilitation.
This includes children and adolescents with acquired conditions that can benefit from a defined period of rehabilitation, such as following an Acquired Brain Injury. It also includes children and adolescents with either congenital or developmental-based conditions, following a specific event or surgery that requires a defined period of rehabilitation.

**Post-acute care**

Post-acute care services aim to assist people discharged from a public hospital, including emergency departments, acute services and sub-acute services, who have been assessed as requiring short-term, community-based supports to assist them to recuperate in the community and to ensure a safe and timely discharge. The most common post-acute care services are community nursing, personal care and home care services.

**Hospital in the Home**

Hospital in the Home is the provision of hospital care in the comfort of the person's own home, or other suitable environment. Patients are regarded as hospital inpatients, remaining under the care of their treating doctor in the hospital and receive the same treatment that they would have received had they been in a hospital bed. Patients may be able to receive all their hospital care through Hospital in the Home, or they may have a stay in hospital first.

**Transition care**

The Transition Care Program is jointly funded by the Victorian and Commonwealth governments. The target group for the Transition Care Program is older people who have completed a hospital episode and who:

- require slow-stream therapy to support an ongoing but slower recovery process
- require short-term care to actively maintain their functioning whilst they, and their families, consider and explore the long-term care options that are available.

The Transition Care Program is delivered both in bed-based settings and in the person’s home. It is being progressively implemented in the major metropolitan and large regional health services. Victoria currently has 570 transition care places, which will increase to a total of 1000 places over the next four years. 68 of these additional places have been operationalised in 2008-09.
6. Mental health

The mental health system in Victoria comprises multiple services delivered and/or funded by both the state and territory and Commonwealth governments. These services include clinical services, as well as support services used by persons with mental illnesses in areas such as employment, housing, and drug and alcohol treatment.

The consultation paper *Because Mental Health Matters: A new focus for mental health and well-being in Victoria*, released in May 2008 points to a new set of directions for mental health in Victoria. It builds on the:

- Improving Mental Health Outcomes in Victoria, undertaken by the Victorian Government with the Boston Consulting Group (2006).

In early 2009, the Victorian Government will release a new Victorian Mental Health Strategy that will provide a vision and framework to address the ongoing challenges and changing requirements of mental health service development and delivery over the next decade.

Community consultations will also commence in early 2009, to guide the *Review of the Mental Health Act*, which will seek to amend legislation to provide an effective and contemporary legislative framework for the treatment and care of persons with a serious mental illness.

The mental health system

Mental health care involves a complex range of services and providers. While public specialist mental health services are often seen as the major provider, many other important providers are involved, including general practitioners, private psychiatrists and psychologists, either in private clinics or other government-funded programs such as community health centres.

Private psychiatric services provide clinical ambulatory and inpatient care. Far more private providers are available within the metropolitan area than in regional and rural areas, with about 90 per cent of psychiatrists working in Melbourne. Like many other Victorians, people with mental health problems also require access to a broad range of health and community services, including general health care, housing assistance and social support.

Specialist public mental health care

Public mental health services provide both specialist clinical and psychosocial rehabilitation care for people with severe mental health problems and/or associated psychiatric disability.

Settings vary from acute and secure inpatient beds to community-based beds and ambulatory services, and range from short to long-term care and rehabilitation.
While general hospital boards manage clinical mental health services, Psychiatric Disability Rehabilitation and Support Services are governed by non-government or community health agencies.

Three main program areas deliver clinical mental health services, reflecting the different needs of people across the lifespan. They are:

- children and adolescents (0–18 years)
- adults (16–64 years)
- aged persons (65 years or older).

These services are often called area mental health services because they are organised and delivered on an area basis, within a geographically-defined catchment area. The purpose of a catchment area is to ensure a service takes primary responsibility for providing mental health services to people who live in its area (area of origin) and to provide a mechanism for funding to services. The catchment area approach is different from the organisation of general medical services where people can typically present at a hospital or service of their choice. However, this difference does not preclude the delivery of service to a person who presents in an area other than the one where they reside, where there is an urgent necessity.

Victoria has 13 child and adolescent services, 21 adult area mental health services and 17 aged person services. The ‘accessing services’ section of www.health.vic.gov.au/mentalhealth identifies the catchment areas for child and adolescent services, adult and aged person services by suburb and illustrates these via maps of metropolitan and rural Victoria.

The strength and diversity of linkages with other health and community care services vary with locality, depending on local governance arrangements.

Some state-wide and specialist services, such as forensic, eating disorder and mother–baby services, are located in large metropolitan hospitals, with links to rural and regional services to facilitate state-wide access.

Specialist mental health care programs have been developed to address the high prevalence of mental health problems in the corrections system and, to a limited extent, in child protection services.

The adult and youth justice systems provide a range of primary, secondary and tertiary health care services to people in custody, at court and in prison. It also refers victims, offenders and people in need of assistance to specialised health and other support services.

When specialist mental health care is no longer required, the client may be referred back to a primary care provider or choose to cease treatment.

Entry to specialist public mental health care may be via:

- general practitioner referral
- presentation to a hospital emergency department - either self-presentation or via ambulance, police and/or crisis assessment and treatment services
- direct referral in person or through a telephone triage/intake system (either self referral or by a family member/carer/friend or government program, such as child protection or drug and alcohol service)
- court order to either an area mental health service or forensic mental health service.
If entry is sought to public specialist clinical mental health care, a clinical (triage) assessment is undertaken to determine the relative need for care, and if so, the type of care required. Access to a private mental health service provider is at the discretion of the provider.

Utilisation of mental health services

Over 59,000 people (about 1.1 per cent of the Victorian population) accessed public specialist mental health services in 2007-08, nearly 13,000 or just over 20 per cent of them requiring a hospital bed.

As at 1 July 2008 the admitted public specialist mental health system consisted of
- 966 acute beds, including 583 beds in 24 adult acute units; 113 beds in 18 specialist acute units; 215 beds in 17 aged acute units; and 55 beds in six child and adolescent acute units
- 103 beds in eight secure extended care units
- 154 forensic beds, including 118 beds in three forensic units funded by the Department of Human Services and 36 beds in prisons funded by the Department of Justice
- Eight beds in two short stay units

Figure 15 shows 12.5 per cent growth in the number of adult inpatient beds since 1999-2000. In particular, this incorporates 25 new beds at Casey Hospital and the growth in forensic beds at the Thomas Embling Hospital. Additional capacity over the past two years has been added with the development of short stay beds at the Royal Melbourne Hospital and Werribee Mercy Hospital to assist with emergency department demand. Further growth in beds will occur with the completion of works currently underway or in planning at Maroondah and Northern Hospitals.

Figure 15: Adult inpatient psychiatric beds, 1999-2008*

* Includes: adult acute, adult specialist, secure extended care units, short stay and forensic beds funded by the Department of Human Services.
Figure 16 depicts the number of separations or discharges from adult inpatient units since 1999-2000, and shows an overall increase of 4,156 separations or 24 per cent since 2001-02. Despite the increase in forensic beds during this period it should be noted that the rate of separations for forensic beds is considerably less than that for adult acute units, hence the moderate overall growth in separations when compared to the growth in additional beds.

**Figure 16: Total number of separations from inpatient psychiatric beds**

As well as providing inpatient care, the public specialist mental health system provides ongoing care in the community.

In 2007-08, consumers accessing community mental health services received 1,028,479 hours of recorded service, a decrease of 4.2 per cent compared with 2006-07 (Figure 17).

The 2007-08 reduction in reported community contact hours is due to a combination of factors, including:
- improved data entry compliance by services resulting in more accurate contacts by each attending clinician and the exclusion of non-reportable service activity from data entry
- recruitment issues, particularly in non-metropolitan services, resulting from the skills shortage currently being experienced nation-wide
- a data recording backlog in some services.

In 2007-08 there were 59,149 more contact hours recorded for consumers of community mental health services than in 2001-02, an increase of 6.1 per cent.
The discussion paper *Because Mental Health Matters: A new focus for mental health and well-being in Victoria* outlines the key reforms needed in the mental health system in Victoria, to enable a greater emphasis on wellness, early intervention and recovery. These include:

- developing a stronger focus on children and young people
- developing a strong prevention and early intervention capacity, to decrease dependence on acute and crisis intervention
- making recovery and the ability of people with a mental health problem to actively participate in our community a priority
- the recruitment, training and retention of appropriately skilled workers, which is crucial to the delivery of high-quality services to better meet client needs and maximise client outcomes, and accommodate service growth
- better meeting the needs of individuals with mental health problems, and especially those with complex combinations of physical and mental health problems
- responding to particular types of disorders and increased complexity (including youth psychosis, co-occurring substance misuse and eating disorders).

The specialist mental health service system operates in a challenging environment of increasing service need and changing complexity in core clients, as evidenced by the:

- increasing number and acuity of emergency department presentations – four per cent of all emergency department presentations are from people with a mental health problem and/or substance misuse problem
- increasing rates of acute inpatient involuntary admissions (70 per cent of all admissions are involuntary)
- crisis presentations (13 per cent increase in crisis assessment and treatment contacts since 2001-02).
- Chronic acute inpatient bottlenecks (14 per cent of patients stay 35 days or more).
Key achievements

Victoria is recognised nationally and internationally for its progressive and innovative developments in the delivery of mental health services. Since 1999, service enhancements have improved the experience of many Victorians with mental health problems in accessing and receiving care.

More people are now supported in community-based facilities, acute care is co-located with general hospitals and many individuals are managed successfully by primary care services.

Some innovative outreach programs connect to key settings, such as schools and homeless crisis accommodation. Simultaneously, systems have been strategically developed to better provide social supports that are essential for optimal rehabilitation and recovery for clients who face multiple health and social problems.

These achievements are the result of investment by the Victorian Government in public mental health services and stronger partnerships with a network of non-government agencies. They are also the result of the efforts of a dedicated workforce and some inspiring leaders.

Key achievements initiated by the Victorian Government since 1999 include:

- $240 million capital investments or commitments for new and upgraded mental health facilities
- Mental health investment increased by 95 per cent from $453 million in 1999-2000 to $884 million in 2008-09
- Expansion of mental health emergency department services to assist hospitals to respond more effectively and efficiently to mental health presentations
- Development and implementation of ‘step up/step down’ Prevention and Recovery Care places (sub-acute mental health services) to provide intensive short treatment and support options for consumers recovering from an acute episode who are not ready to return home, or to prevent avoidable admission to an acute inpatient facility
- Investment in new prevention and early intervention programs targeted at children (disorder programs) and young people (early psychosis programs) at risk of mental health problems
- Expansion of dual diagnosis services to better support young people who have co-existing problems with mental health and alcohol and other drug misuse
- Development and implementation of Integrated Rehabilitation and Recovery Care Services, which involve partnerships between Psychiatric Disability Rehabilitation and Support Services and clinical mental health services. This targets consumers in metropolitan secure extended care units and community care units with severe mental health problems and enduring psychiatric disabilities
- Expansion of counselling services in community health services to provide accessible, brief or extended psychological or social interventions for people with complex but not necessarily severe problems
- Development of mental health services in prisons, involving enhanced assessment and triage on reception and a broader range of specialist and primary mental health service options for all prisoners
- Development and implementation of the Families where a Parent has a Mental Illness strategy, a service development strategy involving collaboration between mental health services, other government departments, non-government organisations, consumers and carers.
- 17 dedicated mental health positions in emergency departments in 15 health services.
Investment in mental health

Since 1999–2000, the budget allocation for Victorian public specialist mental health services has increased by 95 per cent, from $453 million to $884 million (Figure 18). On a per capita basis, mental health funding increased by 64 per cent, from $88 per head in 1999–2000 (nominal dollars) to $141 per head in 2007-08.

Figure 18: Mental health funding since 1999-2000

The split in funding between different service types reflects Victoria’s relatively high level of investment in community-based treatment, with 65 per cent of service funding directed to community residential, clinical ambulatory, and psychiatric disability rehabilitation and support services (Figure 19). Victoria led the nation over this period in investing in community-based care.
Figure 19: Victorian specialist public mental health funding 2008-09 by service setting

Future priorities

In order to meet the challenges facing the mental health system, an additional $128 million has been provided over four years in the 2008-09 State Budget to begin implementing the Victorian Mental Health Reform Strategy. Key initiatives include:

- $16.8 million for new integrated children and youth services, and family support, to help prevent the onset of mental illness in young people before conditions become chronic
- $10.4 million over four years towards a 24-hour, seven-day-a-week state-wide mental health information and referral service for Victorian families, similar to Nurse on Call
- $5.5 million over four years for a trial of a new mental health triage service to ensure patients are quickly directed to the most appropriate service
- $15.5 million for works at Heidelberg Repatriation Hospital, including the Centre for Trauma-Related Mental Health Services. The Centre is a re-development of the Veterans’ Psychiatry Unit and will provide a 20-bed unit for inpatients and outpatients, treating veterans and non-veterans suffering from post-traumatic stress disorder, anxiety disorders and major mood disorders
- $5.5 million has been provided to reconfigure the mental health Adult Acute Unit at Ballarat Hospital to improve access and client amenity and to refurbish Ballarat’s Queen Victoria building to accommodate community mental health facilities
- $3 million has been provided to Dandenong Hospital to progress the detailed planning of the proposed re-development and expansion of mental health facilities which will increase beds from 77 to 150. The Dandenong expansion will include additional adult acute, secure extended care, aged acute and residential care beds
$39.1 million will be committed to build and staff new Prevention and Recovery Care Services to provide places for patients who are not sick enough for hospital but not yet well enough to go home.

- matching funding of $7.5 million for a national perinatal screening and support initiative for mothers and expectant mothers.

The following actions will be considered over the next decade to support the reform strategy:

- addressing pressures within the existing public mental health system
- investing in targeted mental health promotion and prevention priorities in key settings and for population groups at risk
- strengthening the specialist mental health system to achieve a more consistent response across a continuum of emergency, acute and community-based services
- investing in targeted prevention and promotion activity
- development of a Mental Health Workforce Strategy
- continued development of a more performance-based public mental health service funding system with a stronger outcomes focus
- modelling of the mental health needs of populations together with cost effective interventions to identify opportunities for achieving greater efficiency in respect to resource allocation
- expansion of the role of individual funding packages in treating and supporting people with complex needs
- working with the Commonwealth to enhance funding flexibility, better share reform costs and benefits, and progress shared infrastructure issues such as information development and reporting.

Performance management, monitoring and reporting

Performance of mental health services is monitored through a number of financial, activity and clinical mechanisms.

In addition, mental health services require systems for monitoring and evaluating their quality and effectiveness against the national standards for mental health services. This performance monitoring and evaluation occurs in a number of ways. All mental health services are required to meet certain performance targets as part of their service agreements with the Department of Human Services. Indicators of performance include the number of new consumers, the numbers of admissions and discharges, the average length of stay in an inpatient unit, the number of community contacts, and the timeliness of data reporting. These are measures of a service’s activity level and allow for comparison with the performance of similar services across the state.

Services also monitor their performance for other reporting requirements. Clinicians are required to keep certain statistics to help the service meet its obligations. A system-wide database for collecting patient information, known as RAPID (Re-development of Acute and Psychiatric Information Directions), operates across Victoria’s mental health service system.

Every person who becomes a registered consumer of a public mental health service is given a unique state-wide identifier. Strict levels of confidentiality and privacy apply to the use of this system, and
clinicians need to be thoroughly familiar with, and abide by, these. Quarterly validation reports are run by the Department of Human Services on the contact data.

**Outcome measurement**

Outcome measurement is another mechanism for improving service quality for individual consumers and the service as a whole. Outcome measures are questionnaires used with consumers to assess their mental health and well-being at different points of time during contact with mental health services. They are commonly used at the beginning and end of an episode of treatment, and at each review of an individual service plan. Nationally-agreed suites of measures apply to each services age group. Outcome measures help clinicians identify what has improved for a consumer and areas that require further treatment and support. Clinicians complete most of the measures, but there is a consumer self-rating measure in the suite for each age group. These measures can help highlight changes in an individual consumer over time, and they can also be used at a broader level to reflect on the effectiveness of clinical practice. More information on this can be found at www.health.vic.gov.au/mentalhealth/outcomes/index.

**Clinical accountability**

A clinical director is responsible overall for the clinical leadership of an area mental health service. The authorised psychiatrist has specific powers, duties and functions under the Mental Health Act 1986 and is able to delegate all of these functions (with the exception of the power of delegation and duties in relation to the Forensic Leave Panel) to any other psychiatrist employed by the mental health service. Delegated functions include responsibility for assessment and treatment, and other decisions regarding the type and level of service provided to consumers and their carers. Delegates then act with all the powers of the authorised psychiatrist.

Individual clinicians are expected to uphold high levels of clinical accountability. All professionals involved in treatment are responsible for their actions and decisions in dealing with consumers and their carers. Supervisors are legally accountable for ensuring proper supervision. Clinical staff are accountable to discipline seniors to ensure work completed is at the relevant level. Staff are also accountable to team leaders for work within the team and for meeting agreed expectations. Most importantly, staff are accountable to the consumers and carers with whom they work, to provide them with the best possible service.

**Mental health service standards and guidelines**

As a condition of funding, organisations are required to adhere to the service standards and guidelines applicable to the funded activity, including program management circulars and the Chief Psychiatrist Clinical Practice Guidelines that have been issued by the division. Program management circulars and the Chief Psychiatrist Clinical Practice Guidelines inform mental health practitioners and services about the operation and clinical issues in relation to the Mental Health Act.

Program management circulars articulate or clarify departmental policy on key aspects of service provision. These are posted on the website at www.health.vic.gov.au/mentalhealth/pmc/index.htm
The Chief Psychiatrist Clinical Practice Guidelines provide specialist advice on various aspects of clinical service. The current guidelines are also posted on the website at www.health.vic.gov.au/mentalhealth/cpg/index.htm

**Mental Health National Minimum Datasets**

Under the National Health Information Agreement, Victoria is obliged to supply three national minimum datasets to the Commonwealth by 31 December each year. These are: community mental health care national minimum dataset, residential mental health care national minimum dataset, and mental health establishment’s national minimum dataset. These datasets were developed under the auspices of the Australian Health Ministers' Advisory Council National Mental Health Working Group Information Strategy Committee, and are provided each year to the Australian Institute of Health and Welfare. The Institute uses these datasets, in collaboration with states and territories and the Department of Health and Ageing, to produce an annual report *Mental Health Services in Australia.*

The community mental health care national minimum dataset includes unit-level data on mental health service contacts in community settings. Service contacts can be with a patient/client, with a carer or family member, or with other professionals including other services providers.

The national minimum dataset for residential mental health care provides data on episodes of residential care for residents in all government-funded mental health services.

The mental health establishment’s national minimum dataset, which commenced in 2006-07, combines the former National Survey of Mental Health Services and the community mental health establishment’s national minimum dataset. It collects a range of service, expenditure and other data elements from all state-funded specialised mental health services. Data is reported at a number of different levels of aggregation.

Further information, including formal scope statements and data definitions, is available from: http://www.aihw.gov.au/mentalhealth/index.cfm.
7. Hospitals’ capacity to meet demand

Traditionally, hospitals have treated patients in an acute inpatient setting, such as a hospital ward. The ability to move patients into and out of an acute inpatient setting without undue delay, while maintaining appropriate standards of care, is a key aim of the public hospital system.

Demand for acute care has increased steadily over the past decade. Victoria has the second highest public hospital admission rate in Australia. The ability of hospitals to manage this demand relies on there being sufficient capacity across the health system. Traditionally, hospital capacity has been measured by the number of available beds. However, this is no longer a particularly useful measure of capacity in light of new models of care such as day surgery and bed substitutes such as Hospital in the Home, which reduce the need for acute patients to stay overnight or longer.

The changing models of care and a shift to same-day services have resulted in shorter hospital stays and reduced the need for more beds across the hospital system. How a hospital applies the models of care and manages the flow of patients through the hospital from admission to discharge, has a greater bearing on its capacity to treat acute patients than the number of available beds.

Planning and managing patient demand

Victoria compares favourably with other Australian jurisdictions in its use of acute inpatient beds, having both the highest level of bed utilisation and the shortest average length-of-stay in Australia (Victorian Auditor General’s Office, 2008). This indicates that the Victorian public hospital system is comparatively efficient compared with other Australian jurisdictions. Nevertheless, delays in access to emergency departments and elective surgery indicate there is room for improvement in the way that Victorian public hospitals manage patient flow.

The ability of patients to ‘flow’ smoothly through the system is subject to capacity and resource limitations within hospitals and queuing and bottlenecks for services will occur. Good patient flow has patients moving through a hospital without delay, eliminating waits and delays and saving time, effort and costs. Realistically, perfect patient flow through a hospital is not achievable, however, the extent to which hospitals manage the identifiable bottlenecks that interrupt flow and slow a patient’s journey has a direct influence on patient flow. Managing fluctuating demand for hospital services remains a key challenge for improving patient flow, to ensure that bed access and staffing levels are able to adequately respond to changes in health care needs of patients in hospitals at any one time.

Bottlenecks arise when there is a delay in discharging or transferring patients into more appropriate types of care settings within the hospital, and can occur at various points in the continuum of hospital service provision.

A significant cause of bottlenecks and delays in hospitals is ‘variation’, with different patients taking different journeys through the health system, depending on their health care needs. Managing variation in patient flow is a part of every health and hospital system and requires differences in patient illness and injury, demand through emergency departments and patient demographics to be addressed. Variation
can lead to significant differences in the average length-of-stay for similar patients across different hospitals.

The recent Victorian Auditor-General Report (2008) that examined whether patient flow and bed management in Victoria’s public hospitals was effective and efficient found that:

- both the Department of Human Services and Victorian hospitals are adequately planning for inpatient services to provide sufficient capacity to meet demand
- current patient flow processes have allowed Victoria to achieve amongst the best time-to-treatment and bed efficiency performance levels in Australia. However, more could be done to further improve the efficiency and effectiveness of these processes.

The audit report’s recommendations and identified areas for improvement are consistent with the range of work being undertaken by the Victorian Government to improve patient flow across Victoria’s public hospitals.

Managing patient flow

When a patient requires surgery or further treatment following a stay in an emergency department to cure or reduce the severity of their condition, the hospital will admit them to hospital as an inpatient. Admission is the process where the hospital assumes responsibility for a patient’s care and treatment, and accommodates them on either a same-day or overnight basis. Hospitals face a daily challenge of managing inpatient admissions, with increasing demand for acute inpatient care placing growing pressure on hospital resources. Managing this demand, while balancing the competing demands for elective surgery and emergency admissions, adds to the challenge.

Effective management of inpatient admissions is vital if hospitals are to achieve good patient flow. Admitting patients only when appropriate and necessary reduces the demand for beds and makes them available for patients who do need them. For example, hospitals can choose to admit patients on the same day of surgery rather than the night before. Similarly, by considering patterns in admissions from the emergency department, hospitals can improve scheduling for their admissions for elective surgery. From a patient and hospital perspective, effective management of admissions not only prevents long waits in the emergency department and consequent congestion, but also prevents hospital-initiated postponements of elective surgery. Consequently, the opportunity for elective surgery patients to receive care within clinically appropriate timeframes is maximised.

Effectively managing the current and forecast demand for acute admissions is central to patients being able to access acute care in a timely manner, with less pressure on hospital resources. Managing this demand requires strategies to divert patients from hospital, such as patients with avoidable admissions, and substitutes to acute inpatient care. Demand management strategies can free up acute beds for those who need them most, and improve patient flow.

The Victorian Government funds a range of strategies focused on reducing demand for acute inpatient services, including those that substitute inpatient care and divert patients from needing inpatient care. Current patient flow processes have allowed Victoria to achieve amongst the best time-to-treatment and bed efficiency performance levels in Australia (Department of Health and Ageing, 2008).
Not all patients who require acute care need to receive this care as an inpatient. Changes to models of care and substitution strategies mean that many admitted acute patients can receive alternative care, reducing the utilisation of acute inpatient beds. Substitution strategies provide patients with the same clinical outcomes and quality of care they would receive as admitted patients. The use of chairs for chemotherapy and renal dialysis patients is an example of substitution.

To varying degrees, Victorian hospitals have implemented a range of substitution strategies that aim to reduce the use of inpatient beds for many patients, making them available to those who need them most. Key substitution strategies include: short-stay units, medihotels, Hospital in the Home and day surgery/23-hour procedure units.

While substitution helps to provide an alternate care setting for those patients who require acute inpatient care, there are also patients whose admission may be avoidable. Hospitals have implemented strategies to prevent avoidable admissions, diverting patients from entering the acute care setting. Key strategies include the Hospital Admission Risk Program and Residential In-Reach.

The Victorian Government has also implemented a number of other initiatives which aim to enable effective inpatient demand management. Initiatives include:

- The Winter Demand Strategy: in 2008, $6 million was provided to assist health services to meet the surge in emergency demand during the winter period. Key elements of the strategy include funding an additional 100 beds for 100 days, piloting models of care to reduce unnecessary presentations of residents from residential care facilities to emergency departments, and the expansion of intensive care unit liaison nurse programs.
- A $321.5 million new beds package commencing in 2008-09 represents new investment in 100 acute, 170 sub-acute and six critical care beds that will improve bed access and patient flows in Victorian hospitals (Box 4).
- Bed access managers: to co-ordinate admissions and prioritise the allocation of inpatient beds.
- Electronic bed management system: to provide hospitals with the capability for ‘real time’ organisation-wide monitoring and management of bed capacity. The system is currently being piloted in selected hospitals, with plans to extend the system to other health services in the future.
- Re-designing hospital care programs: to build health service capability to create and spread sustainable improvements in the delivery of patient care by applying process re-design methodologies.

Effective management of hospital patient discharge is a critical hospital process. Hospitals need to ensure that they discharge patients in a timely manner to ensure sufficient beds are available for admission. If managed well, effective patient discharges can significantly improve patient access and flow. The Victorian Government has introduced the following initiatives to improve patient discharge:

- Emergency department care co-ordination to support discharge from emergency departments and early discharge planning for inpatients admitted from the emergency department.
- Primary Care Partnerships service co-ordination and e-referral strategies to streamline referral processes to community providers.
- A State-wide Health Service Directory that provides an electronic database of community services.
- Introduction of a single point of access for Health Independence Programs to facilitate patient flow from hospital by co-ordinating discharge planning referrals.
Box 4: Beds package

In December 2008, the Victorian Government announced the $321.5 million bed package to treat up to 63,000 extra patients in Victoria's public hospitals. The package provides:

- $34 million per year for 100 acute beds
- $10 million per year for four intensive care unit beds and two neonatal intensive care unit beds
- $31 million per year for 170 sub acute beds
- $10 million per year for diversion programs for emergency department and short stay capacity, community based rehabilitation and additional emergency department diversion under the Hospital Admission Risk Program.

The funding comes on top of the $1.81 billion budget increase to health in May 2008.

The bed package aims to increase the capacity of hospitals as a whole. The additional acute, intensive care and short stay beds will improve the transfer of patients out of emergency departments. It makes a significant investment in sub-acute beds, which promotes patient flow by allowing hospitals to transfer long-stay patients into more appropriate sub-acute care setting, freeing up beds in acute wards.
8. Standards of quality in Victorian hospitals

Providing good quality safe care is the priority of all clinical staff and the teams in which they work.

Victorian hospitals continue to provide safe, high-quality health care. For example, over the last six years, cardiac surgery survival in all public hospitals remains consistent and is as safe as that of hospitals overseas (Australasian Society for Cardiac and Thoracic Surgeons, 2007), whilst adult intensive care patients have a higher than expected survival rate using an internationally-validated risk adjustment tool (Victorian Intensive Care Data Review Committee, 2006).

The Department of Human Services has promoted accreditation of acute hospitals as a significant component of its quality policy since 1993. Victoria is the only jurisdiction in Australia to have all its hospitals accredited by a recognised accreditation body. Accreditation provides assurance to consumers that services are safe and of a high-quality and drives systematic improvement within the hospital system, providing better service standards and streamlining hospital policies.

At times hospital care may sometimes lead to clinical incidents. These incidents need to be considered in the context of the complexity of hospital care and the often poor state of health of the patient receiving care. Most of these clinical incidents are of a minor nature. A "clinical incident" describes a range of incidents in a health care setting that resulted - or could have resulted - in unexpected harm to the patient. These incidents include medication errors, patient falls, health care-associated infections, pressure ulcers, equipment failures and errors in diagnosis. They are generally considered within one of three categories:

- sentinel events: events in which death or serious harm to a patient has occurred
- adverse events: incidents in which harm resulted to a person receiving health care
- near misses: incidents that did not cause harm.

Quality and safety initiatives undertaken by the Department of Human Services have clearly demonstrated actual improvements to quality and safety, including:

- a 33 per cent reduction in the prevalence of pressure ulcers over three years as a result of surveillance, education and a mattress replacement program
- a surveillance program to reduce hospital-acquired infections has demonstrated a statistically significant reduction in the number of patients with methicillin-resistant staphylococcus aureus bacteremia
- the in-hospital death rate of major trauma patients has fallen from 15 per cent in 2001-2002 to 12 per cent in 2005-2006.

In 2008, the Auditor-General undertook a review into Patient Safety in Public Hospitals. There were four recommendations arising from the report which are all currently being addressed by the Department of Human Services (Victorian Auditor-General’s Office, 2008).

There are four fundamental domains of quality and safety: consumer participation, clinical effectiveness, effective workforce and risk management.
Consumer participation

Consumer participation is critical to improving the quality of care as it ensures the delivery of health services are targeted to consumer and community needs by incorporating their decision-making into planning, development and evaluation.

In February 2006, the Department of Human Services launched the community participation policy: *Doing It With Us Not For Us*. This policy has been very successful in focusing participation across the health services at an individual care level, and in planning and development. It has also been beneficial in encouraging the Department of Human Services to consult and form partnerships with individuals and communities, with the policy now being adopted by several other jurisdictions across Australia.

One example of the policy’s success has been an overwhelming increase in the use of the Consumer Nominee Program run by the Health Issues Centre to recruit consumers, carers and community members to form partnerships with the Department of Human Services and health services.

Other initiatives include: the Evaluating Effectiveness of Participation projects, development of a comprehensive suite of participation performance indicators and the evaluation of the legislated community advisory committees. Results are located at www.health.vic.gov.au/consumer.

**Quality of care reports**

The Quality of care reporting awards, now in their eighth year, distinguish the ability of health services and their community partners to report in an open and informative way to the public on the quality and safety of patient care. Reporting to the public is a key strategy in facilitating the continuous improvement of health care.

**Public hospital patient charter**

The public hospital patient charter brochure provides information on patients’ rights and responsibilities and is translated into 17 languages and can be accessed at www.health.vic.gov.au/patsat.

**Cultural diversity initiatives**

A number of initiatives that aim to meet the needs of Victoria’s culturally diverse community are in operation and can be accessed at www.health.vic.gov.au/cald.

**Clinical effectiveness**

The Victorian Quality Council describe the application of ‘effectiveness of health care’ as: *Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.*
The Victorian Government has developed a number of initiatives to address clinical effectiveness, including:

**Consultative Councils**

Consultative Councils are specialist advisory committees created for the purpose of advising on highly specialised areas within health care with the purpose of reducing mortality and morbidity rates, either through education or systemic reform.

There are currently three Consultative Councils in Victoria:
- Consultative Council on Obstetric and Paediatric Mortality and Morbidity: conducts research and analysis into incidents and causes of maternal deaths, stillbirths and the death of children under 18 years of age.
- Victorian Surgical Consultative Council: studies cases of avoidable mortality and morbidity, and provides feedback and information to the surgical community to improve surgical practice.
- Victorian Consultative Council on Anaesthetic Mortality and Morbidity: aims to identify and advise upon issues impacting the safety and quality of anaesthesia practice.

**Clinical registries for quality improvement**

A number of clinical registries are supported by the Department of Human Services. These are predominantly in areas of high-risk or high-cost care such as cardiac surgery, trauma, vascular surgery and intensive care. Clinical registries identify and investigate variation in clinical outcomes. The variations can then be investigated further, often with targeted studies, with the ultimate aim of improving patient care.

**Clinicians Health Channel**

The Clinicians Health Channel is an extensive, internet-based clinical library that provides important clinical knowledge resources to assist public health care sector clinicians in clinical decision-making, research and education.

**Effective workforce**

Delivery of high-quality health care depends heavily on the commitment and skills of the health workforce. The efficiency and effectiveness of Victoria’s health workforce is critical in achieving health outcomes.

For safety and quality reasons, health workforce services are closely regulated, and often involve specific requirements around education and training, accreditation, registration, credentialling and delegation processes.

Credentialling is the formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence and suitability to provide safe, high-quality health care services. Credentials, in effect, belong to the clinician.

Risk management

Risk management is an approach to improving the quality and safe delivery of health care by identifying circumstances that put patients at risk of harm, and taking action to prevent or control those risks. The Victorian Government has introduced a range of clinical risk management procedures in order to mitigate risks to patients receiving care in hospitals.

Sentinel event program

The Victorian sentinel event program endeavours to create a learning environment within Victoria’s health care system and, through this awareness, improve the safety of patient care.

Victoria was the first state to publicly report this data and has recently published its sixth public report. Other states have consequently produced similar reports. Based on this publically available data, trends around sentinel event issues seem to be consistent at a national level.

The sentinel event program shares the lessons learnt with the wider health care community through the Risk Watch newsletter, which provides information on:

- alerts for significant events
- sentinel event annual report
- recommendations to individual health services and the sector.

Victorian Health Incident Management System

The Victorian Health Incident Management System project was initiated in May 2006 in response to recommendations made by the Victorian Auditor General regarding the need for state-wide standardisation in incident reporting in health services. Its goal is to implement a systematic approach for reporting clinical incidents, consumer feedback and occupational health and safety data that will enable state-wide data analysis to support quality improvement initiatives.

Patient safety monitoring

Understanding how well the patient safety system is performing, at both state and health service level, is essential. Key patient safety monitoring mechanisms in Victoria include the following:

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2 Incident is defined as ‘an event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage’ (ACSQHC 2006). Incidents comprise ‘adverse events’ and ‘near misses’ directly relating to patients, staff and others, as well as various other non-individual incident types such as incidents involving infrastructure, facilities, security and so on.
Patient safety indicators/variable life adjusted display

The ability to track improvement and monitor patient safety event rates at a hospital level is provided by routinely collecting administrative data in conjunction with a set of well-developed indicators.

By way of addressing the need to monitor and improve the safety and performance of Victoria’s hospitals, the Department of Human Services has undertaken some innovative and complex work, resulting in the Australian Patient Safety Indicators. This involves a set of patient-safety indicators that provide information on potential in-hospital complications and adverse events following surgery, procedures and childbirth. They highlight potential areas of concern or exceptional practice to prompt and guide further investigation.

The patient safety indicator set includes:

- death in low mortality diagnostic groups
- complications of anaesthesia
- in-hospital fracture
- post-operative haemorrhage or haematoma
- post-operative deep vein thrombosis/pulmonary embolus
- obstetric trauma – vaginal or caesarean delivery
- stroke in-hospital mortality
- heart failure in-hospital mortality
- acute myocardial infarction (heart attack) in-hospital mortality
- pneumonia in-hospital mortality
- Hip fracture in-hospital mortality.

Eleven indicators, in areas of known concern, in sufficient numbers and that are amenable to change, are being piloted at a selected group of health services. Health services are receiving reports to support testing on the usability and relevance of the indicators and the reports, to assist in the improvement of patient safety.

Blood Matters: Better, Safer Transfusion program

The Blood Matters: Better, Safer Transfusion program commenced in 2004 as a joint initiative of the Department of Human Services and the Australian Red Cross Blood Service. The program aims to improve outcomes in patients requiring blood and blood product transfusion in hospitals by enhancing the safety and appropriateness of blood and blood product use. The framework for the program is the implementation of best practice guidelines.

Pressure ulcers

Pressure ulcers are a largely preventable patient safety problem and are increasingly described as an indicator of the quality of care provided by health care organisations. Pressure ulcers are caused by unrelieved pressure (shear forces and friction) that result in damage to the skin and underlying tissue. They are recognised world-wide as one of the five most common causes of harm to patients.

The Victorian Pressure Ulcer Initiative demonstrates that investment in quality of care has the potential to increase the efficiency and productivity of health care in a sustainable way.
Clinical networks

Networking helps co-ordinate health care across the continuum from community to acute, with benefits in improved quality and safety of care for patients. Networks can lead to the systematisation of clinical support between local and central services, identifying what each can do to support the other so that care can be provided safely at different sites. The use of shared protocols for clinical management is considered to reduce inefficiencies and duplicated effort within the current system.

Five state-wide clinical networks have been established:
- maternity and neonatal clinical network
- emergency care improvement and innovation clinical network
- stroke clinical network
- renal health network
- integrated cancer services.

Clinical networks have a key role in both providing sound clinical information to the Department of Human Services, as well as providing information to clinicians in regard to clinical practice issues.

Preventing hospital-acquired infections

All hospitals have infection control procedures and policies and staff take every precaution to avoid infections. However, the risk of infection can never be completely eliminated as some patients have a higher risk of acquiring an infection than others. Strategies to prevent hospital-acquired infections have been developed around infection control activity and cleaning standards.

Start clean – Victorian infection control strategy

The Victorian infection control strategy, Start Clean 2007–2011, was launched in October 2007 by the Minister for Health. The strategy is supported by $10 million of funding to facilitate the three key components: prevention; consumer information and participation; and detection and management.

Key initiatives include:

Hand hygiene

The state-wide hand hygiene program has been implemented in all public hospitals. Funding has been provided to ensure that data on hand hygiene compliance, is collected and collated by the hand hygiene co-ordinating centre based at Austin Health, and provided to the Department of Human Services.

In addition, hand rub is required to be made available in all wards attached to (or near) each patient bed and at the entrance to wards, lifts and at hospital entrances.

A target of an overall mean hand hygiene compliance of 55 per cent in all audited areas by June 2008 has been set. Hospital hand hygiene compliance rates are to be reported in the Annual Quality of Care reports. The state-wide hand hygiene compliance target is now at 60 per cent based on the second quarter of 2007-08 reporting cycle.
The Victorian state-wide program has now been developed into a National Hand Hygiene Program through the Australian Commission on Quality and Safety in Healthcare.

**Hospital cleaning**

In 2008, an expert committee was commissioned to review and update the *Victorian cleaning standards*. The review included comparing these standards with international practices.

**Rapid testing**

One of the key strategies in *Start Clean* was to purchase and implement technology that will reduce the time of a methicillin-resistant staphylococcus aureus test from days to hours. This technology would assist with more appropriate treatment and care of patients with methicillin-resistant staphylococcus aureus or those who had come into contact with another patient (outbreak situation).

Screening programs for patients in high-risk areas/wards (intensive care units, renal, haematology and oncology) for methicillin-resistant staphylococcus aureus will be launched in 2009. This program has been timed to coincide with the implementation of the rapid testing machines.

**Antibiotic approval and restriction systems**

As part of the *Start Clean* strategy, the Department of Human Services has provided funding for the implementation of the antibiotic approval systems, Guidance DS and infectious diseases electronic antibiotic advice, into 15 hospitals. There are five hospitals that already have an antibiotic approval/restriction system in place – taking the total to 20 Victorian hospitals.

**Victorian Hospital-Acquired Infection Surveillance System**

Victorian Hospital-Acquired Infection Surveillance System has been progressively developed since 2002. The primary aim of the system is to lower the number of infections acquired in Victorian public hospitals through the collection and analysis of data on hospital-acquired (nosocomial) infections in acute care. Surveillance activities are targeted at those patients at highest risk of hospital-acquired infections.

The trends presented in the Victorian Hospital-Acquired Infection Surveillance System report are positive, with a reduction in surgical site infection rates for coronary bypass graft surgery, knee arthroplasty, colon surgery and caesarean sections.
9. Performance reporting and data

Performance reporting is used to provide a basis for assessment of the performance of public health services, including their service delivery and finance performance. It is a critical component of governance controls, ensuring organisations remain accountable to their principal stakeholders and that they perform efficiently and effectively.

Within the health context, performance reporting and data collection is used as a mechanism to ensure transparency and accountability for the funding public hospitals receive, and the delivery of health outcomes for the Victorian community. Through their reporting obligations, hospitals provide performance information to the Victorian Government, the Commonwealth Government and the Victorian community.

A range of Key Performance Indicators are used to assess the performance of health services. Each stakeholder has differing requirements, depending on their specific perspective. In general, public hospitals are required to report on three broad measures:

- **Access**: to ensure that patients have timely access to hospital care.
- **Quality**: to ensure that hospitals provide patient services in accordance with agreed standards of treatment and care.
- **Financial**: to provide an overview of financial activities, including evidence of financial position, in the short and long-term.

**Commonwealth hospital performance reporting**

Major performance reporting requirements at the Commonwealth level are outlined in the National Health Care Agreements, bilateral agreements between the Commonwealth Government and each state or territory which govern the provision of funding from the Commonwealth to the states and territories to provide free public hospital services to the Australian community.

The National Health Care Agreements require the states and territories to provide, and allow for, the publication of performance information against an agreed set of performance indicators.

The Commonwealth publishes the data it collects annually by 30 June in the subsequent year of the data’s collection. It does so through a variety of publications, including *The State of Our Public Hospitals*, an annual report which assesses the performance of public hospitals in each state and territory.

The National Health Care Agreements also provide for ongoing co-operation between the Commonwealth and the states and territories in developing the national minimum data sets and comparable performance indicators. The National Health Information Agreement provides the platform for co-ordination of the development, collection and dissemination of health information in Australia, including the development, endorsement and maintenance of national data standards.

Work undertaken as part of the National Health Information Agreement has resulted in a number of agreed national definitions for elements of the hospital system. These are outlined in the National Health Data Dictionary, which contains standard data definitions and data elements for use in data collection conducted by any Australian health or community services agency.
Victorian hospital performance reporting

Victoria has developed a system of hospital governance which provides health services and hospitals with a high degree of independence in the everyday administration and functioning of the hospital, while the Victorian Government sets the broad policy guidelines and strategic directions for the health and hospital system as a whole. Providing devolved responsibility to health services’ boards aims to ensure that decisions taken by boards are both relevant to the local circumstances of the hospital, and are able to be effectively and efficiently implemented.

The Health Services Act 1988 formally defines public health services and their roles. To ensure an appropriate level of accountability for these public health services, business rules for a monitoring structure have been implemented which include:

- Statement of Priorities
- Performance Monitoring Framework
- Bonus Funding Framework.


Emergency performance targets

The government has set the following time-based emergency targets for treating patients to drive performance and improve achievement targets (Box 5):

- Triage Category one - 100 per cent seen within desirable time
- Triage Category two - 80 per cent seen within desirable time
- Triage Category three - 75 per cent seen within desirable time

The Victorian Government has also set the following admission-based targets to drive performance and improve achievement targets (Box 6):

- Emergency department patients transferred to a hospital bed within eight hours
- Non-admitted emergency patients length of stay is less than four hours.

While the hospital system is treating record numbers of patients, the Victorian Government is committed to maintaining high performance targets.

Hospitals are continuing to treat all resuscitation patients (triage category one) in timely way. While more category two and three emergency patients are treated within clinical times.

Victoria has consistently performed better than the national average in promptly treating patients in emergency departments. The median time to treatment for emergency departments in Victoria is 22 minutes - two minutes faster than the national average. In addition, 74 per cent of patients were seen within the recommended time compared with 70 per cent nationally.
Elective performance targets

The Victorian Government has set the following time-based elective targets for treating patients to drive performance and improve achievement targets (Box 7):

- Category one - 100 per cent of patients treated within 30 days
- Category two - 80 per cent of patients treated within 90 days
- Category three - 90 per cent of patients treated within 365 days

In Victoria, all urgent patients receive their surgery within the 30-day clinically desirable treatment time. The continuing improvement in waiting times for elective surgery patients and the reduction in the number of patients waiting for surgery has also been a key priority for the government.

Long-waiting elective surgery patients are benefiting from faster access to treatment as a result of an additional $60 million for elective surgery provided by the Commonwealth and Victorian governments. This has led to over 13,000 more patients being treated in 2008 than in 2007.

Commonwealth figures also show that Victoria performed well in elective surgery, maintaining one of the highest proportions of elective surgery admission seen within desirable treatment times in Australia.
Box 5: Emergency department patient care service standards and targets for 2007-08

Medical experts set standards for treating people within a reasonable time. These treatment standards are based on best practice principles and the latest scientific and medical evidence. For individual patients, the time they wait will vary according to their relative clinical need as judged by their treating clinicians.

The Government sets targets for the timely treatment of patients in consultation with hospital staff and clinical groups. The purpose of these targets is to drive performance and improve achievement of these standards.

- **Hospital bypass** - All emergency departments can experience periods of high demand. During these periods, metropolitan hospitals may ask the ambulance service to take non-urgent patients to another hospital emergency department. The Government has set a target for the thirteen major metropolitan hospitals which requires them to spend no more than three per cent of time on bypass.

- **Emergency department** - All patients attending emergency departments are ‘triaged’ or assessed for urgency. The first priority is to treat the most urgent patients.

There are five triage categories which have been established by the Australasian College of Emergency Medicine. These categories indicate the desirable time within which patients should be treated. The Victorian Government sets targets for hospitals for the three most urgent categories. The performance of the 16 major metropolitan hospitals and five major rural hospitals is measured against these targets.

<table>
<thead>
<tr>
<th>Emergency department triage categories</th>
<th>National standards-desirable treatment times</th>
<th>Targets</th>
<th>Possible characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resuscitation (patient unconscious)</td>
<td>Seen immediately</td>
<td>100 per cent seen within desirable time</td>
<td>Heart not beating; barely breathing; life-threatening injuries; drug overdoses</td>
</tr>
<tr>
<td>2. Emergency</td>
<td>Seen within 10 minutes</td>
<td>80 per cent seen within desirable time</td>
<td>Very severe pain; severe breathing difficulties; major fractures</td>
</tr>
<tr>
<td>3. Urgent</td>
<td>Seen within 30 minutes</td>
<td>75 per cent seen within desirable time</td>
<td>Moderately severe blood loss; persistent vomiting; dehydration</td>
</tr>
<tr>
<td>4. Semi-urgent</td>
<td>Seen within one hour</td>
<td>No target set</td>
<td>Less severe symptoms or injuries; mild bleeding; foreign body in eye; sprained ankles; possible fractures; abdominal pain</td>
</tr>
<tr>
<td>5. Non-urgent</td>
<td>Seen within two hours</td>
<td>No target set</td>
<td>Minor illnesses or symptoms; rashes; minor aches and pains</td>
</tr>
</tbody>
</table>
Box 6: Transfers from the emergency department

The Victorian Government has set a standard for transfer from the emergency department to a hospital bed for clinically-necessary admissions. Hospitals are then expected to work towards that standard, improving performance through expanded capacity, implementation of new models of care and efficient use of resources.

Emergency department patients transferred to a hospital bed:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department patients transferred to a hospital bed within eight hours</td>
<td>80 per cent of patients are transferred within eight hours</td>
</tr>
</tbody>
</table>

The Victorian Government introduced the current standard in 2005-06 to encourage more timely transfer of emergency department patients to a hospital bed. This encourages hospitals to transfer these patients to a hospital bed within eight hours of arrival, with a target of 80 per cent.

Non-admitted patients’ length of stay in the emergency department:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-admitted emergency department patients’ stay is less than four hours</td>
<td>80 per cent of non-admitted patients stay less than four hours</td>
</tr>
</tbody>
</table>

The Victorian Government introduced this standard in 2005-06 to encourage more timely treatment of patients who do not require admission to a bed. The standard requires that at least 80 per cent of non-admitted emergency department patients are seen within four hours.
Elective surgery is any form of surgery that, in the opinion of the treating health professional, can be delayed for at least 24 hours.

In Victoria, all urgent patients receive their surgery within the 30-day clinically desirable treatment time. The continuing improvement in waiting times for elective surgery patients and the reduction in the number of patients waiting for surgery has also been a key priority for the Government. Victorian hospitals have been faced with significant emergency demand pressures which has resulted in reduced elective surgery activity and impacted on performance.

**National standards for elective surgery**

Clinicians assess individuals requiring elective surgery and assign them to an elective surgery urgency category. The urgency categories are:

<table>
<thead>
<tr>
<th>Category</th>
<th>National standards-desirable time to treatment</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point it might become an emergency, such as cancer requiring urgent surgery.</td>
<td>100 per cent of patients treated within 30 days</td>
</tr>
<tr>
<td>Category 2</td>
<td>Admission within 90 days desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency, such as hip and knee joints requiring replacement.</td>
<td>80 per cent of patients treated within 90 days</td>
</tr>
<tr>
<td>Category 3</td>
<td>Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency, such as cataracts, varicose veins or infected tonsils.</td>
<td>90 per cent of patients treated within 365 days</td>
</tr>
</tbody>
</table>
Types of reporting required by current systems

**Governance reporting requirements**

General governance reporting requirements exist for health services. They include both annual reports and the Statements of Priorities process.

The Minister for Health agrees on a Statement of Priorities each year with the board chair of the 18 major public health services established under the *Health Services Act 1988*, and also periodically approves the strategic plans of health services. All other public hospitals have Health Service Agreements rather than Statement of Priorities, which are also agreed between the service and the Minister, through the Department of Human Services. Multi-purpose services have tripartite agreements, which are signed by the Commonwealth, the state, and the agency.

The key accountability requirements for health services are outlined in the annual Statement of Priorities or Health Service Agreements, which sets out key government policy and directions, the strategic goals of the health service, priority government targets and the health service’s funding. In addition, key policy and program priorities are set out each year in the public hospitals and mental health services’ policy and funding guidelines. The 2008-09 Statement of Priorities are available at [http://www.health.vic.gov.au/yourhospitals/sops.htm](http://www.health.vic.gov.au/yourhospitals/sops.htm).

**Access reporting requirements**

Hospitals provide regular data reports to the Department of Human Services on various aspects of access. A number of Key Performance Indicators directly relate to these datasets and are made available to various stakeholders in a variety of ways:

- A variety of data is available on the websites of the Department of Human Services, the Department of Health and Ageing and the Australian Institute of Health and Welfare.

**Financial reporting requirements**

Health Services must be managed in accordance with legislated, standard business practices. Stakeholders have an interest in ensuring that they operate in a financially sustainable manner.

The Department of Human Services produces comprehensive guidelines on the nature and structure of the financial reports to be provided by health services as a part of their obligation to provide annual reports to Parliament. All annual reports are lodged with Parliament and are available on hospitals’ websites.

**Quality reporting requirements**

In addition to monitoring performance of access there is also monitoring of quality performance. Two levels of performance monitoring occur. Firstly, a screening process looking for "flags" that indicate that
results are outside agreed tolerances. This prompts a second and more targeted investigation that may occur at a health service or as collaborative process between the Department of Human Services and health services.

An example of an incident data collection includes:

- the Victorian hospital-acquired infection surveillance system
- blood matters (better safer transfusions program)
- sentinel event program
- quality use of medicines program

Reporting of this data has a safety focus, identifying areas of potential concern at a systems level, for example, outliers in terms of rates of infection or trends in types of incidents.

The Surgical Outcomes Information Initiative of the Victorian Surgical Consultative Council looks at surgical procedure outcome data from the Victorian Admitted Episodes Dataset to inform quality improvement.

Hospital data collections

While the Department of Human Services may, at times, require data to be provided about specific matters, the major data collections conducted are:

- Victorian Admitted Episodes Dataset
- Victorian Emergency Minimum Dataset
- Elective Surgery Information System
- Victorian Integrated Non Admitted Health Minimum Dataset
- Agency Information Management System based data collections.


Validating the quality of hospital data

The Victorian Government is committed to improving the accuracy and reliability of all hospital data for reporting, funding and planning. The Department of Human Services has developed a comprehensive set of rules around how data is collected and reported and hospitals have a clear responsibility to submit data that is accurate and complete.

Data reported to the Department of Human Services by health services is subject to rigorous input edit processes, requiring adherence to strict editing tolerances, correction and re-submission. Edit tolerances are periodically reviewed and edits themselves reviewed so that their application adds value to the data.

Health services submit a range of datasets with patient level information to the Department of Human Services for funding and accountability purposes. Key activity and financial information, such as Weighted
Inlier Equivalent Separation\(^3\) activity, expenditure on salaries and wages and other items, is also routinely submitted by health services for monitoring purposes.

The quality of data supplied by hospitals and health services to the Department of Human Services is governed by processes and practices which may be grouped into seven areas: 1) Development and review; 2) Input editing; 3) Output editing; 4) Compliance monitoring and enforcement; 5) Investigation; 6) Audit; and 7) Education.

Health service data submission and coding processes are also subject to independent audit which provides periodic validation of data submission practices. Audit results inform health service practice changes and validate data used in health service funding.

The Victorian Admitted Episodes Dataset audit has well-established data audit processes and is used to verify the admitted patient case mix funding process.

A pilot Victorian Emergency Minimum Dataset audit was conducted in 2006-07 and a more extensive audit of Victorian Emergency Minimum Dataset data is set to occur in 2009. The Department of Human Services also undertakes audits of Victorian Ambulatory Classification System (outpatient) data.

Monitoring to ensure the entirety of data is also undertaken and penalties apply for non-compliance with published reporting requirements.

Comprehensive documentation is provided on the web at www.health.vic.gov.au/hdss describing the data elements of each data collection, the edits applied to the data and reporting timelines which apply. The content of the data sets are annually reviewed to validate that they satisfy reporting obligations and determine if the reporting burden on health services is justified.

\(^3\) The unit of payment used in the Casemix system.
References:


Boston Consulting Group (2006), Improving Mental Health outcomes in Victoria: the next wave of reform, Department of the Premier and Cabinet, Melbourne


Department of the Premier and Cabinet (2001), Growing Victoria Together, Victorian Government, Melbourne

Department of the Premier and Cabinet (2005), A Fairer Victoria, Victorian Government, Melbourne

References are provided for external sources of data and information only.
Department of the Premier and Cabinet (2008), *Next Steps in Australian Health Reform, the proposals of the Victorian Premier*, Victorian Government, Melbourne


http://www.oecd.org/home/0,2987,en_2649_201185_1_1_1_1_1,00.html


Appendix A – Key policy documents

Below is a list of key health documents produce by the Victorian Government. It includes documents used in the production of this submission.

Annual Report 2007-08 Department of Human Services, October 2008

Because mental health matters: A new focus for mental health and well-being in Victoria Consultation Paper, May 2008

Better faster emergency care: Improving emergency care and access in Victoria’s public hospitals, January 2007


Consultation draft: Guidelines for the Victorian Emergency Department Care Coordination Program 2008, November 2008


Doing it with us not for us – Participation in your health service system 2006-09: Victorian consumers, carers, and the community working together with their health services and the Department of Human Services, January 2006

Elective Surgery Access Policy evaluation, prepared by Dench McLean Carlsson for the Department of Human Services, February 2007

From hospital to home: Victoria’s Pathways Home program report 2003–2008

Guidelines for ambulance presentations in the emergency department, March 2007

Health independence programs guidelines, September 2008

Hospital Admission Risk Program, August 2006

Improving care for older people: a policy for health services, November 2003

Mental health care: Framework for emergency department services, August 2007

Primary Health Report Primary Health Branch 2006–07


The Promoting health independence: a framework for better care


Victorian Population Health Survey 2006 Selected findings, October 2007

Victoria—public hospitals and mental health services: Policy and funding guidelines 2008–09, June 2008


Appendix B - Commonwealth and state and territory roles and responsibilities

<table>
<thead>
<tr>
<th>Service type</th>
<th>Roles and funding arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals</td>
<td>• Co-funded by the states and territories and the Commonwealth under the Australian health care agreements, states and territories responsible for operating and regulating public hospitals within their jurisdictions.</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>• Funded by health insurance funds and the Commonwealth, through private health insurance rebates and funding for services for eligible veterans and their dependants on a fee-for-service basis.</td>
</tr>
</tbody>
</table>
| Medical services             | • Most medical services are provided by GPs and medical specialists on a fee-for-service basis.  
  • The Commonwealth provides Medicare rebates of 75-100 per cent of the cost of care.  
  • Patients make a co-payment if there is a gap between the Medicare rebate and the doctor’s fee.                                                                  |
| Dental services              | • Individuals bear most costs on a fee-for-service basis.  
  • Health insurance funds and the Commonwealth PHI rebate partly subsidise the costs of people with private health insurance.                                                    |
| Allied health and other practitioners | • Individuals bear most costs on a fee-for-service basis.  
  • Health insurance funds and the Commonwealth PHI rebate partly subsidise the costs of people with private health insurance.                                                    |
| Medications                  | • Commonwealth subsidises most of the cost of pharmaceuticals listed under the PBS and RPBS  
  • Individuals pay most of the cost of medicines not listed on the PBS or RPBS, with some costs reimbursed by health insurance funds.  
  • Medications used by inpatients in public hospitals do not attract PBS benefits, and are funded by states and territories and the Commonwealth under the AHCA.  
  • Medicines used by inpatients in private hospitals attract PBS benefits |
| Community health             | • Community health services – including maternal and child health, alcohol and drug rehabilitation and mental health programs – are primarily funded by state and territory governments.                                             |
| Public health                | • Both the Commonwealth and the states and territories fund initiatives aimed at protecting or promoting the health of the population.                                                                                           |

(Source: Department of Premier and Cabinet, 2008)