

Victorian Ambulatory and Classification System (VACS) and Funding Model

A profile for 1997/98 – 2008/09

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Background

General and specialist services provided in public hospital outpatient and emergency departments play a key role in the health care system and represent a vital interface between inpatient and community care.

Public hospital emergency services provide essential care for predominantly unscheduled care that often requires decisions about treatment and actions to be taken rapidly. Delivery of emergency care is an integral part of the public health system and the quality of emergency care has a key role in determining health outcomes of patients.

Typically, outpatient services include a number of visits within a short time frame and may overlap with other public and private inpatient and community-based services. These services essentially provide specialised consultations, pre and post hospital care, and other general medical and allied health services. Hospital outpatient services are important for teaching and training, and the development of innovative service models. They play a special role in particular areas and for particular population groups, for example persons from non-English speaking backgrounds.

Prior to 1997/98, operating and emergency department funding were historically based, perpetuating inequalities in funding. The lack of links between activities and funding provided perverse incentives in the provision of services. Inadequate documentation and data systems handicapped planning and proper management.

Following several years of development, Victoria subsequently introduced a funding model based on the Victorian Ambulatory Classification System (VACS) on 1 July 1997 for the 17 major metropolitan and Geelong hospitals and on 1 July 1998 for Ballarat and Bendigo hospitals (see Appendix 1 for listing).

In Victoria in 2007–08, there were 1,243,082 VACS (unweighted) encounters and a total of 560,893 VACS allied health occasions of service in major hospitals. In 2008–09, the total VACS budget for VACS funded hospitals for Victoria (excluding DVA patients) will be \$573 million (including the emergency services grant) or 80 per cent of the total State funding for non-admitted services (\$717 million). Overall, in 2008–09, non-admitted services will constitute 13 per cent of total hospital expenditure in Victoria.

Objectives of the Funding Model

The primary objectives of establishment of the VACS classification and funding system were:

- Improve fairness in terms of allocation of funding across hospitals
- Maintain service efficiencies.
- Create a profile or broad description of services provided by acute public hospitals.
- Provide incentives to maintain and restructure hospital outpatient services to improve services for patients.
- Identify possible 'gaps' and duplications and enable more detailed service planning.

The system incorporates casemix funding principles. It is both simple and economical for hospital management use, and ensures equity and efficiencies in funding allocations. The funding system has been designed to follow existing clinical service profiles, yet provide information to foster change in growth and service patterns.

The value of an outpatient classification system lies in its ability to define and reflect service patterns, while ensuring flexibility and innovation. The accuracy and stability of the system is also important for funding purposes. The extent of data collected must be administratively appropriate, as well as precise and clinically meaningful.

The sheer volume of services and the very short time span of most visits necessitated a classification appropriate to the clinical purpose. Unlike inpatient services, there was no agreed international, national or local classification system comparable to the current inpatient classification system ICD-10-AM Version 3. At the inception of VACS, a number of classification systems were reviewed for their possible use in Victoria. They included Ambulatory Patient Groups (APGs), Ambulatory Visit Groups (AVGs) and 'episode of care' models. Most of these systems required detailed patient-level data. Hospital outpatient information systems generally were in the early stages of development.

Development of the VACS funding model has evolved over a number of years, as outlined in Appendix 2 – Development of VACS.

VACS Classification

Clinical specialties and weights

Clinical specialties form the basis of the VACS system. There are 47 categories, all of which are weighted, except for allied health and emergency medicine. The 35 'weighted' and 12 'unweighted' clinical specialties are outlined in Appendix 3.

Appendix 3 lists the 2008/09 cost weights for each of the 35 weighted clinical categories. These are derived annually as part of the Victorian Cost Weight Study using data from VACS hospitals who have been able to provide robust and timely data (*see Appendix 1*).

Hospital staff make the initial assignment of hospital clinics to the categories defined under the classification system. Newly assigned clinics are evaluated annually by the VACS Clinical Panel of eminent senior clinicians from a range of specialties. A schedule of approved clinics and those pending approval is distributed to hospitals on a quarterly basis.

Patient encounters

Hospitals are funded on the basis of patient encounters. The encounter is defined as the clinic visit, plus all ancillary services (pathology, radiology and pharmacy) provided within the 30 days either side of the clinic visit. The 30-day window has been chosen to encompass the majority of services associated with a particular visit and to enable a reasonable and practical time period for reporting and funding. This approach more closely reflects patterns of clinical care and provides better resource utilisation and controls than the “unbundled” fee-for-service or occasions of service systems.

NOTE: In categories 101–502, a doctor (or for categories 401 and 402, a midwife performing equivalent responsibilities) must see the patient at each encounter.

For reporting purposes, only the clinic visit needs to be reported as VACS activity. Encounters are paid on the basis of the cost weight, which is derived from the annual Cost Weight Study, and incorporates the ancillary services. For more details on casemix funding, see: <http://www.health.vic.gov.au/casemix/index.htm>

Some examples of AIMS Activity Reporting

Patient A

- 04–06–08: Imaging examination conducted in preparation for clinic visit.
- 20–06–08: Initial visit to the Oncology clinic (VACS 110- Oncology)
- 25–06–08: Follow up visit (VACS 110-Oncology).
- 03–07–08: As a result of the subsequent clinic visit, pharmacy and pathology services were ordered and a repeat pharmacy prescription given.
- 08–07–08: Visit to the Nephrology clinic (VACS 108 - Nephrology)

Bundling Process

All components of encounter are linked by 1) UR Number and 2) Clinic Code. If code is missing from patient record, UR number is sufficient to identify ancillary services.

For this patient the imaging will be linked to the initial Oncology visit. The subsequent pharmacy and pathology services will be linked to the follow up Oncology visit.

AIMS Reporting

June 08	Two encounter under VACS 110 Oncology – includes clinic visit and imaging, pathology
June 08	One encounter under VACS 110 Oncology – clinic visit, pharmacy and pathology
July 08	One encounter under VACS 108 Nephrology

Patient B

- 12–06–08: Initial visit to the ENT clinic (VACS 205 – Ear, Nose and Throat).
- 27–06–08: Flu visit to ENT Clinic (VACS 205 – Ear, Nose and Throat).

Patient B would be reported in AIMS as having 2 encounters in June 2008 under VACS 205 ENT

- June 2008: Two encounters for VACS 205 ENT

Funding Model

The number and type of public patient encounters determine the variable funding received by VACS providers. The funding model also recognises 'fixed' elements and activities such as teaching and other services.

Annual throughput targets are set and hospitals are funded up to target. Significant variation, in terms of estimated activity levels and mix of services, are audited and payments adjusted accordingly where hospitals do not meet the targets specified.

To ensure a smooth transition, compensation grants were provided to the VACS-funded hospitals for the first three years from 1997-98 to 2000-01 but were removed in 2001/02.

Funding arrangements for non-admitted patients under the VACS funding model include the following components.

Non-admitted patient emergency services grant

The funding model, introduced on 1 July 2002, applies to hospitals with major 24-hour emergency services. It recognises hospital and emergency department availability and non-admitted workload. Hospital 'availability' relates to services provided by the hospital, but not necessarily by the Emergency Department (ED), that must be available to the ED on-call, regardless of the actual level of activity. At the ED level, availability relates to the minimum level of staff and resources required to be able to treat complex emergency cases, whether they arrive or not. While ensuring 'availability' serves both admitted and non-admitted patients, the activity associated with admitted patients is costed and recompensed through Weighted Inlier Equivalent Separations (WIES)¹ payments.

The cost of having ED services available to non admitted patients has been allocated on the basis of each hospital's share of the total number of multi-day emergency WIES. The model also explicitly recognises the actual workloads associated with non-admitted patients. Funding for non-admitted patients is allocated funding on the basis of weighted patient attendances, based on triage category.

VACS variable grant

The variable grant is calculated on the number of public weighted encounters. In 2008-09, the case payment for a non-admitted VACS patient throughput up to target is \$167 per weighted public encounter.

VACS allied health services grant

This grant is determined on the basis of allied health occasions of service, up to target, as reported by hospitals to the Department. In 2008-09, the VACS Allied Health payment rate is \$59 per allied health occasion of service.

VACS base grant

This grant provides for fixed or non-variable activities and services provided to patients outside defined clinical categories (for example, phone consultations and calls, administration of patients etc). In 2008-09, it represents approximately 12 per cent of the total non-admitted grant budget.

VACS teaching grant

This grant recognises the importance of non-admitted services for teaching and training. In 2008-09 it represents 6 per cent of the total non-admitted grant for individual hospitals.

¹ More information on WIES can be found on the Casemix Funding in Victoria website: www.health.vic.gov.au/casemix

Specified grants

A number of services to non-admitted patients have either a relatively specialised function or are provided in a manner that cannot be readily funded in terms of patient encounters. Such services are however an important part of hospital services, and are funded through specified grants. Examples of specified grants are liver transplant services, cochlear implant clinics and genetics. In 2008–09 Specified grants represent 3 per cent of the total non-admitted grant for individual hospitals.

LINK - For more details on VACS targets, cost weights and modelled budgets refer to the *2008–09 Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines (including the Conditions of Funding)*: www.health.vic.gov.au/pfg/

Monitoring and accountability

Standard collection and reporting methods have been developed to ensure comparability across hospitals. The reporting method has been kept simple, requires minimal administrative effort and maximises the use of existing data.

All reporting is based on the aggregated number of encounters in each of the 35 weighted and 12 unweighted clinical specialties. Each hospital reports its monthly totals through the Agency Information Management System (AIMS). Details of VACS reporting forms can be found on the AIMS website at: <http://www.health.vic.gov.au/aims/> Reporting also meets Commonwealth requirements on occasions of service as well as encounters.

Formal establishment of clinic schedules for funding purposes occurs on an annual basis and is undertaken by the VACS Clinical Panel. Health Services are required to advise the Department of any new clinics or changes to clinics during the year. A copy of the VACS Notification form can be found on <http://www.health.vic.gov.au/vacs/>

Allocation of new clinics to a VACS category are reviewed by the VACS Clinical panel. *Frequently Asked Questions* and *New Clinic Approval and Funding Submission* documents have been posted on the VACS website (see: <http://www.health.vic.gov.au/vacs/>).

Annual schedules providing clinics and their VACS allocation for each health service are published annually.

VACS Audits

The first audit of the system undertaken in 1999 to verify the approved clinics, assess and ensure the reliability and accuracy of the data system and check adherence to counting rules, highlighted that the system was effective and well accepted by the hospital industry.

The second audit [*Victorian Ambulatory Classification System (VACS) Clinical Verification and Activity Audit*], to investigate VACS outpatient clinic services, was undertaken in 2005. Findings highlighted that overall the system continues to work well. The auditors did note however more pertinent issues, such as data accuracy, non compliance with counting rules and definitions for counting and some reporting which have since been addressed to improve the value of the VACS reporting and funding system. A copy of the VACS audit *Executive Summary* and *Department Responses to VACS Audit Recommendations* documents have been provided to hospitals and relevant parties and are also available on the VACS website: <http://www.health.vic.gov.au/vacs/>.

LINK: For more information on reporting requirements and source data definitions for returns collected via the Agency Information Management System for the financial year commencing July 2008, see the *Agency Information Management System (AIMS) (Version 16) 2008/09 Public Hospital user manual* <http://www.health.vic.gov.au/aims/man2009.htm>

Service profiles: Public outpatients

In 2007–08, there were over 1.25 million unweighted encounters (1,243,082) amongst the 19 VACS hospitals. This represents a 29 per cent increase over the first year of operation with 966,036 encounters.

Figure 1 shows the number of encounters in each of the 35 VACS categories used for funding purposes (excluding emergency medicine and allied health categories, and DVA encounters). The percentage of hospitals providing services in each of the clinical specialties is provided in brackets for each category. For example, the category with the largest number of public encounters is obstetrics, with 249,433 encounters provided at 60 per cent of VACS hospitals.

Across the 19 hospitals in 2007–08, the top 20 VACS categories accounted for approximately 89 per cent of all VACS funded encounters, with the top 10 categories accounting for 71 per cent. These percentages remain almost identical to those obtained in the first year of operation (89 per cent and 68 per cent respectively).

Table 2 shows the number of unweighted VACS encounters by VACS category from 1997–98 to 2007–08. **Major increases** in terms of both number and percentage changes were recorded for Paediatrics Surgical (6,083 encounters, 235%), Neurosurgery (11,321 encounters, 115%), Reproductive Medicine (4,372 encounters, 106%), Paediatrics Medical (6,720 encounters, 105%), Endocrinology (8,443 encounters, 75%), Oncology (26,821 encounters, 72%), and Obstetrics (93,479 encounters, 60%) categories. These increases reflect changes in treatment practices and for Obstetrics, the extension of services at a number of hospitals. The **major decreases** were recorded in Orthopaedic applications (10,068 encounters, -62%) and Dental (8,332 encounters, -52%) categories and possibly reflect coding changes as well as treatment changes.

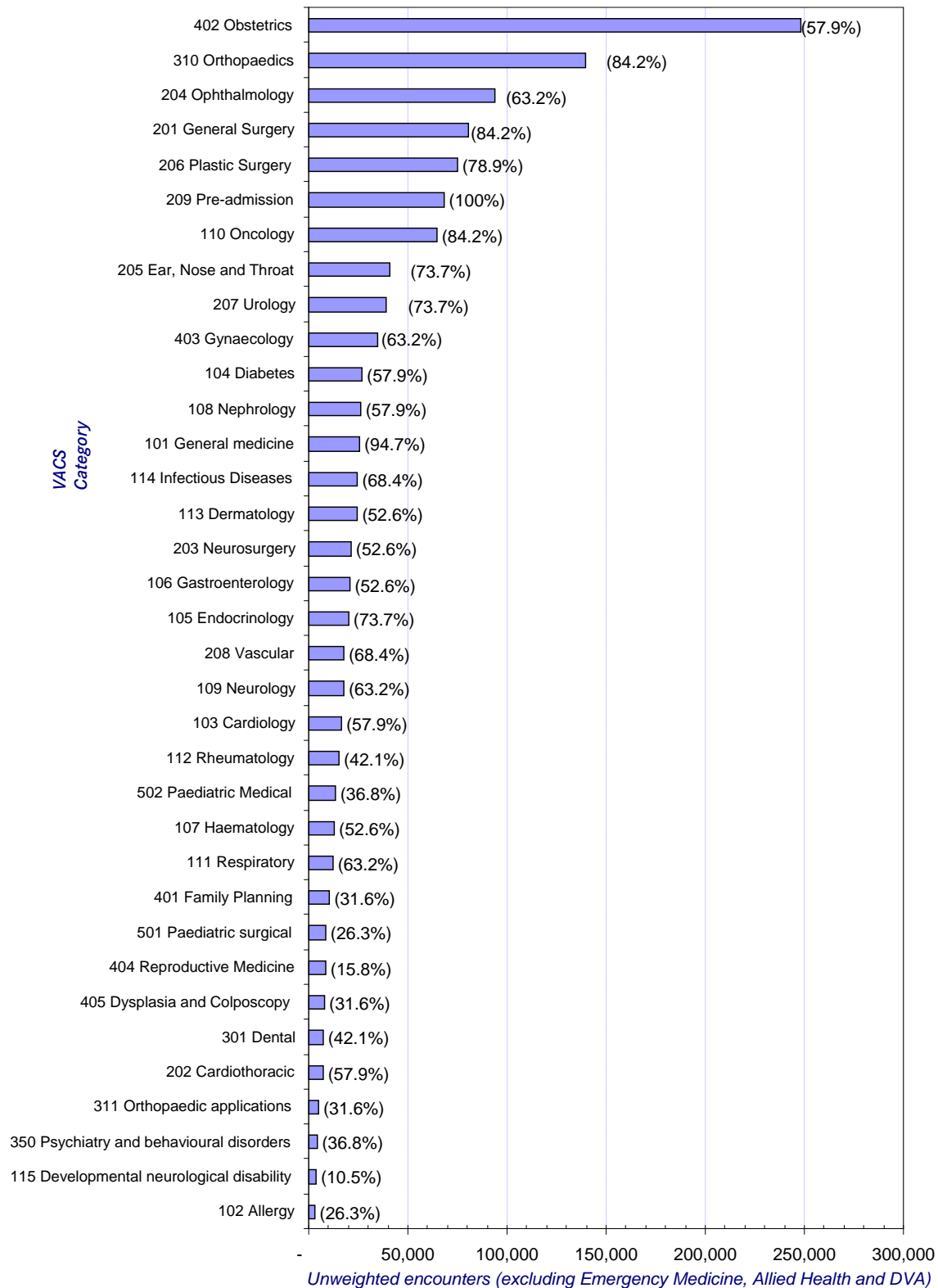
Table 3 compares, for 2006–07, ratios of VACS public encounters (unweighted) to both total WIES, and inpatient separations by hospital. Across all hospitals, the average number of encounters per separation and per WIES13 in 2006–07 were 1.4 and 1.78 respectively. These are very similar to those found for the first year of operation in 1997–98 (1.59 and 1.78 respectively).

Table 3 indicates that most hospitals (with the exception of Mercy Public Hospital, the Royal Victorian Eye and Ear Hospital and Royal Women's Hospital) had a ratio below 2.00 in 2006–07, both in terms of separations and WIES13. The hospital with the highest ratio of both 'Encounters to Separations', and 'Encounters to WIES13', was the Royal Victorian Eye and Ear Hospital, with 6.14 and 8.49 respectively. Dandenong Hospital (0.70) and Peninsula Health (0.44), both had a ratio less than one VACS 'Encounter per Separation' and less than one VACS 'Encounter per WIES13' (0.88, and 0.66) respectively). These results reflect the level of public outpatient activity and the specialties provided at individual hospitals.

Further analyses are now under way to explore the changes across hospitals over the past five years.

Link to WIES on the page: <http://www.health.vic.gov.au/casemix/define>

Figure 1: Unweighted public encounters for 19 Victorian public VACS hospitals and the percentage of hospitals reporting activity to AIMS by VACS-funded categories, 2007–08



Source: VAED, VACS 2007-08 (extracted 9 September 2008)

Note: Data labels indicate the percentage of hospitals submitting data to AIMS within each of the VACS categories in 2007-08, as at 9 September 2008.

Table 2: VACS encounters (unweighted and excluding DVA) 1997–98 and 2007–08

VACS category	Victorian State total public encounters 1997–98 (unweighted)	Victorian State total public encounters 2007–08 (unweighted)	% Difference +/-
101 General Medicine	33,694	25,843	-23%
102 Allergy	2,113	3,294	56%
103 Cardiology	16,218	16,262	0%
104 Diabetes	19,406	26,721	38%
105 Endocrinology	11,301	19,744	75%
106 Gastroenterology	20,568	20,551	0%
107 Haematology	8,770	12,668	44%
108 Nephrology	23,435	26,377	13%
109 Neurology	13,807	17,070	24%
110 Oncology	37,322	64,143	72%
111 Respiratory	10,037	12,326	23%
112 Rheumatology	15,452	14,651	-5%
113 Dermatology	23,037	23,898	4%
114 Infectious Diseases	19,352	24,410	26%
115 Developmental Neurological Disability	4,613	3,626	-21%
201 General Surgery	65,227	80,133	23%
202 Cardiothoracic	5,066	7,399	46%
203 Neurosurgery	9,873	21,194	115%
204 Ophthalmology	76,370	93,144	22%
205 Ear, Nose and Throat	43,920	40,706	-7%
206 Plastic Surgery	50,718	74,142	46%
207 Urology	31,578	38,400	22%
208 Vascular	13,566	17,295	27%
209 Pre-admission	46,268	68,540	48%
301 Dental	15,943	7,611	-52%
310 Orthopaedics	98,160	139,189	42%
311 Orthopaedic applications	15,105	5,037	-67%
350 Psychiatry and Behavioural Disorders	3,752	4,077	9%
401 Family Planning	7,224	11,037	53%
402 Obstetrics	155,954	249,433	60%
403 Gynaecology	48,646	35,882	-26%
404 Reproductive Medicine	4,135	8,507	106%
405 Dysplasia and Colposcopy	6,408	7,971	24%
501 Paediatric Surgical	2,591	8,674	235%
502 Paediatric Medical	6,407	13,127	105%
Total	966,036	1,243,082	AV 29%

Source: VAED, VACS 1997–98 & 2007–08 (extracted 7 October 2008)

Note: VACS encounters do not include DVA

Table 3: Ratio of total VACS encounters (unweighted) to total WIES-funded separations and WIES13 by hospital, 2006-07

Hospital	Total Separations	Total WIES13	Total Unweighted Encounters	Ratio Encounters : Separations	Ratio Encounters : WIES13
Alfred Hospital	58,491	67,375	93,875	1.60	1.39
Austin & Repatriation Medical Centre	81,899	58,650	79,203	0.97	1.35
Ballarat Health Services	30,276	20,133	35,709	1.18	1.77
Barwon Health	59,090	43,965	67,256	1.14	1.53
Bendigo Healthcare Group	26,912	19,854	33,210	1.23	1.67
Box Hill Hospital	45,838	38,083	49,325	1.08	1.30
Dandenong Hospital	41,076	32,716	28,684	0.70	0.88
Mercy Public Hospital (E Melb)	20,871	18,322	68,632	3.29	3.75
Monash Medical Centre	78,781	66,620	109,295	1.39	1.64
Northern Hospital	36,498	30,508	38,745	1.06	1.27
Peninsula Health	60,148	39,998	26,247	0.44	0.66
Peter MacCallum Cancer Institute	21,489	14,143	25,749	1.20	1.82
Royal Children's Hospital	35,017	40,452	68,863	1.97	1.70
Royal Melbourne Hospital	99,147	62,768	106,522	1.07	1.70
Royal Victorian Eye and Ear Hospital	13,442	9,730	82,597	6.14	8.49
Royal Women's Hospital	31,681	23,672	133,814	4.22	5.65
St Vincent's Hospital	51,009	43,267	65,603	1.29	1.52
Sunshine Hospital	39,799	23,069	58,285	1.46	2.53
Western Hospital	41,175	35,503	54,382	1.32	1.53
Total	872,639	688,829	1,225,996	1.4	1.78

Source: Victorian Admitted Episode Dataset (VAED), 2006-07; AIMS, 2006-07

Note: VACS encounters do not include DVA

Appendix 1: VACS - Funded hospitals

- Alfred Hospital
- Austin and Repatriation Medical Centre
- Ballarat Health Services
- Bendigo Health Care Group
- Box Hill Hospital
- Dandenong Hospital
- Frankston Hospital (*includes Frankston VACS held at Rosebud*)
- Geelong Hospital (Barwon Health)
- Mercy Public Hospital–Heidelberg *
- Monash Medical Centre (*includes Monash VACS held at Moorabbin*)
- Northern Hospital
- Peter MacCallum Cancer Institute
- Royal Children’s Hospital
- Royal Melbourne Hospital
- Royal Victorian Eye and Ear Hospital
- Royal Women’s Hospital
- St Vincent’s Hospital
- Sunshine Hospital* *
- Western Hospital

* In 2005 Mercy Hospital related from East Melbourne to Heidelberg

**Until 1998, Sunshine Hospital formed part of Western Hospital (see Appendix 2)

Appendix 2: Development of VACS

1993: In order to generate debate and raise issues relating to short-term options for funding non-admitted patients, the Department released a discussion paper, *Funding for Non-Admitted Patients*, in December 1993. Response to the paper indicated that generally there was support for an activity-based funding approach for outpatients, but support was mixed for the specific options proposed in that paper.

A number of classification systems were reviewed for their possible use in Victoria:

1. Ambulatory Patient Groups (APGs)
2. Ambulatory Visit Groups (AVGs)
3. 'Episode of care' models.

Most of these systems required detailed patient-level data.

1993–5: The use of the Commonwealth Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) was also trialled in Victoria at the Royal Children's Hospital and Geelong Hospital over 1993 to 1995.

1995–8: The Victorian Ambulatory Classification System Advisory Committee was established in 1995 and saw the development and implementation of the new system.

A number of studies were undertaken to provide detailed resource weights for the major clinical specialties. These studies included:

- Development of Relative Resource Weights for Non-Admitted Patients, May 1995.
- Relative Resource Weights for Non-Admitted Patients, July 1996.
- 1996 Victorian Cost Weight Study, September 1997.
- 1997 Victorian Cost Weight Study, September 1998.

1996–7: The Department commissioned a project in 1996 to develop a funding allocation framework for emergency services in Group A and B hospitals. A discussion paper was released in March 1997. The primary theme of the paper was that emergency departments, by their nature, incorporate a higher level of 'fixed' costs (the cost of availability) and such departments must provide capacity to deal with major crisis at peak times. Following a review of all available data by the Emergency Services Categorisation and Funding Taskforce, it was agreed that staffing data, in terms of staff numbers and costs, is the most appropriate data from which to identify emergency services costs.

The non-admitted component of emergency departments has been subsequently considered separately. Details can be found on the Department's website at: <http://www.dhs.vic.gov.au/ahs/vacs/index.htm>

1997: The new system was introduced on 1 July 1997.

1997–8: A two-phase audit was conducted during late 1997 and early 1998.

1998: VACS was extended for use in two major rural hospitals: Bendigo Health Care Group and Ballarat Health Service. Western Hospital became two separate entities—the Western Hospital and the Sunshine Hospital.

2000–1: Two new VACS categories within the Allied Health category—Cardiac Rehabilitation (610) and Hydrotherapy (611)—were implemented in response to requests from the field.

2002–3: New version of Non-Admitted Patient Emergency Services Grant system introduced.

2005: VACS Clinical Verification and Activity Audit conducted.

- 2006: VACS clinic schedule reporting moves from annual to quarterly reporting.
- 2006: VACS website is updated with *Frequently Asked Questions* and *VACS New Clinic Approval and Funding Submission Process* – For Metro and Rural Hospitals (<http://www.health.vic.gov.au/vacs/>).
- 2006: *VACS Clinical Verification and Activity Audit Executive Summary and Recommendations: Department of Human Services Response* published on the VACS website: <http://www.health.vic.gov.au/vacs/>
- 2007 VACS Review

Appendix 3: Cost weights - (VACS) 2008-09

VACS Code	Description	Weight
101	General medicine	1.675
102	Allergy	1.393
103	Cardiology	1.396
104	Diabetes	1.208
105	Endocrinology	1.273
106	Gastroenterology	1.229
107	Haematology	2.019
108	Nephrology	1.453
109	Neurology	1.563
110	Oncology	1.632
111	Respiratory	1.672
112	Rheumatology	1.314
113	Dermatology	1.076
114	Infectious diseases	1.668
115	Developmental neurological disability	1.559
201	General surgery	1.155
202	Cardiothoracic	1.726
203	Neurosurgery	1.653
204	Ophthalmology	0.785
205	Ear, nose and throat	0.834
206	Plastic surgery	0.769
207	Urology	1.010
208	Vascular	1.164
209	Pre-admission	1.370
301	Dental	1.233
310	Orthopaedics	1.256
311	Orthopaedic applications	0.624
350	Psychiatry and behavioural disorders	1.942
401	Family planning	1.061
402	Obstetrics	0.727
403	Gynaecology	0.773
404	Reproductive medicine	0.825
405	Dysplasia and colposcopy	0.836
501	Paediatric surgical	1.012
502	Paediatric medical	1.337
550	Emergency medicine	n / a
601	Audiology	n / a
602	Nutrition	n / a
603	Optometry	n / a
604	Occupational therapy	n / a
605	Physiotherapy	n / a
606	Podiatry	n / a
607	Speech pathology	n / a
608	Social work	n / a
609	Other allied health services	n / a
610	Cardiac rehabilitation	n / a
611	Hydrotherapy	n / a

Notes:

1. 2008-09 cost weights have been set using 2006-07 VACS cost data, except for VACS 102, 115, 311 and 501 which have been set using a 3 year rolling average.
2. Weights are not detailed for VACS 550 - 611 as these categories are funded as fixed grants.

