

Health 2040

A discussion paper on the future
of healthcare in Victoria

Ministerial foreword

The Andrews Labor Government was elected to end the crisis in Victoria's health and ambulance services. Since last year's election, the Government has worked hard with our health sector to get on with the job of improving our health system. We are absolutely committed to supporting Victorians to access the care they need, when they need it, closer to home.

Victoria has the most efficient healthcare system in Australia, but we need to improve the outcomes it delivers. If we want better health outcomes for all Victorians, we need a health system that delivers the best value for patients, their carers and local communities.

This starts with a focus on prevention, so that people can make healthy choices about their lives.

When people do get sick, we must put them and their loved ones at the centre of care, instead of building our care system around the needs of institutions.

We must work smarter and with greater innovation.

We also need new funding and service models that allow us to think more broadly about how and where people access health services.

Historically, health funding has focused on public hospital beds and episodic care. In the face of the increasing incidence of chronic disease and an ageing population, this approach will increasingly fail to deliver the care people expect in the most efficient and effective way. Doing more of the same is not an option – we must do things differently. We need to focus on the whole healthcare system in order to deliver better outcomes.

This discussion paper aims to start the conversation about what our goals should be. This includes the alignment of the mental health system with the broader hospital and community health sector and ways to ensure that the most vulnerable members of the Victorian community have access to the kinds of support services they need. This work is already underway in the consultation around the Government's 10 Year Mental Health Plan that this discussion paper complements.

What should our health system look like in two decades' time? How can we make sure that all Victorians continue to have access to high-quality treatment and services, no matter where they live or what they earn?

We need a clear vision for Victoria's health system so that we can take advantage of the major advances happening in science, technology, models of care, system governance, citizen engagement, funding and accountability mechanisms.

This paper will frame our discussion at the Victorian Health Reform Summit in September 2015. We are also seeking your input through our designated health reform website at www.health.vic.gov.au/healthreform.

We strongly encourage you to participate in this vital process to shape the Victorian health system for the next 20 years.

Everyone involved in the health and social services systems, including public, private and not-for-profit health service providers, patients, carers, academics and the wider community has a part to play in deciding what we want our health system to be.



Jill Hennessy MP
Minister for Health



Martin Foley MP
Minister for Mental Health

To receive this publication in an accessible format phone (03) 9096 6970, using the National Relay Service 13 36 77 if required, or email Liz.Grunwald@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health & Human Services September 2015.

Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

ISBN 978-0-7311-6797-5

Available at www.health.vic.gov.au/healthreform

Printed by Finsbury Green, Port Melbourne (1508035)

Contents

Ministerial foreword	1
A complex system facing big challenges	4
Victoria's health system	4
Our challenges	4
How you can help	5
Part 1: Why we need change	6
Where we are now	6
The case for change	6
A national concern	10
Part 2: What principles should guide healthcare reform?	12
Part 3: What should be the priorities for reform?	14
A person-centred view of healthcare	14
Preventing and treating chronic disease	16
Improving people's health outcomes and experience	18
Improving the way the system works together	20
Better health for people in rural and regional areas	22
Valuing our workforce	24
References	26

A complex system facing big challenges

Victoria's health system

The health care system exists to improve the health and wellbeing of all Victorians. The Victorian Government is responsible for delivering the system that looks after Victorians. It sets the direction and funds the services that people use every day.

The government funds more than 500 organisations to provide healthcare to Victorians. This includes hospitals and emergency services, and services provided in the community and in people's homes. Many of these services require specialised buildings and equipment; Victoria's public health infrastructure is worth around \$11.3 billion.

Our public health workforce is one of the largest in Australia. The 100,000 people who work in our public health services are the heart of Victorian healthcare. Another 160,000 work in private health, including those working in general practice, allied health, community pharmacy, specialist care, diagnostic services and private hospitals.

The health system provides everything from health promotion to hospital care. People move back and forth across different types of care on a daily basis and at different stages in their lives.

Our challenges

The health system is always evolving to meet the changing needs of Victorians. However, the changes of yesterday do not meet the demands of tomorrow. While much has been achieved over the past 10 to 20 years, far-reaching change must happen to meet the challenges we now face:

- an ageing population, together with new discoveries, new technology and new treatments which are creating growing demand for healthcare
- lifestyle choices and behaviours that are contributing to higher levels of chronic disease
- disparities and inequalities in health outcomes for certain population groups
- people's changing needs and expectations
- unprecedented financial constraints that are unlikely to diminish.

These challenges have become truisms of the system, and it will take concerted and unified effort to address them. We must act now to effectively position our health system for the future and ensure that it is sustainable for the long term. This requires a clear vision, knowing what needs to be done to achieve that vision and deliberately charting our progress toward it.

How you can help

This discussion paper is the start of a conversation about how we can work together to build and strengthen our health system. It poses questions for you to consider when thinking about the design of our future health system.

Get involved

You can participate by:

- submitting a written response via the health reform website at www.health.vic.gov.au/healthreform
- submitting your ideas via email healthreform@dhhs.vic.gov.au.

The closing date for submissions is 7 October 2015.

Your contribution will help shape the vision for the Victorian health system for the next 20 years.

For further details about any aspect of the consultation please contact healthreform@dhhs.vic.gov.au or visit the website: www.health.vic.gov.au/healthreform.



Part 1: Why we need change

Where we are now

Our health system performs very well overall. Nationally, Australia has one of the highest life expectancies of any country in the world and our survival rates for cancer and cardiovascular disease are among the best in the world. Compared to similar countries, Australia has an efficient health system. (See box.)

Key health statistics

Australia

Life expectancy was 82 years in 2011 (for males and females at birth combined), ranking seventh among Organisation for Economic Co-operation and Development (OECD) countries (AIHW 2015a).

Between 1989 and 2009, the overall cancer death rate fell by 23 per cent for males and 17 per cent for females (AIHW, 2015b).

Australia's health expenditure represented 8.8 per cent of GDP in 2012 compared to the OECD average of 8.9 per cent (OECD, 2015).

Victoria

Victoria has the second longest male life expectancy behind the ACT and the third longest female life expectancy behind the ACT and Western Australia (AIHW 2014b).

With respect to avoidable deaths and the prevalence of type 2 diabetes, only the ACT achieves better outcomes (Productivity Commission, 2014).

The case for change

While much has been achieved by the efforts to improve the system, we have a long way to go in providing healthcare that centres on people, ensures their care is well-coordinated, integrates services around them and personalises the care they receive. There are a number of ways in which the system is still failing to meet people's needs.

Why we need to change the system	The impact on people's lives and the system
Health outcomes overall could be better	Chronic disease, including mental health and cancer, are significant issues for Victoria (see box 'The impact of ill health'). The prevalence of most types of chronic disease is expected to increase in the future (see Figure 1).
Variation in care delivery and outcomes	Not all Victorians have equal access to appropriate and timely healthcare or get the same benefits (see box 'Variation in health outcomes'). Compounding this, people with the same health care needs can be treated very differently and have quite different outcomes, depending on where they are treated (see box 'Variation in care delivery').
Demand for health care is growing faster than funding	Public funding for health services has been constrained since 2011–12 while demand has continued to grow strongly, driven in part by the ageing population (see box 'Growth in healthcare demand and funding').

The impact of ill health

Chronic disease

Among people with several chronic diseases, only four in 10 are in paid employment, compared with eight in 10 healthy people (Business Council of Australia 2011).

The most recent National Health Survey indicates that 35 per cent of the Australian population report having at least one of the following chronic conditions: asthma, type 2 diabetes, coronary heart disease, cerebrovascular disease (largely stroke), arthritis, osteoporosis, chronic obstructive pulmonary disease, depression or high blood pressure (AIHW 2014b). A recent study suggests that across Australasia chronic diseases cause 85 per cent of the total burden of disease (IHME 2013). Currently, nine in 10 deaths have chronic disease as an underlying cause. Furthermore, the incidence and prevalence of these diseases is increasing, driven by risk factors such as smoking and obesity.

Mental illness

People with a mental illness die on average 16 years earlier than the general population and this gap is increasing (UQ News 2014). A study by The University of Queensland and The University of Western Australia showed that 78 per cent of the excess deaths in psychiatric patients could be attributed to common physical health conditions such as cardiovascular disease, respiratory disease, and cancer, not their mental illness (Lawrence 2013).

Cancer

The incidence of cancer in Australia increased by 29 per cent between 2001 and 2009 (AIHW 2014d). Over the same period, cost of cancer care increased over 56 per cent from \$2.9b to \$4.5b (AIHW 2013). Most of this cost was incurred in the inpatient setting, accounting for 79 per cent of total treatment costs in 2008–09 (AIHW 2012).

Growth in healthcare demand and funding

At the national level, total expenditure on health goods and services in Australia grew only 1.5 per cent between 2011–12 and 2012–13 after adjusting for inflation, which is the lowest growth since the mid-1980s. The Australian Government's total health expenditure fell in real terms by 2.4 per cent, contributing to, for the first time in a decade, an overall fall in funding in real terms (AIHW 2014e).

The cost of healthcare increases dramatically with age (see Figure 2). Without significant changes to the current system, the growing and ageing population will have a steadily greater impact on costs over time.

Variation in health outcomes

Aboriginal health

Aboriginal Victorians have higher rates of perinatal mortality and child mortality compared to non-Aboriginal Victorians, as well as higher rates of hospitalisation, potentially preventable hospital admissions and emergency department presentations. Nationally, Aboriginal women have a life expectancy 9.7 years lower than non-Aboriginal women, while for Aboriginal men it is 11.5 years lower (Victorian Government 2012).

Rural health

Victorian data shows that people living in Gippsland and Grampians have worse five-year cancer survival outcomes than people living in all other areas. Furthermore, survival from cancer for residents of metropolitan Melbourne (68 per cent) is generally better than that for residents from the rest of Victoria (64 per cent) (Thursfield 2014).

Socio-economic disadvantage

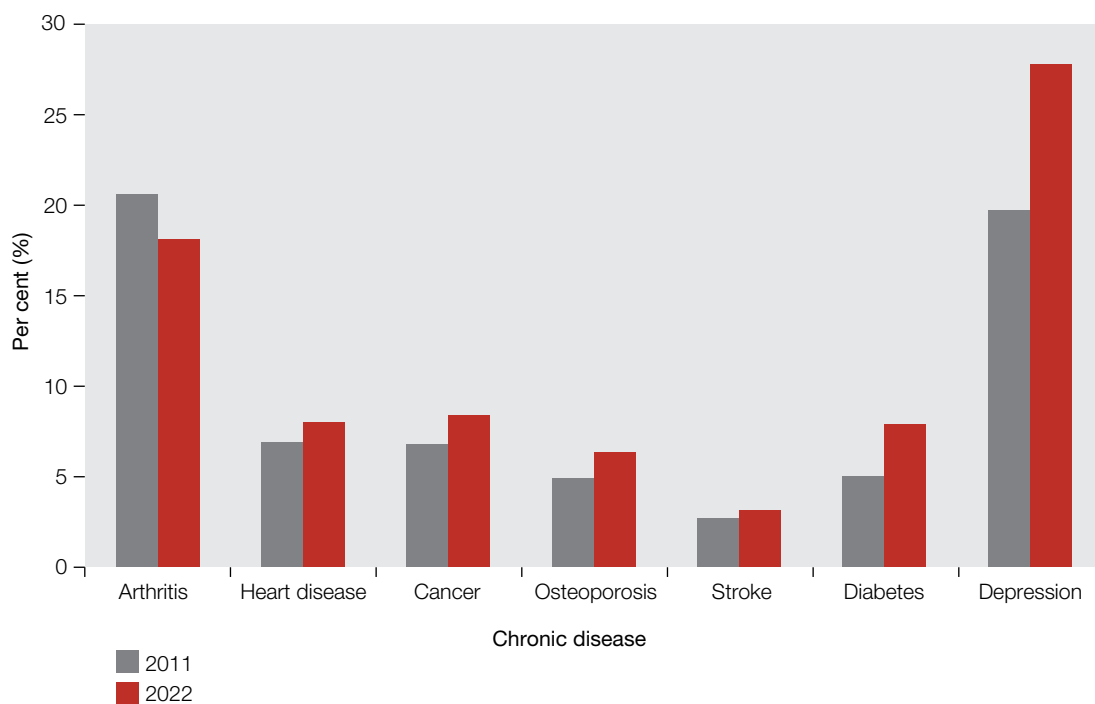
People living in socio-economically disadvantaged areas experience increased health risk factors, such as lower levels of physical activity and higher levels of smoking compared with other Australians (AIHW 2014b). Bowel, lung and cervical cancer are more prevalent in socio-economically disadvantaged areas of Australia (66.6 new cases per 100,000 people in the most disadvantaged areas of Australia compared to 55.2 in the least disadvantaged areas in 2010) (COAG Reform Council 2014).

Variation in care delivery

A 2012 study of clinical appropriateness of health care in Australia found that only 57 per cent of eligible health care encounters by adult Australians provided appropriate care, as assessed by compliance with clinical indicators across 22 conditions (Runciman et al 2012).

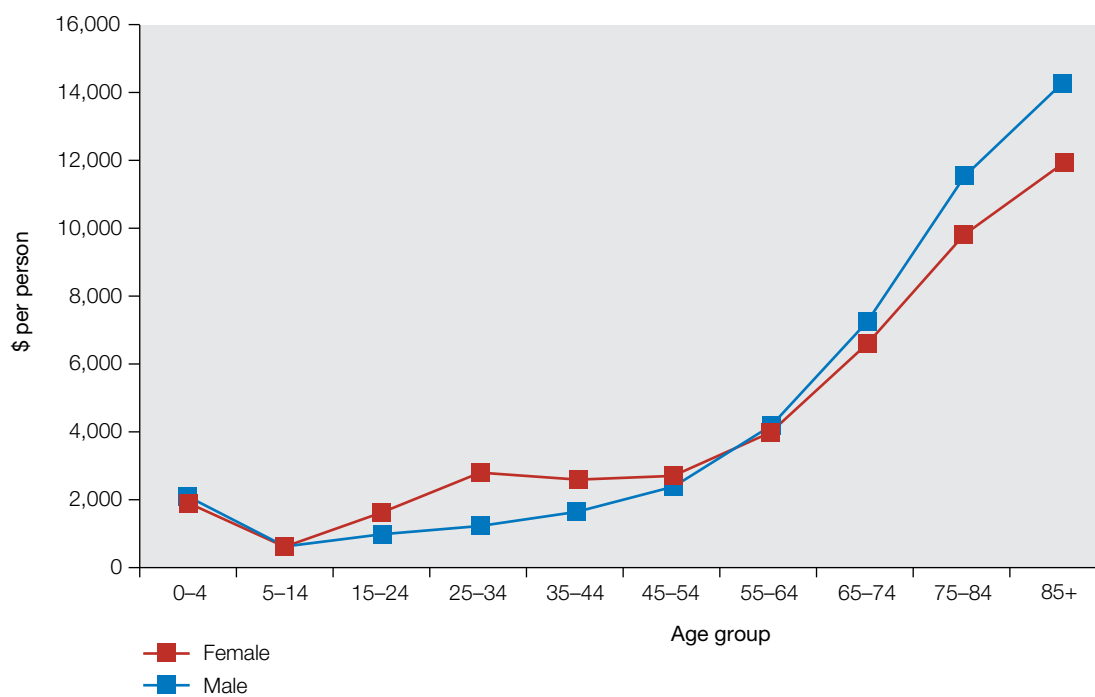
Variation in rates of several common healthcare interventions has been identified across defined populations across Australia, ranging from 1.6-fold variation for caesarean sections to 7.4-fold variation for cardiac catheterisation (ACSQHC & AIHW 2014).

Figure 1: Estimated prevalence of selected chronic diseases in 2011 and projected prevalence in 2022



Department of Health (Vic), Metropolitan Health Plan Technical Paper Update November 2014

Figure 2: Allocated health expenditure per person, by age and sex, 2008–09



Source: AIHW, *Australia's Health 2014*.

A national concern

Responsibility for healthcare system policy and funding is split between the Commonwealth and states and territories (see box). Australia is missing an opportunity to have a world-class health system due to the incremental, siloed approach to national health reform that fails to look at the health system as a whole.

It is vital for the Commonwealth and state and territory governments to work cooperatively to get the right policy settings and funding arrangements in place to allow the system to work in a unified way.

Roles and responsibilities

The Commonwealth government has a substantial role in national policy making, but tends to fund rather than deliver health care services through Medicare, the Pharmaceutical Benefits Scheme, aged care subsidies and subsidies for private health insurance premiums.

State governments are mainly responsible for funding, delivering and managing a range of public health services, including public hospitals (which the Commonwealth partly funds), community health and mental health services, ambulance and emergency services and public dental care. States also regulate health care providers and private health facilities.

Both the Commonwealth and State governments fund and deliver other health services, such as preventive health programs, community health services, health and medical research, Aboriginal and Torres Strait Islander health, mental health, palliative care, health workforce and health infrastructure.

Funding agreements

To ensure the services people need are available, it is critical that the Commonwealth funds healthcare in a transparent and predictable way, taking into account all factors that drive cost growth. This has not been the case in the past, with the Commonwealth making unexpected changes that have big impacts on the system.

Federation reform

The Commonwealth Government has established two parallel reform agendas: one addressing federation reform and one on tax reform. Health is central to these reforms, and they provide an opportunity for future funding agreements to incorporate all elements of the health system – not just hospitals – to encourage more holistic, system wide responses that deliver better individual and population health outcomes.

Recently, the Council of Australian Governments (COAG) leaders agreed that the Victorian and Tasmanian Premiers would progress reform options relating to health, including:

- **a new focus on primary care and keeping people out of hospital** – such as individual packages of care and coordinated care for people with (or at risk of) chronic disease
- **sustainable funding and financing of public hospitals in an integrated health system** – such as extending Medicare to cover hospital treatments.

Despite these reforms, current levels of Commonwealth funding will not be enough to maintain and improve services in the future. Further work is being undertaken to determine the level of funding needed, and how it can be found.

Primary care reforms

Reform focused on primary and community health is central to preventing chronic disease and providing the care that people need to manage chronic and complex conditions. The Commonwealth Health Minister has recently acknowledged the need for reform in the primary health sector, including through the current Commonwealth Medicare Benefits Schedule Review and the work of the Primary Health Care Advisory Group.

Governments need to work together to achieve more fundamental reform of primary care. Expanding fee-for-service care through Medicare will not necessarily provide people with the kind of care they need if they have a chronic disease. Medicare does not provide care that is coordinated and integrated around the needs of patients; and it does not help the people providing the care to do this. We need to think about better ways for governments to work together to encourage prevention and community-based services that better support patients with chronic disease. This also means a focus on how different parts of the system can better work together to improve outcomes: including how general practice, pharmacies, specialists, allied health providers and publicly-funded community services work together, and how they work with both public and private hospitals.

These issues are explored further in part 3 of this discussion paper.

Part 2: What principles should guide healthcare reform?

In order for us to achieve healthcare reform, we need to be guided by principles that describe the kind of system we want.

Like Victoria, other jurisdictions are, to some extent, considering what a future system should look like, as well as how we can get there. In the United Kingdom, for example, a *Five Year Forward View* has been developed to set out the future direction for the health system in England (see box).

Should reform focus on how the different players in the system need to work together to deliver health and wellbeing outcomes? Should it focus on ensuring that everyone needing healthcare has equitable access to it, and can achieve the best possible outcomes regardless of their circumstances or where they live? Should the emphasis be on disease prevention and early intervention? Should it be about focussing on the needs of individuals rather than institutions? Should a focus on making healthcare sustainable into the future drive our thinking? Should the focus be on outcomes of care, and ensuring that individuals, providers and governments are held accountable for achieving them? Should reform focus on the needs of those who are most vulnerable and most in need, including Aboriginal people and people with chronic and complex conditions?

Some of these ideas overlap and reinforce one another. We need to ensure we have a clear set of mutually reinforcing principles that provide a clear rallying point for collective effort.

Identifying these principles is the first and most important step on the road to reform.





National Health Service *Five year forward view*

‘... there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment.

One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.’

Source: NHS, 2014, *Five Year Forward View*, pp. 7–8

Starting the conversation

What principles should guide reform of the Victorian healthcare system?

From your perspective, what would describe the kind of the healthcare system you would want to encounter as a patient?

Part 3: What should be the priorities for reform?

In this discussion paper, we have selected six broad themes as starting points for further exploration of healthcare reform direction. These are introduced below but are intended to be neither prescriptive nor exhaustive. At the heart of these themes is the idea that the healthcare system should be designed from the perspective of the people who use the system.

The six themes are:

1. A person-centred view of healthcare
2. Preventing and treating chronic disease
3. Improving people's health outcomes and experience
4. Improving the way the system works together
5. Better health for people in rural and regional areas
6. Valuing and supporting our workforce

We need to design a system that delivers what we need, rather than merely managing the reality we have. This requires creativity and new approaches. Each of the themes explored here are intended to stimulate thinking about other important elements of reform.

A person-centred view of healthcare

Why this is important

People want to be able to make informed decisions about their healthcare and choices of treatment. They also want the same kind of choice and experience from healthcare that they encounter in other aspects of their lives and in their contact with service industries. A significant proportion of healthcare is already self-managed and a person-centred healthcare system can ensure people are able to better manage their own health.

When patients are involved in informed decision-making, there is potential to reduce costs associated with repeated hospital presentations and admissions, and expenditure on marginal treatments that do not improve quality of life.

Person-centred healthcare enables choice, personalisation, positive experience and active individual participation in health and treatment.

How things look now

The Victorian health system has – like most healthcare systems across the globe – developed around a model of care that has tended to:

- entrench a stark information imbalance – clinicians know and patients do not
- focus on treating episodic illness rather than taking a focus on life-long wellbeing
- organise around healthcare providers rather than people.

The consequence for the Victorian community is that people experience confusion and frustration as they try to navigate the system, may end up visiting an emergency department or being admitted to hospital for reasons that could have been prevented, may receive care that is unnecessary, inappropriate or unwanted, and are likely to feel powerless and ill-informed about their own health and healthcare.

What could we do better?

A person-centred approach could ensure that the health system meets the needs and values of the people it exists to serve. Facilitating and empowering individuals and communities to be more health



literate and to take greater responsibility for managing their own health is an intrinsically positive outcome. People who are more informed, engaged and in control of their health are likely to be healthier. It can also save money. In the UK, a study found savings of 7-20 per cent were possible through a suite of innovations that involve patients, their families and communities more directly in the management of long-term conditions (Horne 2013).

The technology people use in their everyday life has become highly personalised. While the digital divide is a real issue (with some parts of society having more limited access to technology), there are many opportunities for person-centred care to be supported by technology. Telehealth and personal monitoring are areas that could be more actively pursued.

Achieving person-centred care involves consciously and deliberately redesigning the healthcare system. This would require different ways of thinking and acting at all levels in the system. An example is human-centred design, where the design of products is driven by the needs and desires of the people for whom they are being designed. The results can be seen when people experience products and services that 'just work'. Designing a person-centred healthcare system creates the opportunities to design healthcare for experiences as well as outcomes and to think about healthcare in terms of a patient's journey from end-to-end through the system. For patients, this is an emotional journey, which may involve dealing with the impact of bad news and good news, triumph and tragedy, pain and delight.

Starting the conversation

What sort of things could we do to provide greater choice and personalisation in health care?

How do we design for people's experience as well as outcomes?

How do we engage people in designing the healthcare system?

How can the healthcare system improve every individual's end-to-end journey and consider their emotional journey?



Preventing and treating chronic disease

Why this is important

Chronic diseases place a significant burden on individuals, communities and health services. While chronic disease affects all parts of society, it has a disproportionate impact on the ageing, people living with a mental illness and Aboriginal people. Yet many chronic diseases are highly preventable. With the right support, people with chronic disease can manage their own health and get the care and treatment they need in the community. People can be spared the disruption to their lives, and the anxiety, pain and discomfort, of an avoidable hospital admission or attendance at an emergency department.

The design of the system needs to particularly cater for the needs of people with chronic disease and complex care needs. These are the people most affected by fragmentation of the service system, poor coordination, duplication and a focus on episodic, fee-for-service care.

How things look now

The system does not have a strong enough focus on early intervention and prevention. This means that people at risk of chronic disease do not always get what they need to stay healthy, with the system responding to them only after they have become sick.

Most people are happy with the care they receive from their GP, and the quality of care and access to GP care is good for most Victorians. Community health services and the Health Independence Program in Victoria play important roles in providing treatment, secondary prevention, and care planning and coordination for people with chronic disease. In Victoria, Primary Care Partnerships have had some success in improving coordination of care and facilitating partnerships to improve prevention and early intervention. However, the current primary care system still operates largely as

separate individual components, and does not support good links between medical specialists, GPs and allied health services. This means the onus often falls to people with chronic disease – who need all these services as part of their care – to find their way through the system and make it work for them.

What could we do better?

A strong focus on prevention and early intervention can help to keep people healthier for longer. Many chronic conditions also share common risk factors, which means that people can be prevented from developing a wide range of chronic diseases through changes in lifestyle and early detection of health problems. This means there are opportunities for building partnerships and integrated service delivery to improve prevention and early intervention. We could also consider whether we have the right mix of prevention and early intervention initiatives and how we can maximise outcomes in both these areas.

For people who have a chronic disease, the health system can do more to provide the seamless, integrated care they want and deserve. Models such as the person-centred medical home can help do this by providing a single point contact for a person's care and coordinating care around their individual needs.

People also want to be able to access care in different ways, and at times and places that are convenient for them. For example, people would like to see pharmacists have a greater role in patient care, including providing services such as immunisations and blood pressure checks and working with GPs to help people with chronic disease better manage their medication (Consumers Health Forum, 2015).

Many Victorians now use mobile devices that give them access to a wide range of information and services. People expect that personalised health information and health services should be accessible to them in the same way. Technology can inform people about their health and assist with self-management, particularly if patients and providers have access to the same shared system.

Funding models such as bundled payments or pooled funding and care packages can potentially support improved integration and innovative service delivery. For example, bundled payment for acute care that incorporates post-acute care and transition to other care settings may mean that individual providers have more incentive to work across existing barriers to provide people with integrated care. In primary care, packages of care for those with chronic and complex conditions could potentially provide greater flexibility to meet the range of healthcare needs.

Victoria has an expanding translational research capability. It may be worth considering how new discoveries about the causes and treatment of chronic disease can best be translated into clinical practice.

Starting the conversation

Where should we focus our efforts to improve prevention and early intervention?

What are the priorities for improving the outcomes and experience of people with chronic disease?

What are the best ways to improve coordination and integration of services for people with chronic disease?



Improving people's health outcomes and experience

Why this is important

Recent years have seen a much stronger focus in healthcare on patient experience and patient outcomes. Patient experience happens across the continuum of care and goes beyond patient satisfaction alone. Similarly, patient outcomes should reflect the full cycle of care (not just whether a particular treatment was successful) and should include those outcomes that are most relevant to patients themselves (such as their ability to work and do the things they love).

A stronger focus on outcomes and experience can provide an important source of evidence on the performance of healthcare providers; help to guide patient choice, by focusing on the outcomes that matter to them; inform funding decisions; and achieve performance improvement and improved accountability.

How things look now

We know the health outcomes we are achieving at an aggregate level across the Victorian population. We also know how these vary in different places and for people in different circumstances. We have good ways to show how many services people receive and whether they can access care in a timely way. We can also assess whether people are receiving safe and high quality care. However, the current system is not good at measuring people's outcomes from the care and treatment they receive.

Patient experience of some types of care is measured in Victoria, but this is not done comprehensively and generally applies only to a single episode of care (such as an admission to hospital for elective surgery), rather than people's experience as they move between services and different types of care.

What could we do better?

There are potential benefits for the people of Victoria in considering new ways to assess and influence the performance of providers to ensure they are achieving the outcomes that matter to their patients. Patient-reported outcome measures provide a possible way to do this. Patient-reported outcome measures capture a patient's own views of their health such as pain, mobility and mental state, often capturing things that cannot be measured in other ways.

The International Consortium of Health Outcomes Measurement is aiming to develop 50 standard measurement sets incorporating patient-reported outcome measures that it claims will cover 50 per cent of the disease burden in industrialised countries. One of the benefits of this approach is that it does not focus on a single treatment, but covers all the care a person is likely to receive time over for a particular disease or injury.

Variation in healthcare can be related to patient needs or preferences, but unwarranted variation is an undesirable outcome. Patients should not be exposed to inappropriate medical intervention and should be able to make informed decisions about the outcomes that matter to them. This is particularly important in end-of-life care where over-treatment and unnecessary interventions can subvert the wishes of patients to die in the manner and place of their choosing – currently 70 per cent of Australians want to die at home, yet only 14 per cent do so (Swerissen & Duckett 2014).

Low levels of individual health literacy contribute to poorer health outcomes, so considering ways of boosting health literacy could also be an important focus for improving outcomes.

There are opportunities to think about how to make healthcare providers more accountable for the outcomes they achieve – particularly the outcomes that matter most to patients. Determining the best way to measure and assess the performance of providers in delivering the outcomes that matter to people is a complex task, but the right solution could provide significant benefits to people receiving care.

Starting the conversation

How can we make sure health services are accountable for improving outcomes?

How do we ensure we are focused on the outcomes that matter to Victorians?

What can we do to improve people's experience of healthcare?



Improving the way the system works together

Why this is important

Healthcare providers can only provide person-centred care if they are able to work together to combat fragmentation, deliver integrated care and provide people with a seamless experience across the continuum of care.

People expect the healthcare services they use to work together to provide them with the care they need. When this does not happen, it can create frustration and anxiety for people when they are at their most vulnerable. It can also mean they get poorer outcomes from their care.

A system that doesn't work together well impacts disproportionately on people who are most vulnerable and most likely to be multiple service users. This is particularly the case for people needing both health and social services (such as family violence or housing services).

How things look now

Victoria has many public health services serving local communities, each with their own local management structures. Some of these services operate a wide range of services across multiple locations while others are smaller single site organisations. Many other healthcare services, as well as prevention and health promotion services, are delivered by funded agencies such as local government, charitable organisations, home nursing services, and a range of specialist providers (such as women's health, mental health, aged care, and alcohol and drug services). This complex and fragmented environment has worked against effective collaboration to focus on the needs of people as they move through the system.

What could we do better?

Providing person-centred care means looking beyond hospital care to encompass primary and community care, public health and social care, and emergency pre-hospital care. Discussion of reform should explore how to achieve increased collaboration and partnership between providers, based around the needs of the patient. It may be important to consider ways to broaden accountability for achieving improved outcomes that cut across provider boundaries and involve new ways of measuring, funding and coordinating care. Better links between private and public providers can support person-centred care. This might include looking at how public hospitals and private hospitals could work better together, as well as better ways for community health to work with GPs, specialists, private allied health and community pharmacy. Health services working together well could also more effectively participate in 'place-based' efforts to help Victorians living in areas with entrenched disadvantage.

An important question is the role government should have in bringing providers together to target improved outcomes for their communities. One dilemma is how to strike the right balance between autonomy for providers that allows them to be efficient and responsive in meeting the needs of the people who use their services, and the need for them to be jointly accountable for achieving outcomes.

Innovation across the healthcare system exists in pockets in individual services or parts of services. The real challenge is how to achieve major innovation across the system. This was one of the findings of the recently completed Travis Review into the capacity of public hospitals. The Victorian Government recognises the need to act on this and is establishing *Better Care Victoria* to drive innovation right across Victoria's health system. This also goes to the question of what constitutes excellence, and how much it should be defined in terms of collaboration and innovation to deliver system outcomes, rather than a focus on centres of excellence.

Health providers use a variety of information systems, and even individual services use different systems in different settings and disciplines. A focus on addressing this (such as through standardised or patient-held electronic health records) may alleviate barriers to multi-disciplinary care and integrated service delivery, reducing the need for patients to compensate for these limitations (such as by repeating basic information as they move between services and settings of care).

In Victoria, role delineation guidance provides clarification to providers on how their healthcare services need to work together to meet the needs of the Victorian population. Building on role delineation offers the opportunity to consider the relationship between volume, quality and outcomes.

The establishment of Commonwealth Primary Health Networks (PHNs) from 1 July 2015 provides an opportunity to explore ways of improving integration and coordination between general practice and other primary and specialised health care services. Over time, what role will PHNs, public hospitals, Local Hospital Networks and other providers play in delivering, funding or organising the comprehensive network of community-based health services that best meet the health needs of local communities?

Starting the conversation

How should health services work together to strengthen the delivery of health care in Victoria?

What incentives could be used to encourage more partnering across organisational boundaries in Victoria?

What opportunities do Primary Care Networks provide, and what should they do in the future?



Better health for people in rural and regional areas

Why this is important

Overall, Victorians living in rural and regional areas experience higher rates of socio-economic disadvantage and unemployment; are older; and have poorer overall health status, including poorer health outcomes such as life expectancy and cancer survival rates.

The role for public health and social services is even more significant in regional and rural areas given the higher reliance on these services and the lower rate of private health cover.

Rural and regional health services are often the largest employer in their local community and can be an important focus of community life and economic activity. Effective rural and regional health services are essential – not only for improving health outcomes for Victorians living outside the metropolitan area – but to ensuring the vitality of many rural communities, and as a rich source of local employment.

How things look now

There are a large number of independent health services that provide care to people in rural Victoria. Victoria has significantly more rural health services compared to other states. This means that rural health services have a strong connection to local rural communities and have the independence to act locally to support those communities. However, some face significant challenges in relation to the sustainability and viability of local services.

The Department of Health and Human Services' *Strengthening our Regional Hospitals Initiative* supports proactive local solutions that better organise and deliver more sustainable services to local communities. This initiative has already supported health services to streamline local procurement processes, improve access to clinical services through the use of telehealth and establish more effective patient flow between services through the use of regional hospital bed management strategies.

What could we do better?

Primary and community health services working more closely with hospital networks across metropolitan, regional and rural areas could do more to establish sustainable and coordinated pathways to ensure access and appropriate care for people living in rural and regional Victoria.

Victorians have the right to expect access to high quality, safe care regardless of where they live, raising the question of what can be done to tackle variations in outcomes of care across rural and metropolitan Victoria.

Part of making care safer and improving outcomes for people in rural Victoria is their ability to access high-end care when they need it. People should also be able to recover close to home and we should consider how the system can best meet their expectations about getting back to their home and family as quickly as possible.

The Government has accepted the Travis Review's recommendation to develop a services and infrastructure plan to address these issues, with a 20-year outlook but a sharper focus in the first five years. The development of this plan should offer opportunities to think about the kind of infrastructure and capacity that is needed to achieve more equitable outcomes for people in rural and regional parts of Victoria.

In rural and regional areas, consideration of both private and public offerings are relevant. An example is a proposal for a health service alliance in the Upper Hume region to increase clinical capacity through integrated operational planning to benefit five health services and their communities. The services have identified that the key to achieving their objectives was to move beyond single service focused management to a proactive, planned, integrated regional response that manages demand and ensures patients are treated in a timely way in the appropriate setting.

Starting the conversation

What do we need to focus on to ensure that people living in rural and regional areas are able to achieve the same health outcomes as people in metropolitan Victoria?

How can we ensure rural health services are able to contribute to thriving and vital rural communities?

How do we ensure people in rural and regional areas get the high quality and safe care they deserve?



Valuing our workforce

Why this is important

Our health workforce is vital to the health and wellbeing of Victorians. The people in our health workforce provide quality care and positive patient experiences every day. They are the face of every Victorian's experience with the healthcare system. Every day they make a real and meaningful difference in the lives of their patients.

Victoria's health workforce is, however, facing challenges that confront the health system as a whole.

- By 2025, the number of health professionals and workers required to meet our healthcare needs is forecast to increase by as much as a third. At the same time, demographic change may result in relative shortages in some traditional workforce groups.
- Responding to the changing nature of demand requires new skills and different mixes in our workforce.
- People's expectations of care – and their involvement in it – are changing, demanding new skills and abilities on the part of those who provide care in our system.

How things look now

The Victorian health system currently employs over 260,000 people, with approximately 100,000 employed in our public health system for some or all of their working week. In addition, there are more than 90,000 individuals employed in social assistance services, together with more than 750,000 individuals doing voluntary work and around 500,000 providing unpaid assistance to a person with a disability.

What could we do better?

We cannot expect health workers to contribute to reform if they do not feel their safety and wellbeing is protected. They need to be able to work in environments that support them to take care of themselves and each other, as well as providing the best care for their patients. No one should feel unsafe at work and those who are on the frontline of health care – those who dedicate their lives to caring for others – should be able to feel safe and protected from violence and threats of violence in the course of their daily work. The Government's health service violence prevention fund is an important step in addressing occupational violence by helping make healthcare facilities safer for staff as well as patients and visitors. This will not solve the problem on its own. To do so will require the right training as well as leadership and cultural change. The Government has also set up an occupational violence task force to provide advice on ways to address the insidious problem of occupational violence.

To meet the changing needs of Victorians, the health workforce needs to be engaged in creating a more person-centred system. Changes to education and professional development may be one way to help the health workforce support people to make choices about their care and look after their own health and wellbeing.

The health workforce is not evenly distributed across Victoria, with relative shortages in rural and regional areas of the state. Thinking of new ways to tackle this problem is likely to be important to improving outcomes for all Victorians.

There is value in thinking about different ways to actively engage health workers in healthcare reform, together with health services, peak bodies, trade unions, the education sector and government. How can we make best use of the skills of the workforce, and what skills will be needed in the future?

Everyone will become a patient at some point in their lives. Every health worker is also a user of the healthcare system. This gives them a unique perspective and a vital role, not just in enacting reform, but in shaping its direction.

Starting the conversation

What more can we do to ensure health workplaces are free from violence and bullying, and health workers are empowered to innovate and participate in reform?

What kind of changes to education and training are needed to support reform?

How can the health workforce be better engaged in designing and delivering on healthcare reform?

References

AIHW (Australian Institute of Health and Welfare) 2012, *Cancer survival and prevalence in Australia: period estimates from 1982 to 2010*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2013, *Health system expenditure on cancer and other neoplasms in Australia, 2008–09*, Canberra

AIHW (Australian Institute of Health and Welfare) 2014a, *Australian hospital statistics 2012–13*, Health services series no. 54. Cat. no. HSE 145. Canberra.

AIHW (Australian Institute of Health and Welfare) 2014b, *Australia's Health 2014, Australian health*, series no.14, Cat. No. AUS 178, Canberra: Australian Institute of Health and Welfare

AIHW (Australian Institute of Health and Welfare) 2014c, *Health expenditure Australia 2012–13*, table 2.13, Canberra.

AIHW (Australian Institute of Health and Welfare) 2014d, *Cancer in Australia: an overview 2014*, Canberra.

AIHW (Australian Institute of Health and Welfare) 2014e, 'Health expenditure Australia 2012–13', *Health and welfare expenditure* series no. 52. Cat. no. HWE 61, Canberra.

AIHW (Australian Institute of Health and Welfare) 2015a, Life Expectancy [internet] <www.aihw.gov.au/deaths/life-expectancy/>, accessed 2 September 2015.

AIHW (Australian Institute of Health and Welfare) 2015b, Australia's health 2012: what's the good news? [internet] <www.aihw.gov.au/australias-health/2012/good-news/>, accessed 2 September 2015.

ACSQHC (Australian Commission on Safety and Quality in Health Care) & AIHW (Australian Institute of Health and Welfare) 2014, *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study*, Sydney.

Business Council of Australia 2011, *Selected facts and statistics on Australia's healthcare sector*, Melbourne: BCA.

COAG (Council of Australian Governments) Reform Council 2014, *Healthcare in Australia 2012–13: Five years of performance*.

Consumers Health Forum 2015 CSF survey shows support for expanded pharmacist role <www.chf.org.au/pdfs/chf/20150802-Pharmacists-and-GPs-survey.pdf> [media release; 2 August 2015], accessed 1 September 2015.

Duckett SJ, Bredon P, Weidmann B & Nicola I 2014, *Controlling costly care: a billion dollar hospital opportunity*, Grattan Institute, Melbourne, p12.

Horne M et al. 2013, *The business case for people powered health*, NESTA Innovation Unit, London.

IHME (Institute for Health Metrics and Evaluation) 2013, 'DALY estimates for Australasia' <www.healthmetricsandevaluation.org> reported in *Australian Institute of Health and Welfare (AIHW)*, 2014. Australia's Health 2014 Australian health series no.14 Cat. No. AUS 178, p98.

Lawrence D, Hancock KJ & Kisely S, 2013, *The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers* BMJ. 2013; 346:f2539.

OECD (Organisation for Economic Cooperation and Development) 2015, Compare your country <www.compareyourcountry.org/>, accessed 22 September 2014.

Productivity Commission 2014, *National health agreement performance information 2012–13*, Commonwealth Government of Australia, Canberra.

Runciman W et al. 2012, 'CareTrack: assessing the appropriateness of health care delivery in Australia', *The Medical Journal of Australia*, 197:100–105. Of the 35,573 eligible encounters, 66 per cent were at general practices, four per cent at specialist practices, 17 per cent at hospitals and 13 per cent at other practices.

Swerissen H & Duckett S 2014, *Dying Well*, Grattan Institute, Melbourne.

Thursfield V, et al. 2014, *Cancer in Victoria: Statistics & trends 2013*, Cancer Council Victoria, Melbourne

UQ News 2014, 'Closing the gap' for people with mental illness, <www.uq.edu.au/news/article/2013/05/closing-gap-people-mental-illness>, accessed 10 October 2014.

Victorian Government 2012, *Koolin Balit – Victorian Government strategic directions for Aboriginal health 2012–2022*, Melbourne, Department of Health.

Victorian Population Health Survey 2011–12, unpublished..

