

*Victoria—Public Hospitals
Policy and Funding Guidelines
1998–99*

Contents

Section A — Policy

Highlights of the 1998–99 Policy.....	1
1. Introduction.....	3
2. Purchasing Policy—Access, Quality and Efficiency.....	7
2.1 Increased Recurrent Funding.....	7
2.2 DVA Patients.....	11
2.3 Higher payment for Aboriginal and Torres Strait Islander Patients.....	12
2.4 Capital Expenditure.....	12
2.5 Activity Trends.....	13
2.6 Throughput WIES Targets.....	13
2.7 Network and Regional Targets.....	16
2.8 Same Day Medical Throughput and Caps.....	17
2.9 Unit Rates.....	19
2.10 Responses to Targets.....	19
2.11 Force Majeure.....	20
2.12 Major Changes in Services Provided.....	20
2.13 Superannuation.....	20
2.14 Workcover.....	21
2.15 Water and Sewerage Reform.....	21
3. Inpatient Classification and Cost Weights.....	22
3.1 AN-DRG Version 3.....	22
3.2 ICD-10-AM and AR-DRG Version 4.....	22
3.3 Coding Standards and Adjustments.....	23
3.4 HIV/AIDS.....	23
3.5 Calculation of Inlier Boundaries: Trim Points.....	23
3.6 New Same Day DRGs.....	24
3.7 Calculation of Inlier Weights.....	24
3.8 Prostheses Adjustments.....	25
3.9 High Outliers.....	26
3.10 Mechanical Ventilation Co-Payment.....	26
3.11 Thalesaemia.....	27
3.12 Rehabilitation.....	27
3.13 Specified Grants.....	28
3.14 Victorian Maintenance Dialysis Program (VMDP).....	29
4. Quality Programs—Hospital Access.....	31
4.1 Emergency Services.....	31
4.2 Elective Surgery.....	32
4.3 Critical Care Inter-hospital Transfers (CCIHTs).....	32
4.4 Purchase of Private Hospital Critical Care for Public Patients.....	33
4.5 Hospital Access Development Program.....	33
5. Training and Development / Research.....	34
5.1 Medical.....	34
5.2 Nursing.....	35
5.3 Allied Health.....	35
5.4 Research.....	35

6. Non-Admitted Patients and Emergency Services Funding.....	36
6.1 Victorian Ambulatory Classification System.....	36
6.2 Non-Admitted Patient Grants - Other Hospitals.....	37
6.3 Emergency Services Funding.....	37
6.4 Radiation Oncology.....	38
7. Quality Programs—Effectiveness, Safety, Performance.....	40
7.1 Maternity Services Enhancement Strategy.....	40
7.2 Pneumococcal Vaccination.....	41
7.3 Best Practice.....	41
7.4 Infection Control.....	41
7.5 Clinical Risk Management.....	41
7.6 Performance Indicator Development.....	42
7.7 Patient Feedback Indicators.....	42
7.8 Accreditation.....	42
7.9 Statutory Immunity.....	43
8. Quality—Ambulatory Services Development.....	44
8.1 Post Acute Care.....	44
8.2 Hospital in the Home.....	44
8.3 Home Enteral Nutrition (HEN).....	44
8.4 Continuous Positive Airways Pressure (CPAP).....	44
8.5 Artificial Limbs.....	45
8.6 Palliative Care Substitution.....	45
8.7 The Family Choice Program.....	45
8.8 Service Development Projects and Reviews.....	45
9. Casemix Formula.....	47
9.1 Variable Payments.....	47
9.2 Other Grants.....	47
9.3 Enhancement Programs.....	49
10. Modelled Budgets.....	50
11. Specific Programs and Technical Details	
Appendix 1: Consultation and Liaison	
Appendix 2: Metropolitan and Rural Targets	
Appendix 3: Hospital Access Program	

Section B — Conditions of Funding: Acute Health

Section C — Supplementary Information

Current Cost Weights—Inpatients

Current Cost Weights—Victorian Ambulatory Classification and Funding System

Calculation of WIES

Regional Contacts

Section A — Policy

Highlights of the 1998–99 Policy

Highlights of the 1998–99 Policy

- The 1998–99 budget consolidates past reforms and recognises the need for growth, over time, to meet current and future demand for hospital services. It provides a continuation of the key initiatives to enhance performance and manage demand in a more strategic manner. Additional funding (\$133 million) has been provided to account for wage increases, growth in demand due to population growth and technological change, improvement to maternity services and the decline in private health insurance among Victorians.
- In 1998–99, a total of \$76.7 million is provided for quality initiatives. This includes \$29.5 million for the Hospital Access Program.
- Additional funding of \$12.9 million is allocated to enhance maternity care by increasing antenatal and postnatal care provision; improving maternity services for women with special needs; promoting care during pregnancy and childbirth that reflects best available evidence on effectiveness; and improving the provision and quality of information on care options for women using maternity services.
- In metropolitan areas during 1998–99 and 1999–2000 the Austin and Repatriation Medical Centre (including relocation of the Mercy Hospital for Women which will continue to be managed by the Sisters of Mercy), and the proposed new hospitals at Berwick and Knox will be put to contestable tender. In rural areas the Latrobe Regional Hospital has been managed by Australian Hospital Care, Ltd since February 1997 with the commencement of services from the new hospital scheduled for August/September 1998. Tenders will be received during June for the new Mildura Hospital.
- For metropolitan Networks, the 1998–99 policy delivers modelled budgets and aggregate throughput levels which deliver modest growth. Activity targets have increased for most metropolitan Networks and Barwon Health with increases targetted to outer metropolitan areas. It is expected the Networks, in their fourth year of operation, will continue to deliver a steady improvement in performance covering quality, efficiency and access to a full range of services.
- With the exception of funding for veterans and Aboriginal and Torres Strait Islanders, the broad pricing system introduced two years ago will continue. This incorporates a strong base level of throughput (Target A) and growth options at three levels: a 2 per cent margin for flexibility; options; and a Tender Pool. The Tender Pool will continue for Networks and rural hospitals to enable them to undertake additional throughput volume at price rates specified by them. The Tender Pool has been increased by some 40 per cent.
- A major new funding program for veterans is under negotiation. When implemented, a new casemix based price will be available to all public hospitals treating veterans in Victoria. This price will be higher than that provided for other public patients, and hospitals are advised to develop service quality and marketing plans to attract and retain veterans.
- Higher payments will be provided for all Aboriginal and Torres Strait Islander inpatients to enhance their care. It is estimated that, in Victoria, Aboriginal and Torres Strait Islander patients account for about 0.6 per cent of all public hospital WIES. In 1998–99 the WIES6 formula will provide an additional payment for these patients. All Aboriginal and Torres Strait Islander patients will be funded at 10 per cent higher than the usual payment for WIES6.
- In 1998–99 ambulatory casemix funding will continue for all major (that is, Group A) hospitals. These hospitals provide about 75 per cent of all outpatient services. This system pays on the basis of encounters in clinical specialty categories. The new ambulatory classification and funding system will also be extended to the rural regional hospitals at Ballarat and Bendigo. Compensation funding has been continued this year with some minor adjustments following a review of targets and performance.

- Same day medical caps will be standardised and set at the level of 6.5 per cent across the State.
- As part of the introduction of the ambulatory classification and funding system, the funding of emergency departments has been previously shifted from an historical basis to one based on current costs and activities. This has been reviewed and there are more categories and a broader range of funding for the 1998–99 year.
- In 1998–99 the new ICD-10-AM coding system will be introduced. 1998–99 separations and WIES will be coded in terms of the new ICD-10-AM codes and assignment of DRGs will differ from those used in the targets. Any financial impact will be neutralised through the introduction of a specific code mapping adjustment factor for each hospital.
- A major emphasis on rural hospitals will continue. The Rural Specialist Services Grant pool will total \$7.6 million. The payment for each specialty will be up to \$60,000. Eligibility requirements for the Rural Specialist Services Grant have been changed to enable hospitals to have greater flexibility in using this funding for an appropriate mix of specialties. There is a continuation of funding for rural hospital self-sufficiency (\$3.5 million) and new developments through the Healthstreams Program. Healthstreams is a service and funding model that encourages flexibility in the design and delivery of a diverse range of health services and substitution of acute hospital-based care to more appropriate forms of care.
- The Hospital Access Program brings together the former Elective Surgery and Emergency Services Enhancement Programs and the recently established targets for Acute Inter-hospital Transfers. It provides a common incentive program that encourages an integrated approach to managing demand for these services.
- Up to \$3 million will be available to help implement strategies recommended by the Infection Control Taskforce to improve infection monitoring and control in hospitals throughout Victoria.
- Additional money of \$2 million will be transferred to the Public Health Division to fund pneumococcal vaccination for all Victorians aged more than 65, through their general practitioners and other providers. It is expected that this will reduce hospital emergency department attendances and demand for inpatient care, especially for those with chronic cardiovascular or pulmonary disease.
- Indicators of health care quality at a State and hospital level in areas of clinical care, safety and effectiveness will continue to be developed. Priority will be given to further development of measures of patient satisfaction with specific processes of care, and to indicators that examine discharge planning, infection control and adverse events.
- Funding to encourage hospitals to achieve accreditation will continue until the year 2000. By this time accreditation/certification will be mandatory for all hospitals funded by the Department to provide acute health care services.
- The major programs to encourage innovative models of care such as Hospital in the Home will be continued as will the Post Acute Care Program which provides targeted support to patients at high risk of hospital readmission.
- Networks and hospitals will be asked to submit proposals for projects that promote practical use of research evidence on effectiveness of health care, improve continuity and safety of care, or improve information for consumers.
- Major providers will be invited to submit plans for sums of up to \$200,000 per Network for projects that develop clinical resource usage and decision-making systems.

1. Introduction

1998–99 will be the sixth year of casemix funding. It marks the consolidation of improvements to established policies for inpatient and outpatient funding and refinements to major access and performance programs. The major objectives for 1998–99 funding are to improve access to appropriate care through growth and to maintain and extend quality initiatives.

At the time of printing, the Department was reaching the end of negotiations with the Commonwealth Department of Health and Family Services on the Australian Health Care Agreement. If the offer currently on the table is agreed there will not be any changes to funding in 1998–99 except that some funding may be available through the National Development Fund Sub-Program. In the event of a more attractive outcome, hospitals will be advised of targetted initiatives at the earliest opportunity.

There is international recognition that growth in population, ageing of the population and newly available clinical treatments, drugs, diagnostic tests and other technological developments are increasing the demand for and costs of hospital treatment. Additional funding has been provided for 1998–99 in recognition of this increase in demand. Targetted improvement of access to meet demand will continue through incentives to deal with priority areas, and attention will be given to prevention and the promotion of substitutes to hospital care. Allocation of growth WIES has been made to areas of greatest population growth contingent on hospitals' ability to supply services within access criteria. In 1998–99 there will be additional growth in throughput levels for specific providers; a lifting of the level of same day medical caps for all hospitals; and an increase in the number of tender WIES.

Certainty was given to hospitals in 1996–97 by the introduction of options as a means by which the Department contracted additional throughput. Hospitals were able to finalise planning of their year's throughput by end August, enabling early planning. This certainty is continued for 1998–99. The element of contestability will be increased this year by increasing the Tender Pool and enabling Networks and rural hospitals to tender for WIES in terms of volume and price within overall planning and appropriateness guidelines. Networks and rural regions are the major agencies for the planning and distribution of services.

At a State level, the Department will extend the scope of services it provides via contestable provider selection processes consistent with Victorian Government and National Competition policy. The Metropolitan Health Care Services Plan, released in October 1996, foreshadowed a significant private sector role in building new facilities to remodel and refurbish Melbourne's public hospital system. In metropolitan areas during 1998–99 and 1999–2000 the Austin and Repatriation Medical Centre (including Mercy Hospital for Women), and the proposed new hospitals at Berwick and Knox will be put to contestable tender. In rural areas the Latrobe Regional Hospital has been managed by a private group since February 1997 with the commencement of services from the new hospital scheduled for August/September 1998. Tenders are being received during June for the new Mildura Hospital.

Quality

Quality of hospital care will continue to have high priority. In 1998–99 additional funding (\$12.9 million) has been provided for the enhancement of maternity services. Funding will be provided to improve antenatal and post-natal services, to develop services for special needs groups, to encourage initiatives that promote effective care during pregnancy and childbirth and to improve consumer information on care options. A number of strategies to improve infection control in hospitals have been recommended by the Infection Control Taskforce. Additional funding has been provided to strengthen statewide systems for infection surveillance and control, and to assist hospitals to meet best practice guidelines in this area. Additional payments will also be made for all Aboriginal and Torres Strait Islander inpatients to enhance their care.

Further work to develop and report measures of quality of care will be undertaken in 1998–99. Such measures increase information available to the community about the performance of the health care system but are also essential for development of benchmarks and for feedback to acute health care providers. To ensure that there is a clear focus on patient needs, options for incorporating patient feedback into indicators of hospital performance will be further explored.

The focus on improving access to care by providing financial incentives to meet performance targets remains in 1998–99. The new Hospital Access Program brings together the former Elective Surgery and Emergency Services Enhancement Programs with recently established indicators for acute inter-hospital transfers for critically ill patients. Planning for similar targetted systems to promote other aspects of continuous quality improvement will be developed over the coming year.

Objectives

The major objectives for 1998–99 are to:

- Increase the number of patients treated in response to increased demand;
- Encourage providers to develop systems which measurably improve quality and are more consumer focused;
- Develop useful measures of health care quality;
- Improve access to antenatal and postnatal care;
- Improve current performance for emergency and elective services;
- Increase and standardise same day caps and undertake a detailed review of same day funding policies;
- Increase contestability and encourage further care innovations and efficiencies through the extension of the Tender Pool and a specific funding pool for rapid technological advances;
- Maintain the level of hospital outpatients with the continuation of VACS funding and the extension of VACS to Ballarat and Bendigo hospitals;
- Improve access to specialist services in rural areas and support local decision-making with rural hospital targets set by regional consultation and agreement; and
- Improve statewide systems of infection monitoring and control.

The development of the proposals and processes outlined in this document has been undertaken with extensive industry consultation. Industry groups have provided substantial advice and support in the development of general policy initiatives, classification and implementation issues. Details of committees are provided in appendix 1.

Metropolitan Services

Since their introduction, Metropolitan Health Care Networks have undertaken significant actions in improving the efficiency of their services through consolidation and restructuring across their various campuses. In November 1997, the existing North Eastern Health Care Network transferred part of its operations (primarily PANCH/Northern Hospital and the Bundoora Extended Care Centre) to the Western Health Care Network which became the North Western Health Care Network. The Austin and Repatriation Medical Centre was re-established as a independent entity, including Royal Talbot and Larundel.

Networks, in conjunction with the Department, have responsibility for ensuring increased equitable access to hospital services. One of the major directions of Victorian health policy is to redesign existing services to meet the needs of future populations and to ensure services continue to be accessible to changing populations. Network-wide targets with campus reporting allows Networks to redesign services according to local priorities, with appropriate accountability, within a State context.

In September 1997, the Southern Health Care Network voluntarily assumed management responsibility for a number of community health centres in its broad population area, enabling it to plan and provide a broader range of health services.

The major regional centres of Victoria also saw a significant amalgamation of health services during 1997–98. Barwon Health was created in April 1998 bringing together the Geelong Hospital, the Grace MacKellar Aged Care Centre and four community health centres in the Barwon and south coast areas. These elements together form a significant provider of the full range of health services for the Barwon region. This complements earlier amalgamations of acute and aged care services in the Ballarat Health Services and Bendigo Health Care Group.

Rural Services

Two major challenges face acute hospitals in rural communities. The first is maintaining access to specialist services at a time when it is difficult to attract and retain specialists in rural areas. The second challenge relates to small rural hospitals, and involves encouraging these hospitals to provide a wider range of community-based as well as bed-based health services. The policy for 1998–99 continues the policies established earlier to address both of these challenges. It is desirable that major regional referral hospitals and sub-regional hospitals have an appropriate range of specialist services so that rural people can access these services within their local area rather than travelling to Melbourne.

The Rural Specialist Services Grant will continue to foster and maintain specific specialty services in rural regional and sub-regional hospitals. In 1998–99, funding for each specialty will continue up to \$60,000, with the total amount to be spent \$7.6 million.

For the purposes of grant allocation under the Scheme, core specialist services include specialist services of general surgery, obstetrics and gynaecology, anaesthetics, and general medicine for sub regional and regional hospitals. For larger rural communities served by regional hospitals additional specialist services of paediatrics, orthopaedic surgery, psychiatry, geriatrics and rehabilitation and emergency medicine and other specialist services may be supported through the Rural Specialist Services Grant. Further details may be obtained from the Regional Provider Manager. Applications for these grants must be received by the Department prior to the 20 September 1998. Applications should be addressed to Regional Provider Manager.

The shortage of trained specialists in rural areas requires general practitioners to assume responsibility for delivering a greater range of services, particularly in the areas of obstetrics, anaesthetics, minor surgery and accident and emergency services. A Continuing Medical Education subsidy program for rural general practitioners commenced on 1 July 1996. The joint contribution to the costs of the program by the Department, hospitals and general practitioners will continue in 1998–99. The Rural and Isolated Grant has been retained at 1997–98 levels.

The Department has established the Healthstreams Program to enable more flexible funding and purchasing arrangements in small rural communities. Healthstreams now has eight agencies approved as participants in the Program with a further eleven agencies holding approved in principle status. These agencies have received Implementation Grants totalling almost \$300,000 to date. Considerable interest has been shown by other agencies in participating in this Program.

In 1998–99 rural regions will have an extended role in WIES allocation and Rural Specialist Services Grant recommendations. For 1998–99, a Rural WIES Transfer Transitional Compensation Grant has been established. Rural regions have responsibility for appropriate service planning and delivery within their region and the tables in appendix 2 reflect these regional allocations. In some cases this has meant the movement of WIES between hospitals within the region. A compensation grant will be paid for one year, 1998–99, to assist this transition. It is not applicable for WIES moved on a temporary basis during the year where hospitals perform under target.

2. Purchasing Policy—Access, Quality and Efficiency

The budgets for casemix funding from 1996–97 to 1998–99 are given in table 1. Table 1 shows a continuing modest increase in funding outlays.

Table 1: Casemix Funding Outlays 1996–97 to 1998–9

	1996–97 (\$M)	1997–98 (\$M)	1998–99 Budget (\$M)
Casemix Variable Payments			
Non-tional Fixed Grant	\$5.01	\$5.30	\$5.5
Variable Grant/ Additional Throughput	\$9.21	\$9.56	\$1,010
Performance Enhancement Program	\$2.0	\$3.4	\$3.0
Casemix Fixed			
Non-Admitted Patient Grant	\$3.58	\$3.56	\$3.72
Training and Development	\$1.32	\$1.27	\$1.16
Specified Grants	\$2.26#	\$2.62#	\$2.75
Other Grants	\$1.5	\$4	\$2.1
Total Budget	\$2,173	\$2,269	\$2,389

Notes:

Excludes Psychiatric Primary Care and Public Health Specified Grants.

- Figures for 1996–97 exclude Fairfield Hospital. Figures for 1997–98 exclude end of year throughput, elective and other adjustments, but includes post budget amounts such as \$17 million for increased HSUA wage agreements.

- Figures for 1997–98 and 1998–99 exclude funding under the Information, Information Technology and Telecommunications Strategy of \$25 million in each year.

- Totals may not add due to rounding

In 1998–99 the total Budget is \$2,389 million, an increase of 5.2 per cent over 1997–98 expected actual expenditure. The Government's budget process requires a annual productivity saving of 1.5 per cent from all Government sectors including the hospital sectors. This involves a return to Government from the Acute Health Program of \$27.5 million, however, as in past years these funds have been returned to hospitals for specific purposes.

The Department's budget for hospitals includes provision to pay agreed wage increases during 1998–99 and an allowance for increases in non-wage costs. Additional funding has been provided to public hospitals to meet increasing demand for public inpatient services associated with population growth and ageing; the impact of new technology; and the continuing decline in private health insurance coverage. Funding has also been provided to maintain and improve the quality of patient care, with a specific initiative providing additional care for maternity patients.

High levels of industry performance have been achieved since the introduction of casemix funding. The *Report on Government Services Provision* published in 1998 provides an interstate comparison of Victoria's hospitals against those in other States, while information on individual Victorian hospital performance is published quarterly by the Department in the *Hospital Services Report*. This report includes information on inpatient activity; access to emergency services and elective surgery; and enables comparisons to be made between individual hospitals.

In previous years, Departmental funding and monitoring has been provided in terms of WIES. This year, the concept of WIES equivalents has been introduced to adequately account for additional throughput and funding for renal dialysis, radiation oncology and emergency department services.

2.1 Increased Recurrent Funding

2.1.2 Growth

Population Growth: The Victorian population is growing at approximately 0.9 per cent each year. The ageing of the population is expected to increase demand for public hospital services by a further 0.7 per cent per year, as older people have a much higher per capita use of hospitals than others and tend to stay in hospital longer because of generally slower recovery and associated illnesses. This estimate is consistent with data agreed by the Commonwealth and all States as part of the Australian Health Care Agreement renegotiations. To meet these combined demand factors additional recurrent funding of \$28.8 million (1.6 per cent) has been provided. Additional inpatient throughput will be largely undertaken in hospitals in the middle and outer suburban areas of Melbourne as these are areas where demographic change is greatest. Growth in renal dialysis and emergency departments will also be met from these funds.

Technology Growth: Public hospitals will receive additional recurrent funding of \$10 million to meet costs associated with new technological developments ahead of them becoming factored into annual case weights. New technology, including new drugs, can enable treatments for conditions previously untreatable. It often increases the cost of the initial treatments but with a more reliable or longer beneficial impact. Examples include cardiac and aortic stenting, more sophisticated implantable electronic devices for cardiac conditions and movement disorders, and microsurgery. Guidelines for applicants will be finalised and distributed in August 1998. Notional 1998–99 grant allocations based on 1997–98 allocations have been included in modelled budgets.

Offset for Decline in Private Patient Revenue: Public hospitals will receive additional recurrent funding of \$9 million to cover the revenue lost as a result of the continuing decline in the number of patients holding private health insurance. This revenue replacement will not normally be available when policy choice, for example co-location of a private hospital, has led to the revenue decline. In such cases there may be several factors at work and each case will be examined on its merits.

2.1.2 Quality

Improved Measures: Quality of hospital care will continue to have high priority. In 1998–99 work will continue on quality of care measures. This will increase the information available to the community about the performance of the health care system. It will also be an essential component for future development of incentive schemes to encourage providers to improve quality. Substantial improvements in access to emergency and elective surgical services have been obtained by providing hospitals with financial incentives to improve performance. Planning for similar targetted systems to promote other aspects of continuous quality improvement will be developed over the coming year.

To continue the focus on patient needs, options for incorporating patient feedback into indicators of hospital performance in areas such pre-admission and post discharge planning and information provision will be explored. Work on clinical and safety indicators, particularly in the area of infection control and adverse events will also be undertaken.

Improved Access: The Hospital Access Program (HAP) replaces the previous Elective Surgery Enhancement and Emergency Services Enhancement Programs. Elements of these two programs have been incorporated into HAP together with indicators designed to decrease the level of inappropriate inter-hospital transfers of patients requiring critical care. Targets are set for waiting times for urgent and semi-urgent elective surgery procedures; for access to, and waiting times in, emergency departments; and for numbers of critical care inter-hospital transfers. Incentive funding of \$29.5 million statewide will be paid to Networks and hospitals prospectively on the assumption that individual targets will be met. Failure to achieve performance targets will result in bonus funds being recalled. The method of purchasing private sector critical care beds for public patients will also change. From 1 July 1998 additional WIES will be allocated to the Austin and Repatriation Medical Centre and Networks providing adult intensive care, for the purchase of private hospital critical care services. Purchase of these services will continue to be coordinated by the Office of the Co-ordinator of Emergency and Critical Care Services (OCECCS).

Maternity Services: An additional \$12.9 million has been provided to improve maternity services throughout the State. In the 1998–99 financial year \$10.7 million will be allocated to networks and rural hospitals to improve coverage of antenatal programs and increase the level of postnatal care. The remaining money will be used to provide targeted services to women with special needs; improve birthing services for Aboriginal and Torres Strait Islander people; and fund projects designed to encourage system wide adoption of practices and care pathways that are known to improve the effectiveness of care in pregnancy and childbirth.

Infection Control: \$3 million will be allocated in 1998–99 to improve infection monitoring and control in Victorian hospitals. Infection control is an integral part of the day-to-day operation of any hospital and Network who are responsible for ensuring that their managers support and allocate appropriate resources for effective prevention, monitoring and control of infection within the facility. This year the Department will strengthen statewide systems to monitor and support the achievement of appropriate standards of infection control, and will implement the strategies recommended by the Infection Control Taskforce.

Pneumococcal Vaccinations: Additional funding of \$2 million will be transferred to the Public Health Division to fund pneumococcal vaccination for all Victorians aged more than 65, through their general practitioners and other providers. It is expected that this will reduce hospital emergency department attendances and demand for inpatient care, especially for those with chronic cardiovascular or pulmonary disease.

Clinical Risk Management: \$1 million will be spent to support and evaluate the current Clinical Risk Management pilot projects.

Best Practice Funding: Networks and hospitals will be invited to submit suitable funding proposals for best practice projects. \$0.75 million in funding will be distributed on a competitive basis. The Department will actively pursue strategies which encourage the use of health care practices which are known to improve health outcomes. Strategies to promote the use of clinical care pathways based on best available evidence; to decrease unplanned or inappropriate variations in care; and to improve information for consumers will also be developed over the next year.

2.1.3 Innovative Programs

Post Acute Care Program: Introduced in June 1995 as a joint Aged Care/Acute Health initiative, this program promotes early identification of patients at high risk of hospital readmission. \$6.2 million in total, of which \$4.2 million is contributed from the Acute Health Division, will continue to be provided to support post acute care projects in rural regions and metropolitan hospital Networks.

Substitution Initiative: The co-ordinated care trial in the Southern Health Care Network will continue in 1998–99. This project substitutes a range of health care services for acute hospital care, while improving health outcomes for patients. The co-ordinated care trial in the North Western Health Care Network, while predominantly focussing on aged care, also includes an acute substitution component, predominantly in respiratory disease care. This trial will also continue to be developed in 1998–99.

Management Information Initiatives: The successful response of hospitals to inevitable change is dependent on accurate and appropriate information systems. Hospitals require clinical and resource information from clinical costing and decision support systems to:

- Plan affordable clinical services within available funding limits;
- Manage actual clinical services against a plan;
- Develop and monitor clinical care pathways to reduce undesirable variations in care and improve effectiveness of care;
- Revise current clinical practices to improve quality and reduce unit costs;
- Bid for additional work at marginal cost;
- Use current resources in the best possible way, particularly in a network environment; and
- Plan revenues and costs over the longer term.

Fundamental to these requirements are information systems that produce patient level activity and cost data. The majority of major hospitals in Victoria have systems in place to provide this information. These systems however need refinement and upgrading.

In recognition of the importance of the availability of high quality, timely and relevant patient level cost data a series of initiatives for 1998–99 will be funded. Funding totalling \$1.5 million will be made available for 1998–99 for Group A hospitals for:

- The development of information and reporting structures appropriate to the needs of hospital managers and clinicians;
- The development and monitoring of clinical care pathways; or
- The development of feeder systems to improve the accuracy of information.

A forum will be held in July 1999 to communicate key findings from the model sites initiatives and a series of educational workshops for hospital decision support staff and clinical managers will be given. A series of workshops will be run for rural hospitals on the application and use of patient based activity and resource use reporting. Further details will be circulated.

2.1.4 Information, Information Technology and Telecommunications (I, IT & T)

Information, Information Technology and Telecommunications Strategy: A commitment of \$100 million over a period of four years has been made by Government towards improving the information technology capability in public hospitals. \$25 million will be provided again in 1998–99 for the further implementation of the Hospital Information, Information Technology and Telecommunications Strategy. Released in late 1996 by the Minister for Health, the Strategy has been well-received by the public hospital industry. The Strategy is phased over several years, and defines performance measures in the form of information capability at the end of each phase. Funding allocations have been made on the basis of business plans from Networks and priority plans for the rural technology alliances. These plans will be key components of local information technology strategic plans. The Hospital Information, Information Technology and Telecommunications Strategy is consistent with the Government's overall multimedia strategy. **Funding for 1998–99 will concentrate on resolution of Year 2000 problems.**

ICD-10-AM: ICD-10-AM is a superior disease classification to ICD-9-CM, with strong endorsement for timely implementation from clinicians and health information managers. Coded data which reflect current clinical practice are fundamental to hospitals maintaining adequate levels of service co-ordination, quality management and clinical service planning. Introduction of ICD-10-AM coding will require hospitals and networks to ensure that health information management and medical records administration personnel are competent in coding to the upgraded classification standards. Provision of the necessary staff development and resourcing by hospitals is considered a core activity and is part of WIES pricing and overall funding levels that have been provided to hospitals under the modelled budgets. Provision has been made in the I,IT&T programs for support of the systems upgrade necessary to support ICD-10-AM coding collection along with other required technical upgrades.

2.2 DVA Patients

The current arrangements for the treatment of Department of Veterans' Affairs (DVA) patients in public hospitals is scheduled to expire on 31 December 1998. The Department of Human Services (DHS) is currently negotiating with DVA for the provision of services in public hospitals for the period ending 31 December 2004. It is expected that the new DVA Agreement will come into effect earlier than January 1999 and perhaps as early as July 1998.

DVA and the Repatriation Commission have determined that they will, in the new agreement, fund on an output basis whether the service is provided in the public or private hospital sector. Negotiations with DVA have resulted in preliminary agreement to an attractive casemix price to be made available to public hospitals treating veterans in Victoria. This price will be differentially higher than that provided for other patients to allow higher levels of service for veterans.

At the same time DVA will considerably enhance veterans' ability to access private hospitals. A patient-level competitive market for veterans care is anticipated. DHS has obtained agreement from the Commonwealth Department of Health and Family Services that preferential access for veterans into Victorian public hospitals will be permitted, providing it does not impair public patient care. This will ensure the ability of public providers to compete on an equitable basis.

In line with the principles of the new DVA Agreement, in 1998–99 public hospital model budgets include funding at the current full variable plus fixed rate for all DVA patients. For the purpose of these calculations, DVA targets have been identified based on historical VIMD data. DVA patients will be separated from and not counted towards the Target A allocation which will be adjusted following removal of DVA patients. Until negotiations are finalised the anticipated new higher case price (above the full variable plus fixed rate) for veterans cannot be modelled.

For 1998–99 it is anticipated that there will be a transition arrangement such that hospitals losing DVA patients will be part compensated for the risk of revenue loss below historic levels and those gaining extra work will be funded at full rates. After year one, all funding will be on a net revenue basis. Details will be provided as soon as possible.

The payments for other DVA patient services, such as outpatients, admitted rehabilitation and psychiatric services will also be based on outputs delivered, but at an attractive differential price.

In April 1998, the Commonwealth Government announced that it would extend eligibility for the DVA Gold Card (this card entitles the holder to have DVA meet the costs of all their hospital and medical treatment) to all veterans who faced danger from hostile forces in World War II. It is expected that this will make a further 12,000 Victorians over the age of 70 eligible for DVA funded services in public hospitals from 1 January 1999.

Hospitals are advised to closely examine these changes and to develop service quality and marketing plans to attract and retain veterans.

2.3 Higher payment for Aboriginal and Torres Strait Islander Patients

It is estimated that, in Victoria, Aboriginal and Torres Strait Islander patients account for about 0.6 per cent of all public hospital WIES. In 1998–99 the WIES6 formula will provide an additional payment for these patients. All Aboriginal and Torres Strait Islander patients will be funded at 10 per cent higher than the usual payment for WIES6.

This initiative has been introduced in response to a recent National Aboriginal and Torres Strait Islander Casemix Study which found that the cost per casemix adjusted separation of treating indigenous patients was about 20 per cent higher than that of treating non-indigenous patients. However this study was based on a small number of hospitals in outback Australia and does not accurately represent experience in Victoria, where average length of stay is only slightly longer for Aboriginal and Torres Strait Islander patients than for other patients. In Victoria, additional costs for providing hospital care for Aboriginal and Torres Strait Islander patients are more likely to arise from social, cultural and economic barriers which frequently result in such patients presenting late in an illness. In addition, extra support and care are likely to be needed to provide culturally sensitive hospital services for Aboriginal and Torres Strait Islander people. This additional funding is expected to improve care for Aboriginal and Torres Strait Islander people and a review will be conducted.

The introduction of additional funding should provide an added incentive for hospitals to ensure that these patients are identified in reporting to the VIMD. The Department is committed to improving the recording of Aboriginality in its health data collections and to reporting on data quality to the Australian Health Ministers' Advisory Council. In accordance with this commitment, the Department will monitor the accuracy of recording Aboriginality in the VIMD and any increases in the reporting of Aboriginal and Torres Strait Islander admissions following the provision of increased funding.

2.4 Capital Expenditure

The 1998–99 Budget announced new capital spending for 1998–99 totalling \$16.7 million (total end cost of \$43.8 million) for the continuing implementation of the Metropolitan Health Care Services Plan. In rural areas, a package of acute capital works totalling \$16.1 million (total end cost of \$43.4 million) will also commence in 1998–99.

The Department has established a pool of capital funding from which allocations will be made across the Networks and non-Network public hospitals in 1998–99 for equipment and infrastructure maintenance purposes. **It is anticipated that allocations from this pool in 1998–99 will be for Year 2000 Compliance needs.**

2.5 Activity Trends

Over the past three years inpatient throughput has continued to increase in terms of total and same day separations and estimated casem ix funded WIES5 as seen in table 2.

Table 2: Activity Trends, 1995–96 to 1997–98 (estimated)

	1995–96	1996–97	1997–98*
Separations			
Total	854,075	883,534	898,750
Same Day	361,286	391,236	410,750
WIES5	733,182	745,600	756,000
Same Day Medical			
Separations	116,590	121,491	129,000
WIES5	35,198	37,060	40,000

* Estimated activity for 1997–98 based on July 1997 to March 1998 year to date figures.

* This Table differs from that presented in the 1997–98 Guidelines due to coding changes which have been applied to earlier years and the inclusion of unqualified newborns in all years of this table.

In 1997–98 funded inpatient WIES throughput is expected to reach approximately 756,000 WIES5. Over the past three years, separations have increased by 5 per cent. Most of this increase is due to same day cases, which increased by 14 per cent. Surgical same day cases increased at a faster rate (15 per cent) than medical same day cases (11 per cent). Same day medical WIES5 which is capped remains at approximately 5 per cent of total WIES5. This level is anticipated to increase with the introduction of a uniform, statewide cap of 6.5 per cent.

2.6 Throughput WIES Targets

Over 1997–98 substantial work was undertaken to examine population utilisation and to determine whether the base targets reflected current and/or expected utilisation. The results of this analysis in brief showed:

- Population utilisation is similar across the metropolitan areas, but with lower utilisation in outer growth areas;
- Population utilisation is generally higher in the country than in the city and the more rural the area the higher the rate of utilisation. This is to be expected and is likely to reflect both different patterns of service and underlying differences in health status. An exception is Geelong, with lower utilisation than comparable rural or metropolitan areas; and
- Multiple factors affect supply and demand for services and these factors are frequently interrelated.

Given this analysis which showed that there was no major disparity in particular metropolitan areas or rural areas, current target relativities were retained. These analyses will be circulated to all Networks and Regions to assist their planning processes.

Changes for 1998–99 are relatively modest and are based on both demand and supply factors especially the expected introduction of new services under the Metropolitan Health Services Plan. Growth in throughput has been targetted to the outer growth areas of the peninsula, south-east, outer-east and outer-west in metropolitan Melbourne and in rural areas to Geelong and Bendigo. A proportion (0.75 per cent) of Target A WIES has been reallocated into the Tender Pool to improve contestability and to introduce greater flexibility in service provision.

Aggregate throughput targets for metropolitan networks and rural regional aggregate targets will continue. This guarantees greater attention to local differences and complexities within Networks and rural regions.

In 1998–99 the unit of measure for casemix adjusted throughput will be formally known as WIES6. For more details and a formal definition see *Section 3—Calculation of WIES*.

2.6.1 Impact of ICD-10-AM on Meeting WIES Targets

AN-DRG Version 3 was introduced on 1 July 1997 and will continue in 1998–99. The grouping software used is AN-DRG Version 3.1.

From 1 July 1998, all hospital admissions will be coded to ICD-10-AM. Preliminary analysis has shown that for a hospital undertaking exactly the same work there will be differences between the WIES calculated under ICD-9-CM, the current system, and that calculated under ICD-10-AM. These differences will vary depending on the particular casemix of each hospital. Due to these expected differences, a code mapping adjustment factor has been developed for each hospital, based on its 1997–98 casemix. This factor calculates the expected difference based on an analysis of all cases in the 1997–98 acute patient population in the Cost Weight Study. The derivation of this factor will be circulated to all Networks, regions and hospitals.

The mapping adjustment factors will be applied to WIES after grouping on the mapped ICD-10-AM data to AN-DRG and WIES6 calculations at the hospital and Network level.

In terms of the payments to hospitals, this means that adjustments to WIES throughput values will only reflect actual throughput changes relative to 1997–98 and not fortuitous mapping adjustments between ICD-9-CM and ICD-10-AM. To achieve this, mapping adjustment factors may need to be revised at the 6 and 12 month reviews. This would most likely have a normative effect to return hospital budgets closer to the modelled budgets from the 1997–98 activity data.

2.6.2 Target A

The total number of WIES has been set at higher levels than those of 1997–98, reflecting growth funding.

In the metropolitan area (including Geelong) the Target A (excluding DVA) is 491,724 WIES6 and in the rural area 169,058 WIES6. Appendix 2 shows the comparison between 1997–98 and 1998–99 targets for inpatients in WIES5 terms.

Target A WIES will be funded at a rate comprising both notional fixed and variable components. The notional fixed component does not purport to directly relate to the level of irreducible or irremovable cost incurred by an individual hospital or Network. Rather this component is used to differentiate payment for different types of hospitals thereby reflecting varying infrastructure levels and economies of scale.

For major providers the Target A price will be \$2,197 for public patients and \$1,797 for private patients. Networks and hospitals will subdivide the annual Target A throughput into quarterly targets to aid monitoring of throughput during the year, and to assist scheduling of cash flows.

2.6.3 Target A Margin

As has operated over the past two years, a margin has been set at 2 per cent of Target A. This margin recognises that it is not always possible for a Network or hospital to precisely meet its Target A volume. Any throughput above the Target A level up to 2 per cent, will be funded, but at marginal rates. Similarly any short fall in throughput below the Target A level up to 2 per cent will result in reduction in payment at marginal rates. The margin for smaller hospitals (with an annual throughput of less than 2,000 WIES) has been set at between 2 and 4 per cent.

2.6.4 Option WIES

Options are additional WIES available to hospitals. They are optional in that providers can choose to accept or decline them. The unit rate has been set at \$1,368.

Option WIES are allocated to major providers, and other hospitals on the basis of the Department's assessment of demand, taking into account the Metropolitan Health Services Plan, past achievement of targets and general financial criteria.

There are 41,490 Option WIES⁶ available for distribution across the State in 1998–99. The number of Option WIES for individual providers has been adjusted in some instances to more fairly equalise price per total WIES prior to the bid for Tender WIES.

2.6.5 Tender Pool

Up to 15,000 WIES will be set aside in a Tender Pool. This pool provides the State with the opportunity to provide some throughput at marginal rates by hospitals or Networks who are able to provide additional throughput at lower prices or who have available capacity. The Tender Pool draws on the principles of the National Competition Policy by tendering a small portion (around 2 per cent) of the State's throughput to be provided by any public hospital, providing planning guidelines are met. It is anticipated that most work in the Tender Pool will be undertaken by major providers. However smaller hospitals outside the metropolitan area will also be able to bid for a portion of this pool.

Administrative details of the Tender Pool are set out below:

- Tender WIES will be offered in lots of 200 WIES for major providers (50 for other hospitals);
- Separate prices can be nominated for each lot;
- The tender should not result in throughput being diverted to an extent that Government planning and service guidelines are compromised;
- Hospitals or Networks are required to meet their contracts for their full allocation of Option WIES before they can enter the Tender Pool; and
- No reallocation by Networks or hospitals during the year is allowable.

Hospitals and Networks will be asked to nominate the volume and price at which they are willing to do work from the Tender Pool. Tenders will be required to be submitted by 15 August and will be allocated by 30 August, to enable certainty in hospitals' throughput planning. These tender WIES have been notionally allocated in the modelled budgets.

2.7 Network and Regional Targets

The following table sets out the targets for 1998–99.

Table 3: Metropolitan and Rural Targets, 1998–99

	Target A WIES6 (excluding DVA)	Margin A WIES6 (excluding DVA)	Option WIES6 (excluding DVA)	DVA Targets WIES6	Total WIES6
Inner & Eastern	109,392	2,185	8,874	6,199	126,650
ARMC	41,569	831	3,842	7,801	54,043
Peninsula	26,832	537	2,163	1,427	30,959
Southern	75,249	1,503	6,536	2,157	85,445
North Western	107,598	2,151	9,561	3,162	122,472
Women's and Children's	47,675	953	1,432	23	50,083
Barwon Health	29,719	594	1,694	2,197	34,204
Denominational	53,690	1,074	2,537	1,516	58,817
Total Major Providers	491,724	9,828	36,639	24,482	562,673
Barwon-South Western	23,350	528	236	1,679	25,793
Gippsland	35,349	744	889	1,818	38,800
Grampians	31,375	698	1,585	2,129	35,787
Hume	36,419	785	1,475	2,422	41,101
Loddon Mallee	41,445	904	479	3,690	46,518
Kooweerup	1,120	32	187	43	1,382
Total Rural Regions	169,058	3,691	4,851	11,781	189,381
Grand Total	660,782	13,519	41,490	36,263	752,054

Note: Figures exclude Tender WIES

2.7.1 Metropolitan Targets (including Geelong)

Almost half of the projected throughput for the major providers is provided through the Inner and Eastern and the North Western Health Care Networks. This year DVA WIES have been identified separately from public targets. In 1998–99, there have been major increases for the Peninsula Health Care Network, the Southern Health Care Network, and Barwon Health. Details are provided in appendix 2.

Campus level activity will be monitored to ensure consistency with the principles of the Metropolitan Health Care Services Plan. Any significant departure from the agreed service plans or indicative levels will be assessed by the Department. Quarterly targets at the network and campus level will be nominated by Networks and included in the Health Service Agreement (HSA). Significant departure from network target levels, (greater than 2.5 per cent) after consultation with the Network, may result in financial penalties. Same day caps will operate within overall WIES6 targets.

Targets (A plus Margin and Options) will continue to be administered quarterly at the network level. Non-admitted patients will have a budget ceiling for each hospital campus.

2.5.2 Rural Targets

In general, the allocation of throughput targets in 1998–99 shows a similar position to previous years, with an increase to Bendigo Health Service. Details are provided in appendix 2.

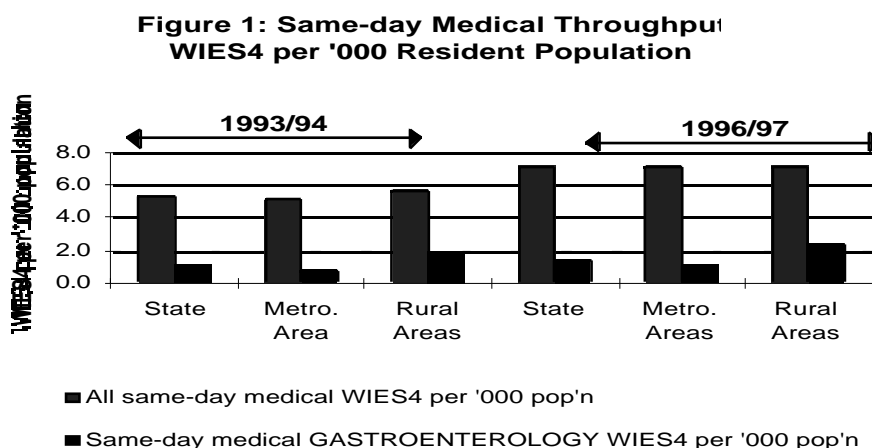
Allocations to individual rural hospitals will continue to be determined by rural regions. Reallocations have been decided on factors such as the achievement of throughput targets over recent years, and the planned direction of services within the region in future years.

Quarterly targets will be nominated by each Group B hospital and included in the relevant Health Service Agreement. This will assist monitoring of throughput and scheduling of cash flows. Significant departures from these targets (greater than 2.5 per cent) after consultation with the hospital and the Regional Office, may result in financial penalties. Same day caps will operate within the overall WIES6 targets. Details on individual hospitals are provided in appendix 2.

2.8 Same Day Medical Throughput and Caps

Same day caps were introduced in 1995–96 in response to the very high levels of growth in certain same day medical DRGs following the introduction of casemix funding. The aim of the caps was to ensure appropriate admission criteria were followed and prevent inpatient casemix payments for cases that should have been funded under outpatient block grants.

Same day caps apply to a limited set of medical DRGs and certain procedural DRGs. Caps should not affect the appropriate substitution of multi-day care for same day care for patients. Most cases where substitution is possible between a multi-day stay and a same day stay are grouped into DRGs other than those subject to a cap.

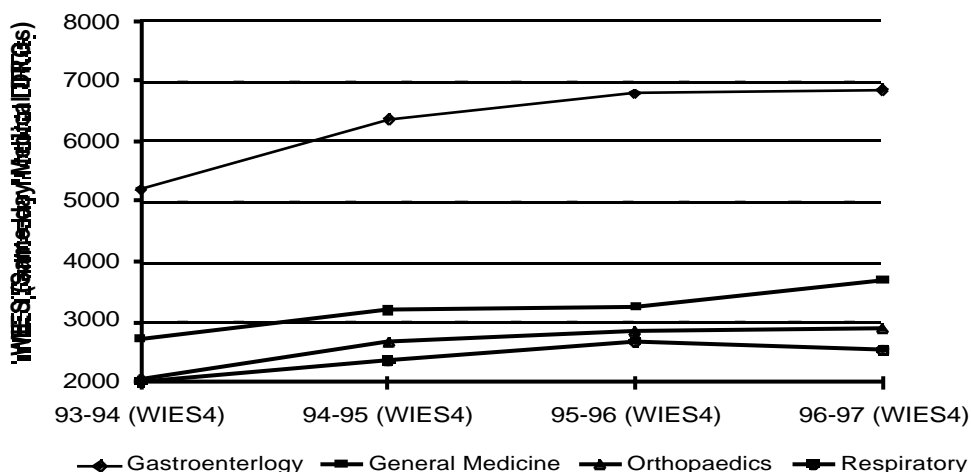


An examination of same day medical caps and throughput trends during 1997-98 showed that:

- The relative proportion of DRGs/episodes covered by same day caps varied substantially between hospitals;
- Same day medical admission practice varied considerably within and between hospitals;
- Same day admission rates vary between metropolitan Melbourne and rural Victoria, with the Peninsula Network having the highest rates of same day medical WIES4 per 1000 population;

- Same day DRG caps include a number that are based on procedures. Most of these DRGs are in gastroenterology; and
- Growth in same day medical throughput since 1994–95 is dominated by gastroenterology.

Figure 2: Same-day Medical DRG Throughput by specialty - Top four, Victoria



Same day medical throughput caps have to date been set at 1995–96 historic levels. For 1998–99 caps will be standardised at 6.5 per cent of total funded throughput across Victoria. Specialist hospitals will be excluded from same day medical caps and will not contribute to Network caps. These excluded hospitals are Royal Children’s Hospital; Royal Women’s Hospital; Royal Victorian Eye and Ear Hospital; Caulfield General Medical Centre; Peter James Centre; and Mercy Hospital for Women. Rural hospitals will be subject to the same level of caps.

In 1998–99 there will be:

- A full review of admission criteria and practice, and funding options for same day medical DRGs;
- A series of random hospital audits of patients admitted as same day medical DRGs to examine current practice; and
- A review of same day gastroenterological service provision which will examine hospital specific and geographic area specific trends in the provision of services; the logic of the inclusion of procedure based care in the list of target same day medical DRGs; the cost of service provision for metropolitan and rural hospitals; and possible funding options for 1999–2000.

2.9 Unit Rates

The unit rates for all WIES6 are given in table 4.

Table 4: Unit Rates, 1998–99

Target	Unit Rates per Public WIES6			Private
	Notional Fixed Rate	Variable Rate	Total Unit Rate	WIES6 Total Unit Rate
A Major Providers	\$829	\$1,368	\$2,197	\$1,797
Rural Group B (large)	\$843	\$1,368	\$2,211	\$1,811
Rural Group B (small) & C	\$864	\$1,368	\$2,232	\$1,832
Rural Group D & E	\$887	\$1,368	\$2,255	\$1,855
Margin A	–	\$958	\$958	\$678
Option	–	\$1,368	\$1,368	\$968
Tender		To be determined	To be determined	To be determined

The notional fixed grant was standardised in 1995–96, when hospitals in Group D and E received a higher rate than larger hospitals in recognition of their higher infrastructure costs relative to inpatient throughput; the relative inelasticity of many costs in smaller hospitals; and because of the reallocation of targets from smaller hospitals to the larger regional hospitals.

For 1998–99, as previously, it has been recognised that higher infrastructure costs also apply to smaller Group B (those with less than 10,000 WIES per year) and Group C hospitals in rural areas. Overall these hospitals have had fewer Option WIES allocated to them than have Networks and other major hospitals. Thus the notional fixed rate for these hospitals has been increased.

As larger Group B hospitals do not have these costs to the same degree, their notional fixed rate is unchanged. As for 1997–98, Barwon Health and the Networks have been grouped as Major Providers. Major providers have a lower notional fixed rate reflecting economies of scale in their infrastructure.

The variable payment will be \$1,368 per WIES6 and will be payable on all WIES (except those in the Target A Margin and Tender Pool). In 1998–99, the variable payment will continue to include the amount which used to be separately identified as the public medical payment.

2.10 Responses to Targets

2.10.1 Major Providers

Major providers are required as soon as possible, but no later than 1 August 1998, to advise the Department on:

- Quarterly throughput levels and indicative campus level throughput;
- The amount of allocated Option WIES that they will take up as proposed in table 3; and
- Their ability to comply with the timetable in respect of Option WIES.

Tenders for the Tender Pool WIES must be received by the Department by 15 August 1998. Formal notification of the outcome of the Tender Pool will be provided by 30 August 1998.

2.10.2 Group B Hospitals

Group B hospitals are also required to advise the Department by 1 August 1998 on:

- Quarterly throughput levels; and
- The number of Option WIES to be taken up (where appropriate).

Rural hospitals will also be able to tender for Tender WIES. Tenders are required to be received by rural Provider Managers by 15 August 1998.

2.11 Force Majeure

Circumstances (including industrial action), beyond the reasonable control of hospital management, may sometimes prevent the attainment of targetted throughput. In previous years, in these circumstances, the Department has, on a case by case basis, funded hospitals according to their cash flow projections irrespective of throughput, only for so long as force majeure continues. Hospitals are expected to mitigate their financial exposure and throughput decline during and following such events and will not be additionally funded for extra “catch-up” throughput in specific service areas undertaken around a period of force majeure. In general the relevant quarters performance will be used to determine the net impact of any period of force majeure.

2.12 Major Changes in Services Provided

Funding is provided to hospitals and Networks on the basis that the current range of services are continued. Before hospitals or Networks undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed and agreed with the Department. In rural areas the appropriate discussion should be held with the Regional Provider Manager or Acute Health Manager. In the metropolitan area, discussions should be held with the Acute Health Program and the Region. In all cases, the Director of Acute Health Division must provide the final approval.

2.13 Superannuation

The Superannuation Guarantee levy rate will increase from 6 per cent to 7 per cent from 1 July 1998 and funding available to hospitals has been increased to meet these costs. As in 1997–98, unfunded liabilities in respect of the Contributory Scheme are being met directly from the Department of Treasury and Finance.

With the implementation of National Competition Policy and the introduction of competitive neutral costing for Victorian hospitals from 1 July 1998, it is likely that hospitals will be outsourcing and privatising some of their business units. In these situations hospital employees who are members of the Contributory Scheme, and who take up employment with the private provider, may be provided with three options in relation to their accumulated benefits. They are:

- Receive resignation benefits;
- Defer their benefits; or
- Elect to transfer their benefits (referred to as the transfer benefit) in accordance with the section 9 of the Superannuation (Portability) Act 1989.

In the latter case, payment of unfunded liability becomes due if an “approved employee” accepts a position with an “approved employer”. Put simply, the benefit cannot be transferred without the unfunded liability being met. Therefore the employee will not have this option available unless hospitals request and receive prior approval from the Department before offering a transfer benefit to employees.

2.14 Workcover

There are two significant changes to Workcover in 1998–99. They are, first, a change to the definition of remuneration to include superannuation which took effect from 1 January 1998; and second, an increase in the average premium rate from 1.8 per cent to 1.9 per cent, to take effect from 1 July 1998.

Hospitals have not yet been billed for the period 1 January 1998 to 30 June 1998 in relation to the change in the definition of remuneration. The Victorian Workcover Authority has advised that certification forms will be sent to hospitals in July 1998 to calculate the required payment for the period, but payment by hospitals is not anticipated until November 1998.

Funding available to hospitals has also been increased to take account of the 1998–99 full year impact of the change in definition in remuneration and the increase in the premium rate from 1.8 per cent to 1.9 per cent of payroll.

2.15 Water and Sewerage Reform

In line with the Government's user pays policy for water, hospitals will be required to pay commercial rates for water consumption and sewerage disposal in 1998–99. Government has given an undertaking that hospitals will not be disadvantaged by this measure and \$3.5 million has been provided to meet these additional costs.

Water authorities will introduce a *Sewerage Disposal Charge* from 1 July 1998 which will have a financial impact on hospitals, as hospitals previously did not pay this charge. The charge is levied for the volume of waste sent through the sewerage system for treatment. In most cases the volume is not metered and a discharge factor of 90 per cent for hospitals has been put in place. This assumes that 90 per cent of the water metered as coming into the property goes into the sewer and a rate of between \$0.76 and \$0.78 per kl is applied (minus any allowance for trade waste). The options for hospitals are to:

- Accept the 90 per cent discharge factor;
- Carry out a self assessment to determine the appropriate factor;
- Install meters on discharge to sewer points; or
- Undertake a detailed audit to determine the appropriate factor.

Hospitals should contact their local water authority to ensure that a proper assessment has been undertaken.

The Department will be requesting each hospitals to provide an annual estimate of the impact of the new water and sewerage charges, based on their first quarter charges. If the total impact exceeds the amount of funds provided by Government, a submission will be made to Treasury to increase the amount provided to hospitals.

3. Inpatient Classification and Cost Weights

3.1 AN-DRG Version 3

AN-DRG Version 3 was introduced on 1 July 1997 and will continue in 1998–99. The grouping software used is AN-DRG Version 3.1.

The Department engaged Hospital Services Research Group to conduct the 1997–98 Victorian Cost Weights Study of 1996–97 inpatient activity. A review of all weights was undertaken and the proposed areas of change were considered both through the Cost Weights Study itself and through formal Departmental consultations.

After reviewing submissions from clinicians and hospitals relating to clinical issues impacting on the cost weights, a small number of DRGs were identified as requiring further investigation. Almost universally issues relating to these DRGs were found to be due to DRG classification issues requiring resolution through the Australian Casemix Clinical Committee or poor cost data.

A full list of weights is given in *Section C: Supplementary Information*. WIES6 amendments and a full explanation of WIES6 are given in *Section C: Calculation of WIES*.

3.2 ICD-10-AM and AR-DRG Version 4

AN-DRG Version 3.1 will continue for 1998–99, although hospitals will move to code inpatient admissions according to ICD-10-AM from 1 July 1998.

The implementation of ICD-10-AM will provide substantially improved data quality. Coded data which reflects current clinical practice is essential for casemix-based funding and development, service planning and coordination, and epidemiology and other clinical research. However, it will take some time before the DRG grouper software has been redeveloped to maximise the value of the additional ICD-10-AM precision.

Data collected in the Dual Coding Study suggest that the DRG allocation for some patients differs depending on whether clinical details are coded using ICD-9-CM directly or if clinical details were first coded in ICD-10-AM and then mapped back to ICD-9-CM for grouping to DRGs.

Preliminary data from the Dual Coding Study indicated that reductions for some groups of DRGs are greater than for others. As a result, some hospitals may be more likely to be affected and provision has been made to modify the funding policy to ensure that they are fairly treated. The Dual Coding Study was, however, relatively small (10,000 cases) and targeted to problematic DRGs. The mapping tables used were preliminary and have since been refined. Its results therefore do not predict mapping effects in the total Victorian data of almost 800,000 cases.

The National Centre for Classification in Health (NCCH) has provided a number of mappings between ICD-9-CM and ICD-10-AM. Forward mapping files provide ICD-10-AM mapped codes for each ICD-9-CM code and backward mapping files provide ICD-9-CM mapped codes for given ICD-10-AM codes. Each set of mapping files provides two types of maps: logical maps which give the most appropriate DRG allocation, and historical maps which give the most appropriate map on clinical meaning. In most cases the two are identical.

In addition, to lessen the impact of moving to ICD-10-AM the Department has developed an algorithm to improve the mapping of obstetrics codes based upon the presence of additional ICD-10-AM codes of Z37.* and Z39.0*, within the reported secondary diagnosis list. The mapping process will be incorporated into the construction of VIC-DRGs in 1998–99.

The effect of the move to ICD-10-AM on the ability of each hospital will be assessed and hospital specific code mapping adjustment factors used when comparing each hospital's coded throughput against target. Factors will be developed through comparing WIES6 allocation on 1997–98 VIMD data before and after simulated ICD-10-AM to ICD-9-CM mapping. Where necessary, adjustment factors will be re-assessed progressively through 1998–99.

Version 4 of the classification (AR-DRG 4) is expected to be available for implementation from 1 July 1999. A decision on its introduction must await further analyses. It will not be introduced before 1 July 1999. A collection of ICD-10-AM data is essential to the analyses and testing of the classification.

3.3 Coding Standards and Adjustments

The success and fairness of casemix funding is based on accurate and honest reporting of diagnostic information. Two coding audits have been conducted using 1993–94 and 1995–96 data. The 1993–94 data showed 86.5 per cent of the audited episodes were coded into the same AN-DRGs; 5.9 per cent were “overcodes”; and 7.6 per cent were “undercodes”. In 1995–96, same coding was 88.3 per cent, a slight improvement of 1.8 per cent; 5.0 per cent were “overcodes”; and 6.5 per cent “undercodes”. There are however differences across hospitals emerging that need closer examination.

It was decided to postpone a third audit planned for 1997–98 data due to additional hospital resources required for the introduction of ICD-10-AM coding. It is now planned to conduct an audit on ICD-10-AM codes and resultant AN-DRGs using 1998–99 data, commencing early in the 1999 calendar year. As well as providing a check on the accuracy of codes, the audit will be of great educational assistance to hospital coders using the new classification system.

It is intended that the next audit contract will cover a three year period to allow both annual audits and supplementary audits with larger sample sizes where the primary audit identifies hospitals with significant coding anomalies. In these cases the cost of the supplementary audit, VIMD data correction and WIES adjustment will be borne by the hospital.

3.4 HIV/AIDS

Due to changes in admission practice, coding and funding, this cluster of DRG codes has been assessed in light of the latest cost weight data. Some weights for these DRGs have increased significantly.

Part of the problem in the earlier weights appeared to relate to the classification of same day patients. The proportions of same day patients in the various HIV/AIDS DRGs differed significantly between the 1996–97 and 1997–98 Victorian Cost Weights Studies. Time series data demonstrated that the proportion of same day separations in these DRGs was variable, potentially resulting in inappropriate variations in the cost weights.

The Commonwealth has indicated that under AN-DRG Version 4 that all same day HIV/AIDS cases are likely to be in a single DRG.

After discussions with representatives of the Ministerial Advisory Committee on HIV/AIDS and Related Diseases and service providers and detailed consideration of all available data, an addition four HIV/AIDS DRGs have been designated as same day DRGs. In addition, AN-DRG 780 Chemotherapy, was split into VIC-DRG 778 (Chemotherapy without HIV/AIDS) and VIC-DRG 779 (Chemotherapy with HIV/AIDS).

3.5 Calculation of Inlier Boundaries: Trim Points

For WIES6 new inlier boundaries were calculated from the 1997–98 Victorian Cost Weights Study. For most DRGs the low boundary was set at a third of the average length of stay for the DRG and the high boundary was set at three times the average length of stay

for the DRG. Inlier boundaries were converted to integers by truncating the low boundary and rounding the high boundary. The average length of stay was calculated after excluding extreme cases (up to 2.5 per cent of the longest stays and up to 2.5 per cent of the shortest stays). Where more than 2.5 per cent of separations occurred in either the highest or lowest length of stay category, no cases were excluded. For example, in many DRGs more than 2.5 per cent of separations are same day so for these DRGs no separations were excluded under low trimming.

For some DRGs the low boundary was calculated using a multiplier of 2/3 rather than 1/3 and the high boundary was calculated using a multiplier of 3/2 rather than 3. These modifications were based upon clinical discussions during the development of WIES1 to WIES4 and are detailed in *Section C*.

Where no episodes occurred for a DRG within the Cost Weight Study data base, the WIES5 boundaries were retained.

After clinical consultations regarding an altered payment structure for DRG 003, WIES5 boundaries were also retained for DRG 003. (This modification resulted in a slightly higher high outlier boundary and fewer high outliers than if the boundaries had been calculated using the 1997–98 Victorian Cost Weights Study). The 1997–98 inlier boundary points were retained for DRG 954 as small numbers of patients with extended stay were considered likely to inappropriately increase the boundary and reduce the appropriateness of the payment rates for shorter stay patients.

For the purpose of calculating inlier boundaries, same day separations were excluded when calculating the DRG mean for those DRGs that had designated same day DRGs. In such cases including same day cases would have inappropriately lowered the high boundary point resulting in a large proportion of non-same day separations being classified as high outliers.

Exceptions to this trimming method are neonates; high cost AN-DRGs; and specific AN-DRGs where the trim points have been modified, as advised by clinical specialists, to better delineate between levels of patient severity. The trimming changes notified in 1997–98 have been continued for 1998–99.

3.6 New Same Day DRGs

Changes in clinical practice over the last few years has resulted in significant declines in average length of stay for many DRGs, resulting in substantially lower boundaries and in some cases lower weights. In many cases reduced length of stay resulted mainly from a higher proportion of patients being treated on a same day basis. Where reductions in inlier weights were identified as mainly due to high growth in same day cases, the DRGs were classified as same day DRGs. This resulted in twelve additional same day DRGs plus the additional four HIV/AIDS DRGs which were classified as same day DRGs. These are listed in *Section C*.

3.7 Calculation of Inlier Weights

Weights were calculated from the average costs of inliers based upon the new inlier boundaries. Trimming was undertaken according to the criteria used for the 1997–98 Victorian Cost Weights Study. In calculating weights the following adjustments were made:

- The average costs of some DRGs were increased to adjust for prosthetic costs;
- All weights were subjected to rebasing to maintain state wide WIES equivalence between WIES versions. This was done by calculating both WIES5 and WIES6 on the same twelve months VIMD dataset and then scaling all WIES6 weights by the ratio of total WIES5 to total WIES6. Agreed target WIES5 levels were adjusted by similar hospital specific indices;

- Where there were fewer than 150 inliers in 1996–97 and where 1996–97 average cost differed by more than 20 per cent from the 1995–96 average cost, data were combined for 1996–97 and 1997–98. This process was undertaken to reduce the extent of statistical variation due to small numbers. The exceptions were for the average costs associated with the HIV/AIDS DRGs (801 to 805), which were calculated on 1996–97 data to reflect changes in actual drug costs; and
- In some cases preliminary weights were inconsistent with grouper logic. For these DRGs data for multiple DRGs were combined for the purpose of calculating inlier boundaries and weights. For example, where the preliminary weight for the DRG with CC was lower than the preliminary weight for the corresponding DRG without CC, data for both DRGs were aggregated to calculate a combined set of inlier boundaries and corresponding weight.

In addition a number of DRG specific adjustments were made:-

- The total and variable inlier weights for DRG 148 were increased by the equivalent of \$20,000 to incorporate the cost of cochlear implants previously paid via specified grants;
- The average cost of DRG 003 was reduced by 20 per cent to adjust for the extension of mechanical ventilation payments to DRG 003;
- Between the 1995–96 Victorian Cost Weights Study and the 1997–98 Victorian Cost Study cost increases for same day patients in DRG 421 (knee procedures) were considered unlikely. The 1998–99 weight has been set based upon an average cost mid way between these points. The appropriateness of the reported costs will be examined during the coming year; and
- Rapid growth in both separations and average costs for multiday patients within DRG 942 (other factors influencing Health Status Age >79 or W CC) occurred between the 1996-97 and 1997–98 Victorian Cost Weights Studies. Growth was particularly pronounced for patients with principal diagnosis related to social reasons for admission. Consequently the 1998–99 weights have been set at last year's values while the appropriateness of casemix payment for these patients is assessed.

3.8 Prostheses Adjustments

Historically, prostheses costs have been poorly allocated to patients within hospital information systems. In many cases, costs associated with prosthetic devices are recorded under operating room costs and allocated accordingly. Consequently, under WIES4 and WIES5, adjustments were made to increase the reported average price for a number of DRGs where prosthesis costs were known to be significant. Data collected from the National Costing Study Service Weight Study and data from two Victorian Hospitals were used as a basis for making these adjustments. Costs were part recovered by reducing theatre costs across most surgical DRGs.

The adjustment for prostheses were recalculated for WIES6. This was necessary because the adjustment factors used previously, based upon data collected for patients admitted in the early 1990s, did not accurately reflect current medical practice and prosthetic prices. Further, in the 1997–98 Victorian Cost Weights Study eight hospitals reported prostheses costs separately. Consequently, a significant proportion of prosthetic costs were allocated by the hospitals, lessening the need for adjustment.

Adjustments were made by assuming that hospitals that were unable to allocate prosthesis costs have the same average prosthetic costs as the hospitals that allocated prosthetic costs to individual patients. For the purpose of calculating WIES6 weights, the average cost of inliers was adjusted for prostheses in 41 DRGs where the prosthesis adjustment increased the average cost by at least \$20 and by at least 1 per cent of average costs.

For nineteen DRGs, the average cost allocated to patients in 1996–97 was significantly lower than the previous adjustment factor. In these cases the previous adjustment factor was used as the basis for adjustment rather than the average from the eight hospitals.

For three DRGs this process appeared to give anomalous results. The WIES4 adjustment for lenses (DRGs 98 & 99) was significantly higher than the published price in 1996–97. The average cost reported by hospitals, however, was significantly lower than the published price. After consultation, the prosthesis adjustment was set at the highest price of prostheses actually used plus an allowance for ocular fluid.

The other DRG treated differently was DRG 241 where the changed method of adjusting for prostheses resulted in a reduction in prosthesis costs of almost \$10,000. Because of the large reduction, advice was obtained about preferred prosthesis for this DRG. Based upon this advice a prosthesis cost of approximately \$8,000 higher than the reported average cost in the eight hospitals was used in developing the cost weights. This increase related to recent development of a superior prosthesis. Actual costs will be reviewed in 1998–99.

3.9 High Outliers

High outlier weights have been adjusted to ensure that, when using Network payment rates, variable payments for high outlier days are at least \$125 per day (equivalent to the nursing home rate) and no more than \$496 per day. As for WIES4 and WIES5 high outlier weights are adjusted by the specific high outlier adjustment factor. Surgical DRGs were allocated a high outlier factor of 0.7, medical DRGs were allocated a high outlier factor of 0.8 and some specialist DRGs were allocated a high outlier factor of 1.0.

Implicit in the allocation of the high outlier factor is the assumption that high outlier days on average cost less than inlier care. This assumption was questioned by some hospitals during 1997–98. Data provided by the Royal Children’s Hospital suggested that, for a few DRGs, while the intensity of care given to high outliers reduced over time the cost of care past the high boundary was still significantly higher than the average daily cost for inlier care. However, the significance of the results were difficult to interpret due to small sample size. Average daily costs for inliers and high outliers were compared based upon the Victorian Costing Study data for the DRGs identified as potentially having high outlier per diems by the Royal Children’s Hospital. These data supported the Royal Children’s Hospital data for two DRGs (DRG 718 and DRG 725). High outlier weights have been set at 1.2 and 1.3 for these DRGs based upon average daily costs from the cost weight study.

As the costs associated with prostheses and theatre are usually incurred early in a patient’s stay these costs are excluded when calculating high outlier WIES for DRGs with significant theatre and prosthesis costs.

With the complexity for trimming and outlier weights increasing as more precise costing data become available, a review of trimming and outlier funding policy is planned for 1998–99 in consultation with AR-DRG Version 4 evaluations.

3.10 Mechanical Ventilation Co-Payment

3.10.1 Extension to DRG 003

During 1997–98, analysis of the available data for DRG 003 (Tracheostomy except for Mouth Larynx or Pharynx, Age > 15) demonstrated that a considerable proportion of the variation in costs for patients allocated to DRG 003 related to the time spent in ICU rather than the time spent in hospital. Time spent in ICU, and days of mechanical ventilation, varies considerably between hospitals for inliers and it was therefore decided to provide a separate funding factor for mechanical ventilation in this DRG.

Under WIES6, DRG 003 will be eligible for mechanical ventilation co-payments after a patient has spent four days on mechanical ventilation (i.e. day 5 is the first day for which co-payments are made). The setting of a threshold for mechanical ventilation co-payments means that the costs associated with the first 4 days of ICU are fully included in the inlier weight for DRG 003. This is consistent with the grouper assignment of patients with more than 94 hours of continuous ventilation to this DRG and with the observation that many non-ventilated patients in this DRG spend about four days in intensive care.

3.10.2 Mechanical Ventilation Co-payment Rate

During 1997–98, the accuracy of the co-payment rate (0.7729) for mechanical ventilation was checked against the 1997–98 Victorian Cost Weights Study data. Given that the co-payment represents an adjustment for treating the most severely ill patients in ICU, the total ICU cost, less the total indirect ICU costs for eligible DRGs, was divided by the estimated number of mechanical ventilation days. This estimate of the per diem cost of mechanical ventilation was very similar to the current payment rate (0.7729 * Full WIES price).

The WIES5 mechanical ventilation co-payment rates will be retained for WIES6:

- 0.7729 WIES6 per eligible day on mechanical ventilation; and
- 3.132 WIES6 per eligible neonate episode on mechanical ventilation.

To be eligible for the copayment the patient must:-

- Have been ventilated for at least six hours (or 102 hours for DRG 003);
- Be admitted to a hospital with a recognised intensive care unit; and
- Be allocated to a DRG which is eligible for the co-payment.

3.11 Thalesaemia

Thalesaemia cases were demonstrated by costing data to require more resources than other patients within relevant DRGs. For 1998–99, each thalesaemia case in DRGs 760 and 761 will continue to receive a co-payment of 0.2648 WIES. These WIES will be part of the hospital's WIES target and general funding arrangements

3.12 Rehabilitation

Rehabilitation is an area that requires special attention as the nature of its activities do not readily fit into one AN-DRG category. In recent years considerable work has been undertaken to assess the feasibility and development of a new classification system, and in 1998–99 a proposed funding model that will more accurately reflect the diverse nature and cost of services required by rehabilitation patients will be circulated for discussion and possible implementation on 1 July 1999. This funding model is based on the Casemix Rehabilitation and Funding Tree (CRAFT) classification.

Analyses have been carried out on a full year's rehabilitation data from the Victorian Inpatient Minimum Dataset (VIMD). The preliminary model developed through clinical and statistical analyses has been further modified on clinical advice.

In brief, rehabilitation will be classified according to sixteen sub-groups: two groups are for stroke-neurological patients; seven groups for orthopaedic patients depending on type of procedure and functional status; one for cardiac/pulmonary patients; and a separate category each for spinal injury, burns, head injury and patients with amputations. There are a further two groups for general "other" rehabilitation.

Cost weights for payment for the sixteen categories have been provided from rehabilitation cost data which has been collected from a small number of acute hospital rehabilitation units as part of the 1997–98 Victorian Cost Weights Study.

A paper detailing the new funding model will be circulated to the field for comment in July 1998. The paper also proposes that funding for spinal, amputation, head injury and burns patients should not be based on cost weights but, due to the nature of these patients and the type of rehabilitation required, be provided by a specified grant.

Designation status would also be retained with the introduction of the model. Over 1998–99, issues relating to the introduction of the model, such as outlier payments, and admission and discharge rules will be addressed, and working groups will be formed to provide input and recommendations. Seminars will be also be held during the year to refine

the proposed model. Shadow budgets outlining the impact of the introduction of the model will be provided to agencies during 1998–99 and refinements incorporated into the model.

Rehabilitation grants for 1998–99 will continue on a similar basis as previous years. Bed day payments will continue in 1998–99 at rates comparable to those established for Aged Care Services Output Group 113, with increments for Consumer Price Index (CPI) factors.

Funding will be provided at the following rates:

Level 1:	\$345 per bedday
Level 2:	\$287 per bedday

A capped number of beddays will be allocated to designated agencies for each level of service.

3.13 Specified Grants

In 1998–99 specified grants will continue to be paid to compensate hospitals for services which do not fall neatly into inpatient or outpatient service arrangements, and for classes of hospital care which DRGs do not measure well. The following specified grants will be retained with some modifications in 1998–99:

- Heart and Liver Transplants;
- Neonatal Intensive Care Unit (NICU) Cots;
- Spinal Injuries;
- Neonatal Cardiac Surgery;
- Paediatric Cardiac Investigations; and
- Paediatric Weights.

Non-English Speaking Background Grants will continue in 1998–99. These grants are available to all public acute hospitals with greater than 1,000 annual admissions of patients from non-English speaking backgrounds (NESB) and are aimed at helping hospitals to develop planned and integrated approaches to service delivery for these patients. In 1998–99 the non-admitted component of the NESB grant, previously identified as part of the Victorian Ambulatory Classification System, will be combined with the existing NESB specified grant.

The Department is aiming to improve the future allocation of NESB grants and to develop performance indicators for hospitals in receipt of these grants, to help ensure that the grants are being used to meet identified needs in this area. Better information on the preferred language of service users is required in order to meet these aims. A trial to develop ethnicity identifiers for frontline service providers is currently being undertaken as part of a joint Commonwealth Department of Immigration and Multicultural Affairs / Australian Bureau of Statistics initiative.

All specified grants will be subject to review as a means of improving the identification of acute health outputs.

3.14 Victorian Maintenance Dialysis Program (VMDP)

Maintenance dialysis services are funded by way of a combination of a fixed capitation grant and WIES throughput payments. Updating overall dialysis costs is not a component of the annual cost weight study. A study to examine renal dialysis service provision and costs, in the context of the VMDP, was put to tender in early 1998, with the successful tenderer being ACIL Consulting. Based on the results of the study, and after consultation with the Renal Dialysis Clinical Committee, program grants for the five treatment modalities have been set for the 1998–99 financial year.

As per the recommendation of ACIL Consulting, hospitals participating in the VMDP will continue to receive funding in two components — the fixed capitation grant and a WIES equivalent throughput (variable) payment. The variable payment for in-centre and satellite haemodialysis has been retained at approximately \$17,182 per patient per annum. The variable component for peritoneal dialysis is included in the fixed capitation grant. Table 5 provides a comparison of the 1997–98 and new 1998–99 fixed capitation grant.

Table 5: Fixed Capitation Grants 1997–98 and 1998–99

Treatment Modality	1997–98 Fixed Capitation Grant per patient per annum *	1998–99 Fixed Capitation Grant per patient per annum
In-Centre:	\$26,400	\$24,526
Satellite:	\$26,400	\$19,517
Home Haemodialysis:	\$32,200	\$27,809
Continuous Ambulatory Peritoneal Dialysis:	\$34,200	\$34,992
Intermittent Peritoneal Dialysis:	\$34,200	\$25,180

* Contains capital component of approximately \$5,000 per annum.

All but one of the program grants for the five treatment modalities were set at the price recommended by the consultants. The price for satellite treatment is higher than the recommended price.

The study revealed that the cost of in-centre dialysis is higher than satellite dialysis due to in-centre patients requiring a particular procedure not required by the type of patients receiving dialysis at satellite centres. This is reflected in the higher capitation grant for in-centre patients. The option of continuing the weighted average of the in-centre and satellite rate was considered but was not adopted as it would impact disproportionately on hospitals with significant winners and losers according to the ratio of in-centre to satellite utilisation. Although more costly, the alternative of fully reimbursing in-centre costs and paying a premium for satellite treatment of \$1,500 per patient per annum has been preferred.

The study of renal dialysis service provision and costs did not specifically address capital equipment replacement, but noted that a solution to the problem of capital consumption was integral to a long term plan for the provision of services. This issue will be addressed and a capital funding solution determined by 1 October 1998. The report also recommended that the Department consider tendering out renal dialysis services in the medium term.

The study revealed that, over the period of June 1995 to June 1997, the number of total dialysis patients in Victoria grew an average 1.95 per cent per quarter, or 8.03 per cent per annum. The highest level of growth was in satellite patients, while the number of patients in other treatment modalities was stable or declining slightly. Home haemodialysis has shown the most significant change with patients declining from 200 in June 1995 to less than 150 in June 1997. The above growth rate and use of treatment modalities are expected to continue in 1998–99 and funding for these levels has been provided.

4. Quality Programs—Hospital Access

Appropriate access of patients to elective surgery, emergency and critical care services is an essential attribute of a high quality health care system. The provision of funding through the Hospital Access Program (HAP) is an incentive for Networks and individual hospital campuses to improve patient access to these services.

The HAP has been introduced for 1998–99 to bring together the former Emergency Services and Elective Surgery Enhancement Programs and recently established indicators focussing on inter-hospital transfers of critical care patients. This approach recognises the interrelated nature of demand management across these three areas and emphasises the need for an integrated approach by Network/hospital management to service delivery, including bed management, in order to attain a balance in meeting demand for elective, emergency and critical care services. Details are provided in appendix 3.

Incentive funding to hospitals has been modelled on the assumption that targets for Networks and hospitals will be met. Failure to achieve performance targets results in bonus funds being recalled.

Commencing in 1998–99, bonus payments will not be paid until the Acute Health Schedule of the Health Service Agreement is signed.

4.1 Emergency Services

Incentive funding to improve the delivery of emergency department services and encourage improved management of hospital beds was introduced in 1994–95 under the Emergency Services Enhancement Program (ESEP). Since the Program's introduction, there has been a significant improvement in the access to and timeliness of patient treatment in hospital emergency departments.

Performance criteria will continue to focus on the:

- The time the most urgent patients (categorised as triage 1, 2 or 3), wait to be treated;
- Waiting times of patients requiring admission to a ward; and
- The number of occasions of ambulance bypass.

For 1998–99, the major change to the emergency services performance criteria has been to admission block targets. In 1998–99:

- Targets are expressed as the proportion of admissions blocked compared with the total number of emergency department admissions to a ward, rather than as actual numbers;
- An annual benchmark for admission block targets has been determined, based on the average performance of the two best performing hospitals with an emergency department level of E1. This benchmark does not apply to all hospitals. However, the expectation is that hospitals will reach or exceed it in 2000–2001;
- Actual 1998–99 annual targets have been set for individual hospitals by determining their performance expectations in relation to benchmark performance;
- Hospitals will determine quarterly targets to achieve the annual target, in consultation with the Department. This will provide flexibility for changes in services; and
- Seasonal issues, such as the specific timing and extent of influenza outbreaks, have been built into the targets in two ways. Firstly, proportional targets allow for variations in the actual number of admissions blocked, as long as they are in line with fluctuations in the emergency department workload (as reflected by admissions). Secondly, enabling hospitals to determine quarterly targets in consultation with the Department means that higher targets can be chosen for quarters when there is greater demand on hospitals, because of factors such as influenza and related conditions. Should epidemiological data indicate more than one influenza outbreak in the same financial year or a more

serious outbreak than usual, the Department will give consideration to reducing bonus recall.

4.2 Elective Surgery

Incentive funding to improve the delivery of elective surgery was introduced in 1994–95 under the Elective Surgery Enhancement Program (ELSEP). Since the Program's introduction, the number of patients requiring urgent elective surgery (category 1 patients) waiting longer than the clinically recommended 30 days has reduced to virtually nil. In addition, despite continuing pressure placed on public hospitals due to a growth in the cost and quantum of demand for elective surgery and a decline in private health insurance levels:

- The number of patients requiring semi-urgent surgery (category 2 patients) waiting beyond the clinically recommended 90 days has been more than halved since the Program was introduced; and
- The total number of patients on the waiting list has stabilised.

For 1998–99, targets for category 1 patients remain at 1997–98 levels, that is all of these patients should be treated within 30 days.

The major change to the elective surgery performance criteria has been to targets for category 2 patients and total waiting list numbers:

- Annual target reductions for category 2 patients have been maintained at 24 per cent;
- Annual target reductions for total waiting list numbers have been maintained at 6 per cent;
- Annual targets for category 2 patients and total waiting list numbers have been based on adjusted 1997–98 targets rather than 1997–98 performance; and
- Hospitals will determine quarterly target reductions for category 2 patients and total waiting list numbers to achieve the annual target reduction, in consultation with the Department. This enhances the ability of hospitals to manage seasonal fluctuations in emergency and non-elective critical care services, as well as plan for events, for example, capital works programs.

4.3 Critical Care Inter-hospital Transfers (CCIHTs)

The transfer of critically ill patients has been reviewed within the Office of the Co-ordinator of Emergency and Critical Care Services. While some transfers are unavoidable, transfer of such patients generally needs to be kept to the minimum.

A critical care inter-hospital transfer as defined in this Program is a transfer of a patient from one public hospital to another for intensive or coronary care. To reduce the current level of transfers of such patients indicators have been introduced for 1998–99.

The indicators compare:

- The number of patients transferred because no intensive care bed is available, with the total number of intensive care patients; and
- The number of patients transferred because no coronary care bed is available, with the total number of coronary care patients.

Current data can provide information on the utilisation of intensive care and coronary care services, but it has not been possible to accurately measure the current number of critical care inter-hospital transfers at the hospital level, or to set performance benchmarks or targets based on comprehensive data. For 1998–99, targets for each participating hospital have been negotiated between Networks and the Department, based on the best available hospital and Departmental data on the current level of hospital and statewide transfers.

Future data collected through fields introduced to the 1998–99 version of the VIMD will enable the setting of benchmarks and timeframes. It is anticipated that a benchmark approach will be implemented in 2 to 3 years.

4.4 Purchase of Private Hospital Critical Care for Public Patients

In addition to transfers within the public system, public patients may be transferred to private hospital intensive care and coronary care beds, when there are no appropriate critical care beds available in the public system.

These transfers are authorised by the Office of the Coordinator of Emergency and Critical Care Services (OCECCS). To date payment for the treatment of these patients has been met by the Department via a budget allocation to the OCECCS.

In 1998–99, the Austin and Repatriation Medical Centre and Networks which provide adult intensive care will take financial responsibility for transfers of public patients to the private sector. The OCECCS role in authorising these transfers will not change. Private sector utilisation will continue to be approved only when no public critical care beds are available.

The funding allocation provided to Networks and the Austin and Repatriation Medical Centre for these transfers is based on non-same day WIES activity for 1996–97, and may be used to expand critical care bed capacity to limit the need for transfers to the private sector. Networks and the Austin and Repatriation Medical Centre will be responsible for the cost of purchasing private critical care should they exceed their allocated funding.

OCECCS will continue to receive funding for the purchase of critical care from private hospitals for patients transferred from rural hospitals and the Women's and Children's Health Care Network and public patients presenting to private hospital emergency departments for whom no public beds are available.

4.5 Hospital Access Development Program

The need for ongoing development of Networks and new approaches to access will also be recognised through the implementation of a Hospital Access Development Program during 1998–99. This Program will rechannel recalled Hospital Access Program funds to projects which improve access practices.

5. Training and Development / Research

During 1997–98 review of the framework for the allocation of the Training and Development Grants has continued. This work is not complete, but significant enhancements to allocation systems have been implemented while others are foreshadowed for 1999–2000.

5.1 Medical

In 1997–98 the Grant was allocated as a block payment based on pre-existing funding levels to clearly indicate that the Grant should not be seen as a salary payment, but rather as a contribution towards the costs inherent in professional training and development.

In 1998–99, 5 per cent of the Grant will be linked to an evaluation of hospital performance in relation to training to ensure that expenditure of the Grant results in training of an acceptable quality. The proportion of the Grant applied to performance will rise in the following year to 10 per cent. Subsequent changes to this proportion will be dependent on a review of performance criteria and compliance by hospitals.

Performance Criteria for Eligibility for the 5 per cent payment include:

- ITAC accreditation for all subsidised intern positions;
- College accreditation for specialist training positions;
- Certification of candidate training plans available on an annual basis;
- Documented rural training agreements for rural rotations;
- An annual report from supervisors to provide details of the program, achievements and plans for the forthcoming year; and
- An evaluation tool administered for all positions attracting the Grant providing information on quality and comprehensiveness of training experience.

In March of each year, hospitals will be surveyed to record the number and variety of training positions to enable the Department of Human Services to maintain an overall picture of the training component of the medical workforce.

The 1998 survey has quantified the disparity between funded and actual positions. In light of the pending implementation of recommendations by the Commonwealth's Medical Training Review Panel, and consolidation of service changes at metropolitan networks changes, no changes are proposed for funding levels in 1998–99. It is anticipated that during 1998–99 the Department will undertake further analysis and benchmarking. Further the March 1999 survey and pending recommendations of the Australian Medical Workforce Advisory Committee (AMWAC) will inform possible reallocations in 1999–2000.

In 1998–99 the medical component of the Training and Development Grant has been reduced by \$16.5 million — equivalent to the amount of funding provided for medical officers only on the basis that they are full-time employees. This component of the Training and Development Grants does not relate to teaching and training but is a vestigial element of the original Training and Development Grant pool which included input funding as a surrogate for complexity. As the AN-DRG system and cost weight data have become more sophisticated, the Training and Development Grant pool has been progressively reshaped. This component of funding has been absorbed into the WIES funding pool and reduces the productivity saving requirement on WIES price.

5.2 Nursing

1997–98 saw the introduction of funding allocations for continuing nursing education programs. Networks and hospitals were asked to submit detailed business plans and subsequently \$1.7 million has been allocated. This initiative will continue and it is anticipated that this pool of funds will increase to \$4 million in 1998–99. A similar process to that employed in 1997–98 will inform allocations, however it is intended that clearer guidelines will be provided to assist with the preparation of program proposals.

Modifications to the funding levels paid per nurse were implemented in 1997–98 and a rural supplement of \$250 was introduced for nurses undertaking post-graduate nursing courses requiring metropolitan clinical placements. In 1998–99 the payment per graduate undertaking a nurse program will decrease further while the amount for nurses undertaking post-graduate nursing courses will increase. The rural supplement will remain the same at \$250.

In 1997–98, funds were made available to hospitals providing clinical placement of 50 days or more in an academic year to student midwives, who previously had not been funded through the post-graduate payment under the Training and Development Grant. \$3000 per student was provided to hospitals. It is anticipated that this will increase in 1998–99. It is proposed that over time, parity be sought between this payment for clinical education of student midwives and that paid for student midwives under the post registration training program.

5.3 Allied Health

Initial work on a review of the undergraduate allied health component of the Training and Development Grant has commenced, and it is anticipated that 1998–99 will be used to develop an output based formula for allocation on the basis of clinical placement days. Financial modelling and industry consultation will occur prior to changes being implemented.

5.4 Research

The 1998–99 Budget included additional funding (\$4 million) for medical research. These funds, managed by the Public Health Division, are expected to flow predominantly for increased infrastructure support for medical research institutes, with some funds allocated for specific medical and public health research initiatives.

Hospital funding for research support within the casemix funding model will not change from 1997–98. Hospitals should take note of the 1997 Report of the Parliamentary Economic Development Committee Inquiry into Medical and Public Health Research in Victoria and ensure that they fully and transparently account for research support funds.

Capital funding for independent or co-located medical research institutes will continue to be considered on an annual basis as part of the overall capital program.

6. Non-Admitted Patients and Emergency Services Funding

6.1 Victorian Ambulatory Classification System

General and specialist services in outpatient and emergency departments play a key role in the health care system and represent a vital service and interface between inpatient and community care. The Victorian Ambulatory Classification System (VACS) was introduced for funding purposes from 1 July 1997 for all Group A hospitals. 1998–99 will see the continuation of activity based funding for outpatient services in all Group A hospitals and the extension of the VACS system to the Ballarat Health Services and the Bendigo Health Care Group. Data from the system has been provided to all Networks and hospitals and a short paper will be circulated in 1998–99 detailing the full first year results.

The system has been designed to be relatively neutral in its impact on existing services and, as for 1997–98, there will be no growth incentives for outpatients. Budgets will continue to be capped meaning that hospitals will be allocated a specified maximum budget. Funding in 1998–99 is guaranteed up to the budget ceiling. Where hospitals failed to reach target levels set for 1997–98, adjustments for the current year have been made. Where activity fails to reach target levels across the agreed profile of services, the variable grant may be adjusted during the course of the year. The only notable difference in funding for 1998–99 is that compensation grants have been retained at 50 per cent of 1997-98 levels. Details are provided in *Section 9 Casemix Formula*.

6.1.1 Clinical Panel

The VACS Clinical Panel has evaluated all new and reviewed clinics notified by hospitals to the Department during 1997–98. Hospital specific clinic schedules for 1998–99 have been set and hospitals will be advised of changes to their individual clinic schedule by August 1998. The process of notification of clinic changes will continue during 1998–99.

The Clinical Panel has recommended that VACS 116 (Complex Nephrology and Renal Failure) should be collapsed into VACS 108 (Nephrology). This recommendation is supported for 1998–99.

The section of this document, *Casemix Formula*, describes the funding components of the non-admitted patient grant for 1998–99. Further details on the development of VACS, the definition of the “encounter” and the ambulatory funding model are outlined in the publication *Victoria—Public Hospitals Policy and Funding Guidelines 1997–98*.

6.1.2 Reporting and Audit

Reporting under the new system will continue through the Agency Information Management System (AIMS). Reports on occasions of service need to continue as part of State responsibilities under the existing Commonwealth/State Medicare Agreement. The AIMS S9 form will be used for reporting data as part of the Victorian Ambulatory Classification System for non-admitted patients funded by Program 111.

In the case of a new clinic commencing during the year, or changes to existing clinics, assignment to a VACS category will be made by the hospital. The hospital will be required to advise the Department of any changes occurring during the year. An annual review by the Clinical Panel will assess the assignment of all new and reviewed clinics.

During 1997–98 an audit was undertaken and a report on its findings will be circulated in August 1998 to Networks and hospitals. Generally the system has been found to be reliable, stable and accepted by the hospital field. Modifications to definitions in some

categories require to be made and hospitals will be informed through the usual channels over 1998–99.

6.2 Non-Admitted Patient Grants - Other Hospitals

Outpatient budgets for the remaining Group B hospitals will continue to be divided into an emergency services grant and an outpatient grant. The Emergency Services Grant has been established on the same basis for Group A hospitals.

Non-admitted patient budgets for Group C, D and E hospitals will essentially be unchanged from 1997–98.

6.3 Emergency Services Funding

The Discussion Paper *Paying for Hospital Emergency Care* outlined a number of possible solutions to improve and identify emergency service funding. The Department has acted on several of the recommendations of the report since its release in March 1997. During 1997–98 key activities have included:

- The establishment of a joint Taskforce comprising representatives of the Victorian Branch of the Australasian College for Emergency Medicine, the Victorian Ambulatory Classification System Advisory Committee, hospital emergency departments (including a non-metropolitan hospital) and the Emergency Nurses Association;
- The collection of updated information on emergency department staffing numbers and costs in all Group A and B hospitals; and
- A review of the categorisation of emergency departments based on the staffing numbers and related costs, the organisational arrangements in place and an assessment of relevant activity data.

Following a review of all available data by the Emergency Services Categorisation and Funding Taskforce it was agreed that staffing data, both in terms of staff numbers and costs, continues to be the most appropriate data on which to base the emergency services grants. The existing model for establishing the funding levels will therefore continue for 1998–99. The categorisation of hospital emergency departments for the purpose of establishing emergency service grants for 1998–99 is outlined in table 6.

The review of more current data has resulted in adjustments for particular hospitals. In addition these figures include 1997–98 adjustments for CPI and prospective wage award increases which were not identified in the *1997–98 Policy and Funding Guidelines*. It must continue to be stressed that the grant does not represent the total actual emergency department cost, as emergency services funding is also provided through inpatient WIES payments. Training and Development Grants also funds staff working in all areas of hospitals, including hospital medical officers and registrars.

Table 6: Emergency Department Categorisation and Notional Funding Levels for 1998–99

Categorisation & Funding		Hospitals
E1	\$8.330 million	Alfred, Austin and Repatriation Medical Centre, Monash Medical Centre, Royal Melbourne Hospital
E2	\$5.186 million	Box Hill, Dandenong, Frankston, Geelong, Northern, St Vincent's, Western (Footscray)
E3	\$3.624 million	Ballarat Base, Bendigo, Maroondah,
E4	\$2.082 million	Angliss, Goulburn Valley, Latrobe Regional
E5	\$1.562 million	Mildura, Wangaratta, Warrnambool
E6	\$1.041 million	Central Wellington, Hamilton, Sandringham, Swan Hill, West Gippsland, Williamstown, Wodonga
E7	\$0.520 million	Wimmera, Echuca, Bairnsdale
E9	(Specialist)	Royal Children's Hospital (\$4.165m), Western (Sunshine) (\$2.916m), Royal Victorian Eye & Ear Hospital (\$2.082), Royal Women's Hospital (\$1.041m), Mercy - East Melbourne (\$0.729m)

6.4 Radiation Oncology

A system for defining and measuring non-admitted radiation oncology services for four hospitals: Alfred Health Care Group; Geelong Hospital; Peter MacCallum Cancer Institute; and Austin and Repatriation Medical Centre has been developed with assistance from these hospitals. In 1998–99 a standard payment rate will be introduced for key components of radiation oncology services, with additional payments for specialist services not provided in all four centres, and for growth. Revenue arrangements already in place will continue. The funding comprises four key components:

- A variable payment for megavoltage therapy costs with each hospital given a target number of weighted activity units, based on throughput achieved in 1997–98. Average cost weights for megavoltage courses, simulation, dosimetry and consultations have been derived from industry wide cost data based on 1994–95 figures prepared by Robert H Wilson & Associates. No separate targets will be set for these individual components, and centres will be free to allocate resources between these components, provided the target number of courses is met. Where a centre does not meet its target activity levels, funding may be reduced. Price per weighted activity unit for 1998–99 will be \$99;
- Associated costs closely related to megavoltage activity will be paid at a standard rate to all hospitals. Based on previous cost estimates, these costs are calculated at 45 per cent of the variable payment rate. The associated costs include categories of:
 - Other Associated Departmental Costs (such as allied health);
 - Patient transport;
 - Patient Accommodation; and
 - Education Costs;
- Specified grants will be paid to cover other payments made by the Department for specialist services, not delivered by all four sites. These include SXRT, DXRT, Brachytherapy, and Stereotactic Radiosurgery and are based on historical payments; and
- Additional payments will be made to each hospital for growth of output in 1998–99, up to a limit of 2.5 per cent. This recognises that radiotherapy treatments are increasing as the population increases, and that existing levels of treatment are considered below accepted norms. In addition, recognising that output has grown by 15 per cent in the three years to 1997–98, past growth of 2 per cent from hospitals will be recognised.

Given that the introduction of output funding for outpatient radiotherapy services has been under active consideration over the past two years, using a model similar to that adopted, a

full transfer to the new funding model will be made in 1998–99 without any transitional funding arrangements. Payments will be made subject to the transmission of a data report from each centre indicating occasions of service undertaken. The data will continue to be transmitted using the existing electronic method involving the completion of Form 111-S8 of the Agency Information Management System (AIMS). This is consistent with the funding conditions of other services/outputs.

7. Quality Programs—Effectiveness, Safety, Performance

7.1 Maternity Services Enhancement Strategy

This Strategy will be implemented over a four year period with \$12.9 million available in 1998–99, building to \$16.4 million recurrent funding in 1999–2000.

The objectives of this major initiative are:

- To promote improvements in the continuum and quality of care available to women with differing needs for antenatal, intrapartum and postnatal care;
- To provide women with information about available options for care and information about the effectiveness of these options to enable informed decision making; and
- To improve services and health outcomes through the promotion of practice based on best available and clinical guidelines evidence and the development and implementation of performance indicators.

\$9.7 million for additional postnatal care will be allocated to Networks and rural regions according to the number of births in hospitals in 1996–97. Part year funding amounting to \$1 million will be allocated to Networks and rural regions for increased provision of antenatal care. Funds will be provided in the form of specified grants and hospitals will be required to demonstrate measurable improvement in the provision of antenatal and postnatal care. Particular attention will be given to the strategic targeting of services to women with special needs, who are at risk of poorer health outcomes, and to improving continuity of care, particularly with respect to community providers of antenatal and postnatal care and support. The performance of hospitals in improving services will be closely monitored, including through targeted patient satisfaction surveys.

Participation in antenatal care, birthing and postnatal health outcomes have been shown to be poorer for Aboriginal and Torres Strait Islander women and their babies. Under the Commonwealth Birthing Services Program in Victoria, there have been several successful pilots of antenatal and postnatal support provided by Aboriginal and Torres Strait Islander health workers in collaboration with hospitals and community medical services. However, to date there has been no recurrent source of funding to build on this work. Part year funding of \$0.2 million, building to \$0.6 million full year funding, will be provided to community managed aboriginal health services for community health workers to assist women and infants with antenatal, intrapartum, and postnatal care.

The Department wishes to collaborate with clinicians and health care managers; with consumers; with community providers; and with colleges and other professional organisations to improve the effectiveness of maternity care across the state over the next four years. In 1998–99, \$2 million will be available for the investigation of effectiveness of care and evidence based practice; evaluation of models of care; costing studies; and initiatives for the provision of consumer information and improved communication between health care providers and mothers and their families. Priorities for development will be established in collaboration with stakeholders and submissions sought from a range of organisations with expertise in service delivery, strategic development, clinical research and program evaluation.

In association with the implementation of this strategy, hospitals will be required to provide additional patient level data on postnatal domiciliary care. These data will be provided at a patient level through the Agency Information Management System to allow for linking with the VIMD. Hospitals will be expected to participate and collaborate in research and evaluation conducted as part of the maternity services enhancement strategy. Allocations for maternity services have been incorporated into the modelled budgets for the Networks and notionally set for rural hospitals. Final allocations for rural hospitals will be determined by the Regional Office.

7.2 Pneumococcal Vaccination

Additional funding of \$2 million will be transferred to the Public Health Division to fund pneumococcal vaccination for all Victorians aged more than 65, through their general practitioners and other providers. It is expected that this will reduce hospital emergency department attendances and demand for inpatient care, especially for those with chronic cardiovascular or pulmonary disease.

7.3 Best Practice

Many hospitals are participating either in local or national initiatives to research and encourage 'Best Practice'. The Department sees this as an important development in improving patient care. As an incentive to directly foster these elements of best practice a limited amount of funds (\$0.75 million) was allocated last year. The aim was to encourage hospitals and provide models for other hospitals to meet standards beyond the current industry standards.

Projects within this Program includes an assessment of outcomes for medical and surgical management of miscarriage; a review of radiotherapy services in Victoria; research on increasing the number of organ donors; and a major stroke project.

Chest pain evaluation areas are being piloted in three major emergency departments. This is the second year of a three year pilot for which a total of \$1.8 million dollars will be provided over the course of the pilot program.

The Department will continue to encourage the provision of care which is in accordance with known best practice. Limited initiative funding will be available for programs or projects that promote practical use of research evidence on effectiveness of health care. Networks and hospitals will be invited to submit suitable funding proposals for projects that promote integration of available knowledge on effectiveness into routine service delivery; improve continuity and safety of care; or improve information for consumers. Detailed information on format of submissions, eligibility criteria and external review procedures will be circulated to all Networks and hospitals in August 1998.

7.4 Infection Control

Infection control is an integral part of the day to day responsibilities of every hospital in the State. The Department will support statewide programs for monitoring, investigating outbreaks and providing expert advice on infection control. The \$3 million allocated to improving infection control surveillance and practices will also be used to provide some supplementary funding to help networks and hospitals meet best practice guidelines.

Infection control processes, policies and resources were audited in all Victorian acute public hospitals in 1997–98. Hospitals were notified of local issues of immediate concern, identified by the Infection Control Taskforce, to be remedied by June 1998. To address longer-term issues Taskforce recommendations will be implemented in 1998–99. These include investigation of the feasibility of an on-line hospital infection control advisory service; establishment of an Expert Working Group to develop infection control performance indicators; and modification of the infection control survey tool with development of a timetable for re-survey of Victorian hospitals. In addition all plans submitted to the Department for major capital works, redesign or structural maintenance must include an infection control risk assessment plan.

Networks and hospitals will be asked to submit a costed infection monitoring and control plan by 30 October 1998 with a strategy for implementation which does not rely on additional recurrent financial assistance to maintain appropriate standards and practices.

7.5 Clinical Risk Management

There are currently four pilot Clinical Risk Management projects. There will be a formal evaluation of these pilots in 1998–99. The evaluation will focus on the value of various methods for collecting and analysing clinical incident information, such as retrospective review of medical records, standardised and anonymous incident report forms, centralised collation and analysis of incident reports and, to a limited extent, adverse event codes from the VIMD and VEMD databases. Strategies for preventing identified incidents will also be assessed.

The formal evaluation will also include recommendations for approaches to adverse incident monitoring and management which can be generalised across the hospital system.

7.6 Performance Indicator Development

The Acute Health Quality Committee has identified the development and refinement of indicators of health care quality as the priority initiative for the 1998–99 financial year. Further work will be undertaken to identify selected useful indicators for monitoring at State level in the following areas: clinical care; safety of care; effectiveness of care; and access to outpatient services. Initial priorities within these areas will be discharge planning; infection control; and adverse events. Existing hospital access indicators will also be reviewed and redeveloped.

It is intended to keep indicator reporting requirements to a minimum and to develop a set of key performance indicators that reflect quality monitoring currently occurring in the acute health sector. Networks and hospitals will be consulted at key stages of the indicator development program including the strategies for benchmarking, reporting and effectively using performance indicator data.

The Hospital Services Report, published quarterly, contains a wide range of data about the health care system, including private health insurance; hospital throughput; waiting lists; emergency department activity; ambulance bypass; and unplanned readmissions. The report is targeted to the general public and the hospital sector.

7.7 Patient Feedback Indicators

Patient perceptions and feedback on quality and performance of acute health care services are an integral part of quality improvement. Stage 3 of the Patient Satisfaction Survey was conducted in 1997–98. Patients from all Victorian public hospitals were interviewed and there was public release of comparative benchmark data for grouped hospitals.

The Department intends using the aggregate outcomes of the survey to focus future quality improvement initiatives. Further work is currently underway to determine useful patient feedback measures for specified care processes (access, discharge planning, complaints systems and quality of information); the best options for regular monitoring of these measures; and appropriate benchmarks and performance targets.

7.8 Accreditation

The current funding incentives to encourage hospitals to achieve accreditation will continue until the year 2000. By this time accreditation/certification will be mandatory for all acute hospitals funded by the Department. Hospitals may currently seek accreditation through the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program (EQuIP) or certification through the ISO 9000 Quality Management System.

The Department will provide limited seeding funding to support networks and hospitals who wish to use concurrent approaches to quality assessment and improvement, including the Australian Quality Awards and Quality Committed Enterprise Programs offered through the Australian Quality Council. However, use of these programs alone will not currently satisfy Department accreditation/certification requirements.

Hospitals not currently accredited/certified, or booked for survey, by the ACHS or ISO assessors by June 30 1998, will be required to advise the Department of their intended plan to meet accreditation requirements by the year 2000.

The Department will require hospitals to provide evidence of their level of achievement following an organisation-wide accreditation or certification survey or assessment. The results should be forwarded to the Department within 30 days of results being notified by the accrediting or assessing body.

In the event that accreditation/certification is not awarded the reasons for this should also be advised. The Department response will be based upon the following principles:

- The hospital will be given the opportunity to address areas of non-conformance;
- If appropriate, the hospital will be referred to a professional body for assistance;
- If necessary there will be further investigation and/or third party review; and
- Community access to public health care services will be preserved.

7.9 Statutory Immunity

Currently all metropolitan network hospitals and 70 per cent of rural hospitals have been granted statutory immunity under Section 139 of the Health Services Act 1988. A range of other non-hospital agencies and medical colleges also have statutory immunity provisions for quality assurance processes.

The Public Health Division has let a tender for an evaluation of the effectiveness of the statutory immunity provisions and the scope for improvement with respect to non-hospital agencies. The results of this review will be available by July 1998. The outcomes of this evaluation will inform the review of statutory immunity provisions within the acute sector.

Hospitals without accreditation/certification by a third party and which have not been granted Statutory Immunity must send the Department a comprehensive quality improvement plan. Hospitals in this category will be asked to provide these plans by December 1998.

8. Quality—Ambulatory Services Development

8.1 Post Acute Care

The recurrent budget for this program is \$6.2 million. No major changes are proposed to the operation of the program during 1998–99, apart from statewide adoption of a scientifically trialled and validated risk screening tool for patients being considered for the service. An evaluation of the program has been tendered. This evaluation will include: health outcomes and cost benefits; patient and carer perceptions and satisfaction; and impact on acute and community care sectors, particularly with respect to service integration and coordination. The outcomes of the evaluation projects will inform future policy and purchasing arrangements.

8.2 Hospital in the Home

The 1998–99 budget for this program is \$5 million. No major changes are proposed for 1998–99. Emphasis will continue to be on growth - encouraging health care providers to recognise the merits of home based acute care as a substitute to hospital care. There are two elements to the program: incentive funding (\$4 million); and service development funding (\$1 million). The emphasis for service development funding will be on: clinical and/or treatment areas currently under-represented in HITH; and rural (provincial) service development and access.

To continue the focus on quality improvement of home based acute care service provision, the Department will commission an independent audit of HITH. This will focus on: clinical conditions and nature of treatment for which patients are transferred to HITH; patient assessment, referral, care planning and discharge procedures; protocols for dealing with emergencies; recording of adverse incidents and variations to care plans; and recording of HITH patients on VIMD (Victorian Inpatient Minimum Database).

8.3 Home Enteral Nutrition (HEN)

The 1998–99 Budget for this Program is \$2 million. In 1997–98, funding was allocated to 45 provider hospitals. As a means of encouraging professional collaboration and streamlining administration and reporting, funds will now be allocated on a Network or regional basis.

Major developmental projects are:

- Development and implementation of the minimum data set;
- Four research and development projects into outcomes and development of best practice service models; and
- Professional education and development support.

Details will be provided to Networks and hospitals in July 1998.

8.4 Continuous Positive Airways Pressure (CPAP)

The 1998–89 Budget for this Program is \$0.5 million. The clinical criteria have been expanded to include patients who have 15 apnoea's/hypopnoea's per hour with underlying cardiovascular, neurological or pulmonary disease. Standard reporting formats will also be developed for activity, financial and compliance reporting.

The current term of preferred suppliers of CPAP devices and associated services will expire on 30 June 1998. Suppliers selected through a new tender for preferred suppliers will operate for the next 12 months from 1 July 1998. The Department will invite submissions for research and development projects, the outcomes of which, will inform future policy development and improvements in services.

8.5 Artificial Limbs

Hospital budgets for 1998–99 will be capped at previous year's actual expenditure. However, funds will be adjusted to actual activity levels and any surplus redistributed within the Program to agencies with activity levels over target.

Consistent with Government policy directions, hospitals will be required to contest the provision of artificial limb services in the market through a competitive tendering process. The process should meet the requirements of an external audit including accountability, transparency and competitive neutrality. New provider arrangements will be implemented in January 1999. Details will be provided to Networks and hospitals in June 1998.

The Department will evaluate the Program with the aim of improving service delivery and purchasing arrangements.

8.6 Palliative Care Substitution

In 1998–99, \$3.2 million will be made available to Networks and rural hospitals to develop palliative care services over a six month period. The objective of the Palliative Care Substitution Project is to provide public hospitals with incentives and a framework to develop and test palliative care services delivered in non-acute settings as an alternative to care provided in acute health settings.

An amount of funds equivalent to the cost of operating the required number of palliative care beds based on Aged, Community and Mental Health (ACMH) prices will be identified as a specified grant for each hospital which participates in this project. The total WIES for those hospitals will be reduced by the WIES equivalent of that grant. This grant will be linked to performance indicators on the provision of substituted palliative care services. These performance indicators will be developed and tested during the course of the project.

8.7 The Family Choice Program

The Family Choice Program provides support to families of children and young people aged between 0–17 years inclusive with high medical needs and/or dependence on bio-medical technology to enable a child to live at home. The support provided by the program will be flexible, individualised and tailored to particular families based on a case management approach. One type of care provided to a number of children in this program (overnight awake attendant care) is equivalent to admitted patient care.

Current funding for the children receiving overnight awake attendant care, including funding received by specified payments or WIES payments, will be transferred to the Hospital in the Home Program. Funding for growth will be from WIES substitution and these funds will also be transferred to the Hospital in the Home Program. Special funding arrangements incorporated into a daily rate of reimbursement will be negotiated for this group of children. Negotiations regarding the transfer of funds and the appropriate daily rate for treatment will be undertaken in June 1998. Modelling in this document is in accordance with current funding arrangements.

8.8 Service Development Projects and Reviews

A number of major service reviews are currently underway. These include

Review of Radiotherapy Services: This Review has aimed to provide Government with an analysis of options for the future development of radiotherapy services in Victoria. A consultant's report was released in May for industry comment. Final recommendations will be confirmed by the Department and implementation will commence in 1998–99.

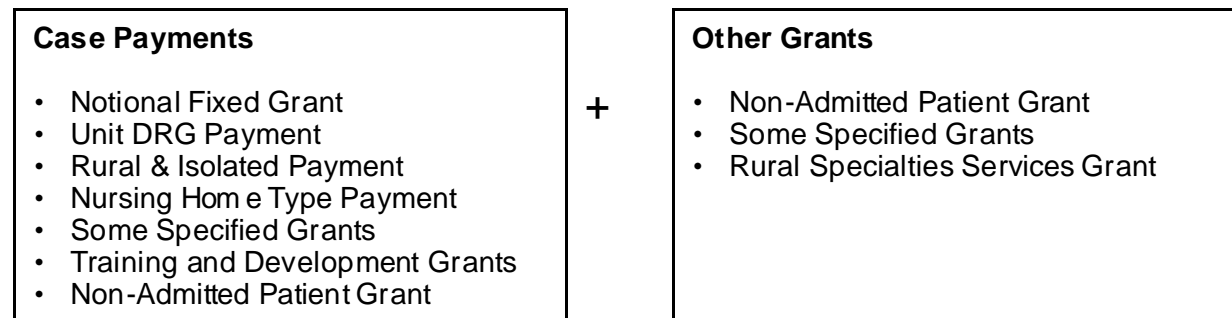
Ministerial Taskforce on Trauma and Emergency Services: This Taskforce is reviewing the structure and the coordination of trauma and emergency services in Victoria. It will report and provide advice to the Minister in late 1998.

Breast Care Reform Project: Following the report of the Breast Diseases Working Group, the Department has established a Breast Care Implementation Advisory Group which is responsible for developing the implementation strategies for restructuring breast care services in Victoria. A report from the Group is anticipated in late 1998, with implementation of purchasing and reform policy to begin in the third and fourth quarters of 1998–99. One million dollars has been committed to the program in 1998–99.

Review of the HIV/AIDS and Infectious Diseases Services: HIV/AIDS and Infectious Diseases Services successfully tendered to the Alfred and Royal Melbourne/Western Hospitals respectively will be reviewed. The review is expected to be completed by August 1998.

9. Casemix Formula

The basic casemix funding formula will continue during 1998–99.



9.1 Variable Payments

9.1.1 Inpatients

Unit DRG Payment

For hospital throughput up to the level prescribed by Target A, the variable case payment per patient treated is \$1,368 per WIES6. Private patients will be paid at \$968 per WIES6.

Target A Margin will be paid at \$958 per WIES6.

Option WIES will be paid at \$1,368 per public WIES6.

Same day medical targets for specified DRGs have been defined for each hospital and same day medical throughput in excess of these targets will not be funded.

Rural/Isolated Payment

The rural and isolated hospitals payments will be \$14 and \$35 per WIES6 respectively, and will apply to those hospitals designated in the Funding Guidelines.

Nursing Home Type Payment

Nursing home type patients in acute hospitals will be funded at \$125 per day.

Rehabilitation in Designated Units

Rehabilitation in designated units will be funded at \$345 and \$287 per day.

9.1.2 Non-Admitted Patients

VACS Variable Grant (Group A hospitals)

For non-admitted throughput up to target the case payment will be \$104 per weighted encounter. Targets have been set at 1997–98 activity levels. Case payments have been calculated for the year as shown in the modelled budgets and will be paid on a quarterly basis. Case payments will only be paid for public encounters and, where activity varies significantly from the agreed profile of services, or fails to reach target, adjustments will be made.

9.2 Other Grants

9.2.1 Inpatients

Notional Fixed Grant

Notional fixed grants have been standardised and reflect differences in infrastructure costs. The rates for grant are \$829 per fixed WIES for Major Providers (i.e. Networks and Barwon Health), \$843 for large rural Group B hospitals, \$864 for smaller rural Group B and C hospitals, and \$887 for rural Group D and E hospitals. The notional fixed grants are then adjusted for historic differences in superannuation costs. For details on the calculation of notional fixed WIES refer to *Section C: Calculation of WIES*.

Training and Development Grant

These grants will continue for 1998–99 with the exception of grants for Salaried Medical Officers. The rates are detailed below:

Hospital Medical Officers Year 1, 2 and 3	\$34,209 per EFT
Accredited Registrars	\$35,634 per EFT
Clinical Academic Staff	\$39,594 per EFT
Grade 1 Registered Nurses	\$12,424 per EFT
Post-graduate Nurses	\$11,388 per EFT
Post-graduate Midwifery Nurses	\$ 9,835 per EFT
Pharmacy Trainees	\$24,306 per EFT
Medical Radiation Interns	\$24,080 per EFT
Medical Biophysics Trainees	\$13,631 per EFT
Physiotherapists Grade 1, Year 2	\$14,197 per EFT
Occupational Therapists Grade 1, Year 2	\$14,197 per EFT
Speech Pathologists Grade 1, Year 2	\$14,197 per EFT
Medical Laboratory Scientists	\$11,531 per EFT

Payments are made only for positions and staffing approved or otherwise recognised by the Department. Detailed definitions of the payment conditions for Training and Development Grants are included in the Funding Guidelines. In addition, there is an undergraduate allowance calculated as 10 per cent of the total training and development grant for Group A and B hospitals. Research grants will continue at the rates of \$1,443,805 and \$481,268.

Specified Grants

Approved specified grants will continue in 1998–99.

9.2.2 Non-Admitted Patients

Emergency Services Grant

The non-admitted Emergency Services Grant will be allocated separately to account for emergency services. The levels of funding are outlined in Table 6.

Base Grant

In 1998–99, the Base Grant will continue at the same level as 1997–98.

Teaching Grant

In recognition of the importance of non-admitted services for teaching and training a specified grant will continue to be allocated as a teaching grant. In 1998–99, the Teaching Grant will continue at the same level as 1997–98.

Allied Health Services Grant

This grant will be determined on the basis of allied health occasions of service as reported by hospitals to the Department at an average cost of \$38 per occasion of service.

Other Grants

These include services approved by the Clinical Panel for specific funding. The outpatient component of the NESB Grant has been transferred to the inpatient specified grant.

9.3 Enhancement Programs

The Hospital Access Program replaces the Emergency Services Enhancement Program and the Elective Surgery Enhancement Program. Criteria for receiving the payments are outlined in appendix 3.

10. Modelled Budgets

11. Specific Programs and Technical Details

Appendix 1: Consultation and Liaison

The development of the proposals and processes outlined in this document have been undertaken with industry support and advice. The Department has regular liaison with metropolitan Networks, country hospitals and the Victorian Healthcare Association on matters relating to casemix development. Refinement of the AN-DRG Version 3 weights has been through the consultants Health Services Research Group and after discussions with representatives of the Casemix Clinical Sub-Committee. Major consultative groups include:

- The Victorian Casemix Clinical Committee has provided substantial advice and support in the development of general policy initiatives, classification and implementation issues.
- The Victorian Ambulatory Classification System Advisory Committee (VACSAC) has overseen the implementation of the system. The Clinical Panel chaired by Dr Peter Greenberg, oversaw the assignment of clinics for the new system.
- The emergency categorisation was developed by the Emergency Services Categorisation and Funding Taskforce.
- The Victorian Advisory Committee on Casemix Data Integrity examines data issues related to casemix funding and includes departmental and industry representation.
- The Acute Health Quality Committee, chaired by Professor Stephen Duckett, have advanced strategic policy directions, particularly relating to accreditation policy and the ongoing development of acute health performance indicators.
- The Acute Inter-hospital Transfer Working Group, which includes representation from the Health Care Network administration, the emergency, intensive care and cardiology fields, assisted in the development of the critical care component of the Hospital Access Program through examination of and comment on policy proposals, historical data, definitions and benchmarks.
- The Advisory Committee on Elective Surgery, chaired by Mr Brian Collopy, provided advice on the Elective Performance Enhancement Program, and monitors public hospital waiting lists.
- The Consultative Council on Emergency and Critical Care Services, chaired by Professor Ian Brand, received regular reports and provided comment on the emergency and critical care elements of the Hospital Access Program as it was developed.
- The Hospital in the Home Advisory Committee, provided advice on the evaluation of Phases One and Two of the HITH Program and the development of the 1998–99 Program.
- The Post-acute Care Advisory Committee, which includes representation from each of the funded PAC projects, monitors the implementation of the Program, advises on inter-patient developments and the development of the 1998–99 Program
- The CPAP (Continuous Positive Airways Pressure) Review Board has assisted in the development of the pilot program and will monitor its implementation and continued development during 1998–99.
- The Radiation Oncology Steering Committee has assisted the development of an output based funding system for outpatient radiation oncology.
- The Renal Reference Group, chaired by Mr Peter Donnelly, consists primarily of practising clinicians. This Committee played a key role in commissioning and reviewing the renal cost consultancy. It monitors on an ongoing basis both growth and technical developments in this modality.
- The Industry Finance Committee provides a forum to discuss and resolve financial issues including directions for purchasing policy.
- The Clinical Costing Standards Committee convened by Mr Dean Athan develops standards for activity costing after industry consultation and promulgates regular updates and refinements.
- The Activity Costing Advisory Committee, chaired by Mr Alan Studley, has representation from all Networks and regional hospitals. This committee advises on the quality of activity costing systems and their integration into management and quality monitoring reporting.

Appendix 3: Hospital Access Program

The Hospital Access Program (HAP) has been introduced for 1998–99 to bring together elements of the former Emergency and Elective Surgery Enhancement Programs and recently established indicators focussing on reducing the number of critical care (intensive and coronary) inter-hospital transfers. The aim of the Hospital Access Program for 1998–99 is to improve the access of emergency, elective and critical care patients to acute health services. The eligibility criteria, funding and performance criteria for each of the service delivery components of the HAP are listed below.

Commencing in 1998–99, bonus payments will not be paid until the Acute Health Schedule of the Health Service Agreement is signed.

1. Emergency services

The maximum funding allocated to the emergency services component of the HAP will be \$13 million.

To be eligible for HAP funding allocated to emergency services, hospitals must:

- Have a 24 hour emergency department;
- Be a Group A or B hospital;
- Have provided more than 4000 non same day projected emergency WIES5 during 1997–98; and
- Be able to provide data via the Victorian Emergency Minimum Dataset (VEMD).

The maximum bonus payment for each hospital eligible for the emergency services component of the Program has been determined according to the projected number of 1997–98 non-same day emergency WIES5 (NSDEW). Linking funding levels to NSDEW remains the simplest and most effective way of taking account of both numbers and complexity of emergency department patients.

Bonus allocations for emergency services will be paid in advance. Funds will be recalled at the end of each quarter where targets are not met.

Performance criteria

The emergency services performance criteria will continue to focus on ambulance bypass, waiting time to treatment and waiting time prior to admission to a ward. The ambulance bypass targets and targets for waiting time for triage categories 1 and 2 remain at 1997–98 levels.

Ambulance bypass—Target: a maximum of 5 occasions of ambulance bypass per quarter.

Bonus reduction for failing to meet target: a 2% reduction in the maximum quarterly bonus allocation for each occasion of ambulance bypass in excess of the quarterly target. The maximum reduction for failing to meet this target is 100% of the total quarterly bonus.

Waiting time for triage category 1 patients—Target: 100% of patients receive immediate treatment.

Bonus reduction for failing to meet target: a 20% reduction in the maximum quarterly bonus allocation for each patient waiting longer than the target. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

Waiting time for triage category 2 patients—Target: 80% of category 2 patients receive treatment within 10 minutes.

Bonus reduction for failing to meet target: a 1% reduction in the maximum quarterly bonus allocation for each 1% of patients less than the quarterly target. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

Waiting time for triage category 3 patients—Target: 75% of category 3 patients receive treatment within 30 minutes.

Bonus reduction for failing to meet target: a 1% reduction in the maximum quarterly bonus allocation for each 1% of patients less than the quarterly target. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

The waiting time of emergency department patients requiring admission to a ward is an area where improvement is required, particularly from major metropolitan hospitals. If a patient waits in an emergency department for more than 12 hours prior to being admitted to a ward because a bed is unavailable, their admission is defined as blocked. The time the patient waits is measured from the time they arrive at the emergency department to the time of their departure from the emergency department.

For 1998–99 admission block targets are expressed in terms of the **proportion** of admissions blocked compared with the total number of admissions to ward from the emergency department. This enables flexibility in the actual number of admissions blocked, in response to changes in the emergency department workload.

An annual benchmark level of 4.37% of admissions blocked has been determined. For 1998–99 this does not apply to all hospitals. However, the expectation is that hospitals will reach or exceed this benchmark in 2000–2001.

The benchmark has been calculated by averaging the performance of the two best performing hospitals with an E1 emergency department. The performance of rural hospitals and metropolitan hospitals with an emergency department level other than E1 could not be used as the basis for determining the benchmark, as the best performing hospitals in these categories have achieved zero admission block figures. Data used to determine the benchmark is taken from Quarters 3 and 4 of 1996–97 and Quarters 1 and 2 of 1997–98. This ensures that the impact of the yearly influenza outbreak is factored in.

Annual targets have been set for individual hospitals by determining their performance expectations in relation to admission block benchmark performance. Negotiation on hospital targets may occur in particular circumstances. Targets differentiate between 3 groups of hospitals as follows:

- Metropolitan hospitals performing better than the benchmark and all rural hospitals - targets aim to maintain their level of performance during Quarters 3 and 4 of 1996–97 and Quarters 1 and 2 of 1997–98;
- Metropolitan hospitals performing slightly worse than benchmark level - targets are set at benchmark level; and
- Metropolitan hospitals performing significantly worse than benchmark level - targets are based on a 50% improvement in the difference between their performance during Quarters 3 and 4 of 1996–97 and Quarters 1 and 2 of 1997–98 and the benchmark level. These hospitals are expected to work toward performing at benchmark level in 2000–2001.

This approach to target setting aims to maintain or improve the performance level of all hospitals and improve statewide performance.

Hospitals must determine quarterly targets to achieve their annual target in consultation with the Department. Quarterly targets should be finalised prior to the commencement of the 1998–99 financial year.

Target: to not exceed the maximum proportion of admissions blocked.

Bonus reduction for failing to meet target: a 4% reduction in the maximum quarterly bonus allocation for each 0.01% of admissions blocked in excess of the quarterly target, to a maximum reduction of 60% of the total quarterly bonus allocation.

2. Elective surgery

Hospitals which perform elective surgery are eligible for funding allocated to this component of the HAP and the maximum funding allocated to the elective surgery component of the HAP will be \$13 million.

Non waiting list hospitals (that is, hospitals which do not participate in the targetted elective surgery component of the Program) will be allocated funds on the basis of 50% of their proportion of the statewide projected non-same-day elective surgical WIES5 for 1997–98.

Waiting list hospitals

Hospitals which participate in the targetted elective surgery component of the Program will be allocated a proportion of the available bonus funds on the basis of the net number of patients to be removed from the waiting list, weighted according to the hospital's projected non same day elective surgical WIES5 for 1997–98.

This method of allocation recognises the size and nature of a hospital's waiting list and the magnitude of the task to reduce it. This formula for allocating bonus funds directs more funding to hospitals with larger waiting lists of more complex patients, which therefore require relatively more resources to reduce numbers. These hospitals provide performance data to the Department via the Elective Surgery Information System (ESIS).

Bonus allocations for elective surgery will be paid in advance. Funds will be recalled from participating hospitals at the end of each quarter where targets are not met.

Performance criteria

The elective surgery performance criteria will continue to focus on category 1 and category 2 patients and total waiting list numbers.

The approach to category 1 patients is unchanged from 1997–98, aiming for none of these patients to be delayed for more than 30 days. However, for 1998–99 annual targets have been set for category 2 patients and total waiting list numbers. Hospitals must determine quarterly targets for category 2 patients and total waiting list numbers to achieve the required annual targets, in consultation with the Department. Quarterly targets should be finalised prior to the commencement of the 1998–99 financial year. This approach will enhance the ability of hospitals to manage seasonal fluctuations in emergency and non-elective critical care services.

Performance will be assessed as at the census date at the end of each quarter.

Category 1 patients—Target: no category 1 patient delayed for more than 30 days.

Bonus reduction for failing to meet target: a 20% reduction for each category 1 patient delayed for more than 30 days. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

Category 2 patients—Target: a 24% reduction based on the adjusted 1997–98 target for the number of category 2 patients who are delayed for over 90 days.

Bonus reduction for failing to meet target: a 1% reduction for each percentage point by which the number of category 2 patients delayed more than 90 days exceeds the target at each quarter. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

Total waiting list—Target: a 6% reduction based on the adjusted 1997–98 target for the total number of patients on the waiting list.

Bonus reduction for failing to meet target: a 1% reduction for each percentage point by which the total waiting list exceeds the target at each quarter. The maximum reduction for failing to meet the target is 100% of the total quarterly bonus.

3. Critical Care Inter-hospital Transfers (CCIHTs)

Incentive funding linked to the attainment of targets for the maximum number of intensive and coronary care transfers due to a bed not being available at the sending hospital has been introduced for 1998–99. The transfer of patients because the sending hospital does not have the specialty/service available to provide treatment is appropriate and performance measures do not apply to these transfers. The maximum funding allocated to the CCIHT component of the HAP will be \$3.5 million.

To be eligible for HAP funding allocated to the reduction of inappropriate CCIHTs, hospitals must:

- Have a level 2 or 3 adult intensive care unit;
- Have a level 2, 3 or 4 adult coronary care unit; and
- Be located within a Melbourne metropolitan Health Care Network/ARMC.

CCIHT incentive payments have been determined based on the projected number of 1997–98 non-same day WIES5. This method acknowledges the relationship of coronary and intensive care provision to both emergency and elective services and makes some allowance for complexity by focussing on non-same day WIES.

Bonus allocations for CCIHTs will be paid in advance. Funds will be recalled at the end of each 6 month period where targets are not met.

Performance criteria

The CCIHT criteria will focus on inappropriate transfers of intensive care and coronary care patients.

The targets are proportional. The percentages are based on:

- The number of patients transferred because no intensive care bed is available, as a proportion of the total number of intensive care patients; and
- The number of patients transferred because no coronary care bed is available, as a proportion of the total number of coronary care patients.

Given the limitations of current data collections in providing intensive care and coronary care information, it has not been possible to ascertain the current number of critical care inter-hospital transfers at the hospital level. As a consequence, the Department and the Networks have negotiated on and agreed to, targets for the maximum number of inappropriate transfers for each hospital participating in this component of the HAP.

Performance against agreed targets will be assessed 6 monthly, enabling hospitals to plan for changes in demand influenced by seasonal factors. Performance from one 6 month period can not be carried over to the next 6 month period.

Targets: to not exceed the maximum proportions of inappropriate intensive care and coronary care transfers.

Bonus reduction for failing to meet targets: a 6% percent reduction in the maximum 6 monthly bonus allocation for each inappropriate transfer in excess of the targets.

The maximum reduction for failing to meet the coronary care target is 70% of the total 6 monthly bonus allocation. The maximum reduction for failing to meet the intensive care target is 70% of the total 6 monthly bonus allocation.

The maximum reduction for failing to meet both targets is 100% of the total 6 monthly bonus allocation.

4. Hospital Access Development Program

The need for ongoing development of Networks' and hospitals' approach to access will also be recognised through the implementation of a Hospital Access Development Program during 1998–99. This Program will rechannel recalled HAP funds to projects which further integrated approaches to demand management.

Review and reporting

Any hospital which artificially reduces its transfers, waiting list numbers or waiting times, or otherwise misreports its performance, will have its bonus payments adjusted by the Department.

Hospitals which fail to achieve any bonus payments for any of the three components of the Program for two consecutive quarters may be reviewed by the Department.

During 1998–99, the VEMD and the ESIS will be transferred to the RAPID Data Warehouse. Prior to this transfer, and for a transition period to be determined, hospitals participating in emergency and elective components of the 1998–99 HAP will be required to report their emergency and elective activity in accordance with current processes, by the seventh working day of each month.

CCIHT data will be supplied to the Department via the VIMD, by the hospital receiving the transfer. An additional validation process will be implemented by the Department to audit

and reconcile differences between sending hospital and receiving hospital data. Failure to supply accurate and complete data by the due date may result in recall of up to 40% of bonus payments.

The Department will continue to publish quarterly hospital and statewide emergency services and elective surgery performance data including:

- the number of patients treated in emergency departments;
- the number and percentage of patients treated within ideal times in emergency departments;
- the number of patients staying for extended periods in emergency departments; and
- the number of elective patients booked and waiting by category and hospital.

Data will also be provided to the Department of Human Services' Executive Management Information System (EMIS).

The 1998–99 Hospital Access Program will be reviewed prior to the next financial year.