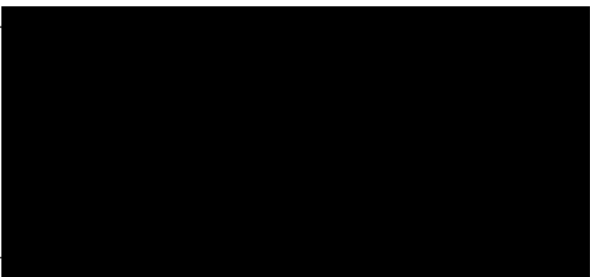**IN THE MATTER OF THE ROYAL COMMISSION
INTO FAMILY VIOLENCE**

ATTACHMENT FD-2 TO STATEMENT OF FRANCES MARIE DIVER

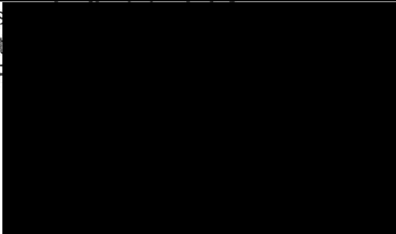|	
Date of document: 3 August 2015 Filed on behalf of: the Applicant Prepared by: Victorian Government Solicitor's Office Level 33 80 Collins Street Melbourne VIC 3000	████████████████

This is the attachment marked **'FD-2'** produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.
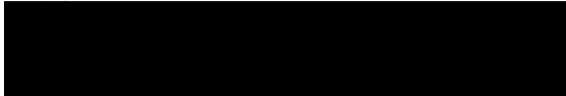
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Department of Health

health

The Victorian health services governance handbook

A resource for Victorian health services and their boards

State Government
Victoria

The Victorian health services governance handbook

A resource for Victorian health services and their boards

Contents

Contents - *continued*

About this handbook

The Victorian health services governance handbook is a resource to assist public health service board members and other interested parties to better understand the role of directors of health service boards and the operating environment of the public sector health service entities they govern.

The handbook documents and summarises information on roles and responsibilities and consolidates statutory and policy-based elements, including those in the *Health Services Act 1988* (HSA), other Acts, and policy and administrative documents.

The State Services Authority (SSA) has developed a good practice guide on governance for members of all Victorian public sector entity boards. The *Good practice guide on governance for Victorian public sector entities* provides information on the fundamentals of good governance that are common to all public entities, regardless of their function and size.

While this handbook incorporates some key concepts from the SSA guide, it is designed to complement it by providing material specific to the Victorian public hospital and health services sector.

Although this handbook sets out material of key importance to health service boards, the boards of other entities, for example, community health centres – other private and other not-for-profit entities delivering Victorian Government health services, will also find the material provides valuable background for their service provision activities.

In this handbook, all board members are referred to as directors or chairs as appropriate, and the roles and responsibilities are outlined as applying to all boards. The term 'health services' is used to refer to both the 'public hospitals' and 'public health services' listed in the HSA, and also multi purpose services unless otherwise specified. Boards of management and boards of directors, both referred to in the HSA, are termed 'boards of directors' in this handbook.

In addition, 'patients' and 'consumers' are terms often used to describe users of hospital services. In this handbook, 'consumers' has been used, unless it is part of a publication title or a quotation.

The SSA guide and a shorter, introductory document titled *Welcome to the board*, which covers key elements of good governance, can be found by visiting <www.ssa.vic.gov.au>, or the SSA may be contacted for a CD version by phoning (03) 9651 1321 or by emailing <info@ssa.vic.gov.au>.

Victoria's health services governance model

Victoria's public health services are independent legal entities established under the *Health Services Act 1988*.

They are governed by boards of directors, the members of which are appointed by the Governor-in-Council on the recommendation of the Minister for Health.

Victoria's health services

Victoria has a long-established system of devolved governance for healthcare delivery. Health services are organised into local network entities that are governed by a board, the members of which are appointed by the Governor-in-Council on the recommendation of the Minister for Health (for the largest 19 boards, this is through Cabinet). The entities are incorporated public statutory authorities established under the HSA. Positioned at 'arm's length' from the government, Victorian health services have separate legal status and are not part of the Crown. The HSA has provisions for three statutory authority categories: public health services, public hospitals and multi purpose services, and outlines different provisions for each category.

Ambulance Victoria is established under *the Ambulance Services Act 1986* and that Act should be consulted to understand where provisions might differ to those applying to public health services.

The various groupings of health services are listed in this document's appendix.

The 13 metropolitan health services and six major regional health services are defined under the HSA as 'public health services' governed by boards of directors. The HSA was amended in 2004 to incorporate governance provisions for 'public health services' to reflect contemporary good governance practice for large public entities. The changes were made following a review by the Victorian Public Hospital Governance Reform Panel (2003).

There are three denominational hospitals delivering public health services in Victoria. The boards for these entities are required to comply with the HSA in relation to providing public health services.

Nine of the subregional health services, 11 local health services and 47 smaller rural health services are defined in the HSA as 'public hospitals' and are governed by boards. Mildura Base Hospital is a privately operated subregional health service, which delivers public health services under contract with the government.

Among the smaller rural health services, seven are multi purpose services. Multi purpose services are integrated health and aged care services that provide flexible service options for small rural and remote communities. These are subject to a set of governance provisions similar to 'public hospitals' and are governed by boards.

Devolved governance for service delivery

The 2004 amendments to the HSA involved a fuller articulation of the roles and responsibilities of boards and other key parties for metropolitan and major regional health services and as a result, more fully describes the devolved governance model. The amendment introduced the *Statement of priorities* (SoP) as an accountability instrument for these health services. The SoP process has since been expanded to cover all health services (except Mildura and multi purpose services).

Boards interact with the Minister for Health, to whom they are responsible for the effective and efficient governance of their health service. In addition, the Department of Health also interacts with boards and health service management to give effect to the governance framework outlined in this handbook.

The Victorian Government sets health policy and, in addition to the Department of Health, the central agencies – the departments of Premier and Cabinet (DPC) and Treasury and Finance (DTF) – have roles in broad policy development and advice to government. DTF plays a leading role in economic, financial and resource management, and formulates and implements the government's budgetary and financial policy objectives.

Devolved governance allows health services to make local decisions to meet local needs, recognising that a solution in one place – with a unique combination of patients and service demand, culture or workforce – may not be the most effective solution in another environment.

Devolved governance is premised on 'responsive regulation', that is, accountability through agreed mechanisms or through intervention when 'self-regulation' falls short. Self-regulation refers to the actions undertaken by the board to assure itself that its services are high quality and safe. This approach of responsive regulation of Victorian health services aligns with contemporary governance and regulatory thinking. The regulatory systems in place, combined with sound management practices, foster strong governance for the health system.

Providing health services is a complex and challenging undertaking, with various levels of government and public and private sectors involved in the sector. Organisational experts identify healthcare executives as having a challenging management task.

> They must 'do good' for their communities while 'doing well' for their organizations in a time of dramatic changes on all fronts – from human resources, to technology, to reimbursement. In a high-pressure environment where demand for services, insistence on cost control, conflict between professions, clamor for the latest technologies, and emphasis on quality all converge, they must pursue goals to ensure both survival and progress.
>
> *(Shortell & Kaluzny 1994, p. xi)*

In a devolved governance model, board directors need to be aware of a large array of legislative and other accountabilities, and understand the complexities of the health system they help to govern and support. The combined role of the board and health service managers is to ensure effective and efficient provision of services. This 'balancing act' is illustrated in Figure 1.

Figure 1: Making health services work: 'the balancing act'

Complex challenges

Attract and retain workforce
- Medical and clinical workforce supply

Negotiate and attract funding
- Capped state government funding
- Competition for donations and research funding

Contain costs
- Industrial awards
- Staff-patient ratios
- Inflation
- New technologies

Manage demand
- Population growth
  - New technology
  - Free healthcare
- Supply-driven demand

Health service

Access
- Treatment is provided within clinically appropriate times

Efficiency
- Resources are used well

Quality
- Safe high-quality care is provided
- Consumer-centred care

Financial
- Balanced budget
- Long-term financial viability

Multiple performance objectives

Victoria's health services governance: roles and responsibilities

- The Minister for Health is accountable to Parliament for the performance of a health service, and the board is accountable to the Minister.
- The Governor-in-Council appoints and removes board members on the recommendation of the Minister for Health.
- The Minister may direct a health service, initiate reviews or request information in the public interest.
- The department advises government on health strategy, policy, planning, funding allocation and the performance of health services.
- The board oversees the health service on behalf of the Minister and in accordance with government policy and its legal obligations.
- The board chair leads the health service and manages key relationships.
- The chief executive officer (CEO) is appointed by and reports to the board, and is responsible for the day-to-day management of the health service.

The governance of a public health service refers to how the sector and entities are controlled and managed. Governance includes: formal structures; the relationships between the board, the Minister for Health and the department, senior management and stakeholders (including consumers); and the administrative arrangements that support these relationships. Good governance enables health services to set goals with clear accountabilities, perform efficiently and effectively, and to respond strategically to changing demands.

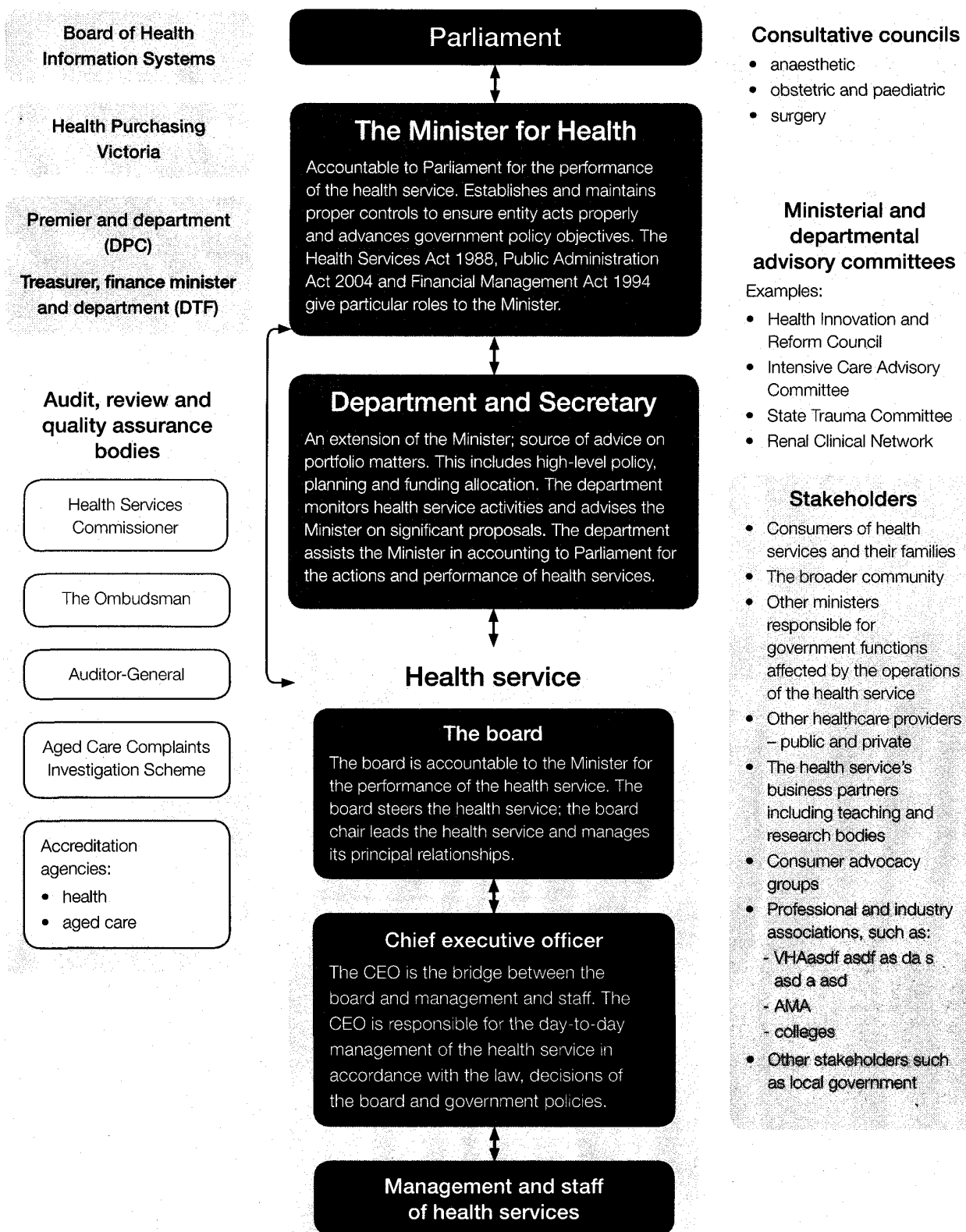Public health service governance operates within a broader public sector accountability framework (see Figure 2). In this framework, the Minister for Health is accountable to Parliament and the community for the performance of health services, and the board is accountable to the Minister.

Accountability for health services is further strengthened by independent audit and review agencies, such as the Victorian Auditor-General and the Health Services Commissioner.

Figure 2: Health service accountability framework and key relationships

Board of Health Information Systems

Health Purchasing Victoria

Premier and department (DPC)

Treasurer, finance minister and department (DTF)

Audit, review and quality assurance bodies

Health Services Commissioner

The Ombudsman

Auditor-General

Aged Care Complaints Investigation Scheme

Accreditation agencies:
- health
- aged care

Parliament

The Minister for Health

Accountable to Parliament for the performance of the health service. Establishes and maintains proper controls to ensure entity acts properly and advances government policy objectives. The Health Services Act 1988, Public Administration Act 2004 and Financial Management Act 1994 give particular roles to the Minister.

Department and Secretary

An extension of the Minister; source of advice on portfolio matters. This includes high-level policy, planning and funding allocation. The department monitors health service activities and advises the Minister on significant proposals. The department assists the Minister in accounting to Parliament for the actions and performance of health services.

Health service

The board

The board is accountable to the Minister for the performance of the health service. The board steers the health service; the board chair leads the health service and manages its principal relationships.

Chief executive officer

The CEO is the bridge between the board and management and staff. The CEO is responsible for the day-to-day management of the health service in accordance with the law, decisions of the board and government policies.

Management and staff of health services

Consultative councils
- anaesthetic
- obstetric and paediatric
- surgery

Ministerial and departmental advisory committees

Examples:
- Health Innovation and Reform Council
- Intensive Care Advisory Committee
- State Trauma Committee
- Renal Clinical Network

Stakeholders
- Consumers of health services and their families
- The broader community
- Other ministers responsible for government functions affected by the operations of the health service
- Other healthcare providers – public and private
- The health service's business partners including teaching and research bodies
- Consumer advocacy groups
- Professional and industry associations, such as:
  - VHAasdf asdf as da s asd a asd
  - AMA
  - colleges
- Other stakeholders such as local government

Role of the Minister for Health

The Minister for Health is responsible to Parliament for the performance of health services, and is accountable for establishing and maintaining proper accountabilities and controls to ensure that health services provide high-quality healthcare in a cost-effective way in accordance with government policy objectives and priorities. The role and accountabilities of the Minister are established by legislation, primarily the HSA.

The Minister approves the strategic plan that boards of metropolitan and major regional health services are required to prepare in accordance with guidelines established by the Minister (s. 65ZF of the HSA). By October each year, the Minister agrees annual performance priorities and targets with the boards of metropolitan and major regional health services through the SoP (s. 65ZFA).

The power to give directions is articulated in the HSA. For metropolitan and major regional health services and smaller rural health services (ss. 66A and 40B, respectively), the Minister may issue written directions to a board on any matter the Minister considers necessary or expedient if the Minister considers that the direction:

- is in the public interest
- will give effect to the objectives of the HSA.

The HSA also specifies that the Minister must not issue a direction that involves the caring for or employing a person or supplying goods unless in accordance with a tender process.

The Minister has a role in sanctioning the non-performance of a health service. In the event of non-performance with respect to performance expectations and targets, several sanctions are available to the Minister under the HSA. The Minister is able to appoint delegates to a board to assist with improving performance, and the Minister can also dismiss a board and replace it with an administrator (see further detail later in the handbook).

Victoria's Health Priorities Framework

The *Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan*, and the *Rural and Regional Health Plan* outline development priorities for Victoria's health services over the next decade, recognising that the health system needs to be responsive to an increasing and ageing population with changing disease patterns and provide the right care in the right settings.

The plans provide information on the key challenges facing the health sector in Victoria, including the need to reorient the service system to respond to changing needs and expectations. This includes the need to provide more care through ambulatory and community-based (non-hospital) services to meet changing patterns of demand and achieve a more cost-effective system. The seven priorities that underpin the health plans are as follows.

1) Developing a system that is responsive to people's needs

Instituting a system that is responsive to people's needs requires capacity planning along the continuum of care. Capacity gaps have been identified in community-based primary care. Comprehensive planning is needed to address these gaps. Planning must also consider specific local needs and pay attention to all aspects of health service operation, including clinical effectiveness, cost-effectiveness and fiscal management.

2) Improving every Victorian's health status and health experiences

Improving the health status of consumers requires action to improve health literacy among the whole community, thereby engaging them in maintaining optimal health status for themselves and their families. This includes ensuring that support services, such as interpreters, are available where needed. It also requires information about health and early health promotion interventions to reach and engage all vulnerable people and consumers.

3) Expanding service, workforce and system capacity

As the population continues to grow and age, and illnesses change, the capacity of health services needs to expand and change. In the future, hospital capacity will need to expand further and, accordingly, the Victorian Government will continue to provide more hospital beds. But it will also shift the focus of expansions in capacity from acute care to primary healthcare, and the distribution of care, in order to ensure these expansions respond to community needs.

A fundamental aspect of expanding capacity is increasing and diversifying the skills and expertise of the health workforce. Industry and professional bodies will play an important role in developing the workforce and providing leadership.

4) Increasing the system's financial sustainability and productivity

Achieving sustainable and cost-effective organisation of care requires changing the incentives upon which the healthcare system is built. This task will require improvements in the funding arrangements between governments, greater flexibility in funding models, and rigorous fiscal management.

5) Implementing continuous improvements and innovation

Maintenance of high standards of leadership, improvements and innovation relies on ongoing, targeted translational research, developing new evidence and sharing knowledge. Up-to-date research outcomes, evidence and information need to be shared between health professions and throughout the health workforce. Increased health and medical expertise will ensure Victoria maintains a high level of commitment to leadership in research and innovation.

6) Increasing accountability and transparency

High-performing health systems are accountable to their communities for delivering health services. Greater transparency in information about the performance of the health system will lead to choices, responsibility and accountability in terms of health outcomes, including improved quality of healthcare and taxpayer value.

Transparent reporting of accurate and relevant information about the health system's performance will help to drive improvements throughout the metropolitan health system and to direct the allocation of resources.

7) Improving utilisation of e-health and communications technology

Obtaining the best possible healthcare and outcomes relies on clinicians making informed and judicious decisions. For people and clinicians to make informed decisions, the knowledge held by various people in the system must be managed well at a systemic level.

The health plans can be found at: <http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Priorities-Framework-2012-2022:-Metropolitan-Health-Plan> and <http://www.health.vic.gov.au/healthplan2022/rural.htm>.

Role of the Secretary and Department of Health

The Secretary to the Department of Health has some statutory functions and is supported in undertaking many of these by the department. The HSA articulates the role of the department through the functions of the Secretary as follows:

- to advise the Minister on the operation of the HSA
- to develop policies and plans with respect to health services provided by healthcare agencies
- to fund or purchase health services and monitor, evaluate and review publicly funded or purchased health services
- to encourage safety and improvement in the quality of health services provided by healthcare facilities
- in consultation with healthcare agencies, to develop criteria or measures that enable comparisons to be made between the performance of healthcare agencies providing similar services
- to collect and analyse data to enable the Secretary to perform the Secretary's functions under the HSA, or any other Act
- to do anything else the Secretary considers appropriate to ensure the objectives of the HSA are met.

The Secretary and department assist the Minister to perform certain functions, for example, administering programs, and in relating to boards and health services. It is important that the chair and CEO foster an effective working relationship with the department, and vice versa.

The department has a broader administrative role supporting the health, ageing and mental health portfolios. The department assists and advises the Minister on:

- statewide health strategy
- health policy and program development
- the governance and performance of health services
- service and capital planning
- funding policy and allocation.

As part of its role, the department evaluates and provides advice to health services on compliance with departmental policies and guidelines. It also advises on health services' strategic directions (often expressed through strategic plans), especially regarding alignment with government policy and key directions.

Each year, the department publishes the *Victorian health policy and funding guidelines*, which set out the key budget, program and policy changes for the coming financial year. The guidelines can be found at <www.health.vic.gov.au/pfg>.

The department develops policies for specific services, for example, maternity services, surgery, cancer services, quality and safety, aged care, subacute and ambulance services. Examples of policy documents include *Future directions for Victoria's maternity services, Patient-centred surgery: strategic directions for surgical services in Victoria's public hospitals and Victoria's cancer action plan*. Departmental program areas consult with health services on policy priorities and to gain an understanding of emerging program issues such as new treatments, care models or workforce planning issues. Some programs use clinical networks to assist them in this process. Further information on individual programs, key documents and current program priorities is available on the department's website at <www.health.vic.gov.au>.

The department has a key system-level role to play not only within individual programs but at a 'whole-of-system' level. This involves shaping and enabling the health system to function in an integrated way between all levels of healthcare and community services, and where services of differing sizes and capabilities need to work together to improve the experience for consumers accessing the system. This is a dynamic multidimensional interaction between health services and the department at consumer, clinician and health service levels.

The department's annual report is available each year on the department's website at <www.health.vic.gov.au/about_us/annual_report> and provides more detail on programs and the department's operational environment.

Powers of the Secretary

The Secretary has powers to give directions to health services in relation to a number of specified matters including:

- the training of healthcare professionals
- the number and type of people health services should employ, and the conditions
- the conditions on which the health service should make use of facilities, services, equipment or supplies provided by another health service or should allow another health service to make use of its facilities, services, equipment or supplies
- the manner in which admissions, care and treatment should be coordinated between health service facilities
- carrying out audits for casemix funding purposes
- action to be taken or avoided to enable the state to comply with the terms of agreements with the Commonwealth
- a requirement that a health service appoint Health Purchasing Victoria (HPV) as its agent for the purposes of obtaining or purchasing goods and services.

Under s. 115M of the HSA, the Secretary may also give written directions to multi purpose services in relation to action to be taken or avoided to enable the state to comply with the terms of any agreement made between it and other jurisdictions.

The Department of Health's performance monitoring role

The department is responsible for monitoring the performance of health services, with expectations articulated primarily in the SoP or service agreements. The relationship with and performance of health services is managed through a point-of-contact structure in the department. This point-of-contact structure is designed to enable the department to take a 'whole of health service' approach in its performance discussions with health services and to work with program areas to prioritise their interactions with health services.

For metropolitan health services, the point of contact is the 'health service lead', a staff member in the Performance, Acute Programs and Rural Health Branch. For rural health services, this person is the health service lead in the relevant rural region.

The *Victorian health services performance monitoring framework* applies to all Victorian health services. The framework consists of a formal monitoring and meeting cycle, which specifies the indicators that are formally monitored and their business rules, and a performance assessment system that allocates formal monitoring categories: standard monitoring, performance watch and intensive monitoring. This framework can be found at: <www.health.vic.gov.au/hospital-performance>.

The department works with health services to understand the factors that may contribute to performance and to support health services to improve performance where challenges have been identified. If remedial action is required an escalation process is followed, which involves an initial discussion with relevant health service executives. The board may also be involved in discussions to reach an acceptable resolution. The HSA sets out the powers of the Minister regarding inadequate performance.

Where service improvement is identified as required, a plan for improvement should be agreed between the health service and the department. Where performance improvement involves improving clinical care or implementing new care models, program areas work with health services to reorient care provision to meet acceptable care standards and models of care. Service redesign projects, based on accepted improvement methodologies, can also be undertaken.

The department may increase the accountability requirements for health services where:

- there is significant non-performance with respect to agreed expectations and targets
- programs are in their developmental phase and data is being collected for evaluation purposes
- there is a major risk to community safety.

The department also manages governance policy and support for boards (such as statewide learning and development approaches), develops key frameworks (such as the *Clinical governance framework*) and provides advice and manages processes for nominating and appointing board members.

The department establishes funding policy parameters for health services, and reviews funding policy from time to time to ensure it continues to support appropriate care or innovation. The funding model for health services is outlined later in this handbook.

System-level committees and councils

Health Innovation and Reform Council

The Health Innovation and Reform Council was established in March 2012.

The functions of the council are to provide advice to, and report to, the Minister and the Secretary on the effective and efficient delivery of quality health services at the request of the Minister.

Consultative councils, clinical networks and committees

The Minister and the department have established a range of system-wide committees to provide advice on priority issues. These include the clinical consultative councils (the Victorian Consultative Council for Anaesthetic Mortality and Morbidity (VCCAMM), the Victorian Surgical Consultative Council (VSCC) and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)).

There are a range of other program-based committees, for example, the Intensive Care Advisory Committee and the Emergency Access Reference Group.

A range of clinical networks also provide advice on implementing initiatives to strengthen clinical service provision. They bring together clinicians and professional groups from across the sector to drive system change and improvement in operational effectiveness and efficiency for higher risk clinical services. Existing networks carry out these roles in relation to cancer, cardiac, emergency care, maternity and newborn, palliative care, paediatric, renal and stroke care.

Health Purchasing Victoria

HPV is an incorporated statutory authority established in 2001 under s.129 of the HSA. It is a public authority that represents the Crown (s. 130). Its purpose is to improve the collective purchasing power of Victorian public hospitals and health services, and to achieve 'best value' outcomes in procuring health-related goods, services and equipment. The products and clinical services include prosthetic devices, pharmaceutical products, hypodermic needles, sterilisation consumables, surgical dressings, catering supplies, nurse agency services and pathology services.

HPV is governed by a board, which is accountable to the Minister. Board members are appointed by the Governor-in-Council on the recommendation of the Minister (s. 134D).

HPV works in partnership with public hospitals and health services in order to understand their requirements, to facilitate large-scale collective tenders, and manage common-use contracts on behalf of the State. It also works closely with the department.

Section 131(d) of the HSA requires HPV to monitor health services' compliance with purchasing policies and HPV directions, and to report irregularities to the Minister.

Contract compliance surveys have been conducted annually since 2005. HPV requests CEOs to provide a report of their organisation's compliance to the contracts arising from the HPV tender program using a standard form.
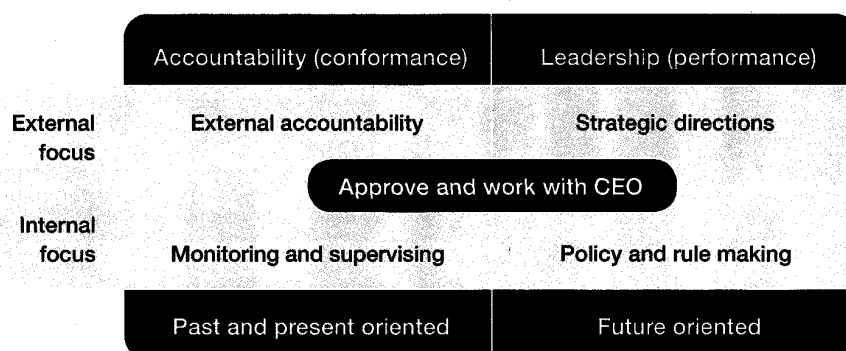
HPV's web address is <www.hpv.org.au>.

Role of the board

The board of a health service is accountable to the Minister for Health for the health service's performance. The role of a health service board is to steer the entity on behalf of the Minister in accordance with government policy.

This governance role broadly involves strategic leadership of the organisation, monitoring performance against agreed objectives and ensuring accountability and compliance. The latter has external and internal facets (see Figure 3 for one representation). Board members do not participate in day-to-day management of the health service, which is the role of the CEO and staff.

Figure 3: Health service board functions

	Accountability (conformance)	Leadership (performance)
External focus	External accountability	Strategic directions
	Approve and work with CEO	
Internal focus	Monitoring and supervising	Policy and rule making
	Past and present oriented	Future oriented

Adapted from Tricker 1994

The role of the board as the governing body of a public entity is outlined in general in the SSA's publication on the role and composition of a board, which can be found at <http://www.ssa.vic.gov.au/governance/board-composition-a-roles/role-of-the-board.html>.

The role of a health service board is more specifically defined in the HSA, which sets out the objectives of the HSA and the functions of boards. The objectives of the HSA (s. 9) are to make provision to ensure the following:

- Healthcare agencies provide high-quality health services.
- An adequate range of essential healthcare services is available to all Victorians.
- Health services are governed and managed effectively, efficiently and economically.
- Public funds are used effectively by healthcare agencies and are allocated according to need.
- Purchasing arrangements for health services and supply chain management by health services provide value for money.
- Healthcare agencies are accountable to the public.
- Users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about healthcare.
- Healthcare workers are able to participate in decisions affecting their work environment.
- Users of health services are able to choose the type of healthcare most appropriate to their needs.

Metropolitan and major regional health services

The functions of boards of directors of metropolitan and major regional health services are specified in the HSA (s. 65S). They are to:

- develop SoPs and strategic plans for the operation of the health service and to monitor compliance with those statements and plans
- develop financial and business plans, strategies and budgets to ensure the accountable and efficient provision of health services and the long-term financial viability of the health service
- establish and maintain effective systems to ensure the services provided meet the needs of the communities serviced by the health service and that the views of users and providers of the health service are taken into account
- monitor the performance of the health service to ensure that
  - it operates within its budget
  - its audit and accounting systems accurately reflect its financial position and viability
  - it adheres to its financial and business plans, strategic plans and SoPs
  - effective and accountable risk management systems are in place
  - effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided
  - any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner
  - it continuously strives to improve the quality of the health services it provides and to foster innovation
  - the committees established or appointed under the HSA operate effectively
- appoint a CEO and to determine, subject to the Secretary's approval, their remuneration and the terms and conditions of appointment

- monitor the performance of the CEO each financial year, having regard to the objectives, priorities and key performance outcomes specified in the service's SoP under the HSA
- establish the organisational structure, including the management structure, of the health service
- develop arrangements with other relevant agencies and service providers to enable effective and efficient service delivery and continuity of care
- ensure the Minister and the Secretary are advised about significant board decisions and are informed in a timely manner of any issues of public concern or risks that affect or may affect the health service
- establish a finance committee, an audit committee and a quality committee
- appoint a primary care and population health advisory committee, and at least one community advisory committee
- facilitate health research and education
- adopt a code of conduct for staff of the health service
- provide appropriate training for directors
- carry out any other functions conferred on the board by or under the HSA.

The HSA also specifies that it is the responsibility of the board to ensure the CEO convenes an annual meeting of the health service sometime between 1 July and 31 December. At each annual meeting the HSA (s. 65ZG) requires the board to:

- submit the report of operations and financial statements prepared in accordance with part 7 of the Financial Management Act 1994 (FMA) (s. 65ZA of the HSA requires the board to include the activities of its advisory committees in this report)
- report on the health services provided to the community in the preceding year and on proposed services in the following year
- report on any other matter that may be prescribed.

Other rural health services and multi purpose services

The HSA only specifies in broad terms the functions of boards of management of rural health services below the regional level. Similar to the larger health services, the HSA (s. 36) specifies that at each annual meeting the board must:

- submit the report of operations and financial statements prepared in accordance with part 7 of the FMA
- report on the health services provided to the community in the preceding year and on proposed services in the following year
- report on any other matter that may be prescribed.

In addition, under s. 25 (division 3) of the HSA, a board is required to appoint a CEO, subject to the approval of the Secretary, and determine their remuneration and the terms and conditions of appointment, subject to the approval of the Secretary. The board is also required to take action to fill any vacancy as soon as possible.

Role of the board chair

The position of board chair is especially important because she or he leads the board and develops its members as an effective team. The HSA does not articulate the role of the chair of boards of health services.

The SSA introductory *Good governance guide* describes the role of the chair of a public sector entity as involving:

- leadership
  - builds an effective board with the necessary skills and capabilities
  - leads the board members and develops them as a cohesive and effective team
  - assists board members' understanding of their role, responsibilities and accountabilities
  - informs members about developments in government policy, priorities and financial reporting
  - sets the board's agenda and ensures key issues are discussed and there are no potential conflicts of interest or duty
  - ensures interactive participation by all board members
  - arranges adequate support for members
  - welcomes new members and leads the process for their induction
  - manages the evaluation of the performance of the CEO and the board
  - represents the board to external parties as an official spokesperson for the entity

- relationship management
  - establishes an effective and constructive working relationship with the CEO
  - acts as the key liaison point between the board and senior management of the public entity
  - informs the Minister about significant issues and events
  - delivers the annual report to the Minister
  - actively encourages a strong relationship between the internal audit committee and the board.

The chair has a particular role to play in relation to effective board operation. This includes effective, efficient and constructive chairing of meetings and managing the evaluation of the CEO and board.

Role of the chief executive officer

Metropolitan and major regional health services

The HSA (s. 65XA) specifies that the CEO of a metropolitan or major regional health service is subject to the direction of the board in controlling and managing the health service. The functions of the CEO specified in the HSA (s. 65XB) are to:

- manage the health service in accordance with
  - the financial and business plans, strategies and budgets developed by the board
  - the instructions of the board

- prepare material for consideration by the board including SoPs, strategic plans, business plans, strategies and budgets
- ensure the board and its committees are assisted and provided with relevant information to enable them to perform their functions effectively and efficiently
- implement effective and accountable systems to monitor the quality and effectiveness of health services provided
- ensure the health service continuously strives to improve the quality of the healthcare it provides and to foster innovation
- ensure the board's decisions are implemented effectively and efficiently throughout the health service
- inform the board in a timely manner of any issues of public concern or risks that affect or may affect the health service
- inform the board, the Secretary and the Minister without delay of any significant issues of public concern or significant risks affecting the health service.

The HSA (s. 65XB) further specifies that the CEO in performing his or her functions must have regard to the:

- needs and views of consumers and other users of the healthcare that the health service provides and the community it serves
- need to ensure the health service uses its resources in an effective and efficient manner
- need to ensure that resources of the Victorian public hospital sector generally are used effectively and efficiently.

The HSA (s. 65ZG) also requires the CEO to advertise the details of the health service's annual meeting in a newspaper that circulates in the area.

Other rural health services and multi purpose services

The HSA does not articulate the role or responsibilities of the CEO of rural health services below the regional level. However, the functions outlined above for the larger health services provide a guide.

The HSA (s. 36) specifies that the CEO must convene an annual meeting of the health service between 1 July and 31 December. It further specifies that they must advertise the details of the meeting in a newspaper that circulates in the geographical area.

Communication and relationships

Effective governance in the public sector requires constructive relationships and regular communication between the parties. A number of forums have been established to facilitate regular communication and strengthen partnerships between health service boards/management and the Minister and the department.

Forums for board chairs

The Council of Board Chairs comprises the chairs of the metropolitan, denominational and six major regional health services and Ambulance Victoria. One of the board chairs is appointed as chair of the council by the Governor-in-Council based on a ministerial recommendation. The Minister and the Secretary may also attend. The meetings provide a forum for the Minister to communicate key messages and for board chairs to raise issues, exchange information on governance matters or provide advice on high-level strategic matters.

The council meets quarterly and the department provides secretariat support.

The board chairs of the subregional and rural health services also meet regularly, with the Secretary and Minister attending periodically. The department's regional offices provide secretariat support and organise these forums.

Chief executive officer forums

The CEO–departmental forum comprises the CEOs of the metropolitan and major regional health services and departmental executive officers. It is jointly chaired by a CEO (rotated among health services) and the Secretary. The attendance of other departmental officers at meetings is determined by the topics on the agenda.

The meetings are held monthly and the department provides secretariat support.

The CEOs of rural health services also meet regularly with the department. The department's regional offices provide secretariat support and organise these forums.

External regulatory framework

- A range of external bodies have an oversight role in relation to some important components of health service operations.
- Boards should understand their health service's obligations in relation to these bodies.

The Health Services Commissioner

In Victoria consumers have a right to make complaints about health service providers and to access their health records. The Office of the Health Services Commissioner (OHSC), an independent statutory authority, was established in 1988 by the *Health Services (Conciliation and Review) Act 1987*. The commissioner's role is to receive, investigate and resolve complaints from users of health services, to support healthcare services in providing quality healthcare, and to assist them in resolving complaints. The legislation also requires the information gained from complaints to be used to improve the standards of healthcare and prevent breaches of these standards.

The OHSC also administers the *Health Records Act 2001*, the Victorian legislation dealing with the privacy of health information and an individual's right to have access to their own information. It handles complaints about disclosure of health information and access to health information. The *Freedom of Information Act 1982* also allows consumers to access information contained in public sector medical records, and for incorrect or misleading information to be amended or removed from records.

The Australian Information Commissioner may also refer complaints concerning health information privacy issues raised under the federal *Privacy Act 1988* to the Health Services Commissioner for resolution.

While a coroner investigates deaths (see later in this section), the Health Services Commissioner is empowered to investigate other matters raised through individual complaints about the services provided by Victoria's public health services, and to suggest ways of improving services. If a complaint involves the professional conduct or performance of a registered health practitioner, the commissioner liaises with the Australian Health Practitioner Regulation Agency about its handling and resolution.

The Minister for Health has the power to request the commissioner to conduct independent reviews of health service issues. An example of a report on such a review is the *Analysis of the inquiry held by the Health Services Commissioner 2002 into an incident at The Royal Melbourne Hospital, Victoria*.

More information about the complaints process is available at <www.health.vic.gov.au/hsc/provider>.

The Ombudsman

The Victorian Ombudsman has the power to investigate administrative actions taken by a Victorian government department or public statutory body, including public health services. The Ombudsman is a constitutional independent officer of the Victorian Parliament established under the *Ombudsman Act 1973*, and reports directly to Parliament. The matters investigated by the Ombudsman may arise through individual complaints about administrative actions or through disclosures of serious improper conduct under the *Whistleblowers Protection Act 2001*. An example of a report on such an investigation is the *Whistleblowers Protection Act 2001: Report of an investigation into issues at Bayside Health – October 2008*.

The office also has a role in ensuring compliance with the Freedom of Information Act and the *Charter of Human Rights and Responsibilities Act 2006*.

Further information is available at <www.ombudsman.vic.gov.au>.

The Auditor-General

The Victorian Auditor-General is an independent officer of the Victorian Parliament appointed under the *Audit Act 1994* to examine resource management in the public sector. The Auditor-General is responsible for auditing all public sector organisations, including the department and public health service entities. The independence of the Auditor-General is enshrined in the *Constitution Act 1975*, which establishes the office and gives the Auditor-General complete discretion when deciding whether to conduct an audit, how to carry it out and how to prioritise any particular matters.

Among other things, the Auditor-General is empowered to:

- conduct annual financial statement audits of public sector agencies
- undertake performance audits within the public sector that encompass assessments of the economy, efficiency and effectiveness of the management of public resources by the government or individual government agencies
- examine instances of waste, probity or lack of financial prudence in the use of public resources
- access a broad range of documents under s. 11 of the Audit Act.

The Auditor-General and staff are able to access all public sector information, irrespective of any restrictions imposed by other legislation, including statutory secrecy provisions and Cabinet or commercial-in-confidence confidentiality.

Financial statement audits provide independent assurances to Parliament and the community that the information contained in the financial statements of public sector entities is presented fairly in accordance with Australian accounting standards and applicable legislation. They are carried out at the end of each financial year.

A performance audit evaluates whether an organisation or government program is achieving its objectives effectively, economically and efficiently, and in compliance with all relevant legislation. These are carried out when the Auditor-General considers they are warranted, with the audit program developed in consultation with relevant sectors and agencies. Examples include: *Managing patient safety in public hospitals* (2005), *Access to specialist medical outpatient care* (2006), *Patient safety in public hospitals* (2007–08), *Managing acute patient flows* (2008–09) and *Access to public hospitals: measuring performance* (2008–09).

Health services and the department are required to provide a response to the recommendations of performance reviews. Where appropriate the department and health services act to implement changes as recommended by the Auditor-General.

Coroner

Coroners investigate unexplained natural deaths and deaths suspected to be from direct or indirect trauma. From time to time, this involves investigating deaths that occur in health services.

The importance of a coronial investigation is that it can lead to a greater understanding of risks and hazards in the community as well as to improvements in public health and safety.

By being empowered to hold a public court hearing (an inquest), coroners have a vehicle for raising in public the facts about how a person died and can use the inquest to raise awareness of how that death could or should have been prevented. In conjunction with the work of a coroner, other statutory agencies including the police, the Chief Medical Officer of Health and the Victorian Institute of Forensic Medicine maintain a constant surveillance on potentially fatal hazards in society and ensure that preventable deaths are recognised and brought to the attention of the relevant public and government agencies so that the issues surrounding them can be addressed.

The Aged Care Complaints Investigation Scheme

Some Victorian public sector health services are approved providers of residential aged care services. While the Commonwealth Government is responsible for planning, funding and regulating residential aged care services, the Victorian Government provides top-up funding to public sector residential aged care services (PSRACS) to assist in providing these services.

The Commonwealth's *Aged Care Act 1997* provides for complaints concerning Commonwealth government-funded aged care services to be reported to the Aged Care Complaints Investigation Scheme. This scheme is managed by the Office of Aged Care Quality and Compliance, within the Commonwealth Department of Health and Ageing (DoHA). Under the Aged Care Act services are obliged to compulsorily report incidents or allegations of physical and sexual assault of residents and unexplained absences of residents from services to the scheme.

The Victorian Department of Health also requires Victorian PSRACS to notify it of all compulsory reports made to the scheme at the same time or within 24 hours of the service notifying police and the scheme. This parallel reporting requirement ensures the department is informed of all alleged or suspected incidents of physical or sexual assault and unexplained absences of residents from services. The department has developed a report form that contains no resident identifying information. The form is available at <www.health.vic.gov.au/agedcare/servies/psracs>. Once the incident has been investigated, outcome details, including copies of correspondence from DoHA and reports, should be provided to the Victorian department.

The Office of the Aged Care Commissioner is an additional mechanism established by the Commonwealth Government to independently review the way in which the complaints scheme handles complaints. Further information about the aged care services complaints process can be found at <www.health.gov.au/internet/main/publishing.nsf/content/ageing-complaints-index.htm>.

Accreditation systems

Healthcare facilities

Accreditation is conferred when a health service is externally assessed as meeting a set of standards. The department requires all Victorian public health services to be accredited. The policy objective is continuous improvement of the safety and quality of healthcare.

Accreditation is a necessary part of a comprehensive system to support safety and quality. By itself accreditation against standards does not ensure the safety and quality of healthcare provided to consumers. However, accreditation is effective as part of an improvement system because it can verify that actions are being taken, that system data and information are being used to inform the analysis of issues and program solutions, and that safety and quality improvement is being achieved.

The accreditation process is a formal process of external review based on a series of standards of care and processes. Health services are required to be accredited by an entity that has been accredited by either the International Society for Quality in Health Care Inc. (ISQua) or the Joint Accreditation System of Australia and New Zealand (JAS-ANZ). The main accrediting bodies for hospitals are the Australian Council on Healthcare Standards, the International Organisation for Standardisation and the Quality Improvement Council.

The Australian Commission on Safety and Quality in Health Care has led the development of a new national accreditation and standards framework for public and private sector healthcare organisations. This framework entails compliance with a core set of national safety and quality standards. It is not intended that the core set of national standards cover all areas a health service or regulator may wish to have assessed during an accreditation process.

The national accreditation scheme is based on 10 national safety and quality health service standards. The 10 standards focus on areas that are essential to improving the safety and quality of care for consumers where a substantial body of evidence about harm from care and treatment currently exists and where actions can be taken to effectively reduce harm. The 10 standards are shown in Figure 4.

Figure 4: National safety and quality standards

Standard 1	Governance for Safety and Quality in Health Service Organisations
Standard 2	Partnering with Consumers
Standard 3	Preventing and Controlling Healthcare Associated Infections
Standard 4	Medication Safety
Standard 5	Patient Identification and Procedure Matching
Standard 6	Clinical Handover
Standard 7	Blood and Blood Products
Standard 8	Preventing and Managing Pressure Injuries
Standard 9	Recognising and Responding to Clinical Deterioration in Acute Health Care
Standard 10	Preventing Falls and Harm from Falls

Source: Australian Commission on Quality and Safety in Health Care 2011, p.3

Further information is available at <www.safetyandquality.gov.au>.

Residential aged care facilities

Accreditation for residential aged care services is a formal process of independent external review based on the *Aged care accreditation standards*, and is a condition of funding under the Commonwealth's Aged Care Act.

Accreditation against the standards sets a minimum standard for care and services and promotes continuous improvement.

All residential aged care services are routinely assessed for compliance with the *Aged care accreditation standards* by the Aged Care Standards and Accreditation Agency (ACSAA). In addition to regular accreditation audits, of which reports are publicly available, each service receives at least one unannounced visit each year. For more information about ACSAA, including reports on homes, see <www.accreditation.org.au>.

If compliance issues are identified in residential aged care services, ACSAA usually requires services to implement improvements within a three-month timeframe. In addition DoHA may determine that the compliance issues identified by ACSAA require further follow-up, and a notice of noncompliance could be issued requiring services to take remedial action. In extreme circumstances, sanctions can be imposed where the service must meet special requirements or face closure by the Commonwealth. Information about Commonwealth action taken against residential aged care services is available at <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-sanction.htm>.

Board director fundamentals

This section outlines key board responsibilities, ethical and legal obligations, as well as information on board processes.

- Board members have legal obligations in relation to codes of conduct and managing conflicts of interest.
- The Health Services Act provides an indemnity to board members for anything done in good faith.
- Members are not subject to the *Corporations Act 2001*.

Directors' code of conduct

A code of conduct was issued by the Public Sector Standards Commissioner in 2006 and applies to members of public entity boards. The code is based on the Victorian public sector values and its purpose is to promote adherence to these values. Guidance notes have been developed and both are available on the SSA's website at <www.ssa.vic.gov.au>.

Box 1: Directors' code of conduct

- Act with **honesty and integrity**. Be open and transparent in your dealings; use power responsibly; do not place yourself in a position of conflict of interest; strive to earn and sustain a high level of public trust.
- Act in **good faith in the best interests of the public entity**. Demonstrate accountability for your actions; accept responsibility for your decisions; do not engage in activities that may bring you or the public entity into disrepute.
- Act **fairly and impartially**. Avoid bias, discrimination, caprice or self-interest; demonstrate respect for others by acting in a professional and courteous manner.
- **Use information appropriately**. Ensure information gained as a director is only applied to proper purposes and is kept confidential.
- **Use your position appropriately**. Do not use your position as a director to seek an undue advantage for yourself, family members or associates, or to cause detriment to the public entity; ensure you decline gifts or favours that may cast doubt on your ability to apply independent judgement as a board member.
- Act in a **financially responsible** manner. Understand financial reports, audit reports and other financial material that comes before the board; actively enquire into this material.
- Exercise **due care, diligence and skill**. Ascertain all relevant information; make reasonable enquiries; understand the financial, strategic and other implications of decisions.
- **Comply with the establishing legislation**, or its equivalent, for your public entity. Act within the powers and for the functions set out in your public entity's establishing legislation and/or ministerial charter.
- Demonstrate **leadership and stewardship**. Promote and support the application of the Victorian public sector values; act in accordance with the Directors' Code.

Adapted from Public Sector Standards Commissioner 2006

Conflicts of interest

The directors' code of conduct requires board members to avoid placing themselves in a position of conflict of interest. There are also provisions under the HSA (s. 65W) about disclosure of interest for metropolitan and major regional health service boards. The HSA requires that directors disclose any direct or indirect pecuniary interest in a matter being considered by the board. Further, the declaration must be recorded in the minutes of the meeting and the director with the conflict of interest must not be present during deliberations and must not vote on the matter.

Conflicts of interest should be declared and discussion held with the chair of the board and potentially other directors to determine how a conflict of interest should be managed.

Obligations in relation to conflicts of interest for health service board members are further articulated in government policy. A declaration of private interests (DPI) must be completed by all short-listed candidates for appointment to a board. The department provides a DPI form to directors for this purpose. The DPI provides of the opportunity to disclose pecuniary interests or other private interests that could **reasonably** raise an expectation of a real or a perceived conflict of interest, or could have a material interference with the proper performance of a member's public duties. Pecuniary and other private interests covered in the DPI are: shareholdings and other business interests; trusts; real estate; contracts, agreements or understandings entered into by the person or a family member; and other significant financial or other interests held or accruing to the person or a family member.

Candidates with a background in financial management must disclose in their DPI if they have engaged in consultancy work with professional financial service organisations providing audit, tax and advisory services to health services in Victoria. In addition, any applicants who have provided other high-level advice or management services to Victorian health services must include details of that involvement.

When appointed to a board, members are required to carefully examine issues scheduled for discussion by the board and identify any perceived or actual conflict of interest that may arise. Should this be the case, the member must disclose the conflict of interest, withdraw from any board deliberations and abstain from voting on the matter. The member should also discuss with the board chair any situation where they are unsure if a conflict, whether actual or perceived, may exist.

It is also required that all board members update the DPI on an annual basis.

Indemnity

Sections 38A, 65Y and 115JA of the HSA provide for all members of boards of health services not to be held personally liable for anything done or omitted to be done in good faith when carrying out their duties. Any liability resulting from an act or omission attaches instead to the health service.

Victorian Government public hospital insurance covers the corporate liability of public sector health services arising from negligent medical treatment, as well as the individual liability of those for whom the hospital is legally liable such as full-time and part-time employed doctors (including private practice work that is specifically covered by the insurance), and contracted visiting medical officers undertaking public work. Sum insured limits apply, which are reviewed for adequacy by the Victorian Managed Insurance Authority as part of their role as risk advisor to the government.

The precise nature and extent of an indemnity in any particular case will depend on the circumstances involved. Board members should seek independent legal advice concerning whether they need to take out additional insurance to cover all circumstances.

Executive remuneration policy

Under s. 65XA of the HSA, the boards of metropolitan and major regional health services are responsible for appointing the CEO and determining, subject to the Secretary's approval, the remuneration and terms and conditions of appointment.

The boards of non-regional-level rural health services are also responsible under the HSA (s. 25) for appointing the CEO, subject to the approval of the Secretary, and determining the remuneration and terms and conditions of appointment, subject to the approval of the Secretary.

The salary and terms of appointment for the CEO and other executives must be consistent with the government's executive employment and remuneration policy. Executive remuneration and employment policy for Victorian public entities, including health services, is managed by the Government Sector Executive Remuneration Panel (GSERP). The SSA provides advice and support to the panel, which is appointed by the Premier.

The *Policy on executive remuneration for public entities in the broader public sector* explains how remuneration is determined and approval procedures. Boards are responsible for ensuring their health service adheres to the policy and the approval and reporting requirements. It is recommended that boards and CEOs read the policy, which can be found at <www.ssa.vic.gov.au>.

The policy requires remuneration packages for all CEOs to be endorsed by the GSERP. The GSERP's endorsement must also be sought for other executive packages if the remuneration and terms proposed fall outside guideline rates and policy parameters.

Under the policy, boards are required to establish a remuneration subcommittee with specific responsibility for determining the organisation's policy and practice for executive remuneration and the individual remuneration packages for its executives. The policy also requires information on executive remuneration to be disclosed in two ways:

- in the annual report as required by the FMA and any directions issued under that Act
- in a remuneration committee report to the GSERP that sets out the organisation's policy on executive remuneration, including details of total remuneration packages for individual executives, comparator organisations, and a statement about compliance with government policy parameters.

The policy provides government with a tool to ensure executive remuneration is not excessive and, where increases are appropriate, that they are broadly in line with wage movements in the general community, particularly with public sector levels. The purpose of the policy is to ensure accountability to the government and community by disclosing information on executive remuneration policy and practices through the annual remuneration committee reports to the panel and in annual reports.

Other legal obligations

Board members are bound by common law. For example, they have a common law duty to act honestly, in good faith and with appropriate care, diligence and skill. (Common law is created by judges interpreting statute law and applying decisions as precedents.)

The board is responsible for ensuring the health service complies with all relevant legislative law. Numerous Acts of Parliament apply to public sector health services. In addition to the HSA, other Acts include:

- legislation aimed at improving administration and privacy such as the Health Records Act and the *Public Records Act 1973*
- legislation emphasising financial stewardship, including the FMA and the Audit Act
- legislation that has accountability and transparency as a focus, such as the Freedom of Information Act, Whistleblowers Protection Act, the Health Services (Conciliation and Review) Act and Ombudsman Act
- legislation to improve safety and protect rights of employees, such as *Equal Opportunity Act 1995* and the *Occupational Health and Safety Act 2004*.

Various other federal and state legislative laws may impose duties upon directors in certain prescribed circumstances. An example are the obligations to employees under the *Fair Work Act 2009*.

Importantly, members of the boards of Victorian public health services are not subject to the Corporations Act. This includes s. 588G of the Corporations Act, which requires directors of companies incorporated under it to avoid trading while insolvent, or incurring a debt that would lead the company to insolvency. (Section 588G also makes directors personally liable for debts that are incurred after a company becomes insolvent.)

The SSA *Good governance guide* recommends that to ensure compliance with all obligations, boards should identify the obligations and embed compliance in everyday operational processes, guidelines, manuals and training programs. A compliance program is an important element of good governance and due diligence and it should seek to:

- prevent, identify and respond to breaches of laws, regulations, codes or organisational standards
- promote a culture of compliance within the health service.

As the SSA guide states, the consequences for boards that are not compliant with their obligations are serious. Depending on the circumstances, the consequences may include criminal prosecution, civil action for damages for breach of statutory duty, adverse publicity, appointment of a ministerial delegate to the board, closer monitoring by the department, appointment of an administrator or removal from the board.

Further information and resources relating to board roles and responsibilities, ethics and legal obligations and relevant frameworks are available from:

- the SSA *Good practice guide on governance for Victorian public sector entities* (see <www.ssa.vic.gov.au>)
- the Australian Centre for Healthcare Governance, part of the Victorian Healthcare Association (see <www.healthcaregovernance.org.au>)
- the Australian Institute of Company Directors (see <www.companydirectors.com.au>).

Board process and building effective boards

- Board members are appointed by the Minister by way of recommendation to the Governor-in-Council for periods of up to three years.
- Boards of all health services are required to establish an audit committee and a remuneration committee; boards of metropolitan and major regional health services are also required to establish finance and quality committees.
- Metropolitan and major regional health services must also establish a community advisory committee and a primary care and population health advisory committee.

Board composition and appointments

Metropolitan and major regional health services

The HSA (s. 65T) specifies that boards of directors must have at least six directors and not more than nine, who are appointed by the Governor-in-Council on the Minister's recommendation through the Cabinet. In recommending the appointments, the Minister must:

- ensure at least one director is able to reflect the perspectives of users of health services
- ensure women and men are adequately represented
- give preference to people who are not registered providers within the meaning of the Health Services (Conciliation and Review) Act and who are not currently, or recently, involved in providing health services.

The Governor-in-Council (on the Minister's recommendation through the Cabinet) has the power to appoint one of the directors to be the board chair (s. 65T(2)).

The HSA (s. 65U) provides for directors to be appointed for terms up to three years, and for them to be re-appointed. The HSA does not allow a director of a board to serve more than nine consecutive years on that board.

The department manages the recruitment and appointment process for metropolitan and major regional health service boards. Information is available at <www.health.vic.gov.au/governance>.

The HSA (s. 65U(3)) allows for directors of boards to be paid an annual fee, as well entitling them to payment for reasonable expenses incurred in carrying out the role. The fees are paid in accordance with government guidelines (prepared by DPC) at rates determined by the Governor-in-Council on the Minister's recommendation. The fees paid take into account the degree of responsibility and risk carried by appointees and vary according to the size and complexity of the health service.

The guidelines permit additional payments to directors of boards for committee work undertaken. These payments are made at the discretion of the Minister. The guidelines – *Guidelines for the appointment and remuneration of part-time non-executive directors of state government boards and members of statutory bodies and advisory committees* – are available at <www.dpc.vic.gov.au>.

Section 65V of the HSA provides for the resignation and removal of directors. A director is able to resign by writing a letter for the Governor-in-Council. The resignation needs to be formally accepted by the Governor-in-Council to be effective. In practice, the letter is addressed to the Minister and submitted to the department, which arranges for the letter to be delivered to the Governor-in-Council on behalf of the Minister.

The Governor-in-Council (on the recommendation of the Minister) has the power to remove a director or all directors of a board. The Minister must recommend the removal of a director if the director: is physically or mentally incapacitated; has been convicted of a serious offence; has been absent without leave from all board meetings over a six-month period; or becomes an undischarged bankrupt.

Other rural health services and multi purpose services

The HSA (ss. 33 and 115E) specifies that these boards have at least six members and not more than 12, appointed by the Governor-in-Council on the Minister's recommendation. The HSA permits the board to submit nominees – in order of preference – to the Minister for consideration, providing it first invites nominations from the community through a newspaper advertisement, following a request by the Minister to submit nominees.

Where a rural health service is associated with a university and is prescribed in regulations as a medical school of that university, one board member must be nominated by the Minister from three names submitted to the board by the university council.

In recommending the appointments, the Minister must ensure that men and women are adequately represented. The HSA specifies that registered medical practitioners must not comprise more than one-quarter of the board.

Board members elect the chair. The HSA (ss. 34 and 115F) provides for directors to be appointed for terms of up to three years, and for them to be re-appointed for subsequent terms. Unlike the larger metropolitan and major regional health services, the HSA does not impose any statutory limits on the length of time these directors may serve.

Like the larger health services, the HSA (s. 34) allows for the members of boards of management of small rural health services to be paid an annual fee, as well entitling them to payment for reasonable expenses incurred in carrying out the role. It is current policy that board directors do not receive an annual fee.

The HSA (s. 115F) entitles the directors of multi purpose centres to payment for expenses incurred in holding office but does not allow for them to be paid an annual fee.

Under ss. 35 and 115G of the HSA, a director is able to resign by writing a letter for the Governor-in-Council. In practice, the letter is addressed to the Minister and submitted to the department, which then arranges for its delivery to the Governor-in-Council on behalf of the Minister. The Governor-in-Council, on the recommendation of the Minister, may remove a director. Unlike for the metropolitan and major regional health services, the HSA does not specify circumstances that require the Minister to recommend removal.

Board committees

Boards are able to share their workload by delegating aspects to committees. Committees carry out a thorough analysis of important matters and make recommendations for the board to consider. The board remains accountable for all decisions.

Under the HSA the boards of metropolitan and major regional health services are required to establish three committees: finance, audit and quality committees (s. 65S(2)(j)).

The HSA does not specify any committees that boards of other health services, including Multi purpose services, must establish. However, under the Standing directions of the FMA, all public

sector health services are required to establish an audit committee to oversee and advise the board and CEO on matters of accountability and internal control affecting the operations of the health service. The primary role of an audit committee is to consider reports from officers of the entity and the auditors that provide assurance about the integrity of the entity's financial processes, systems and reporting.

The government's executive remuneration policy also requires all boards to establish a remuneration committee with at least three members. The role of a remuneration committee is to determine the health service's policy and practice for executive remuneration, and the individual remuneration packages for its executives.

It is common practice for large health services to have additional committees such as an education and research committee. Committees may be standing committees or established for a specific purpose. Carver (1997, pp. 145–147) and many other governance experts favour a minimalist approach to committees, counselling that they should be established to aid the process of governance, not management.

The SSA *Good governance guide* advises that committees should be established with:

- a specific charter, with clear terms of reference
- delegations that do not undermine the board's delegations to the CEO
- an appropriate number of directors
- procedures for agendas, minutes and reporting to the board
- a clear expectation that the decision-making responsibilities of the full board are not to be compromised by the activities of any committee, and that significant issues will be reported to the board for discussion and decision making.

Advisory committees

Section 65ZA of the HSA requires the boards of directors of metropolitan and major regional health services to appoint a primary care and population health advisory committee, and a community advisory committee. It also specifies that boards may appoint other advisory committees if they choose. With respect to community advisory committees, boards (s. 65ZB):

- are able to decide the number of members
- must ensure the members are people able to represent the views of the communities served by the health service
- must give preference to people who are not registered providers within the meaning of the Health Services (Conciliation and Review) Act and who are not currently, or recently, involved in providing health services
- must fill a vacancy in the membership within three months of it arising.

With respect to primary care and population health advisory committees, boards (s. 65ZC):

- are able to decide the number of members
- must ensure the members have between them
  - expertise in or knowledge of the provision of primary health services in the areas served by the health service
  - expertise in identifying health issues affecting the population serviced by the health service and designing strategies to improve the health of that population

- knowledge of the healthcare services provided by local government in the areas served by the health service
- must fill a vacancy in the membership within three months of it arising.

Section 65ZD of the HSA permits the Secretary to publish guidelines relating to the composition, role, functions and procedure of advisory committees. Subject to any guidelines, the HSA states that the procedure of an advisory committee is in its discretion (s. 65ZE). Guidelines have been established for community advisory committees but not for primary care and population health advisory committees.

The guidelines define the role of the community advisory committee as follows:

- to provide direction and leadership in relation to the integration of consumer, carer and community views into all levels of health service operations, planning and policy development
- to advocate to the board on behalf of the community, consumers and carers.

The *Community advisory committee guidelines: Victorian public health services* are available at <www.health.vic.gov.au/consumer/pubs/index.htm#qual>.

The HSA does not specify any advisory committees that non-regional-level rural health services must establish.

Board meetings

It is up to the board of a health service to establish its own procedures; the HSA does not set out any requirements. The SSA *Good governance guide* recommends that these procedures be documented in a board charter or governance policy.

Serving on a board can require a substantial time commitment. This includes attending meetings of the board and board committees, and preparing for meetings. Board members are expected to attend at least 75 per cent of board meetings held during the year.

The SSA guide outlines requirements for effective and accountable decision making in meetings, which are:

- a clear definition of how the board conducts business, including whether decisions are taken by consensus or vote
- a carefully prepared agenda
- relevant papers circulated no less than five working days before meetings
- frank and open discussion
- accurate, timely records of decisions, discussion and dissent
- draft minutes provided to the chair within 24 hours and circulated to members when approved
- rules about access to information
- ability and willingness to seek independent and external professional advice at the entity's expense, as required, to help members understand the full implications of decisions.

Board size and quorum

The HSA provides that a board shall consist of between six and 12 members (nine is the maximum for metropolitan and major regional health services, and 12 for all others). While every effort should be made to keep the formal membership to at least six, there is no stipulation in the HSA regarding a quorum.

The procedures of the board, including quorums, are at the discretion of the board (s. 37 of the HSA) and are normally provided for in the health service's by-laws. Practice differs, with some specifying a quorum of three if there are six members on the board, and a quorum of four if there are more than six members. Some by-laws require a quorum of 50 per cent plus one member. However, there is no hard-and-fast rule.

It should be noted that s. 40 of the HSA provides that an act or decision of a board is not invalid by reason only of a vacancy in the membership of the board. This means if by unavoidable circumstances the membership drops below six the existing board can continue to function for a temporary period until the vacancy is filled. What constitutes a quorum during that period will depend on the health service's by-laws.

Board effectiveness

- Boards should develop a comprehensive induction package for new members, and satisfy the ongoing training and education needs of members.
- Each board must evaluate its own performance annually.

Effective boards are the cornerstone of Victoria's devolved governance model. The department has developed a framework to support board effectiveness, the Building board capability framework. This informs boards of current best practice to achieve board effectiveness and the means by which the department will work to support boards to achieve this.

The framework and a board assessment tool are available at <www.health.vic.gov.au/governance>.

Induction and education

Health service boards should develop a comprehensive induction package for new members, as well as formally assessing and satisfying the ongoing training and education needs of directors and of the board as a whole.

Board assessment

Health service boards should evaluate their performance annually to achieve best practice governance. The board chair should ensure that board evaluation occurs regularly, ideally as an annual process, and is responsible for ensuring it is conducted in a constructive and effective manner.

Among other things, the annual performance assessment process should identify skill gaps and training needs, and be used to formulate a program of board education activities for the coming year. In the same way that health services develop staff for their roles, board member development is vital to the effective functioning of the board.

A board assessment guide will be available on the department's governance website at <www. health.vic.gov.au/governance> during 2011–12 to assist boards to design and carry out this important process.

Board selection

Board composition is an important component of board effectiveness. To maximise a board's capacity for effective governance it is essential that there is the right mix of relevant skills, expertise and personal attributes. This requires the specification of required skills, experience and attributes, and an appointment process that addresses key gaps, including adequate discussion and consultation with board chairs. Appointments are usually made in consultation with the board chair.

As well as skills and knowledge it is also important to achieve a balance between new members and ideas and corporate memory. For complex businesses such as health services it can take time to develop expertise and be able to add value. As far as possible, appointment terms are staggered to achieve balance between renewal and corporate memory.

The Minister appoints boards; however, board chairs and members should form a view on the most effective composition for their boards, including skills mix and gaps, and provide advice on this as required.

Health services governance in practice

- Health services prepare strategic plans for the Minister's approval.
- The board agrees an annual SoP with the Minister or Secretary.
- The *Victorian health services performance monitoring framework* is used to monitor performance and to assess the performance of a health service on a quarterly basis.
- Health services prepare and publish an annual quality of care report.
- A range of health service data is published quarterly to inform the community about the activity and performance of health services.

Key accountability documents

The SoP, signed by the board and Minister (or Secretary) each year, sets out the key accountability relationship between government and health services (more information is provided below). The other key documents that are integral to the accountability arrangements for health services are:

- the *Victorian health policy and funding guidelines*, which includes information about government initiatives, program-specific accountabilities and conditions of funding for health services (this publication is available at <www.health.vic.gov.au/pfg>)
- the *Victorian health service performance monitoring framework*, which outlines the performance monitoring requirements and monitoring regime for health services, and includes the business rules for SoP key performance indicators (KPIs) (this publication is available at <www.health.vic. gov.au/hospital-performance>).

Health services strategic plans

Developing strategic plans is an important element of the governance and accountability framework. Under s. 65ZF of the HSA, metropolitan and major regional health services are required to prepare a strategic plan in accordance with any guidelines established by the Minister. Once approved by the Minister the HSA requires a board to advise the Minister if it wishes to deviate from its approved strategic plan.

The strategic plans of health services have a three to five year outlook. They include the health service's role and objectives, and outline strategies to ensure the effective and efficient provision of health services and the financial sustainability of the health service. They provide the strategic context for the health service's annual SoP, and should align with their service plan. There is a separate process for developing and agreeing a service plan for the health service, which is more detailed than the high-level strategic plan.

The guidelines for strategic plans set out minimum content expectations. The aim is to ensure the content of strategic plans is consistent and that they reflect overarching government policy and planning directions.

Statement of priorities

The SoP is the key accountability agreement for metropolitan and major regional health services and is agreed each year between the Minister and the board of a health service. In addition, other health services sign an SoP with the Secretary.

Section 65ZFB of the HSA specifies that a health service's SoP must:

- be consistent with the health service's approved strategic plan
- specify for the financial year to which it relates
  - the services to be provided by the health service and the funds to be provided to the health service
  - the objectives, priorities and key performance outcomes to be met by the health service
  - the performance indicators, targets or other measures against which the health service's performance is to be assessed and monitored
  - how and when the health service must report to the Minister and the Secretary on its performance in relation to the specified objectives, priorities and key performance outcomes
  - any other matters agreed by the Minister and board, or determined by the Minister.

The SoP is developed collaboratively by the health service and the department on behalf of the board and the Minister or Secretary, and is approved and signed by the board chair and the Minister or Secretary as applicable. In the event that a SoP is not agreed by 1 October, the HSA allows for the Minister to determine a SoP for the health service in accordance with s. 65ZFB.

The seven Multi purpose services (see appendix) are jointly funded by the Commonwealth and Victorian governments to provide a combination of health and aged care services designed to suit the particular needs of each small rural community. The funding and services provided are set out in tripartite agreements between the Victorian Government, the Commonwealth Government and the multi purpose service agency.

The annual SoP agreement sets out the KPIs that are used to assess and monitor the performance of a health service. The KPIs cover three aspects of performance: access, financial performance, and quality and safety. The department works with health services on an ongoing basis to develop, refine and modify the KPIs to ensure they continue to provide a balanced perspective of service provision.

A selection of core KPIs is included in the formal assessment framework used to monitor and grade the performance of health services on a quarterly basis through a performance assessment score (PAS). Each of the KPIs included in the PAS is given a weighting and makes a different contribution to the PAS. Points are allocated to each KPI using sliding performance scales. Not all the KPIs included in the PAS apply to all health services; for example, ambulance bypass does not apply to regional and rural health services and only applies to specified metropolitan health services. The scoring process is adjusted to take account of these variations.

Performance against each KPI is reported quarterly to boards via the Victorian Health Service Performance Monitor, which is prepared by the department and disseminated to board chairs and CEOs. To assist in managing performance throughout the quarter, CEOs also receive a Performance Monitor report monthly. All monitoring reports use preliminary or interim results that are subject to confirmation and change, but provide the basis for an initial conversation or to identify emerging issues.

The PAS, together with other threshold performance aspects, determines the level of monitoring a health service receives from the department throughout the annual business cycle.

There are three levels of monitoring:

- **Standard monitoring** applies to those health services performing acceptably against KPIs (70–100 points). This score affords health services the highest level of autonomy; the department meets quarterly with the health service to discuss performance.

- **Performance watch** applies to those health services with a deterioration in performance against targets (50–69 points). Monitoring activities increase and performance meetings with the department are more frequent, either monthly or bi-monthly, with agreed plans put in place to address performance issues.

Intensive monitoring applies to those health services with under achievement against KPIs of below 50 points (0–49 points). The scope of monitoring is intensified and other accountabilities may be put in place involving the board and Minister or Secretary.

A range of risk factors are also taken into account in assigning a monitoring category. For example, health services with a delegate on the board appointed by the Minister also qualify as being on intensive monitoring, and those with a formal review in place have their score adjusted down to the next category (for example, a health services with a PAS of 'standard monitoring' would be on 'performance watch' if there was also a review in place).

The SoP requires health services to comply with conditions of funding outlined in the *Victorian health policy and funding guidelines*, including data reporting requirements.

SoPs for health services are made available to the public, and can be found at <www.health.vic.gov.au/hospitals/sops>.

Annual reports

All health services are required to submit an annual report to Parliament each year. Currently, these are tabled in early to mid September of each year as determined by Parliament. The department provides guidelines to help health services present their annual report as required under the FMA, s. 4.2 of the *Standing directions of the Minister for Finance under the Act and Financial reporting directions*.

The FMA and *Financial reporting directions* apply to all health services. Each annual report is divided into two sections:

- report of operations
- financial statements including explanatory notes.

The guidelines have been developed to illustrate as widely as possible the *minimum* disclosure requirements for health services and can be found at <www.health.vic.gov.au/anrep>.

Quality of care reports

As part of the conditions of funding outlined in the *Victorian health policy and funding guidelines*, all health services are required to publish a quality of care report for each financial year and submit it to the department by 31 December.

The purpose of the quality of care report is to describe the systems and processes in place in the health service to monitor and improve safety and quality. Guidelines issued by the department provide advice on content and presentation, including an outline of minimum reporting requirements. The mandatory minimum quality and safety reporting requirements include a report on:

- performance outcomes for infection control, medication errors, falls prevention and management, and pressure wound prevention and management
- the health service's review of their clinical governance system against the *Victorian clinical governance policy framework* (see the section on clinical governance below for more information)
- accreditation outcomes
- clinical risk management, including credentialling, scope of practice and certification of staff
- complaints management.

The guidelines, which are updated annually by the department by 30 April, are available at <www.health.vic.gov.au/consumer/pubs/index.htm#qual>.
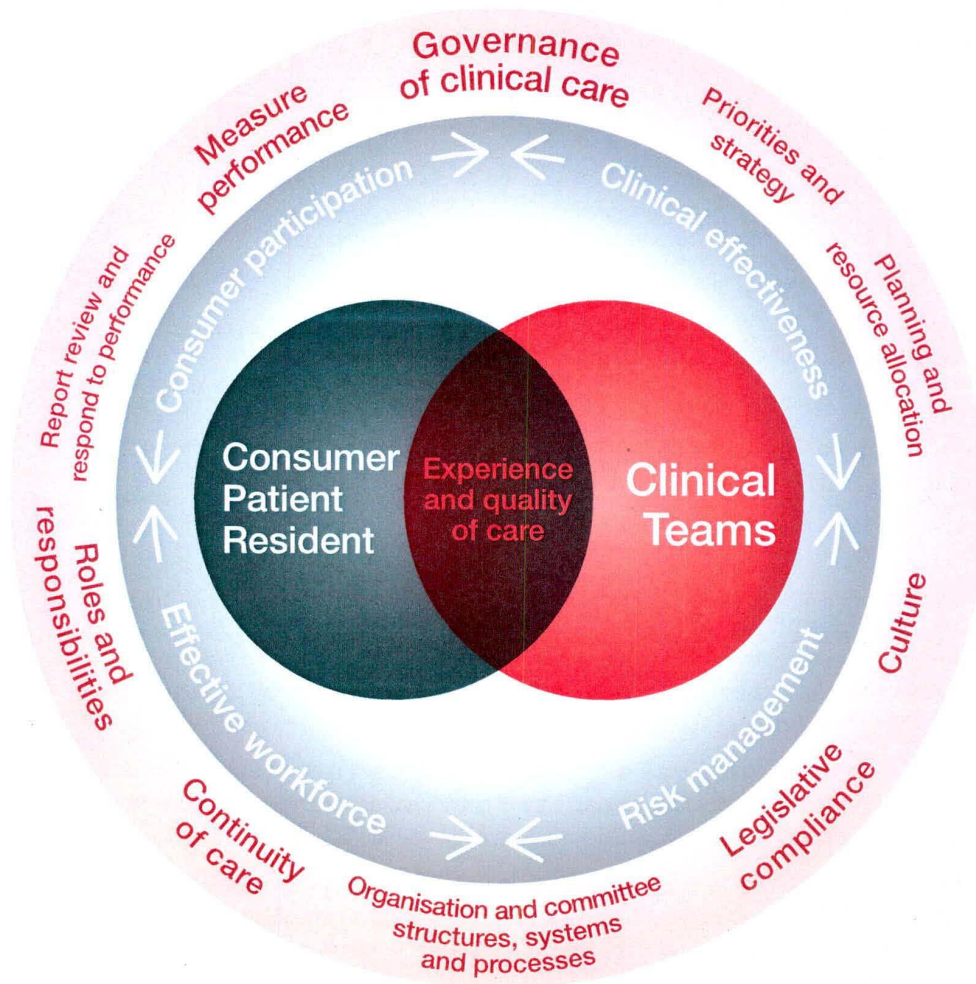
Clinical governance

- Clinical governance should be integrated with corporate governance at board level.
- The department has developed the *Victorian clinical governance policy framework*, and supporting tools, to support effective clinical governance systems.

The governance of clinical care is a key area of responsibility for a health service board. It is the system by which the governing body, managers and clinicians share responsibility and are held accountable for care, minimising risks to consumers and continuously monitoring and improving the quality of clinical care (Australian Council on Healthcare Standards 2004).

Corporations would normally have two levels of leadership, the board and the executive team, led by the CEO. However, depending on the nature of its business and duty of care to its consumers, it may also be supported by an expert leadership group of key professionals. In the case of health case services, the leadership structures should include clinicians.

Clinical governance systems provide accountability for safe care and information that can be used to achieve continuous improvements in consumer safety, illustrated in Figure 5.

Figure 5: Clinical care governance framework

Source: Department of Human Services, 2009

In addition, good clinical governance ensures accountability and increases a 'just' culture. A just culture normally refers to a workplace culture in which actions, omissions or decisions taken by staff in line with their experience and training are not unduly sanctioned; however, gross negligence, wilful violations or other destructive acts are not tolerated. A just culture is open and focuses on continuous improvement (European Organisation For The Safety Of Air Navigation 2006, p.11).

Under s. 65S(2)(d) of the HSA the boards of the metropolitan and major regional health services are required to ensure:

- effective and accountable systems are in place to monitor and improve the quality of the health services they provide
- any problems with quality or effectiveness are addressed in a timely manner.

The HSA (s. 65XB) requires the CEO to:

- implement effective and accountable systems to monitor the quality and effectiveness of healthcare provided
- ensure the health service continuously strives to improve the quality of care and foster innovation.

While the HSA does not articulate equivalent responsibilities for smaller rural health services, government policy and funding conditions impose equivalent requirements.

The board has ultimate responsibility for the governance of clinical care within the health service. It is responsible for ensuring that effective safety and quality systems and robust organisational structures are in place, that their performance is monitored, and that the organisation responds appropriately to safety and quality problems. Boards and management are responsible and accountable for ensuring the systems and processes are in place to support clinicians in providing safe, high-quality care, and in ensuring clinicians participate in governance activities. Boards are responsible for monitoring the effectiveness of systems and processes at a higher level than health service management.

The responsibility for designing and implementing systems and monitoring the effectiveness of clinical care is appropriately delegated to managers and healthcare professionals with specific expertise. Clinicians and clinical teams are responsible and accountable for the safety and quality of care they provide.

The board should ensure they receive systematic reports across the range of quality and safety assurance activities. Table 1 provides an example of standing items that could be reported directly to boards or through board committees.

Table 1: Example agenda items for reporting to boards on safety and quality

Type of report	Suggested frequency of reporting
Key quality and safety strategic priority areas progress and KPI performance - SoP - local priorities	Monthly

Type of report	Suggested frequency of reporting
Clinical risk management report, including response to known risks and incorporating incident trends and proactively identified risks through coronial reports and major hospital or safety reviews	Six-monthly
Victorian health incident management reporting	Monthly
Summary report of incident findings, including systems issues identified, recommendations and improvement plan	Six-monthly
Legislative compliance report	Annually
Accreditation reports	As required
Credentialling and scope of practice	Annually
Outlier performance reporting on performance indicators, issues identified, recommendations and improvement plan *Outliers may be identified through a range of techniques including statistical process control (SPC) charts or comparison to benchmark*	Three- to six-monthly
Consumer participation plan	Annually
Complaints and compliments report, including issues identified, recommendations and improvement plan	Six-monthly
Victorian Patient Satisfaction Monitor report	Monthly
Clinical audit report – evaluation of practice against clinical guidelines/ pathways	Six-monthly
Quality and safety improvement report, including reports on quality improvement initiatives, improvement response to issues identified through risk management activities and performance reports. This should address progress against the quality business plan or improvement plan	Three- to six-monthly
Report on quality and safety workforce development, including leadership, succession planning, education and training	Annually

Type of report	Suggested frequency of reporting
Leadership and culture – boards or committees may choose to have a quality and safety improvement initiative presented to them by a senior clinician and/or clinical team or undertake an organisational climate survey	Three-monthly
Cultural responsiveness framework	Annually

The department has developed the *Victorian clinical governance policy framework* to guide health services in developing and implementing a formal and effective clinical governance system. A guidebook and tools, including detailed activity checklists, have also been developed to assist health services. The policy requires strategies to be developed covering four areas of quality and safety: consumer participation, clinical effectiveness, effective workforce and risk management. Some further guidance (from the guidebook) is provided below.

Consumer participation

Consumers are central to identifying safety and quality issues and the solutions that should be implemented.

Consumer participation should occur at many levels of the organisation, through activities such as community consultation and consumer partnership on governance and management committees, and within improvement initiatives or clinical risk management activities. Consumer participation should be part of planning, policy development, health service management, clinical research, training programs and guideline development.

The organisation should use consumer complaints and compliments, surveys and freedom of information (FOI) requests to inform improvements. Consumer input should be used to develop information resources and communication strategies for patients, residents and carers.

Strategies should be in place to ensure:

- consumers are empowered to participate in their care
- consumers participate in organisational processes including planning, improvement and monitoring
- there is clear, open and respectful communication between consumers at all levels of the health system
- services respond to the diverse needs of consumers and the community with humanity
- consumers provide feedback on clinical care and service delivery and services learn from the feedback
- the rights and responsibilities of 'patients' are promoted to community, consumers, carers, clinicians and other health service staff.

Consumer advisory committees are established to advise the public health services and are a useful mechanism to ensure that consumer participation is effective.

Clinical effectiveness

Clinical effectiveness is ensuring the right care is provided to the right patient who is informed and involved in their care at the right time by the right clinician with the right skills in the right way.

Strategies should be in place to ensure:

- clinicians are empowered to improve clinical care delivery
- clinicians actively involve consumers as partners in their care
- clinical innovation is fostered and supported
- clinical service delivery processes are streamlined and efficient, with clinicians participating in designing systems and processes
- quality improvement activities are planned, prioritised and have sustainability strategies in place
- clinical care delivery is evidence based and standards of clinical care are clearly articulated and communicated
- clinical care processes and clinical outcomes are measured
- clinical performance measures, peer review and clinical audit are used to evaluate and improve performance
- quality improvement activities are reviewed externally
- new procedures and therapies are introduced in a manner that assures quality and safety issues have been considered and actioned.

Credentialling and workforce strategies

All staff employed within health services must have the appropriate skills and knowledge required to fulfil their role and responsibilities within the organisation. Support is required to ensure clinicians and managers have the skills, knowledge and training to perform the tasks that are required of them. Processes should be in place to support the appropriate: selection and recruitment of staff; credentialling of clinical staff including an annual review of practice; maintenance of professional standards; and control to safely introduce new therapies or procedures.

The *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services policy 2007* (updated 2009) applies to all senior medical staff (including dentists) appointed to a Victorian public health service. To support the implementation of the policy the department has now developed a performance development and support process for senior medical staff in Victorian public health services. *Partnering for performance*, released in April 2010, supports the process of regular review of a doctor's performance throughout the credentialling cycle and provides guidance to organisations and senior doctors to assist in enhancing performance.

Strategies to support appropriate practice include:

- workforce development to provide the workforce with appropriate skills and professional group mix
- ensuring the health workforce has the appropriate qualifications and experience to provide safe, high-quality care
- expectations and standards of performance that are clearly communicated
- support through a variety of mechanisms such as training, development and mentoring
- ensuring workforce competence is sustained, innovation is fostered and corporate knowledge is passed on
- ensuring multidisciplinary teamwork is fostered and supported.

An important source of information for boards and organisations about workforce issues is staff or culture surveys, which can provide valuable feedback on the culture of the organisation.

The People Matter Survey, administered by the SSA, measures a range of aspects of workforce culture and climate in the Victorian public sector. The survey focuses on employees' perspectives on the application of the public sector values and employment principles. The survey also measures other aspects of the workplace such as job satisfaction and workplace wellbeing. This information is used by participating organisations to identify their strengths and weaknesses and to measure their progress in embedding the public sector values and employment principles in their organisation's culture.

Public sector entities should arrange for the survey to be run every two years.

Clinical risk management

Clinical risk management is part of a broader organisational risk management system that integrates the management of organisational, financial, occupational health and safety, plant, equipment and patient safety risk.

Minimising clinical risk and improving safety of care requires a systems approach. This is achieved by developing a system-level response to issues that sustain an environment that allows adverse events to occur.

Development of the system-level response should occur within the framework of a 'just' culture, rather than focusing on and blaming individuals. Clinical risk management and improvement strategies are integrated within improvement and performance monitoring functions.

Clinical risk management strategies should be in place to ensure:

- clinical incidents are identified and reported consistent with the requirements of the Victorian Health Incident Management System (VHIMS)
- clinical incidents are investigated and underlying systems issues and root causes are identified
- risks are proactively identified, assessed and reported
- organisational culture supports open communication and a systems approach to learning from incidents
- clinical processes and technology supports are designed to minimise error and ensure clear, unambiguous communication
- a defined system for managing any complaint or concerns about a clinician is in place, promoted and is regularly reviewed for effectiveness
- known clinical risks are proactively addressed
- risk information is considered in settings goals, priorities and developing business and strategic plans
- legislation and relevant Australian Standards are complied with
- policies and protocols are reviewed and managed
- risk management activities are reviewed externally
- methods to improve patient safety are researched and innovative interventions developed.

As outlined above, health services are required to report annually on clinical governance structures and activities as part of their quality of care report.

The clinical governance policy document, guidebook and other supporting materials are available at <www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy_.htm>. Table 2 outlines some key reporting requirements.

Table 2: Some key health service safety and quality reporting requirements

Type of report	Database manager
Infection control surveillance	Victorian Hospital Acquired Infection Surveillance System (VICNISS)
Cleaning standards	Department of Health
Victorian Cardiac Surgery Database Project	Australian Society of Cardiac and Thoracic Surgeons
Victorian Vascular Surgery Database Project	Melbourne Vascular Surgical Quality Initiative
Intensive care	Australian and New Zealand Intensive Care Society
Clinical risk management and VHIMS, which includes sentinel event reporting	Department of Health
Trauma outcomes	Victorian State Trauma Outcomes Registry and Monitoring Group
Pressure ulcers	Department of Health
Community participation plans	Department of Health
Quality of care reports	Department of Health
Cultural diversity and language services plan	Department of Health
Victorian Patient Satisfaction Monitor report	Department of Health / Ultra Feedback Pty Ltd
Accreditation status	Department of Health

Residential aged care services

Some Victorian public sector health services are major providers of residential aged care services, particularly in rural areas.

The department has prepared *Governing quality in public sector residential aged care: an organisational readiness tool* to assist Victorian public sector health service boards analyse the robustness of the clinical governance systems in their organisations in relation to residential aged

care services. The tool covers all aspects of the *Victorian clinical governance policy framework* and adds some specific residential aged care components. Boards and executives are expected to adapt the components to suit their circumstances and use the tool to help align and integrate their governance systems for acute healthcare and residential aged care services. The tool is available at <www.health.vic.gov.au/agedcare/publications/governing_quality.htm>.

Financial governance

Boards have responsibilities under the HSA and FMA for:

- achieving financial targets agreed in the SoP or other service agreements
- monitoring financial performance
- ensuring the health service's financial viability
- establishing an audit committee
- preparing an annual report of operations and financial statements.

Financial governance is a key area of responsibility for a health service board. The boards of metropolitan and major regional health services are required by the HSA (s. 65S(2)) to:

- develop financial and business plans, strategies and budgets to ensure the accountable and efficient provision of healthcare services and the long-term financial viability of the health service
- monitor the performance of the health service to ensure it operates within budget, and its audit and accounting systems accurately reflect the financial position and viability of the health service.

While the HSA does not articulate equivalent requirements for smaller rural health services, all health services have accountabilities under other legislation. Financial performance has several aspects and health services are held to account through a number of mechanisms and processes, some of which are established under the HSA but also the FMA and the Audit Act.

Under the HSA, the board is accountable to the Minister for Health for achieving the financial targets agreed in its annual SoP or service agreement established with the government.

Financial Management Act

The FMA applies to all public sector health services. The CEO is the accountable person under the FMA and he or she is required to appoint a chief finance and accounting officer (ss. 42 and 43). The FMA also requires health services, among other things, to:

- maintain a register of assets (s. 44B)
- keep proper accounts and records of financial transactions (s. 44)
- provide the Minister for Finance with any information requested (s. 44A)
- prepare an annual report of operations and financial statements (s. 45).

Standing directions of the Minister for Finance

In addition to provisions in the FMA, the Minister for Finance has issued *Standing directions* under the FMA that impose additional requirements on health services. The directions supplement the FMA by prescribing mandatory procedures for financial management that must be complied with. The mandatory procedures are high-level requirements that allow agencies to tailor arrangements

to suit their circumstances. DTF has developed the *Financial management compliance framework* to help public sector agencies comply with the directions. The framework, as well as the directions and other related material, is available in the Budget and Financial Management section of the DTF website at <www.dtf.vic.gov.au>. The directions cover three areas:

- financial management governance and oversight, including requirements to implement and maintain a financial code of practice and establish an audit committee
- financial management structure, systems, policies and procedures
- financial management reporting, including information to be included in the annual report required under part 7 of the FMA (s. 45).

Audits by the Auditor-General

In accordance with the Audit Act, the Victorian Auditor-General conducts financial statement audits of all Victorian public sector health services once a year. Financial statement audits provide independent assurances to Parliament and the community that the information contained in the financial statements of public sector entities is presented fairly in accordance with Australian accounting standards and applicable legislation. The health service pays an audit fee determined by the Auditor-General to the Consolidated Fund.

The Auditor-General may also conduct performance audits of any health service program area or quality of care or administrative aspect, such as emergency care, safety or waiting list data. These audits evaluate whether a health service is achieving its objectives effectively, and doing so economically and efficiently, and in compliance with all relevant legislation.

The Auditor-General can compel a person from a health service to answer questions and provide any document necessary to carry out an audit. The Auditor-General can report to Parliament on any audit carried out, and usually does so.

The SSA *Good governance guide* recommends that the board maintains a constructive relationship with the Auditor-General's office, and provides prompt consideration and feedback on any audit opinion or report affecting the health service. To ensure compliance with the Audit Act, the guide also recommends, among other things, that:

- the board's audit and risk management committee and the health service's internal auditors maintain a constructive relationship with the Auditor-General's office
- the health service administers a well-targeted program of internal financial and compliance audits so there are no surprises when the Auditor-General conducts an audit.

Risk management and compliance

- Health services must develop and implement a risk management strategy in accordance with the *Victorian Government risk management framework*.
- Health services must inform the Minister and the Secretary of any major risk that may affect the health service.

Risk management is another key area of responsibility for a board.

Under the HSA (s. 65S(2)) the boards of metropolitan and major regional health services are required to:

- monitor the performance of the health service to ensure effective and accountable risk management systems are in place
- ensure the Minister and the Secretary are informed in a timely manner of any issues of public concern or risks that affect or may affect the health service.

The FMA (s. 44B) requires all public sector health services to develop, implement and keep under review a risk management strategy. The *Standing directions* (s. 4.5.5) require boards and CEOs to implement and maintain risk management governance, systems and reporting requirements as contained within the *Victorian Government risk management framework*.

DTF has developed the *Victorian Government risk management framework* to support best practice in public sector risk management. It provides for a minimum common risk management standard and is also a collective resource that links a variety of risk management information sources. A common standard ensures that a generally accepted method of risk management is being applied across the public sector. All risk management frameworks and processes must, as a minimum requirement, be consistent with the key principles of the *Australian/New Zealand risk management standard: AS/NZS 4360*, or designated equivalent. The standard provides a generic, internationally accepted process for identifying, analysing, evaluating and treating risks after establishing and having regard to the relevant strategic, operational or tactical context. To ensure risks are being managed in a consistent manner, boards are required to attest in annual reports that:

- the health service has risk management processes in place that are consistent with the standard (or equivalent standard)
- the risk management processes are effective in controlling the risks to a satisfactory level
- a responsible body or audit committee verifies the efficacy of the risk management process.

The *Victorian Government risk management framework* can be obtained from DTF or found at <www.dtf.vic.gov.au>.

Data integrity

The department maintains a health data audit program of all health services reporting to the department's key datasets. Health service boards are accountable for the accuracy of data on which their health service reports (via board audit committees), and must regularly conduct internal audits. In addition health service boards are required to provide a statement in their annual report to Parliament that they have appropriate systems and processes in place to assure the quality of reported data.

In addition:

- All health service staff using emergency department (ED) and elective surgery waiting list systems are to have a unique identifier and password to access the systems.
- Changes to specific data fields in health service systems are to be authorised by senior staff.
- Audit logs are to be maintained of all transactions in these systems for specified data fields.

The department is also responsible for receiving complaints and investigating complaints concerning manipulation and/or falsification of public hospital data.

Sanctions for non-performance

Metropolitan, major regional, subregional and rural health services

The HSA provides several avenues for the Minister to intervene in the event of significant non-performance relative to agreed performance expectations and targets. As an avenue of last resort, s. 61 of the HSA empowers the Governor-in-Council, on the recommendation of the Minister, to appoint an administrator to replace a board if particular statutory criteria are met (see below). Upon the appointment of an administrator, the entire board ceases to hold office. However, the board must be notified in writing of this intention and the Minister must give consideration to any submissions made by the board within seven days of the notice.

Under s. 58, the Minister may recommend the appointment of an administrator if the health service:

- is inefficiently or incompetently managed
- is failing to provide an effective health service
- has negligently failed to comply with a health service agreement or interim funding statement
- in the case of 'public hospital' entities under the HSA, has failed to comply with a Health Purchasing Victoria direction or a purchasing policy that applies to it
- in the case of 'public health service' entities under the HSA, has substantially failed to meet any of the objectives, priorities or key performance outcomes specified in its SoP and has failed to identify and adequately address any problems relating to the failure in a timely manner
- in the case of a 'public hospital' or 'public health service', has failed to comply with a direction issued by the Minister
- in the case of a 'public hospital' or denominational hospital, has failed to comply with a direction of the Secretary.

As an intermediate step, the HSA allows the Minister to appoint one or two delegates to a board to assist with improving the health service's performance (ss. 40C and 65ZAA).

A delegate is not a member of the board, is appointed for a period up to 12 months, and is eligible for re-appointment. Delegates are able to resign by writing to the Minister, or the Minister may revoke the appointment.

The HSA (ss. 40D and 65ZAB) specifies the function of a delegate to the board as:

- to attend meetings of the board and observe its decision-making processes
- to provide advice or information to the board to assist it in understanding its obligations under the HSA
- to advise the Minister and the Secretary on any matter relating to the health service or the board.

The HSA (ss. 40E and 65ZAC) requires the board to:

- permit the delegate to attend any meeting of the board
- simultaneously provide the delegate with any information or document provided to board members. In the case of metropolitan and major regional health services, this includes any material provided to members of committees established under the HSA.

Multi purpose services

Section 115Q of the HSA allows the Minister to recommend to the Governor-in-Council that an administrator be appointed to a multi purpose service and/or that the service be closed, if the Minister is satisfied that the service:

- is inefficiently or incompetently managed
- is failing to carry out its functions, or failing to carry them out effectively, or
- has negligently failed to comply with an agreement entered into under the HSA.

Under s. 115R of the HSA, if the Minister proposes that an administrator be appointed, the Minister must, among other duties, give notice in writing to the service and consider any submissions by the service made within seven days of the notice. Upon the appointment of an administrator all members of the board cease to hold office.

The HSA does not provide for the Minister to appoint a delegate to the board of a multi purpose service.

Overview of the national health system

The Victorian healthcare system is administered by the Victorian Government and operates as part of a national system of healthcare financing and delivery.

In 1946 the Australian Constitution was amended to enable the Commonwealth to provide health benefits and services, without altering the powers of states in relation to health service provision. Since that time, the two levels of government have had overlapping responsibilities for funding and delivering health and aged care services.

Funding for health services is provided by all levels of government, private health insurers and out-of-pocket payments by individual Australians.

Overall coordination of the public healthcare delivery system is the responsibility of federal, state and territory health ministers, who constitute the Australian Health Ministers' Conference (AHMC). They are supported by the Australian Health Ministers' Advisory Council (AHMAC), a committee of the heads of the Commonwealth, state and territory health departments or authorities.

Major reforms to health policy and financing arrangements are negotiated through the Council of Australian Governments (COAG), which comprises the Prime Minister, the heads of state and territory governments, and the President of the Australian Local Government Association.

At the April 2010 COAG meeting, the Victorian Government signed the *National health and hospitals network agreement* (NHHNA). All Australian jurisdictions have since signed a new Heads of Agreement on national health reform. This forms the basis of a new national health reform agreement and replaces the April 2010 NHHNA. Under the revised health reform package:

- A devolved hospital governance model is being introduced across Australia with the establishment of Local Hospital Networks (LHNs). These are governed by a council or board and managed by a CEO. Victoria's devolved governance model already meets these requirements.
- States/territories remain managers of the public hospital system and will continue to negotiate service-level agreements with LHNs or equivalents.
- Medicare Locals (MLOs) are being established and will be responsible for supporting and enabling better integrated and responsive local general practitioner and primary healthcare services.
- There will be no transfer of goods and services tax (GST) to the Commonwealth.
- From 1 July 2014 the Commonwealth will increase its contribution to efficient growth funding for hospitals to 45 per cent of activity-based services, and from 1 July 2017 to 50 per cent.
- The Commonwealth guarantees that its additional funding will be no less than $16.4 billion between 2014–15 and 2019–20.
- From 1 July 2012 the Commonwealth and states/territories contribute funding for hospitals into a single, independent national pool. In October 2012 payments to Victorian health services will commence from the national pool.
- The Commonwealth and states/territories will continue to develop a national approach to activity-based funding being introduced from 1 July 2012.
- Victoria's small rural hospitals and some other services, such as complex statewide services, will continue to be block grant funded.
- States/territories will continue to play a significant role in delivering primary healthcare services; there will be no transfer of primary care services to the Commonwealth.
- The Commonwealth will develop a national strategic framework to set out future policy directions and priorities for general practice and primary healthcare.

- Victoria will work with the Commonwealth, in consultation with local government, to consider potential changes in responsibilities for Home and Community Care (HACC) services.

National healthcare system / Medicare

The Commonwealth Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS), together with the grants provided to state/territory governments for free hospital care, comprise the national healthcare funding system known as Medicare. Its aim is to provide universal access to high-quality, affordable healthcare. It is financed largely from general taxation revenue, which includes special Medicare levies based on a person's taxable income and whether or not they have private insurance cover.

Funding for public hospital services

State and territory governments are responsible for administering public hospital services. These are mostly provided by public entities but also by some religious and charitable bodies and some private healthcare companies, which enter into contracts with government to provide public hospital services.

Commonwealth and state/territory governments jointly fund public hospitals. The Commonwealth has contributed funding for hospitals since the early 1970s through intergovernmental agreements. Initially these were the five-year Medicare agreements, which later became the Australian health care agreements.

The National healthcare agreement (NHA) commits the state to providing Victorians (and other eligible people) with universal free access to public hospital services. It also imposes a policy framework and a number of other conditions such as reporting requirements.

Mental health, ambulance, community and public health services

State and territory governments also administer and fund ambulance and mental health services, and a wide range of community and public health programs. The latter include school dental health, maternal and child health, and environmental health.

The Commonwealth also funds mental health services and public health programs.

Under the HACC agreement the Commonwealth and Victorian governments jointly fund state-run HACC programs for older people and people with disabilities. HACC services include home help, delivered meals, shopping assistance, personal care and transport. The state, local government and the non-government sector, including religious, charitable and for-profit organisations, are all involved in providing HACC services (as well as other community care services). The HACC agreement commits the state to providing universal access to HACC services but allows for co-payments.

Aboriginal and Torres Strait Islander health

The Commonwealth and state/territory governments both contribute funding for Aboriginal and Torres Strait Islander health services.

In 2008 the Commonwealth and Victorian governments signed the *National partnership agreement on closing the gap in Indigenous health outcomes ('Aboriginal health national partnership')*. This is a four-year commitment, commencing in July 2009, to closing the gap between Indigenous and non-Indigenous Australians in life expectancy within a generation, and halving the gap in mortality rates for Indigenous children aged under five within a decade.

Under the *Aboriginal health national partnership*, funds are provided to each region in Victoria for projects that focus on five priority areas:

- tackling smoking
- providing a healthy transition to adulthood – including, for example, reduced uptake of alcohol, tobacco and illicit drugs, as well as fewer hospitalisations for violence and injury
- making Indigenous health everyone's business – including, for example, reduced waiting times for health services
- delivering effective primary healthcare services
- better coordinating the journey through the health system – including, for example, improved satisfaction with care, and fewer admissions and incomplete treatments.

Koolin Balit, strategic directions for Aboriginal health 2012–2022, presents the Victorian Government's strategic directions for Aboriginal health over the next 10 years. *Koolin Balit* sets out what the department, together with Aboriginal communities, other parts of government and service providers, will do to achieve the government's commitment to improve Aboriginal health.

It can be accessed at <http://www.health.vic.gov.au/aboriginalhealth/koolinbalit.htm>.

Residential aged care services

The regulation, funding and planning of residential aged care is primarily a Commonwealth Government responsibility. Residential aged care facilities provide accommodation, hospitality services and personal and nursing care to older people who can no longer live in their own homes. In Victoria some 23 per cent of facilities and about 6,400 beds are operated by public sector providers.

The amount of subsidy provided by the Commonwealth to approved residential aged care providers is dependent on the level of care required by residents. In addition, residents pay daily care fees and accommodation payments related to the level of care. Financial hardship assistance is available to people who do not have sufficient assets to pay their accommodation payment.

In Victoria the state government also provides some supplementary funding to public sector residential aged care services.

The number of aged care places eligible for subsidies is capped. The Commonwealth decides the allocation of new residential care places by an annual regional population-based planning process, inviting providers to bid to provide the new places. This process is known as the Aged Care Approval Round.

Since 1 January 2001, payment of Commonwealth subsidies has been contingent on the approved provider being accredited by the designated accreditation body, the Aged Care Standards and Accreditation Agency.

For further information see <www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-information.htm>.

Medical, diagnostic and pharmaceutical services

The Commonwealth subsidises the costs of visits to general practitioners, medical specialists, optometrists and some other allied health professionals, such as clinical psychologists, as well as the costs of diagnostics, such as pathology and medical imaging, through the MBS.

The rate of benefit for out-of-hospital services is at least 85 per cent of the scheduled fee. Doctors can also send accounts directly to Medicare and accept the rebate as full payment. This

arrangement is known as bulk billing and involves no out-of-pocket cost to the consumer.

The cost of medical services provided in private hospitals, such as surgeon and anaesthetist fees, also attract MBS rebates. (Other private hospital costs such as accommodation and surgical supplies are covered by private health insurance; see below.)

The costs of prescribed medicines or pharmaceuticals dispensed in the community by private pharmacy businesses are directly subsidised by the PBS. Individuals contribute out-of-pocket payments, with concession card holders paying a smaller amount.

Public hospitals provide medicines to those admitted to hospital and receiving public care free of charge and the National Healthcare Agreement prevents them from attracting PBS subsidies. Public hospital day stays, outpatients and admitted consumers are covered by the PBS upon discharge if the public hospital is participating in the Commonwealth–state pharmaceutical reform arrangement. If not, outpatients are required (upon discharge) to pay the hospital the PBS co-payment, where applicable, or can be charged up to the cost price for non-PBS items supplied.

The Commonwealth contributes funding for some high-cost drugs for public hospital day admissions, outpatients and other admissions upon discharge through a separate program, the Highly Specialised Drug Program (HSD). Consumers are required to pay the applicable PBS co-payment for HSD items.

Medications listed on the HSD are specialised medications that are used to treat chronic conditions that, because of their clinical use or other special features, are restricted to supply through public or private hospitals that have access to appropriate specialist facilities. HSD items usually have a relatively high unit cost when compared with general PBS items.

The import and supply of medicines and medical devices is regulated by the Commonwealth Therapeutic Goods Administration (TGA) to ensure the quality, safety and effectiveness of the products.

Blood supply

The Australian Red Cross Blood Service, a national organisation, manages the collection, processing and distribution of blood products in all Australian jurisdictions.

The National Blood Authority (NBA), an independent statutory agency established under the *National Blood Authority Act 2003*, provides national purchasing, production and supply planning services to ensure sufficient blood and blood products of the highest quality.

The operations of the NBA are set out in the *National blood agreement*, which has been signed by all Australian governments. Funding of blood services is provided on a cost-shared basis between the Commonwealth (63 per cent) and states and territories (37 per cent collectively).

Veterans and other special categories

Some categories of Australians, such as members of the armed forces and veterans, are covered by special Commonwealth financing arrangements while remaining eligible for mainstream Medicare coverage.

Some injuries and illnesses are covered by other forms of financing. In Victoria, work-related injuries and illnesses are covered by compulsory workers' compensation insurance provided by WorkSafe Victoria, and injuries from motor vehicle accidents are covered by compulsory third-person motor vehicle insurance, administered by the Transport Accident Commission (TAC) in accordance with the Transport Accident Act 1986.

Private sector care

The private sector plays a large role in health service provision. Private sector providers include general practitioners and specialist doctors, private hospitals and day procedure centres, diagnostic and pathology services, pharmacists, and a range of allied health service providers (such as dentists, optometrists, podiatrists, dieticians, physiotherapists and counsellors), as well as alternative medicine practitioners.

As described above, the costs of many of these services are subsidised by the Commonwealth through the MBS and PBS. Costs are also indirectly subsidised through the rebates provided by the Commonwealth to individuals for private health insurance cover. Those younger than 65 years receive a 30 per cent rebate on the cost of private health insurance. There are higher rebates for older people: 35 per cent for people aged 65–69 years and 40 per cent for people aged 70 years and over.

Private health insurance provides cover for private hospital charges, and for public hospital charges where consumers elect to be considered a private patient and treated by a doctor of their choice.

Private health insurance also provides cover for allied health services, such as dental, physiotherapy and podiatrist services, and some aids and appliances, such as eye glasses. These kinds of services are not eligible for Medicare rebates.

Private hospitals and day procedure centres are funded by private health insurance funds, compensation payments (Victorian TAC and WorkSafe), the Commonwealth Department of Veterans' Affairs (DVA) payments and other co-payments. These payments cover the costs of accommodation, nursing, administration and infrastructure. A small proportion of consumers self-insure.

Medical and pharmaceutical services in private hospitals are substantially publicly funded by the Commonwealth. The Commonwealth (through the MBS) provides a rebate of 75 per cent of the scheduled fee for medical services (such as surgical and anaesthetic), with health funds covering the remaining 25 per cent.

Victorian health system fundamentals

Public hospital services

In metropolitan Melbourne the public hospital service system consists of: statewide centres of specialisation; tertiary hospitals providing a comprehensive range of specialist services; and secondary (or community) hospitals providing a range of acute care services to their local communities. There are also day hospitals and facilities providing ambulatory care procedures and subacute care to a wider geographic area.

In rural areas, low-acuity, high-volume services are provided as locally as possible, with high-acuity or complex services often focused in regional and subregional hospitals to improve safety and quality. Public health service organisations in rural areas are also major providers of residential aged care, with more than 5,400 beds throughout rural Victoria.

Consumers require care and services across the illness continuum and in a range of settings. To ensure consumers can access services when they need them, interdependent services must be coordinated. The department plays a role in planning and managing this, within the various funding structures and devolved service delivery mechanisms. Health services also work together in formal and informal partnerships to provide the full range of services required by the community. This minimises service duplication and supports higher quality outcomes, especially for low-volume, specialised or statewide services.

Small rural health services are block-funded, which enables flexibility in funding and service delivery with a local focus for towns with fewer than 5,000 people. It encourages services to: be active in the planning and management of health service delivery to meet local needs; involve the community; and be active in collaborative planning and service delivery arrangements with neighbouring health service providers. This is supported by the ability to use acute health program and primary health program funds flexibly.

The *Victorian health policy and funding guidelines* provides further information on the types of programs that comprise hospital services, such as maternity, cancer care and other services, and their key priority service development and policy focus areas.

Primary care

Primary care is provided throughout the state by both private practitioners (such as general practitioners, dentists, physiotherapists and optometrists) and community health centres run by non-government organisations or integrated with public health service organisations. Community health centres receive funding from the Victorian Government and also provide federally funded MBS-billed services. Specialist medical services are provided by private practices and outpatient clinics in public hospitals.

Mental health services

Public mental health services include both clinical services and non-clinical psychiatric disability rehabilitation and support services (PDRSS). Clinical mental health services are managed by public health services and provide assessment, diagnosis, treatment and clinical case management. PDRSS are provided by non-government community organisations.

Area-based clinical services

Clinical mental health services are divided into three categories based on age, which reflect the different needs of people across the lifespan. They are:

- child and adolescent mental health services (0–18 years)
- adult specialist mental health services (16–64 years)
- aged persons mental health services (65 years or older).

These services are organised and delivered on an area basis within a geographically defined catchment area. Victoria has 13 child and adolescent services, 21 adult area mental health services and 17 aged persons services. Each service category provides inpatient psychiatric services and a range of residential and other community-based services. The program components of each age-based service category are shown in Box 2.

Statewide and specialist clinical services

In addition to the area-based services, a number of specialist services are delivered on a statewide basis. These are also shown in Box 2.

Non-clinical specialist mental health services

PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness. They are only available to those in the 16–64-year age group.

PDRSS comprise the following program components:

- **Psychosocial rehabilitation day programs and home-based outreach** assists people to improve their quality of life, participate in everyday living activities, and function as independently as possible in the community.
- **Residential rehabilitation** provides intensive psychosocial rehabilitation and support in a group treatment setting to prepare residents to live independently in their own setting.
- **Planned respite** may involve social and recreational day activities, including in-home support, holiday and adventure activities, and residential components. These services provide a short-term change in environment for a client and a break for carers.
- **Mutual support and self-help** provides information and peer support for clients or carers.

Box 2: Mental health programs delivered by Victoria's public health service entities

Area-based clinical services

1. Child and adolescent mental health services
- Acute inpatient services – short-term assessment and/or treatment in general hospitals
- Intensive mobile youth outreach services – intensive case management and support
- Continuing care teams – a range of services including: crisis assessment; case management; multi-modal treatments; individual, family and group therapy; parent and carer support; and consultancy services to other service providers
- Day programs – integrated therapeutic and educational programs
- Conduct disorder programs – multilevel early intervention and prevention

Area-based clinical services

2. Adult specialist mental health services

- Acute inpatient services – voluntary and involuntary short-term management and treatment in general hospitals during an acute phase of mental illness
- Triage and crisis assessment and treatment (CAT) services – operate 24 hours a day and provide telephone triage and urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis; includes urgent assessments in EDs
- Mobile support and treatment services – intensive and often longer term support to people with prolonged and severe mental illness; operate extended hours seven days a week
- Continuing care – assessments, treatment, case management, support and continuing care
- Primary mental health and early intervention teams – support and enhance the capacity of primary care providers to recognise and respond effectively to mental disorders
- Community care units – medium to longer term bed-based clinical care and slow-stream rehabilitation services in 'home like' environments in the community
- Secure extended care inpatient services – medium to long-term treatment and rehabilitation for people with unremitting and severe symptoms; includes involuntary clients; often on hospital sites
- Homeless outreach services – specialist clinical and treatment response for people who do not engage readily with mental health services
- Consultation and liaison services – psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and mental health consumers in general hospitals
- Prevention and recovery services (PARC) – bed-based subacute clinical treatment and short-term support for people who do not need or no longer require hospital admission; usually a partnership with PDRSS
- Early psychosis services for young people – for people aged 16–25 years who are experiencing a first episode of psychosis

3. Aged persons mental health services

- Aged inpatient services – short-term management and treatment during an acute phase; located with other aged care facilities or general hospitals
- Aged persons community mental health teams – community-based assessment, treatment, rehabilitation and case management
- Aged persons mental health residential care – specialist bed-based services for people who cannot be managed in mainstream services due to persistent cognitive, emotional or behavioural disturbance; these are transitional rehabilitation and care settings

Statewide and specialist clinical services

- Forensicare (the Victorian Institute of Forensic Mental Health) – provides services to mentally disordered offenders, including secure inpatient services at Thomas Embling Hospital, community-based services, specialist assessment and treatment for prisoners, and an on-site assessment and advice court liaison service to some magistrates courts.

- Personality disorder service (Spectrum)
- Brain disorders service
- Mother–baby services
- Eating disorder services
- Aboriginal services
- Child inpatient services
- Dual disability service
- Neuropsychiatric service

Early Psychosis Prevention and Intervention Centre (EPPIC Statewide).

Residential aged care services

The majority of aged care residential service facilities are owned and operated by the non-government sector – by a mix of religious, charitable and for-profit providers. However, compared with the rest of Australia, Victoria's public health service entities are a relatively large provider.

Most of Victoria's public sector health services are approved providers of residential aged care services, which are primarily funded and regulated by the Commonwealth. In 2010–11 public sector health services across Victoria provided approximately 6,400 residential places through 196 facilities. This represents 14 per cent of all aged care residential places in Victoria and 23 per cent of facilities.

Over 80 per cent of the public health services providing residential aged care services are located in rural Victoria, and for some health services residential aged care is the main bed-based activity. Services are available to the general community, with some specifically targeting older Victorians with specialised care needs, including those with mental health conditions.

The department engages with public sector providers in the process of service and capital planning and development to ensure that state-owned facilities meet local community need and the required standards.

Ambulance services

Another important component of the Victorian health system is the ambulance service. Ambulance Victoria performs an essential link in the healthcare chain, responding to medical emergencies and providing out-of-hospital care and medical transport for emergency and non-emergency calls.

NURSE-ON-CALL

NURSE-ON-CALL is a telephone service that provides immediate, expert health advice from a registered nurse, 24 hours a day, 7 days a week. The service, staffed by registered nurses, is accessible from any landline and mobile telephones in Victoria for the cost of a local call (calls from mobile phones may be charged at a higher rate).

Private hospitals in Victoria

The private hospital sector plays a significant role in health service provision, particularly in metropolitan Melbourne where more than 70 per cent of private hospitals are located. Around 40 per cent of Victorians have private health insurance cover for hospital services. In 2008–09, private hospitals accounted for 37 per cent of the 2.2 million total hospital separations in Victoria (AIHW 2010a).

There are two main types of private hospital: those operated by religious and charitable organisations on a not-for-profit basis; and those operated by commercial, for-profit organisations. A special component of the Victorian private hospital sector is the not-for-profit bush nursing hospital. When they started in 1910, bush nursing hospitals provided nursing care funded by local communities. Currently there are nine bush nursing hospitals in Victoria. These are relatively small in size compared with most public hospitals and located in metropolitan fringe or rural areas. They provide a limited range of less complex services.

Bush nursing hospitals, like other private hospitals, rely on payments by third-party payers such as health insurance funds, as well as co-payments. The Victorian Government provides some public funding, principally for people requiring emergency assessment and/or stabilisation and ambulance transfer.

In the past there has been a tendency for private hospitals to cater for those with less complex conditions than those treated in public hospitals. Over the past 10 years or so some larger private hospitals have developed more complex services such as cardiac surgery and intensive care. However, many provide a limited range of specialised healthcare services in comparison with the public sector. Public hospitals tend to treat more emergencies and those with more complex co-morbidities, while private hospitals tend to provide surgical and elective cases. The public sector provides the vast majority of non-admitted emergency care.

From time to time, the Victorian Government purchases hospital services in the private sector. This includes the purchase of adult intensive care and newborn special care nursery services on a needs basis to manage demand peaks.

Medical research

Major hospitals are often also research centres and postgraduate training institutes, as well as clinical service providers. The research function generates new knowledge about health and disease and supports the timely translation of advances in knowledge and technology into better health outcomes.

Research, training and treatment need to come together to provide a solid foundation for innovation in the health system. Part of this is encouraging Victoria's strong biomedical research industry to better support the health system by fostering the translation of research and discovery into clinical practice.

Comprising more than 13 major medical research institutes (see Box 3), 11 major teaching hospitals and nine universities; Victoria is home to Australia's largest biomedical research community (see <www.vicbioportal.org>).

The Department of Health does not generally fund research institutes or health services for research activities. The Department of Business and Innovation (DBI) has a role in supporting and strengthening biotechnology and medical research capability (see below).

The Commonwealth, through the National Health and Medical Research Council, provides most government funding for medical research.

DBI plays a lead role in shaping and implementing policy and initiatives that attract and maximise investments in Victorian industry, including biotechnology and medical research. DBI also funds projects to strengthen the sector, including supporting construction and other initiatives at the two geographic biotechnology precincts that have a major biomedical and health research focus.

There are two biomedical precincts that bring together universities, research organisations, hospitals and industry:

- The Central biotechnology precinct incorporates the historic Parkville precinct, the Austin Biomedical Alliance, the St Vincent's Hospital Eastern Hill precinct, Western Hospital, Peter MacCallum Cancer Centre and the Olivia Newton-John Cancer Centre at Austin Health. Under development in the precinct is the Victorian Comprehensive Cancer Centre, which is due for completion in 2015.

- The South East biotechnology precinct incorporates Monash University, CSIRO, Southern Health, the Monash Health Translation Precinct, the Australian Synchrotron, the Australian Regenerative Medicine Institute, Alfred Medical Research and Education Precinct, and Melbourne's key pharmaceutical and biotechnology industries.

DBI also manages the Victorian Government's operational infrastructure support grant program for independent Victorian medical research institutes. This program provides infrastructure funding for medical research organisations that conduct fundamental or clinically based biomedical research as their main focus. It assists research institutes to meet the indirect costs of research, including costs associated with the commercial and clinical exploitation of the institutes' research endeavours.

The Victorian Government provides funding to the Victorian Cancer Agency (VCA) to facilitate cancer research across Victoria and its translation into improved outcomes. Each year, the VCA allocates funding provided by the Victorian Government to support translational research and to build cancer research capability in priority areas, for example:

- translational cancer research initiatives – supportive care, palliative care and survivorship research; tumour stream research; cancer clinical trials
- infrastructure and enablers of cancer research – the Victorian Cancer Biobank; platform technology and infrastructure investment; research workforce retention, recruitment and increased capability.

The VCA also administers a range of established Victorian Government funding grants, including funding to support:

- the Rural Clinical Trials Initiative, which is managed by Cancer Council Victoria as part of its Clinical Trials Management Scheme
- the activities of the Victorian Breast Cancer Research Consortium and the Victorian Prostate Cancer Research Consortium
- Cancer Trials Australia to expand its clinical trial infrastructure and capacity.

Further information is available at <www.victoriancanceragency.org.au>.

Box 3: Medical research institutes that receive operational infrastructure support grants from the Victorian Government

Victorian medical research institutes

Baker IDI Heart and Diabetes Institute

Bionic Ear Institute

Centre for Eye Research Australia

Florey Neuroscience Institutes

Ludwig Institute for Cancer Research

MacFarlane Burnet Institute for Medical Research and Public Health

Mental Health Research Institute

Monash Institute of Medical Research

Murdoch Childrens Research Institute

O'Brien Institute

Prince Henry's Institute

St Vincent's Institute

Walter and Eliza Hall Institute of Medical Research

Victoria's health service program and funding arrangements

Many services provided by Victorian public health services are funded by the Department of Health. Health services may also receive funding (either directly or via the department) from a range of other sources including the Victorian Department of Human Services, DoHA, private health insurance funds, DVA, the TAC and WorkSafe Victoria, as well as research or other related bodies.

Health services also receive payments from those who are not eligible to receive free hospital treatment under the National Healthcare Agreement. Visitors and temporary residents in Australia are not eligible for free hospital care or for Medicare benefits unless Australia has a reciprocal healthcare agreement with the relevant country.

Detailed information on the programs that the department funds and works with hospitals to develop, as well as on their funding models, can be found in the *Victorian health policy and funding guidelines* at <www.health.vic.gov.au/pfg>.

In addition, a number of hospital circulars are issued each year, for example, to inform health services of changes to their obligations such as financial and legal changes. These circulars can be found at <www.health.vic.gov.au/hospitalcirculars> and email alerts for new circulars can be requested through the webpage.

Funding allocation process

Health services receive capped funding allocations from the department each financial year. Annual throughput targets and budgets are set at the start of the financial year and health services are cash-flowed up to the targets. Health services are expected to manage within their budgets.

Broadly, the annual funding allocation process is as follows.

- DTF, in consultation with DPC, recommends to the government an amount of recurrent money to fund an agreed volume of activity and price for each program, as well as an amount of money to fund specified capital projects.
- The government decides final recurrent and capital funding amounts via the Budget and Expenditure Review Committee of Cabinet (BERC), and announces these as part of the annual State Budget in early May.
- The department allocates funding to streams within each program, taking into account past throughput and demand growth forecasts, as well as government priorities and BERC decisions. These streams include:
  - non-admitted ED presentations
  - other non-discretionary service growth (for example, dialysis services)
  - elective surgery
  - acute and subacute services
  - mental health services
  - reform programs and incentive schemes.

- The department sets a budget with each health service consisting of an agreed volume of activity paid at agreed prices for a range of service types, with funding amounts measured and allocated using a number of different funding models including the weighted inlier equivalent separation (WIES)/casemix model and specified grants or block funding.

- Final activity targets and funding allocations are agreed in the annual SoP (for metropolitan and regional health services), which are signed by board chairs and the Minister as early as possible in the financial year, or in health service agreements (for smaller rural health services other than Multi purpose services).
- Health services receive payments based on agreed monthly cash flow percentages. Payments are subject to the requirement that health services meet conditions of funding set out in the annually updated *Victorian health policy and funding guidelines*. If activity targets are not met by year end, then some funding is recalled and, if a health service provides more services than its target levels, the department pays for additional activity up to a capped level. This recall policy is outlined in the guidelines.
- A mid-year review of the annual activity targets is carried out and may result in funding re-allocation across funding streams and health service entities and adjustments to original activity targets.

While there are a range of activity-based funding mechanisms and grants that are calculated based on activity levels in health services, these payments do not directly determine the budget of individual clinical units within hospitals. Health service management is responsible for allocating the annual budget across different areas of the hospital and for managing demand for services and activity within the target level of activity and funding.

A key issue for health services to understand is the relative share of funding that they receive through activity-based funding mechanisms – such as WIES, the Victorian Ambulatory Classification System (VACS) and Casemix Rehabilitation and Funding Tree (CRAFT) – specified grants and other sources. This varies widely depending on the composition of the services delivered. Not all costs for services delivered are covered through output-based funding, with specified grants, such as for training and development, contributing to the revenue for care provision.

Funding payment arrangements

Activity-based funding under the *National health reform agreement* (NHRA) commenced on 1 July 2012. Under these arrangements, Victoria's health services receive funds for activity-based funding services through a national funding pool, to which both the Commonwealth and state governments contribute. Payments from the pool will be provided on the basis of national weighted activity units (NWAU). However, Victoria is continuing to determine health service budgets for these services based on existing funding models, including:

- WIES for acute admitted services
- the Non-Admitted Emergency Services Grant (NAESG) for EDs
- a combination of historic levels of VACS and block funding for outpatient clinics.

Services not required to be funded on the basis of activity-based funding in 2012–13 include mental health, subacute, small rural health services and teaching training and research. Funding for these services will flow through a state-managed fund consistent with existing arrangements.

Funding for services outside the scope of the NHRA, such as primary and aged care, will also continue as per existing arrangements.

Counting the number and types of consumers

A condition of funding is that hospitals collect and report electronic information about consumers who use their services. The department maintains health data collections that span a range of care

settings, including admissions to hospital, ED presentations, outpatient encounters, elective surgery waiting lists and other types of care.

Admitted patient information, for example, is reported to the Victorian Admitted Episodes Dataset (VAED) and includes all admitted episodes of care from all public hospitals. Each reported episode of care contains diagnostic and treatment information, admission and discharge dates, and other information.

Other key data collections are the Victorian Emergency Minimum Dataset (VEMD), the Elective Surgery Information System (ESIS), the Agency Information Management System (AIMS), the Victorian Integrated Non-Admitted Health (VINAH) data collection and the Dental Health Program Data Set. Further information about these data collections can be found at <www.health.vic.gov.au/hdss>.

The department provides some of the funding to hospitals on the basis of the number of separations and the type of treatment provided. Since activity-based funding payments depend on accurate records, the department conducts ongoing audits of data to maintain their integrity.

Costing of care

Health services are required to report costs for all state-funded activity, and are expected to maintain activity and costing systems as part of good hospital management practice. The department maintains health cost data collections across a range of care settings including admitted acute, rehabilitation care, outpatient encounters and ED presentations.

Annual collections of cost data are conducted from all metropolitan, most large and some small rural hospitals. Reported costs include the total cost of each episode of care, and 13 category costs (for example, the cost of nurses, surgeons, theatres and pharmacy). The activity-based funding system for admissions to hospital is based on the relative costs of different treatments and procedures.

Services and programs

Funding is provided to Victoria's public health services for a wide range of services (see Table 3) using a number of different funding models or methods. Health services have different service profiles and receive different mixes of funding streams from the department and other sources. Services vary widely across hospitals; for example, while many health services provide acute admitted services, only a few provide radiotherapy services or cardiac surgery.

Table 3: Services delivered by public health services that are funded by the Department of Health

Service	Funding model
Acute admitted services – including emergency admissions, elective surgery, intensive care and critical care, maternity, neonatal	Activity-based funding model + specified grants/block funding
Hospital in the Home (HITH)	Activity-based funding model

Service	Funding model
Renal dialysis services	Activity-based funding model + capitation grants
Subacute admitted services – rehabilitation, geriatric evaluation and management (GEM)	CRAFT funding model + Bed day rates
Subacute ambulatory services (SACS) – community rehabilitation (centre-based and home-based), specialist clinics.	Block grant funding with notional annual activity targets
Victorian Paediatric Rehabilitation Service (VPRS)	Bed day rate (inpatient); block grant funding with activity targets (ambulatory)
Transition care – Transition Care Program, restorative (bed based and home based)care	Occupied place day rate (bed-based and home-based)
Palliative care – inpatient services, community services, and consultancy services	Bed day rates (inpatient) Block grant funding with activity targets (ambulatory)
Emergency services (non-admitted)	Non-admitted emergency services grant (activity basis + availability/block funding)
Urgent care (rural services)	Block grant
Radiotherapy services	Weighted activity unit (WAU) funding model
Specialist (outpatient) clinics – medical specialists and allied health	Block grant
Hospital Admission Risk Program (HARP)	Block grant funding with activity targets
Post-acute care	Block grant

Service	Funding model
Mental health services including: • CAT teams, mobile support and treatment services, telephone triage, continuing care • acute inpatient, extended secure care unit, community care unit, PARC • PDRSS: includes home-based outreach support and residential facility and accommodation support	• clinical staffing levels (EFT), but in the process of transitioning to activity-based model • Bed day rate on availability basis (funded regardless of occupancy status) • Contact hours + block grants + available bed days
Aged care services • Aged care assessment services (ACAS) • Aged residential care supplements (additional to Commonwealth payments) • Aged care service development • HACC primary health, community care and support	• Block funding allocated using population-based formula • Occupied bed day rate • One-off funding • Hours + packages + meals
Community-based/primary health services	Contact hours
Drug treatment services	Episodes of care

Acute services

Acute services for consumers who stay in hospitals, present at EDs or in ambulatory settings are funding by a mix of activity-based (casemix) funding and block grants.

Casemix funding is based on the number and type of cases. Under the casemix system, each consumer is assigned to a category based on their diagnosis and the treatment provided. For those admitted for their care, these categories are known as diagnosis-related groups (DRGs).

DRGs are a method of classifying cases into categories that have similar clinical conditions and similar levels of resource use. Acute admitted services funded by the WIES/casemix payment system comprise hundreds of different DRGs.

Cost weights represent a **relative measure** of resource use for each episode of care in a DRG, and are essentially calculated as the ratio of the average cost of all episodes in a DRG **to** the average cost of all episodes across all DRGs. Victorian cost weights are developed each year using the costs of treating patients as reported to the department by public hospitals.

Casemix funding is based on an episode (separation) that is cost-weighted according to its DRG group and length of stay (LOS). A cost-weighted separation (WIES) is calculated using different cost weights for different types of stay within each DRG. In general, the longer the stay in hospital, the more costly the episode will be, and the more WIES that will be allocated (for instance, those who stay five hours will generally use less resources and cost less than someone who stays five days, even though both might be in the same DRG).

If all separations within a DRG were weighted by a single average cost weight, hospitals with short-stay patients would benefit and those with long stays would be disadvantaged.

Statistical approaches are often used to identify admissions with atypical hospital stays. However, the purpose of setting limits is not to identify 'atypical patients' but to limit the financial impact of the most and least expensive cases. In many heterogeneous DRGs, a significant proportion of low-cost or high-cost patients is expected.

To minimise the relative financial risk for hospitals, the concept of 'inliers' (or usual episodes of care) and 'outliers' was introduced. In general an **average** case is in the range given by the average length of stay (ALOS) multiplied and divided by three. This range is called the 'inlier' and the boundary points of the range are called 'high' or 'low'. Cases outside the inlier range are called low outliers (for short lengths of stay) or high outliers (for long lengths of stay). If the patient's LOS falls within the inlier range, the episode will attract the standard inlier WIES payment for that DRG.

For some DRGs separate cost weights are developed for same-day and multi-day episodes to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day patients. Similarly, for other DRGs, separate cost weights are developed for cases with an LOS of one day to ensure that multi-day cost weights are not diluted by high-volume, low-cost, same-day and overnight care. If the stay is longer than the inlier range, the hospital will receive an additional payment for every day over that range.

Co-payment WIES

The department pays additional cost-weight co-payments to moderate financial risk for hospitals that provide special types of care. These co-payments are in addition to base WIES allocation determined by the case DRG and length of stay. They apply to:

- approved intensive care units – WIES co-payments are based on continuous hours of mechanical ventilation
- endoluminal repair of an aortic aneurysm (AAA stents co-payment)
- closure devices to repair a hole in the heart (ASD co-payment)
- thalassaemia
- Aboriginal and Torres Strait Islanders – a 30 per cent WIES loading on top of the base WIES is paid in recognition of the poorer health status and associated higher costs of care.

The technical specifications of the WIES methodology and adjustments each year can be found in the *Victorian health policy and funding guidelines*, *Part three: Technical guidelines*, available at <www.health.vic.gov.au/pfg/downloads/pfg-part3.pdf>.

Funding adjustment policy

Funding is cash-flowed to health services in instalments throughout the year. For activity-based funding, if actual activity by the end of the financial year is less than the target allocation, the department may take back an amount of funding. Funding recall adjustment rates vary depending on the level below target. The adjustments for smaller rural health services are also different from those for metropolitan and regional hospitals.

The department may pay health services for a specified amount of activity in excess of the target allocation at a variable rate.

The funding recall and payment adjustment rates for various activity types are published in *Part two: Health operations* of the *Victorian health policy and funding guidelines*, available at <www.health.vic. gov.au/pfg>.

Specified grants and block funding

Block funding or specified grants are used to complement acute services' casemix/WIES funding. This recognises that some costs are not directly related to providing care or the level of throughput and that some services are very specialised or complex. The training and development grant recognises the costs involved in training undergraduate and postgraduate students.

Department of Veterans' Affairs, compensable, and private care

Department of Veterans' Affairs

DVA provides a mixture of output-based payments and block grants to the Department of Health to provide hospital services to war veterans. The funding for veterans is provided through a specific DVA agreement and the Department of Health pays health services.

Details of the DVA arrangements and activities funded are published *Part two: Health operations* of the *Victorian health policy and funding guidelines*.

Transport Accident Commission payments

The TAC, a Victorian government-owned organisation, pays the cost of treating transport accident injuries. Funding comes from compulsory payments made by Victorian motorists when they register their vehicles.

Details of the TAC arrangements and activities funded are published *Part two: Health operations* of the *Victorian health policy and funding guidelines*.

Health services also charge TAC directly for specialist medical and imaging costs associated with admitted, rehabilitation and non-admitted services.

WorkSafe payments

Consumers treated in public health services who are covered by WorkSafe Victoria insurance are directly funded by WorkSafe insurers. The rates paid are agreed with WorkSafe Victoria by the department on behalf of health services.

Private care

Health services provide several categories of private care. These are:

- Medicare-eligible patients who elect to be treated privately and who have private health insurance
- Medicare-eligible patients who elect to be treated privately but who do not have private health insurance and are liable for the costs of treatment apart from medical and diagnostic costs, which attract MBS rebates
- visitors to Australia and temporary residents who are not Medicare-eligible patients – that is, not eligible for free public hospital care or MBS rebates – and who are liable for the full cost of treatment.

The department pays health services a reduced WIES price for private cases. The different price reflects the fact that medical and diagnostic costs for (Medicare-eligible) private care are covered by the Commonwealth MBS.

Each year health services are given separate private WIES targets. The department cash-flows funds throughout the year up to the combined target for each health service. The department permits health services to retain all privately generated revenue.

Hospital in the Home

HITH provides treatment normally provided in a hospital in the consumer's own place of residence. In these cases, the person is still regarded as a hospital admission and remains under the care of a hospital doctor. All care may be received through HITH, or a stay in hospital may precede HITH. HITH services are funded through the regular inpatient payment system, the casemix/WIES funding model.

Examples of common conditions and treatments delivered by HITH are intravenous antibiotic therapy for cellulitis, genitourinary tract or respiratory tract infection, anticoagulant therapy and chemotherapy.

There are different models of HITH care. Usually the consumer is visited by a member of the HITH team at least once a day. This could be a nurse, doctor or allied health professional. In some cases there may be a visit to the hospital to receive a component of the treatment, or for further investigation or review. All HITH programs provide access to on-call staff at nights or weekends. Most have arrangements for presentation back to the hospital if necessary, usually via the ED.

At this point, 39 health services deliver HITH services in 52 sites across Victoria. Programs have evolved to meet local needs and profiles, creating a broad range of services and significant variation across Victoria. For example, some HITH services offer advanced nursing care to consumers with a high level of dependency and acuity, such as transplant recipients.

Further information is available at <www.health.vic.gov.au/hith>.

Renal dialysis

When kidneys cease to function at a level that will support life, there are a number of care options available for consumers: transplantation, maintenance dialysis and conservative care.

Maintenance dialysis is an ongoing life-maintaining procedure and is distinguished from acute or intensive care dialysis. The preferred option is for consumers to dialyse at home and maintain an optimum level of health independence. However, currently most maintenance dialysis is undertaken in facility-based settings (predominantly hospitals).

Public maintenance dialysis services in Victoria are presently delivered using a 'hub and spoke' model. Nine major hospital-based centres (hubs) have full-time consultant nephrology staff and act as the central point of a network, which collectively include approximately 70 dialysis satellite services (spokes).

The renal funding model has changed to align with national activity-based funding arrangements and fund services on an activity basis. The renal maintenance dialysis model consists of two streams:

- an activity-based funding stream (WIES), which covers dialysis services provision, including consumables and coordination costs (this will result in a significant increase in the dialysis WIES weight)
- an activity-based funding stream to hub services to cover non-admitted (outpatient) clinical consultations.

The WIES activity-based payment is made to the provider of the maintenance dialysis service.

The provider of the service makes a specified payment for each dialysis episode to their specialist hub as payment for services provided.

Dialysis activity targets and WIES will form part of overall acute activity targets from 2013–14. Home dialysis will continue to be funded as a capitation payment for 2012–13. More details on the funding model for renal services can be found at <www.health.vic.gov.au/renaldialysis>.

Subacute services

Subacute admitted services are delivered in either stand-alone subacute centres or dedicated subacute units within hospitals. There are two types of services: rehabilitation and GEM. Subacute ambulatory services are delivered through the SACS program.

These programs are summarised below; further information on funding and reporting arrangements for subacute services is published in *Part two: Health operations* of the *Victorian health policy and funding guidelines* at <www.health.vic.gov.au/pfg> and also at <www.health.vic.gov.au/subacute>.

Rehabilitation

Rehabilitation care is provided in either specially designated units or in regular hospital wards or non-designated units. The latter are funded through the casemix/WIES funding model.

Admitted rehabilitation services include specialist services for amputees, major head injuries, spinal and paediatrics and general rehabilitation services for high-volume clinical groups, including stroke/neurological, orthopaedic and cardiopulmonary.

The funding model for designated rehabilitation units with 20 beds or more is VicRehab. VicRehab is an activity-based funding model that makes payments on the basis of either bed day rates or episodes of care classified according to the CRAFT model. VicRehab comprises three payment categories:

- Level 1 rehabilitation – amputee, spinal and major head injury/trauma cases where admission is for the first post-acute episode of rehabilitation. These are complex care cases and funding is on a bed day basis at a high rate to reflect the high resource levels.
- Level 2 rehabilitation – these are all other types of care funded through the CRAFT episode of care model. Episodes of care are categorised into a short-stay category or one of 16 groups based on clinical diagnoses and levels of function. These categories (for example, spinal, amputation, orthopaedic fracture and stroke/neurological) are given cost weights measured in rehabilitation weighted units (RWU). Cost weights take into account length of stay and associated costs and are derived from the annual Victorian Cost Weight Study. Funding is calculated on the basis of RWU activity or throughput.
- Special level 2 rehabilitation – These comprise CRAFT categories that cover amputee, spinal, major head injury/trauma and burns cases where the rehabilitation is not the first post-acute episode of rehabilitation. Because these are relatively few in number and highly variable in length of stay and cost, they are funded on a bed day basis rather than an episode-based rate.

To minimise provider risk for smaller units, funding for all cases in designated rehabilitation units with fewer than 20 beds is on a bed day basis. All DVA rehabilitation cases are also funded on a bed day rate basis.

Annual targets are set for each category of rehabilitation and funding cash-flowed throughout the year up to the target. Separate targets (estimates) are set for DVA for cash flow purposes, but these are paid according to actual activity recorded.

Annual targets are expressed in bed days (level 1 and special level 2) and number of CRAFT (RWU) units (level 2). There is a separate bed day price paid for private patients.

Geriatric evaluation and management

GEM involves the care of those with chronic or multiple medical conditions associated with ageing, cognitive dysfunction, chronic illness or disability. The client group is predominantly older people but may include younger adults with clinical conditions generally associated with ageing. They are admitted for review, treatment and management by a geriatrician and multidisciplinary team for a defined episode of care.

Annual targets are set for GEM services and funding cash-flowed throughout the year up to the target. Separate targets (estimates) are set for DVA consumers for cash flow purposes, but these are paid according to actual activity recorded. There is a separate bed day price paid for private patients.

Further information on subacute inpatient services and funding arrangements is available at <www. health.vic.gov.au/subacute>.

Subacute ambulatory care services

SACS provide community rehabilitation services that are time-limited and tailored to meet the needs of the consumer and their carer(s). SACS are available to people of all ages and may follow a hospital stay or hospital day attendance, or may be accessed directly from the community. They are delivered at home or at an ambulatory care centre.

The SACS program also includes a range of specialist clinics that provide specialist assessment, diagnosis, intervention, management, education and support to patients with specific medical conditions. Services are delivered either at home or at a centre. The clinics include:

- continence
- cognitive, dementia and memory services (CDAMS)
- falls and balance
- movement disorders
- chronic pain management
- chronic wound management
- polio
- young adults with complex care needs.

The department funds 36 health services to deliver SACS at more than 50 different sites.

The department provides funding to health services for SACS on an historical block grant basis. Annual activity targets, expressed in 'client service events', are set and health services are cash-flowed throughout the year up to targets. Separate targets (estimates) are set for DVA cases.

The department monitors SACS activity/throughput through VINAH and if consumer numbers by the end of the year are more than five per cent below target a funding recall may be applied.

SACS services are required to operate in accordance with the *Health independence programs guidelines*. These provide direction for and facilitate the alignment of post-acute care (PAC) services, SACS and HARP services. The guidelines are available at <www.health.vic.gov.au/subacute>.

Victorian Paediatric Rehabilitation Service

The VPRS provides care for children and adolescents (up to 18 years of age) who, as a result of injury, medical or surgical intervention, or functional impairment, will benefit from a program of time-limited specialist interdisciplinary rehabilitation.

Inpatient and ambulatory (non-bed-based) paediatric rehabilitation services are provided by The Royal Children's Hospital and Monash Medical Centre (Southern Health). Ambulatory services are also provided by Eastern Health, Barwon Health and Bendigo Health, with Ballarat Health Services to provide services in future.

Inpatient paediatric rehabilitation services are funded on the basis of bed days and annual bed day targets are set (based on 80 per cent occupancy). The rate paid by the department is the level 1 rehabilitation bed day rate for adults.

For ambulatory services, annual targets are set based on client service events; health services are provided with block grant funding.

Further information is available at <www.health.vic.gov.au/subacute>.

Transition Care Program

TCP is jointly funded by the Commonwealth and Victorian governments. Nine metropolitan and seven regional and rural health services provide transition care services across Victoria. Each health service is approved to provide a limited number of places, based on a number of factors including the patient being aged 70 years or over.

Transition care is short-term active care provided to older people at the end of their hospital stay to support people to either maintain or improve their functional capacity while assisting them and their family and carers make arrangements for longer term care.

To be eligible for transition care people must be assessed as eligible for low-level residential aged care by an ACAS while in hospital. TCP is provided both in bed-based and home-based settings.

Commonwealth Government subsidies are paid at a single jurisdictional rate for an occupied place. They are provided directly to health services by Medicare Australia and paid on a monthly advance-and-acquit basis. Health services should be familiar with the eligibility criteria for TCP to ensure that only eligible clients are admitted to the service and that correct payments are received. Commonwealth Government subsidies are paid for up to 12 weeks (with provision for an extension of up to six weeks) for each client, up to the maximum number of approved TCP places at each health service.

The Victorian Government provides a bed day top-up subsidy for bed-based and home-based places. TCP clients are non-admitted hospital patients. Health services need to adhere to relevant TCP reporting arrangements negotiated between Victoria and the Commonwealth Government. Reporting arrangements are detailed at: <www.health.vic.gov.au/pfg/hospitals>.

Restorative care

Restorative care provides care for older people who have completed their acute or subacute episode of care and would benefit from further short-term care to maximise their functioning but are ineligible for the national TCP. The aim is to reduce inappropriate long stays in acute and subacute beds and improve the flow of care. Transfers to restorative care can also occur from the ED or directly from the community.

Health services elect either to operate such beds within a hospital setting and capture these as admitted episodes of care, or to provide care off-site in a suitable residential care facility and identify these as non-admitted episodes of care. Restorative care delivered in a hospital setting is treated as an admitted episode and subject to subacute recall policy. Restorative care delivered in the community is treated as a non-admitted episode and recall will be applicable for health services achieving less than 95 per cent occupancy.

Specialist palliative care services

Palliative care services are provided to consumers with a life-threatening illness whose condition has progressed beyond the stage where curative treatment is available, or to people who choose not to pursue curative treatment. Family, friends and carers of the person with a life-threatening illness are also provided with support.

Specialist palliative care reflects a higher level of expertise in complex symptom control, loss, grief and bereavement. The core funded specialist palliative care services are:

- **Inpatient services:** Inpatient palliative care is provided in acute hospitals to consumers who require complex symptom and pain management or end-of-life care. Care is provided in designated palliative care beds and may involve consultancy teams.
- **Consultancy services:** Consultancy teams provide specialist advice and support to other healthcare workers involved in providing inpatient and community palliative care services. They also assist in coordinating discharge planning.
- **Community services:** Community palliative care services provide nursing, allied health, respite, psycho-social and practical support services to consumers (and carers) in a community/ambulatory care setting or at home.

Funding for designated palliative care beds is provided at the palliative care bed day rate. Palliative care targets are established for admitted services for non-DVA and DVA activity. Funding for DVA activity is uncapped while state-funded non-DVA activity is capped. Health services in rural areas that have exceeded their bed day targets may be able to convert WIES to palliative care after consultation with the department. Changes to targets at a rural or metropolitan health service can only be undertaken after consultation and agreement with the department.

Further information is available at <www.health.vic.gov.au/palliativecare>.

Emergency care

Hospital EDs provide initial diagnosis, stabilisation and early management for people with acute and urgent illnesses and injuries. On arrival at an ED those attending are classified into one of five triage categories based on the urgency of their health issue.

The percentages of presentations by triage category vary from hospital to hospital. The major hospitals treat larger proportions of high-urgency presentations while outer urban and regional and rural hospitals deal with greater percentages of lower urgency presentations.

There are 40 public hospitals in Victoria with designated EDs. These are funded by the NAESG. From 2012–13, the NAESG includes funding previous generated by admission in the ED to better align the funding model with national activity-based funding arrangements. The NAESG funding model has a 24-hour availability component and an activity/throughput component.

Availability funding relates to services provided by the hospital, but not necessarily by the ED, that must be available to the ED on call, regardless of the level of activity. Services provided by the hospital include such things as specialists, operating theatres and ancillary services (imaging, pathology and pharmacy). At the ED level, availability relates to the minimum level of staff and resources required to be able to treat complex emergency cases, unrelated to activity.

Further information on the NAESG methodology is provided in the *Victorian health policy and funding guidelines, Part three: Technical guidelines* at <www.health.vic.gov.au/pfg>.

All other health services that run urgent care centres receive non-admitted grants to cover both emergency and outpatient services.

Trauma services

Health services operate within a statewide integrated system of care for consumers who sustain major trauma. Key features of the statewide system (see Table 4) are:

- designation of three major trauma services (MTS), which operate as the hub of the state system – The Alfred and The Royal Melbourne hospitals (for adults) and The Royal Children's Hospital (for children)
- statewide system organisation and management of response
- triage and transfer guidelines – the Victorian State Trauma System (VSTS) is designed to ensure trauma consumers are appropriately triaged and transferred
- enhanced retrieval and transfer services – an adult retrieval service is operated by Ambulance Victoria
- data collection and monitoring of system effectiveness by the Victorian State Trauma Registry (VSTR).

Some 80 per cent of major traumas are treated at one of the MTSs.

The department provides block grant funding to the three MTSs. Referring health services receive a trauma appropriateness payment (TAP) for appropriate triage and transfer of major trauma.

Integral to the success of the VSTS is the transfer of major trauma to a MTS or, in the case of spinal cord injury, to the Austin Hospital, or for microsurgery to St Vincent's Hospital. These facilities are best positioned to provide definitive care due to the timeliness and depth of their specialist services. If necessary, major trauma cases can be triaged and transferred to other hospitals that provide a higher level of care for further stabilisation first, and then transferred to an MTS for definitive care.

In recognition of the financial impact on public hospitals that refer and transport trauma to MTSs or Austin Hospital or St Vincent's Hospital:

- metropolitan hospitals are allocated $2,000 per major trauma patient
- regional hospitals are allocated $3,000 per major trauma patient.

To be eligible for TAPs, hospitals are required to provide trauma data to the VSTR.

The department and the Victorian Trauma Foundation established the VSTR to monitor and evaluate the VSTS. The registry is supported by metropolitan and regional data coordinators responsible for collecting quarterly trauma data from all Victorian hospitals.

Table 4: Trauma services in Victoria

Metropolitan Melbourne trauma services	
1. Major trauma services (MTS) • The Alfred (adult) • The Royal Melbourne (adult) • The Royal Children's (paediatric)	• MTSs are centres of excellence in trauma management and are the apex of the state's trauma system. • They provide care to more than 80 per cent of the state's major trauma caseload, either through primary triage or secondary transfer.
2. Metropolitan trauma services (MeTS) Adult and paediatric MeTS: • Austin Health • Box Hill Hospital (Eastern Health) • Monash Medical Centre/Clayton, Dandenong Hospital (Southern Health) • Frankston Hospital (Peninsula Health) • The Northern Hospital (Northern Health) Adult-only MeTS: . • Maroondah Hospital (Eastern Health) • St Vincent's Health • Footscray Hospital (Western Health)	• MeTSs are the second level of adult and paediatric trauma services in metropolitan Melbourne.
3. Metropolitan primary care services • Rosebud Hospital (Peninsula Health) • Sandringham Hospital (Bayside Health) • Sunshine Hospital (Western Health) • Angliss Health Service (Eastern Health) • Mercy Hospital, Werribee • Williamstown Hospital (Western Health) • Monash Medical Centre – Moorabbin and Casey hospitals (Southern Health)	• PCSs are the lowest level of adult and paediatric trauma services in metropolitan Melbourne. • They include private hospitals with EDs when authorised under Hospital circular 4/1998.

Regional and rural trauma services

1. Regional trauma services (RTS)

Located in:

- Albury
- Ballarat
- Bendigo
- Geelong
- Horsham
- Mildura (Ramsay Health)
- Shepparton
- Traralgon (Latrobe Regional Hospital)
- Wangaratta
- Warrnambool
- Hamilton

- RTSs are located in major regional centres and receive appropriate referral from the surrounding catchment area. They provide a regional focus in trauma management.
- RTSs provide resuscitation and stabilisation of major trauma patients prior to their transfer to a major trauma service.
- They provide definitive care for a limited number of major trauma cases where the injuries are assessed (in agreement with the major trauma service) as not requiring transfer.

2. Urgent care services (UCS)

There are 49 UCSs

(see <www.health.vic.gov.au/trauma>)

- UCSs are located in small rural communities where higher levels of trauma care are not accessible.
- They provide initial resuscitation and a limited stabilisation capacity prior to early transfer to a regional or major trauma service.

3. Primary care services (PCS)

There are 65 PCSs

(see <www.health.vic.gov.au/trauma>)

- PCSs are located in small rural communities and provide limited resuscitation prior to early transfer to a regional or major trauma service.

Radiotherapy services

Four public health services are funded by the department to provide radiotherapy services in Victoria:

- Alfred Health – provides services at the William Buckland Radiotherapy Centre in Prahran and at the Latrobe Regional Hospital in Traralgon
- Austin Health – provides services at the Austin Hospital in Heidelberg and in Ballarat
- Barwon Health – provides services at the Andrew Love Cancer Centre in Geelong
- Peter MacCallum Cancer Centre – provides services in East Melbourne at the Peter MacCallum Cancer Centre, in Box Hill at the Epworth Centre, in Moorabbin at the Monash Medical Centre, in Western Melbourne at Sunshine Hospital, and in Bendigo.

Most private services are provided by Radiation Oncology Victoria at five locations in metropolitan Melbourne and one location in rural Victoria (Wodonga). The other private service is the Tattersall's Cancer Centre at Epworth Richmond.

The funding model comprises:

- a variable payment per WAU up to set targets for public, DVA and private patient categories
- a DVA premium (where applicable) above the combined variable and associated department cost payment
- private revenue generated by the health service.

More information on funding for radiotherapy activity is provided at <www.health.vic.gov.au/radiotherapy/funding>.

Specialist clinics (outpatients)

Victoria's public hospitals provide services to consumers needing specialist medical, paediatric, obstetric or surgical assessment and care. They also provide associated allied health services such as physiotherapy and diagnostic testing. These services, where a consultation or procedure is provided to a person who is not currently admitted to the hospital, are called specialist clinics.

Consumers are referred to specialist clinics by community-based general practitioners or specialists. Consumers are also referred to the clinics for follow-up after treatment in the ED, or after having been admitted for surgery or medical treatment. Before allocating an appointment, clinics prioritise the referrals they receive on the basis of clinical need.

For health services previously funded through VACS, from 2012–13 funding will be provided in a block based on existing activity levels, due to the incompatibility of counting methods for NWAU and VACS. However, activity levels will continue to be monitored to ensure maintenance of effort. Other regional and rural health services are funded through a historically based block funding grant.

MBS-billed specialist clinics are provided in public hospitals across Australia. A resource kit is available to provide information to assist Victorian public hospitals in making decisions about establishing MBS-billed specialist clinic services and implementing best practice arrangements in operating these clinics. The kit is available at <http://docs.health.vic.gov.au/docs/doc/Specialist-clinics-in-Victorian-public-hospitals-:-A-resource-kit-for-MBS-billed-services>.

Hospital Admission Risk Program

HARP provides care coordination, self-management support and specialist medical care in ambulatory and community-based settings through integrated hospital and community service responses.

The target population for HARP are people who are most likely to benefit from integrated care and have the potential to reduce avoidable hospital admissions and ED presentations. This includes:

- people with chronic heart disease
- people with chronic respiratory disease and asthma
- people with diabetes
- older people with complex needs
- people with complex psychosocial needs
- people with other chronic diseases and complex comorbidites.

HARP is governed by the *Health independence programs guidelines*. These provide direction for and facilitate the alignment of PAC services, SACS and HARP services. The guidelines are available at <www.health.vic.gov.au/subacute>.

Health services are block grant funded to provide HARP services. Data on HARP services is reported to the VINAH dataset. Further information on HARP is available at <www.health.vic.gov.au/harp>.

Post-acute care

The PAC program provides community-based support services to assist people to recuperate after leaving hospital, or following presentation at an ED. This includes DVA and TAC cases.

PAC services support hospitals to manage bed demand by ensuring that people who no longer need acute care are able to safely return home with an appropriate package of community-based services. These are provided for the recuperation period and are generally short term. The most common services are:

- community nursing
- personal care
- home care services.

The PAC program aims to facilitate independence, or transition to continuing care where necessary, and prevent readmissions to hospital. It works in conjunction with but does not replace services provided by other programs, such as HACC and SACS.

The PAC services resource allocation model combines features of a population-needs-based approach with an activity/output-based approach. PAC program providers determine the mix of services provided, taking into account consumers' healthcare needs and psychosocial factors. Activity is reported through the VINAH dataset.

The department sets annual targets for each PAC provider. Separate targets (estimates) are set for DVA consumers because funding for these consumers is uncapped and all (verified) activity is funded. PAC services are required to be operated in accordance with the Health independence programs guidelines available at <www.health.vic.gov.au/subacute>.

Further information on PAC services is available at <www.health.vic.gov.au/pac> and on funding and reporting at <www.health.vic.gov.au/pfg>.

Mental health services

Victoria's public mental health services are aimed primarily at people with relatively severe forms of mental illness or disorder, whose level of disturbance or impairment cannot be managed by other services. Contact may be short or the person may require specialist services for many years. Some have their needs met by a combination of public and private sector services.

Bed-based clinical services are funded on a bed day basis but will move to an activity based model under national activity-based funding arrangements. Funding is based on availability and is provided regardless of occupancy status. Different rates are paid for metropolitan and rural services and prices are published each year in the *Victorian health policy and funding guidelines*. Annual bed day targets (calculated by multiplying number of beds by 365) are set and health services are cash-flowed throughout the year up to the targets.

Non-bed-based community/ambulatory services are currently funded on the basis of clinical staffing levels (EFT). The department has set targets for clinical ambulatory services based on service hours as a first step in preparing for the introduction of activity-based funding.

PDRSS funding

The department funds non-government organisations to provide PDRSS on a predominantly output/ activity basis using a combination of available bed days and contact hours. Funding for some activities is provided in the form of block grants.

Further information is available at <www.health.vic.gov.au/mentalhealth>.

Drug treatment services

The department also provides funding to some health services for drug treatment services, including Southern Health (SEADS program), Eastern Health (Turning Point Alcohol and Drug Centre) and St Vincent's Health. Most departmental funding for drug treatment services is provided to independent community health services and other non-government organisations, as well as some local governments and universities.

Drug treatment services delivered by health services include:

- drug and alcohol prevention and education projects
- voluntary treatment and rehabilitation services
- counselling services
- forensic drug treatment services
- needle and syringe services.

The funding model for alcohol and other drug treatment services is output/activity based. The department sets activity targets and pays a set price per activity unit, including episodes of care. An episode of care for funding purposes is defined as a completed course of treatment that achieves at least one significant treatment goal for the client.

Further information on services and funding is available at <www.health.vic.gov.au/aod>.

Aged care services

Funding is provided to many health services for a range of aged care services. Funding for aged care in Victoria includes, among other programs:

- HACC services
- ACAS assessment, projects and evaluation
- public sector residential aged care supplements
- carer support services
- Victorian eye care services
- low-cost accommodation support programs
- dementia services.

Funding for aged care services constitutes about two per cent of the total annual recurrent funding provided by the department to all health services. However, the amount of funding received by individual health services varies substantially because of different levels of involvement in aged care service delivery. For some rural health services the main bed-based activity is residential aged care. The main aged care programs affecting health services are described below.

Residential aged care

Health services receive most funding for residential aged care services from Commonwealth subsidies and resident contributions. The Victorian Government provides supplementary recurrent funding to cover additional costs that may be incurred by health services due to state policy requirements and public sector enterprise bargaining agreements. Funding is provided on the basis of a set price per occupied bed day.

The department also provides additional funding from time to time to support major and minor capital works, the provision of specialised equipment, and other service improvement initiatives.

Aged care assessment services

These services are multidisciplinary assessment teams that assist frail older people and their carers to identify what kind of care will best meet their needs. The teams can include health professionals such as medical officers, social workers, nurses, occupational therapists and physiotherapists. An ACAS assessment is mandatory for entry to Commonwealth-funded aged care services including the TCP, packaged care and respite or permanent care.

ACAS are jointly funded by the Commonwealth and Victorian governments and are administered by the Victorian Government. Health services receive block funding for ACAS assessments and training. The funds are allocated to health services using a population-based funding formula. The department monitors the number of assessments and the timeliness of the assessments performed by ACAS.

Home and Community Care

The HACC program provides a range of basic support services to frail older people and people with disabilities who have difficulties managing daily tasks and wish to continue living at home. The program also supports their carers and families. The program provides an assessment of a person's needs, as well as a range of services (such as domestic cleaning, personal care, meals, respite and information) that can be combined to assist older people and people with a disability to continue to live independently. It is a joint Commonwealth–state-funded program.

Health services may receive funding for a range of service types, with the most common being nursing, allied health, assessment, planned activity groups and volunteer coordination. A small number of health services also receive funding for delivered meals, personal care and linkages packages.

HACC services are generally funded by a set unit price for an hour of service (or per meal), indexed annually. Some services receive block funding for service system improvement initiatives such as for ethnic service development officers or equity and access positions.

Further information on aged care services and funding is available at <www.health.vic.gov.au/agedcare> and <www.health.vic.gov.au/pfg>.

Community-based/primary health services

The department provides some funding to health services and to not-for-profit agencies for delivering primary health services. Core services include nursing, allied health and counselling. Additional services and programs include:

- diabetes and other chronic disease management programs
- refugee health nursing services
- multidisciplinary child health teams
- support for vulnerable pregnant women.

The department pays health services to deliver primary care services based on a unit price per contact hour. The unit price includes two components: one rate covers allied health and counselling services, and the other covers nursing. The department sets annual targets based on contact hours for each health service and cash-flows funds throughout the year up to the target.

While funding for primary health services comprises a small proportion of the total recurrent funding provided to health services, they are important services for disadvantaged communities and may assist in reducing demand for hospital services. Fifteen per cent of the Victorian Government's investment in community health is directed through metropolitan health services, with more than 30 per cent of community health funding across Victoria directed through hospitals and health services.

Further information on services and funding is available at <www.health.vic.gov.au/communityhealth>.

Dental health

The Dental Health Program provides dental care to eligible Victorians. The department funds Dental Health Services Victoria to deliver dental care through The Royal Dental Hospital of Melbourne and purchases dental care from 54 community health services and rural hospitals (operating from 79 clinics).

The funding model for dental services is activity based and the activity measure is a completed course of care. The funding unit is a Dental Unit of Value (DuV). Agencies are set DuV targets based on their total service delivery funding. The modelling work associated with developing the funding model highlighted the need for robust, unit-level data. A dental dataset has been introduced, which is designed to streamline data submission and analysis.

Medical equipment

Up-to-date and functional medical equipment is vital to modern healthcare delivery. The department provides some funding for medical equipment and health services are obliged to keep assets in good order and keep records to enable their timely maintenance and replacement.

The department provides capital funding to replace high-cost, high-critical-risk medical equipment through the Medical Equipment Program (MEP). MEP supports the provision of safe and effective clinical services; funding allocation decisions take into account the:

- level of critical risk – according to the department's risk rating methodology that includes the safety of care, clinical risk, staff safety and service availability
- risk of clinical service interruption
- impact on capacity to meet demand for services
- impact on statewide services
- impact on capacity for timely clinical diagnosis and intervention to optimise clinical outcomes
- whole-of-life costs of the equipment.

Funding requests to replace high-cost, high-critical-risk medical equipment are made by health services through a submission process. The department requires these to be:

- based on information that aligns with guidance and requirements issued by the department from time to time
- in alignment with strategic plans, service plans and statewide requirements
- clear as to whether the proposed equipment replacement continues present functionality or is a change in functionality
- comprehensive and provide advice on any impacts on workforce, recurrent funding and service delivery
- presented using the department's *Medical equipment asset management framework* business case and full lifecycle costing templates for high-cost equipment.

The department uses a qualified panel to oversee the assessment of submissions. These assessments take into account independent risk and condition ratings prepared by external experts, as well as input from relevant departmental technical and program experts. The panel may also seek further clarification and substantiation from health services regarding their submissions.

Equipment proposals are required to be part of the health service's rolling four-year medical equipment asset management plan. These plans must be based on reducing critical risks to the safety of care, service availability, and occupational health and safety, and accord with service plans, strategic plans and statewide requirements.

Further information on MEP, funding processes and the *Medical equipment asset management framework* is available at <www.health.vic.gov.au/med-equip>.

The medical equipment asset management framework (MEAMF) aims to optimise strategic asset management of medical equipment in Victorian health services and to support development of individual health service medical equipment asset management plans, in line with recommendations from the Auditor-General Victoria.

The objectives of the framework are to:

- establish guidelines and standardised processes
- establish a consistent approach to the treatment and recording of asset management information
- develop medical equipment asset management templates and guidelines for health services to implement.

Capital funding and service planning

The capital investment process

The Victorian public health system delivers services from a large asset base (more than 2.4 million square metres) that includes hospitals, community health centres, ambulance stations and medical equipment. Health assets are among the most intensively used public assets in Victoria, handling significant numbers of people and requiring complex, expensive infrastructure and services to operate.

A strategic, system-wide approach to health asset planning is adopted to address the complex factors that influence current and future capital investment. This includes consideration of government policy, demographic profile, current and future demand, system capacity and the condition and suitability of existing assets.

The degree of projected growth in healthcare activity in combination with the scale of the asset portfolio means that assets must be utilised intensively and their functional life maximised. Their refurbishment and replacement must be prioritised across the system and over time.

Service planning

Health assets are enablers of service provision; investment in them relates to current and future service requirements. Service planning identifies services needed in future and the best way to provide them; this may or may not require expanded, reconfigured, replaced or relocated assets. Health services plan their service delivery independently of the department where this is focused on delivering their core business in the immediate or short term. Where longer term service planning is required, which is related to decisions about the state's recurrent and capital investment, this is undertaken collaboratively by the department (including all relevant areas) and health services, in the context of system-wide policy and planning. It takes account of the role of different health services, hospitals, sites or services within the system, policies such as local access and the sustainability of the service system.

A service plan is used to resolve policy issues and define the core services to be delivered, and is based on comprehensive data analysis. It should clearly identify existing service needs, as well as proposals for new, reconfigured or replacement services. A component of the plan or a companion model of care document identifies the way services should be delivered. This is expected to address effective ways to manage demand, in order to ensure sustainability of service delivery and investment.

Analysis in the service plan of service/business need and of its alignment with government policy and priorities forms an essential part of the next steps. Should the service plan identify a requirement for capital investment, such as a new or expanded facility, the department determines/approves the service profile that will inform that development as this will determine the future capital and recurrent funding to be sought from government.

Capital planning

Health asset capital planning in Victoria is part of the capital investment cycle. It includes establishing the business need and all pre-planning involved in developing a capital project. The capital investment cycle involves a sequence of phases that a project must follow to achieve a capital outcome.

Approval is required from the department and/or government agencies (such as DTF) at each phase of the investment process. Completion of a phase does not guarantee progression through the cycle, nor does it provide any assurance that a project will be progressed through to the business case or funding phase of the cycle. Over the phases of development the project becomes progressively more tightly defined in terms of model, scope, costs, risks and benefits.

The business case phase

The strategic assessment or strategic business case phase is undertaken when the service plan has been finalised. The strategic business case identifies alignment with government strategy, high-level options including capital and non-capital investment options, and the optimal approach for delivering the defined services. It also includes indicative costs and timeframes. A preliminary business case may be undertaken depending on the degree of detail in the strategic business case and other project-related issues, and provides: a summary of the analysis undertaken; sufficient level of detail to enable key decision-makers to understand the issues; a rationale for the selected short-listed options; and details of the implications of the initiative. Following the strategic business case, and in parallel to a preliminary business case where undertaken, feasibility and initial design work is undertaken to establish the scope and cost of the project.

The final business case presents the rationale and justification for the project and is used to seek funding through the Victorian Government budget process. The final business case usually includes the schematic design and 'Cost plan C', which confirms the project budget for the approved scope of works. The final business case for all projects submitted to DTF and government must be signed off by the divisional executive director, as well as Capital Projects and Service Planning Branch.

If government approval of the final business case is obtained – that is, government funding is provided – the project can proceed to documentation and tender. For selected projects to be carried out by agencies, a capital investment funding agreement must be signed. The agreement defines the scope, cost, timeframe and funding arrangements for the project and commits the responsible agency to delivering the project within these parameters. The funding agreement is usually signed at the end of schematic design.

Project implementation

The implementation phase includes detailed design, tendering, construction and commissioning of the facility. Generally, the implementation phase commences upon confirmation of funding from government.

A project control group (PCG), with representation from both the department and the health service, manages the implementation. It is responsible for managing the budget, timeline and quality of the project and reports to a steering committee that has senior representation from both the department and health service.

Design reviews, documentation reviews and risk management workshops are completed before the project is ready for construction tender. Tendering is a critical activity in a capital works project and is normally the accepted means of obtaining a fair price and best value for undertaking construction works. The *Ministerial directions* pursuant to the *Project Development and Construction Management Act (1994)* and the code of practice for the building and construction industry set out specific requirements covering all aspects of tendering.

After the evaluation of tenders by a tender panel, approval is obtained from a departmental delegate to award the tender. Awarding of the contract ensures the beginning of construction, and the externally appointed project manager undertakes the role of superintendent to administer the contract.

Commissioning occurs at the completion of the implementation phase and involves building commissioning and operational commissioning. It marks the beginning of service delivery from a new facility, ensures that all building systems operate effectively and efficiently, and that staff are familiar with operating the facility before client services commence. Building commissioning is completed when the building surveyor issues a certificate of occupancy, which sets out requirements in relation to essential services.

The implementation phase is complete when the agency is able to safely occupy and deliver services efficiently from the facility.

The Gateway Review Process

Planning and development of capital assets must comply with the Gateway Review Process. The Gateway Review Process (GRP) is based on the Gateway Program in the United Kingdom, and was first introduced to Victoria in 2003.

The GRP is a fundamental part of the Victorian Government's program to improve the management and delivery of Victoria's most significant projects and policy initiatives by:

- providing an independent assessment of a project's health at a point in time; and
- improving the capability of project management in government via lessons learned.

Further information and guidelines on the capital investment process can be found at <www.capital.health.vic.gov.au/capdev>.

Appendix: List of health services

Statewide services

Ambulance Victoria

Metropolitan and major regional public health services

Alfred Health

Austin Health

Dental Health Services Victoria

Eastern Health

Melbourne Health

Northern Health

Peninsula Health

Peter MacCallum Cancer Centre

Royal Victorian Eye and Ear Hospital

The Royal Children's Hospital

The Royal Women's Hospital

Southern Health

Western Health

Albury Wodonga Health

Ballarat Health Services

Barwon Health

Bendigo Health

Goulburn Valley Health

Latrobe Regional Hospital

Denominational health services

St Vincent's Health

Mercy Health and Aged Care

Calvary Health Care Bethlehem

Subregional health services

Bairnsdale Regional Health Service

Central Gippsland Health Service

Echuca Regional Health

Mildura Base Hospital (privately owned, operated under contract by Ramsay Health Care)

Northeast Health Wangaratta

South West Healthcare

Swan Hill District Healthcare

West Gippsland Healthcare Group

Western District Health Service

Wimmera Health Care Group

Local rural health services

Bass Coast Regional Health

Benalla and District Memorial Hospital

Castlemaine Health

Colac Area Health

Djerriwarrh Health Services

East Grampians Health Service

Gippsland Southern Health Service

Kyabram and District Health

Maryborough District Health Service

Portland District Health

Stawell Regional Health

Small rural health services

Alexandra District Hospital

Beaufort and Skipton Health

Beechworth Health Service

Boort District Health

Casterton Memorial Hospital

Cobram District Health

Cohuna District Hospital

Dunmunkle Health Services

East Wimmera Health Service

Edenhope and District Memorial Hospital

Hepburn Health Service

Hesse Rural Health

Heywood Rural Health

Inglewood and Districts Health

Kerang District Health

Kilmore and District Hospital

Kooweerup Regional Health Service

Kyneton District Health Service

Lorne Community Hospital

Maldon Hospital

Mansfield District Hospital

McIvor Health and Community Services

Moyne Health Services

Nathalia District Hospital

Numurkah District health Service

Omeo District Health

Rochester and Elmore District

Rural Northwest Health

Seymour District Memorial Hospital

South Gippsland Hospital

Tallangatta Health Service

Terang and Mortlake Health Service

West Wimmera Health Service

Yarram and District Health Service

Yarrawonga District Health Service

Yea and District Memorial Hospital

Multi purpose services

Alpine Health Multi-Purpose Service

Mallee Track Health and Community Multi-Purpose Service

Orbost Regional Health Multi-Purpose Service

Otway Health and Community Services
Multi-Purpose Service

Robinvale District Health Services Multi-Purpose Service

Timboon and District Healthcare Service
Multi-Purpose Service

Upper Murray Health and Community
Multi-Purpose Service

Abbreviations

ACAS	aged care assessment service
CAT	crisis assessment and treatment
CEO	chief executive officer
CRAFT	Casemix and Rehabilitation Funding Tree
DoHA	Department of Health and Ageing
DPC	Department of Premier and Cabinet
DTF	Department of Treasury and Finance
DVA	Department of Veterans' Affairs
ED	emergency department
EFT	equivalent full time (staff)
FMA	*Financial Management Act 1994*
GEM	geriatric evaluation and management
HACC	Home and Community Care (program)
HARP	Hospital Admissions Risk Program
HSA	*Health Services Act 1988*
MBS	Medicare Benefits Scheme
NWAU	national weighted activity units
PAC	post-acute care
PARC	prevention and recovery care service
PBS	Pharmaceutical Benefits Scheme
PDRSS	psychiatric disability rehabilitation and support services
SACS	subacute ambulatory care services
SoP	*Statement of priorities*
SSA	State Services Authority
TAC	Transport Accident Commission
TCP	Transition Care Program
VACS	Victorian Ambulatory Classification System
VINAH	Victorian Integrated Non-Admitted Health data collection
WAU	weighted activity unit
WIES	weighted inlier equivalent separation

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