AMA VICTORIA

# State Budget Submission 2022–2023

## DRIVING A HEALTHCARE-LED RECOVERY FOR VICTORIA

# Contents

# Introduction

Improving our healthcare system during a global pandemic isn't an easy task. But if not now, then when? A potential opportunity ought not be squandered.

2022 presents the chance for a *healthcare-led recovery* for Victoria; not only medical recovery for Victorians whose health has suffered during the COVID-19 pandemic (whether it be through mental illness, the impacts of delayed and or deferred physical care, or through the virus itself), but also economic recovery through investment in essential health infrastructure and services.

In this context, expenditure on health must not be seen as a drain on Victoria's finite resources, but instead as sound economic policy and investment. After all, a sick population cannot work, spend or be productive. Unfortunately, some miss the underlying requirement of a fit workforce: health equals wealth.

AMA Victoria envisages four separate but ultimately interlinked components of our vision of a *healthcare-led recovery.*

The first (regularly and profoundly neglected by state government, to every Victorian's detriment), is *general practice* (GP). That general practice is positioned first in our state budget submission is no accident. General practice shoulders over 90 per cent of the healthcare burden in Victoria, yet receives the least attention from State Government. This must change. Funding must be prioritised to create a *Division of General Practice* within the Victorian Department of Health to ensure that the voice and concerns of general practice are embedded within the very machinery of government, and at a Deputy Secretary level.

Moreover, resources should be directed to improve the interface between general practice and our hospitals, both public and private. Currently, poor communication and interaction between these two critical, but interwoven, healthcare parts results in significant problems, including in safety, equity and access, quality outcomes, training, and duplication.

The *general practice* section of AMA Victoria's state budget submission also includes *aged care* and *rural and regional health*, in recognition of the reality that GPs (as in so many other areas) do most of the heavy lifting in both providing care to elderly Victorians, and in health care provision in regional and rural Victoria. More funding in both areas is urgently needed.

The next component of our envisaged healthcare-led recovery is *mental health*. AMA Victoria acknowledges the government's commitment to mental health reform through its plans to implement all recommendations of the *Final Report of the Royal Commission into Victoria's Mental Health System*. However, there needs to be a fundamental re-orientation of funding priorities towards acute medically-required care so that those patients who are most in need can obtain the treatment and support they require in a timely manner to prevent deterioration. Lived experience alone cannot help in these profound circumstances. Additionally, funding should be directed to ensure that chronic shortages in psychiatric sub-specialities throughout Victoria are equitably addressed.

Thirdly, the recovery must encompass, *deferred care and elective surgery.*

The impacts of deferred care and treatment of other conditions throughout the COVID-19 pandemic will likely overwhelm the health effects of the virus itself. Perhaps the most immediately visible manifestation of this is the known elective surgery backlog- now over 80 000 Victorians- each one with their own story of disability, anxiety, pain, and frustration.

Traditionally, governments have employed blunt mechanisms (such as so-called elective surgery 'blitzes') to clear surgical backlogs. However, with a workforce exhausted and fatigued after managing two years of COVID-19, such a strategy will be unsustainable in the coming year. Similarly, reliance on private hospitals will not suffice, as they are busy looking after their own clients with exhausted staff. Thus, much more creative thinking is required. Potential solutions include community diagnostic centres with a focus on ease of access and convenience for patients and increasing surgical capacity through 'surgical hubs', provided in the public sector by Victorians for Victorians. Regardless, it is incumbent upon the government to learn the lessons of the pandemic and outline a roadmap for managing and funding Victorian elective surgery resumption in future months and years so that our healthcare system has improved capacity (physically increased, fully staffed, beds, including in rural areas, as well as associated education and training of those staff) and does not rely on extended deferral of essential surgery to cope in times of high demand.

Finally, *public hospitals*.

This is well-traversed territory, and our requests will come as no surprise to the Victorian Government.

The crisis in our public hospital system as manifested in 'ambulance ramping' and 'access block' is multifactorial, inside hospital systems, and predates the COVID-19 pandemic; but in many ways, COVID-19 has illuminated, disclosed, identified, exacerbated and precipitated the current crisis, including specifically through workforce experiences. Irrespective of cause or effect, we have a public hospital system under immense pressure.

However, though the problems are indeed profound, the solutions are perhaps surprisingly simple. Victoria's public hospital system requires urgent investment in infrastructure and workforce. This is not only to allow the system to maintain a more sustainable footing, but also to ensure that our public hospitals are able to scale up for any future surges from COVID-19 as well as other viruses such as influenza (thankfully largely absent the past two years). It is likely that cost of living pressures will compel many to shortly cease payment of private health insurance premiums, exacerbating demand. Thus, there is no option but to support Victorians in need now, as the prediction is obvious.

Additionally, we believe that the government should appropriately resource alternatives to inpatient care – including extended hours/after-hours clinics, psychiatry outpatient clinics, 'hospital-in-the-home' services, community care and mobile diagnostic services – to take the pressure off our public hospitals in the first instance.

AMA Victoria appreciates that our agenda is ambitious, but now is the time to be bold in pursuing a healthcare-led recovery for our state. Victorians deserve no less. It must be seen as an investment in the Victorian economy, not as a cost to Treasury.

We extend the hand of cooperation to the State Government and all political parties in seeking to implement our vision for Victoria contained within the following pages.

I am pleased to introduce AMA Victoria's State Budget Submission 2022-2023.

Dr Roderick McRae
President AMA Victoria

# 1 General Practice

Most care in Victoria occurs in general practice. Moreover, most complex illnesses need comprehensive health care planning and provision across both hospitals and primary care. However, there has been a longstanding neglect of general practice by the Victorian Government. The impacts of COVID-19 and subsequent delayed and deferred care will place a profound stress on all parts of system for years to come, and general practice, as always, will shoulder much of the burden.

There are four areas in need of reform:
- High level general practice knowledge and authority in the Victorian Department of Health;
- General practice and hospital interaction;
- Aged care;
- Rural and regional health.

## HIGH LEVEL GP KNOWLEDGE/AUTHORITY IN THE VICTORIAN DEPARTMENT OF HEALTH

AMA Victoria observes that the Victorian Department of Health has an extremely limited understanding of general practice. This includes how it might be able to leverage the knowledge, connections and understanding of GPs to their patients and community and leverage off their existing systems and care models. This has been evident throughout the COVID-19 pandemic: in contact tracing, notification, vaccination, and support to GPs, including personal protection, and the state's aged care response.

### RECOMMENDATION

- The Victorian Department of Health introduce a *Division of General Practice* headed by an experienced, registered specialist GP at the level of Deputy Secretary. This role should oversee the development of structures and practices to improve hospital and GP collaboration, and thus community care. This role will require other GP and administrative support.

## GENERAL PRACTICE AND HOSPITAL INTERFACE

The Victorian Government's lack of understanding of general practice is most evident in the substandard interaction between general practice and hospitals. This chronically poor interaction results in significant problems in many areas including safety, equity and access, gaps and duplication. With respect to referrals, it is scarcely believable that many public hospitals continue to rely on facsimile (fax) as a mode of communication. This results in both clinical governance problems (lost referrals, lack of accountability and audit trails) and efficiency issues (hundreds of pages printed, faxed and refaxed). Funding must also be prioritised for GPs providing care in the community and in hospitals.

### RECOMMENDATIONS

- Mandate that all public hospitals must develop a single point of contact to receive electronic referrals sent by general practitioners;
- Ensure that electronic referrals are able to be received directly from GP software;
- Discharge and outpatient communication from public hospitals to GPs needs to be measured (measure and report on the timeliness, quantity and quality of discharge planning and clinical handover to general practitioners under hospital accreditation standards);[1]
- Mandate that rejection of a referral for clinical reasons must be undertaken by a senior medical practitioner and communication to a general practitioner must include why the referral was rejected in all cases;
- Support GPs to provide care in the community (including via secondary referral to decrease unnecessary referral to hospital in the first instance and *direct* funding to GPs to support models diverting patients away from hospital);[2]
- Employment contracts for GPs providing care in hospitals or outside of hospitals whilst a patient is "admitted" in a hospital-in-the-home style program.

## AGED CARE

The provision of appropriate health care and services to people living in residential aged care facilities (RACFs) is vital. Health care is largely provided by general practitioners in the aged care setting. However, general practitioners require access to a wide range of health professionals and services to provide high quality and timely healthcare. AMA Victoria considers better supporting public hospitals to work with general practitioners would enable aged care residents to be cared for in their place of residence (home) and would also decrease the burden on public hospitals and emergency services. General practitioners advise that residents in RACFs require greater access to in-reach services by both specialists and allied health professionals and that general practitioners require greater access to point of care testing and timely secondary support and streamlined referrals.

Moreover, the COVID-19 pandemic revealed significant communication, coordination and process issues within aged care during the pandemic. Coordination of care and increased primary care capacity with clinical leadership in facilities have been identified as the highest priorities to address current and future needs.

### RECOMMENDATIONS

- Within our proposed *Division of General Practice*, introduce a position for a specialist registered general practitioner with expertise in aged care;
- Support public hospitals to work with general practitioners, RACFs and primary health networks to provide: a full range of in-reach services; timely secondary support and streamlined referrals for GPs; and an increase in point-of-care testing (including imaging and pathology);
- Approval and funding for a General Practice Liaison Officer within RACFs to ensure a primary contact for healthcare providers within RACFs; [3]
- Support a general practice patient-centred medical home care model for all residents in a RACF. [4] This may comprise Victorian-supported voluntary patent enrolment, allowing Victoria to lead the way.

## RURAL AND REGIONAL HEALTH

The provision of accessible and high-quality health care for people living in Victoria's rural and regional areas must be a high priority for the Victorian Government. Key initiatives are required to address health workforce shortages in rural and remote regions, including allocation of funding to support teaching, training, and recruitment and retention of all medical practitioners comprising general practitioners and non-general practitioner specialists in a sensible, planned service and training concept in reduced numbers of healthcare networks. For many general practitioners and GP registrars working in rural and regional areas access to education, research opportunities and support and mentorship from specialists is scarce. AMA Victoria advocates that local and referral hospitals should be appropriately resourced and tasked with supporting general practitioners in their regions to develop and maintain their clinical skills.

### RECOMMENDATIONS

- Within the proposed *Division of General Practice*, introduce a position for a specialist registered general practitioner with expertise in rural health issues;
- Fund and develop strategies to assist general practitioners to provide care in the community and in small rural and regional hospitals- including training and skills maintenance, secondary referral to hospital specialists, and facilitate the development of referral pathways;
- Provide general practitioners working in rural hospitals with priority support from regional hospital hubs and streamlined pathways of care for emergency advice and transfer;
- Provide support to hospitals to upskill and maintain the clinical skills of general practitioners in maternity care (including intrapartum care), anaesthetic care, dealing with trauma, palliative care, minor surgical procedures and reproductive health (including insertion of long-acting reversible contraception and medical termination of pregnancy);
- Fund models of employment, conditions and standards for rural general practitioners and rural generalists providing clinical services at rural health services which are transparent, fair, and consistent.

# 2 Mental Health

Even before the COVID-19 pandemic, there was a need for investment in key mental health priority areas to ensure Victorians receive adequate care, support, and treatment. In the continuing fallout from the pandemic, such investment is urgently needed.

In 2021, AMA Victoria welcomed the *Final Report of the Royal Commission into Victoria's Mental Health System* and congratulated the Victorian Government for its pledge to fully implement all 65 of the Report's recommendations. Nevertheless, we felt compelled to note that the Royal Commission did not go into detail regarding how the recommendations were to be implemented. We stated that, ultimately, the Report's success or failure in fundamentally transforming our state's mental health system depends upon successful implementation of its recommendations and that medical expertise is essential for successful implementation.

In 2022, whilst still acknowledging the Victorian Government's dedication to transformative mental health reform in Victoria, we have serious reservations about the progress being made. It is our objective to ensure that the initial promise of the Royal Commission is realised, and that yet another opportunity for generational reform is not squandered.

For AMA Victoria, the marginalisation of the medical model in mental health has been most problematic. "Heed the health advice" has been a common catchcry throughout much of the COVID-19 pandemic, but this medical advice has not always been heeded in the context of mental health reform.

We appreciate that funding has been allocated by the State Government towards mental health, but in order to meaningfully transform mental health care in Victoria, significantly more funding must be prioritised for acute care (psychosis; psychoactive medication consumption), so that treatment and support is available for those most in need in a nearby facility.

## RE-ORIENT FUNDING PRIORITIES

AMA Victoria considers constructive reform of the mental health system in Victoria will only be achieved through *targeted* investment. In this context, AMA Victoria advocates for three strategic initiatives:

- evidence-based and cost-effective funding for mental health services;
- fully funded public mental health services, including access to psychiatric outpatient care by psychiatrists; and
- integrated and accessible services and systems for prevention, diagnosis, early intervention, and management of mental illness.

There was a lamentable lack of focus on primary care in the Royal Commission's Final Report. AMA Victoria advocates that primary care systems should be strengthened to address multiple health priorities more broadly, as physical, social, economic, and mental health conditions are often inexorably linked.

A key strategy for improving access to quality health care while keeping costs down is to prevent mental health crises in the first instance, which often result in expensive emergency care. This is best achieved by targeted funding that supports general practice to meet the early mental health needs of patients, by investing in the ability of patients to access timely and appropriate care by psychiatrists and other specialist services, and by ensuring the state health system is integrated and easily navigated by patients, carers and health professionals.

To support patients to receive timely and high-quality health care, AMA Victoria also urges that the public psychiatry inpatient and outpatient sector be better resourced to provide at least equivalent care to that provided in the private system. This is because the unique assessment and complex treatment required by some patients can only be provided by the public system.

### RECOMMENDATIONS

- **Invest in ongoing specialist support for general practitioners to treat and manage patients with mental illness early in the illness trajectory, with a recognition of the longer-term nature of many mental illnesses;**
- **Provide adequate resourcing for community care services to address the 'missing middle' through investment in state-wide psychiatric outpatient clinics;**
- **Invest in specialised mental health areas that have not been adequately resourced – emergency departments and crisis presentations, dual diagnosis services, dual disability services, psychotherapy training for psychiatric registrars and general medical practitioners;**
- **Substantially increase the psychiatric bed capacity in public hospitals (or within their networks) beyond the Royal Commission's recommendations;**
- **Appropriate and adequate resourcing of an array of related services – this particularly includes effective funding of drug and alcohol services, housing for persons with a mental illness and forensic services.**

## SHORTAGES IN PSYCHIATRIC SUB-SPECIALTIES

Victorian psychiatrists are leaving the public sector at an alarming rate. The reasons for psychiatrists leaving the public sector are multi-faceted, but encompass the excessive demands placed on them, the increasing acuity of patients, shortened lengths of admission, and greater mental health presentations to the emergency department. Burnout precipitated by COVID-19 is likely to exacerbate this trend only further.

This shortage of psychiatrists in Victoria is particularly evident in regional and rural areas. Data shows psychiatrists continue to demonstrate a strong preference to live and work in major cities, with 92 per cent of psychiatrists working in the metropolitan area.[5] AMA Victoria advocates that there should be opportunities for psychiatry registrars to undertake rural rotations. Furthermore, to combat the geographically inequitable access to psychiatry, the Victorian Government should ensure access to tele-psychiatry for rural and regional patients. This technology and infrastructure could also be used to support the professional development and connectedness of rural psychiatrists and trainees.

Maldistribution of the psychiatry workforce occurs across areas of metropolitan Melbourne and is a trend likely to increase. The four growth corridors in the south-east, north, Sunbury and the west are expected to accommodate close to half of Melbourne's new housing over the next 30–40 years. This presents a need for psychiatry workforce planning to be responsive to changing demographics but should not be at the expense of existing mental health facilities. [6]

There is also a severe shortage of child and adolescent psychiatrist training positions. To become a psychiatrist, a trainee needs to complete a six-month placement in child and adolescent psychiatry. However, there are insufficient training places, creating a bottleneck of trainees and restricting the overall number of psychiatrists trained in Victoria. This is no longer tenable for Victorians.

Moreover, the number of applications submitted for the RANZCP Fellowship Program continues to increase, yet the annual number of available first-year training places has not increased to accommodate demand, or the potential needs of future population growth. Despite evidence of its effectiveness, access to psychotherapy training is quite limited both in metropolitan and regional and rural areas in Victoria. The State Government should invest in greater access for psychotherapy training.

### RECOMMENDATIONS

- Invest in developing the psychiatric workforce, including structures, resources and processes that encourage healthcare workers to undertake a career in mental health;
- Invest in greater access for psychotherapy training for trainees in metropolitan and regional and rural areas;
- Increase the number of rural rotations available for psychiatry registrars;
- Increase the number of child and adolescent rotations available for psychiatry registrars;
- Provide access to tele-psychiatry for rural and regional patients. Such technology could also be used to support the professional development and connectedness of rural psychiatrists and trainees.

# 3 Deferred Care and Elective Surgery

AMA Victoria considers that when we look back, the impacts of deferred and delayed physical care and treatment of all non-COVID conditions throughout the pandemic will likely outweigh the direct health effects of the virus itself.

Most immediately, and even with the introduction of telehealth, our members report that people are not visiting their general practitioners with the same regularity as before the pandemic. It is thus imperative that the Victorian Government immediately resource a campaign to encourage members of the public to see their GP for a check-up and for preventative healthcare (and why, as discussed previously, it is so important for the government to end its neglect of general practice).

Apart from Victorians not checking in with their general practitioners, perhaps the most visible manifestation of delayed and deferred healthcare throughout the pandemic is the elective surgery backlog. Across the globe, healthcare systems that restricted elective surgery to deal with COVID-19 surges are coming to grips with massive backlogs that will take years to resolve.

Victoria is not an exception. Indeed, at least in the Australian context, it is, unfortunately, the exemplar under-performer. Every state and territory other than Victoria treated more elective surgery patients in 2020-21 when compared to 2019-20. The number of elective surgery admissions in Victoria per 1,000 population has fallen by 6 per cent since 2019-20. In 2020-21, 31.6 per cent of Victorians faced an 'extended wait' for elective surgery (patients in categories 1, 2 and 3 waiting longer than specified times (30 days, 90 days, and 365 days respectively). This represents an increase from 27.4 per cent in 2019-20 and just 12.4 per cent the year prior.[7]

Category 2 and 3 procedures include cancer screening procedures like colonoscopy, gastroscopy, and cystoscopy. These are important because they diagnose cancer. We know from a report released in December 2021 by the Cancer Council Victoria[8] that cancer diagnoses were down by 7 per cent in 2020, which has been estimated to equate to over 2400 Victorians with undiagnosed cancer, due to Victorians not going to screening or assessment appointments due to the pandemic. It is incumbent upon the State Government to outline a strategy to increase cancer screening – offsetting the impact of the pandemic.

Meanwhile, the latest Victorian Health Services Performance report showed that the elective surgery waiting list has blown out to 80,826 people, up from 66,000 in October 2021. The implications of this for frustrated Victorians, in pain and in need of essential procedures are well known to the State Government.[9]

Traditionally, governments, particularly in election years, pursue elective "surgery blitzes" to clear such backlogs. However, in 2022, the sheer exhaustion of the medical workforce makes such a strategy a difficult, indeed almost impossible, proposition. Thus, more creative thinking is required.

In February 2022, NHS England released a national plan[10] to reduce its massive waiting list. Along with increased funding, it is creating dedicated surgical hubs to remove pressure from emergency departments,[11] and community diagnostic centres to make assessments for surgery easier.[12] The Royal College of Surgeons of England has also released its own 'action plan' to address the elective surgery backlog,[13] and has proposed a number of creative solutions. AMA Victoria endorses the contents of both documents and commends them to the Victorian Government.

Two final matters bear due consideration by the State Government.

First, restrictions to elective surgery have restricted the ability of current surgical and procedural trainees to perform the elective surgical and procedures necessary for them to gain the training experience needed to qualify as surgeons and proceduralists and to perform operations safely as a surgeon and proceduralist. Accordingly, resources must be prioritised to ensure trainees, to the extent possible, can 'catch up'.

Second, as mentioned previously, the medical and general healthcare workforce are exhausted; staff wellbeing and retention must be duly considered in tackling the elective surgery backlog.

RECOMMENDATIONS

- Funding allocated to a campaign to encourage members of the public to see their general practitioner for evidence-based preventative healthcare;
- A COVID-19 recovery plan that outlines strategies to increase cancer screening, aimed to offset the negative impact of the pandemic;
- A roadmap for managing and funding Victorian elective surgery resumption in future months and years so that our healthcare system has improved capacity and does not rely on extended deferral of essential surgery to manage in times of high demand;
- Publish an annual report setting out the Victorian Government's response to the elective surgery backlog in Victoria;
- Community diagnostic centres with a focus on ease of access and convenience for patients;
- Increasing surgical capacity through surgical hubs- separating out many of the low complexity surgical pathways through additional surgical hubs, improving outcomes for patients and reducing pressure on hospitals;
- Improving patient pathways to reduce avoidable delays by ensuring government are making the best use of the latest technology, clinical time, and expertise;
- Enabling surgical trainees to catch up on missed training opportunities as soon as possible with bespoke programs of training that include enhanced theatre time;
- Continuing to ensure that staff wellbeing and retention is at the forefront of plans for elective recovery; all health services to support less than full time working for surgical teams.

# 4 Public Hospitals

Victoria's public hospitals are in crisis. They have faced a significant increase in demand over several years which has not been met by sufficient increased investment in staffing and infrastructure. Factors including an aging population, an increase in chronic and complex health conditions, and escalating presentations to Emergency Departments (EDs) for mental health conditions, have contributed to a health system under immense pressure. A shortage of inpatient beds means emergency departments are unable to admit patients in a reasonable amount of time. This 'access block' leads to overcrowding and longer wait times for emergency patients, as well as ambulance ramping.

The statistics are damning – and most actually predate the COVID-19 pandemic.

In terms of ED waiting times, in 2020-21, just 62 per cent of patients in the 'emergency' triage category (the second most urgent classification) were seen within acceptable time limits, down from 83 per cent in 2011-2012. In respect of workforce, Victoria's public hospitals had fewer staff per 1000 people than the national average, with 14.8 staff per 1000 people in 2019-20, compared to 15.7 nationally. Regarding hospital beds, Victoria has 2.3 per 1000 people, compared with the national average of 2.5. Per capita funding is perhaps the most disturbing statistic – where Victoria has the unfortunate distinction of coming last in the nation. Whilst per capita funding for Victoria's hospitals increased to $2,687 in 2019-2020 (a 28.4 per cent increase) this is lower than the national average increase of $2,971/42.9 per cent over the same period. It is significantly lower than percentage increases in per capita funding in New South Wales (44 per cent), Queensland (52 per cent), and Western Australia (60 per cent).[14] As canvassed in the previous section of this submission, elective surgery statistics are equally as disquieting.

Concurrently, Victoria's public hospital infrastructure is ageing- with no clear strategy in place for upgrading, improvement and renewal.

Many older public hospital buildings are at end-of-life and are severely constrained in their ability to meet the standards expected in the delivery of health care in 2022 and beyond. Buildings need to be flexible and need to be built to evolve as technology develops, delivery of care models change and community expectations shift.

Similarly, the management of public hospital assets and equipment requires huge investment to ensure end-of-life infrastructure does not fail.

When critical public hospital infrastructure does fail, as we have seen in several major tertiary hospitals in Melbourne in recent years, quality and safety is compromised and public confidence in the system is undermined.

However, though the problems are profound, the solutions are not complicated. Victoria's public hospital system requires urgent investment in workforce and infrastructure. This is not only to allow the system to return to a more sustainable footing, but also to ensure that Victoria's hospitals are able to scale up for any future surges from COVID-19 as well as other viruses such as influenza (largely absent the past couple of years).

AMA Victoria appreciates that the Commonwealth Government has an equally instrumental role in public hospital funding – and we would draw the Victorian Government's attention to AMA's 'Clear the Hospital Logjam' campaign in this regard.[15] However, given the particular ravages of the pandemic on our state – and the longstanding underfunding of our public hospitals as compared to other jurisdictions- the Victorian Government has a special responsibility to adequately fund the system.

### RECOMMENDATIONS

- Provide urgent funding to ensure our public hospitals are adequately staffed to meet demand, with future funding based on projected patient numbers. Match national per capita funding for public hospitals;
- Fund more inpatient beds and increase overall hospital capacity to meet demand and reduce access block in emergency departments;
- Establish strategies to facilitate effective workforce planning and rapid identification of areas of shortage, with data analysis of annual reporting by health services of the numbers of employed hospital medical officers in positions and the number of specialists in each specialty;
- Identify and analyse the amount of un-rostered overtime being worked by junior and senior medical practitioners in public hospitals;
- Increase investment in the maintenance budgets of all public hospitals;
- Implement a maintenance and renewal strategy to address the future infrastructure needs of Victoria's public hospital system, considering an aging population, decrease in private health insurance coverage, ongoing care for COVID-19 patients, impact of deferred care during the pandemic, and elective surgery backlog;
- Ensure new hospital developments are built with consideration given to Enterprise Bargaining Agreement clauses and entitlements, infection control and digital technology requirements.

## ALTERNATIVES TO INPATIENT CARE

These measures will not replace the need for more hospital beds but will help ease the overwhelming demand for inpatient beds currently faced by our public hospitals.

### RECOMMENDATIONS

- Commit significant funding towards Victoria's public hospital specialist outpatient services;
- Resource options to prevent and respond to urgent health care needs outside the acute system such as extended hours and after-hours clinics, psychiatry outpatient clinics, 'hospital-in-the-home' services, community care, and mobile diagnostic services to decrease the need for hospital admission and reduce unnecessarily long inpatient stays by allowing patients to be safely discharged earlier with adequate support;
- Increase funding for diagnostic and rehabilitation services for inpatients – such as extended hours radiology, allied health, and pathology – to decrease delays and allow earlier discharge of patients where clinically appropriate;
- Fund telehealth and virtual care options to decrease the strain on hospitals and presentations to emergency departments – for example, Northern Health's virtual ED; [16]
- Adequately fund support and safe accommodation for patients who are medically fit for discharge but must remain in hospital as 'long stay' patients as they do not have access to the support they need in the community (for example NDIS patients).

# References


1 For more: 10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors. Australian Medical Association, 2017.

2 For more: Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform. Australian Medical Association, 2020.

3 AMAV Recommendations for improved prevention management of COVID in RACFs Final.pdf. Australian Medical Association (Victoria), 2021.

4 What is the Patient Centred Medical Home Model?. NSW Government Agency for Clinical Innovation, 2022.

5 The Royal Australian and New Zealand College of Psychiatrists, Victorian Branch 2019-20 Pre-Budget Submission, 2018.

6 Mental health sector: implications of the Victorian Psychiatry workforce project", Australasian Psychiatry: 1-4, 2019.

7 Elective surgery. Australian Institute of Health and Welfare, 2021. 12 Public hospitals - Report on Government Services. Productivity Commission, 2022.

8 Cancer-in-Victoria-statistics-and-trends-2020.pdf. Cancer Council Victoria, 2021.

9 Victorian Health Services Performance. Victorian Agency for Health Information, 2022.

10 Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care. NHS England, 2022.

11 As NHS England outlines, elective surgical hubs are surgical units that conduct planned, elective procedures only. They might exist within a hospital as a distinct unit or ringfenced theatre; or they might have been established on a separate site. Creating a clear separation between the urgent and elective care pathways has a number of benefits. Staff time and operating theatres can be protected, for example in the event of any future COVID-19 waves. In turn, that makes the planning of treatment easier: enabling more patients to be seen and reducing cancellations.

12 In NHS England's telling, diagnostic services are critical in making sure the right treatment plan can be put in place for a patient as early as possible, making it more likely that treatment will be successful. They are wide ranging, from an x-ray to a check for a broken bone, using a CT scanner to check for cancer, or having a blood test for diabetes. The CDCs are an essential part of the overall aim to more clearly separate urgent and elective care, by taking patients requiring diagnostic services away from acute areas.

13 Action Plan for the Recovery of Surgical Services in England. The Royal College of Surgeons of England, 2021.

14 12 Public hospitals - Report on Government Services. Productivity Commission, 2022.

15 Clear the hospital logjam. Australian Medical Association, 2022.

16 Emergency Department. Northern Health, 2022.