Victorian
Emergency Physicians
Association Inc

Senator Richard Di Natale
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14 February 2013

Dear Senator Di Natale,

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Victorian
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ABN 86 720 322 325

Thank you for receiving this submission to the senate enquiry into Victorian Hospital funding.

I apologise if I'm not utilising a more formal process, but tomorrow's deadline compels me to send this email letter.

I reiterate the words I shared at the Treasury Gardens rally on the 3rd February that the Victorian Emergency Physician's Association (VEPA) expects the unplanned cuts to hospital funding will lead to Emergency Department overcrowding as patients will not be able to access previously existent hospital ward beds and compounded by less Emergency staff also.
It is universally accepted that overcrowding leads to increased mortality rates. Please refer to Statement S57 on the Australasian College of Emergency Medicine (ACEM) to confirm this.

The other issues I wish to submit are:

- The Emergency Department funding model is guesswork and not aligned with demand. It is not surprising that any funding arrangements ultimately dependant on the methods (trusted) people use to count and not community requirements.
The recent IHPA National Efficient Price Determination (NEPD) 2012-2013 plans an activity based formula to fund Emergency Departments using categories devised last century by Prof. George Jelinek to address this. Emergency Medicine has evolved with improvements in Observational Medicine and techniques that not only improve outcomes but also length of hospital stay. The proposed NEPD and especially the current funding model, do not recognise that conditions (especially injuries) that can now be managed with more efficiently in Emergency Departments, receive less funding than the same condition managed with a prolonged ward admission and operating theatre costs. Other perverse incentives in funding models are described by Prof. Anthony Scott (Health Economist) in his NEPD submission.
My fear is regardless of funding model or pressures, is that there will be incentives for resource managers without clinical currency to intrude into the custodianship of the expert care of Specialist Clinicians.

- The ramshackle reactive approach to planning now imposed by the unplanned Hospital funding cuts changes the rules with core business, training, education, community activities and research not having certainty and trust in fund holders to allow the organised efficient delivery of hospital activities.

Hospitals are now embracing a cost minimising model of care with the ultimate efficiency being to shut down. The clinical excellence model of Hospital care where the best is done with the resources available can not be provided in these reactive circumstances and few Hospitals enjoy rents (financial advantages) large enough to continue the remaining Model of Hospital care, that of technological leader.

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-Emergency Physicians tend to have a long vocational life, not only in their craft but usually in their preferred geographical area of practice. This gives targeted care tailored to the needs of the community they serve. Itinerant practitioners not attuned to their community are unheard of. It is disappointing to believe there are fundholders and administrators that undervalue the Emergency Physician's skills and plan a return to the pre 1986 pot luck care of relatively unskilled staff which necessitated the formation of a College of Emergency Medicine in the first place.

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-Health expenditure per head of population has fallen from $3484 per person in 2009 to $3441 in 2010. These are unadjusted raw expenditure numbers and is the first time a per capita health expenditure has fallen since 1967! It is about 9% of GDP (4.9 % government)...below the 'civilised' world (most OECD nations) of 10-12%...USA 16%!

-Victoria has the lowest bed numbers (including mental health) in Australia ..2.7 per 1000.

- The Victorian government has produced a surplus budget consistently and the last Australian economic recession was last century.

-The night time Emergency Department closures now threatened at the Angliss, Sandringham and Williamstown Hospitals will leave massive holes in the service of Emergency care. The definite closure of Casey Hospital Emergency Department now leave the 17,192 people per year that attend there at night out of the total 49,500 census, with no Emergency Access.
The childish responses from politicians and administrators results in the hospital message to the community being:
YOU CAN'T HAVE IT!.....shameful in these circumstances

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