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2015-16 Commonwealth Budget

VHA Pre-Budget Submission

January 2015

1. Background

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

The VHA welcomes the opportunity to contribute to the development of the 2015-16 Commonwealth Budget. The VHA agrees to this submission being treated as a public document and being cited in any reports that may result from this consultation process.

2. The role of the Commonwealth Government in the Health System

Under the National Health Reform Agreement (NHRA), the shared intention of the Commonwealth and the State and Territory governments was to work in partnership to improve health outcomes for all Australians, and ensure the sustainability of the Australian health system[1]. This cannot be achieved without adequate commitment from the Commonwealth and State governments to work in partnership to implement arrangements for a nationally unified and locally controlled health system – which is a key objective of the NHRA[2].

However, the Commonwealth budget delivered in May 2014 resulted in changes to health funding under the NHRA. Victoria is budgeted to receive $676m less over the next three years compared to original agreements under the NHRA funding guarantee. This figure does not include losses to funding through cessation of programs related to the National Partnership on Improving Public Hospital Services, which previously funded the provision of sub-acute beds[3]. Additionally the changes in indexation from 2017-18 will further reduce funding. After this time point it is proposed that hospital funding will no longer be based on efficient growth in hospital activity, but will be based on population and consumer price index (CPI) growth. These growth measures may not always match the growth in cost of care.

[1] Source: "National Health Reform Agreement" Council of Australian Governments, August 2011, Page 4
[2] Source: Ibid
[3] Source: "2014-15 Commonwealth Budget Paper No. 3", Commonwealth of Australia 2014

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The VHA supports the identification of savings in the health portfolio and the opportunities this creates for more effective health spending, so long as health access and outcomes are not negatively affected. The VHA maintains that the identification of savings should not result in a net reduction in health expenditure. In addition, there should be further investment in new technology and preventative health approaches to increase the efficiency and long-term sustainability of the health system. The VHA emphasises the importance of the Government honouring the pre-election commitment to not reduce net funding to health.

Recommendation:

1. The 2015-16 Commonwealth Budget should reinstate the National Health Reform Agreement funding commitments, and should address the ongoing financial implications of adjustments to the funding formula to take effect from 2017-18.

3. The Commonwealth's Commitment to Prevention and Primary Health Care

Prevention and primary health care are required in a system where health care demands are increasing. Increasing health care demands in Australia are related to increasing prevalence of chronic disease and lifestyle risk factors, as well as an ageing population[4]. Changes in health technology and models of care means care can be delivered more effectively in the community compared to hospital settings. Effective prevention and primary health care can prevent avoidable hospital admissions.

Recent policy and budget announcements have seen changes to the investment in preventative health measures, and the structure and systems for delivering primary health care. Specifically:

a) there is reduced investment in prevention and primary health care,
b) the effectiveness of Primary Health Networks (PHNs) will be negatively impacted by their poor alignment to catchments and boundaries of existing state health programs and services, and
c) the proposed changes to Medicare funding and rebates for GP consultations will further weaken the role of primary health care within the health sector.

3a. Investment in Prevention and Primary Health Care

To reduce the prevalence of preventable chronic disease, and to create lasting improvements in the health and wellbeing of people and communities, a prevention system that is coordinated, responsive, sustainable, and that complements the healthcare system is needed. Funding is an essential component required to support such a system. Research[5,6] demonstrates the significant and long-term

[4] Source: "Australia's Health 2014", Australian Institute of Health and Welfare 2014, Page 32.
[5] Source: "Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities", Trust for America's Health, 2008
[6] Source: "Returns on investment in public health: an epidemiological and economic analysis", Taylor R and Clements M, Department of Health and Ageing: Canberra, 2003

returns on investment and cost savings of prevention activities. A 2008 study reported that for every dollar invested in proven community-based disease prevention programs (increasing physical activity, improving nutrition and reducing smoking levels) the return on investment over and above the cost of the program would be $5.60 within five years[7]. In Victoria, a wide range of health services offer preventative services which complement those provided in general practices. However, Commonwealth funding to these services through programs such as Healthy Communities, and Healthy Together Victoria, jointly funded under the discontinued National Partnership Agreement on Preventative Health, was ceased in the 2014-15 Commonwealth budget.

With an increasing prevalence of chronic disease, the VHA suggests that greater investment in prevention and primary care is required to provide the most cost-effective care and prevent avoidable hospital admissions. The reduced Commonwealth contribution to hospital funding further highlights the need for investment in preventative and primary health care services to keep people well and in their community, and avoid reliance on more expensive hospital-based services.

Recommendation:

2. The 2015-16 Commonwealth Budget should reinstate funding to preventative programs, and increase investment in preventative and primary health care measures across Australia.

3b. Aligning PHNs with Established Planning Areas and Networks

In the 2014-15 Commonwealth Budget, the closure of all 61 Medicare Locals (MLs) was announced, to be replaced with 30 Primary Health Networks (PHNs) nationally. Victoria will establish six PHNs across the state, replacing the 17 MLs. The key objectives of the PHNs have been stated as:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time[8].

The proposed boundaries of the PHNs do not reflect the catchments of state based and local government planning areas, established health networks and programs, other organisations and networks that have a role in addressing population based health needs, and the natural inclination and flow of patients. Additionally these boundaries do not reflect the catchments of other key organisations and networks that have a role in addressing health and social determinants of health. Organisations such as Local Hospital Networks (LHNs), Primary Care Partnerships, Local Government, employment organisations and police services are in some cases straddled across the boundaries of three PHNs. Inconsistent boundary alignment will impact on integration of care across health and health related services. These services may be forced to interact with multiple PHNs, leading to inefficiencies in

[7] Source: "Prevention for a healthier America: investments in disease prevention yield significant savings, stronger communities", Trust for America's Health, 2008

[8] Source: "Frequently asked questions on the establishment of Primary Health Networks", Department of Health, last updated 29 November 2014. http://www.health.gov.au/internet/main/publishing.nsf/content/phn-faq accessed 5/12/2014

service planning and delivery, and impeding and increasing the cost of development of programs for the local population.

The VHA calls upon the Commonwealth to work on a bilateral basis with the States and relevant agencies to facilitate integration of care delivery by PHNs with existing state funded agencies, to complement natural patient flow in geographic areas. This is crucial while disparity exists between proposed PHN boundaries and related organisations' catchment areas. Additionally, the VHA recommends that work should be done to align PHN boundaries with the catchments of existing state defined regions, health services, and major programs and networks. Although this may involve increasing the number of PHNs in the short to medium term to facilitate alignment with existing state-based catchments, this will ultimately lead to better service delivery, population health planning, and sector engagement.

Recommendations:

3. The Commonwealth Government should work on a bilateral basis with the Victorian government and relevant agencies to facilitate alignment and integration of care delivery by PHNs with state funded agencies and to complement natural patient flow, particularly where disparity exists between PHN boundaries and other relevant organisations.
4. The Commonwealth Government should consult and coordinate with the Victorian government to work towards aligning PHN boundaries with existing state defined regions, health services and major programs and networks which contribute to health and social determinants of health.

3c. Changes to Medicare Funding and Rebates Impacting on General Practice

Co-payments for General Practice (GP) and out of hospital diagnostic related services were announced in the 2014-15 Commonwealth budget. Co-payments were proposed as a cost-saving measure by reducing service utilisation. The co-payment plan will no longer proceed, and instead a number of changes will be made to the Medicare rebate scheme. These changes include reducing the rebate paid to GPs by $5 for a range of patient consultations excluding pensioners, Commonwealth concession card holders, all children under the age of 16, veterans funded through the Department of Veterans' Affairs, attendances at residential aged care facilities and pathology and diagnostic imaging services[9]. Doctors may choose to recoup the $5 rebate reduction through an optional co-payment. In addition, Medicare rebates for GPs, specialists, allied health professionals, nurse practitioners, midwives and dental surgeons will be frozen until 1 July 2018[10].

The proposed introduction of any form of co-payments will disproportionately affect the most vulnerable and disadvantaged population groups, as well as those with chronic disease. Even without a co-payment, it is known that up to 12% of disadvantaged populations delay GP visits for up to one

[9] Source: "A Strong and Sustainable Medicare", The Hon Peter Dutton MP, last updated 9 December 2014, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-dutton111.htm accessed 11 December 2014.
[10] Source: "Fact sheet – What it means for Doctros", Department of Health, last updated 8 December 2014, http://www.health.gov.au/internet/main/publishing.nsf/Content/strongmedicare_factsheet_doctors accessed 11 December 2014.

year due to costs[11]. These disadvantaged groups are not always eligible for concessions. The consequences of creating a greater disincentive for populations to attend GP appointments is further avoidance of preventative and primary care measures, and increased emergency department (ED) presentations and hospital admissions. The shift in care from GP to hospital settings effectively acts as a cost shifting mechanism to consumers, as well as requiring the states to fund a greater number of ED presentations. Financial modelling by a number of state governments has estimated increases of up to 27% in hospital ED presentations, which cost up to ten times as much as a typical GP presentation[12]. The end result of a co-payment is a more expensive health system, and poorer health outcomes for the population it serves.

Recommendations:

5. The Commonwealth Government should not reduce Medicare rebates for GP consultations.
6. The Commonwealth Government should not freeze Medicare rebates until 2018 for GP services.

4. Establishment of the Health Productivity and Performance Commission

The Commonwealth Government has proposed merging the Australian Commission on Safety and Quality in Health Care (ACSQHC) with the Australian Institute of Health and Welfare (AIHW), Independent Hospital Pricing Authority (IHPA), National Health Performance Authority (NHPA), National Health Funding Body and the Administrator of the National Health Funding Pool, as a cost saving measure. The ACSQHC leads and coordinates national improvements in safety and quality in health care by supporting health organisations, clinicians and policy makers working with patients and consumers[13], while the other named organisations, in particular the IHPA, NHPA, National Health Funding Body and the Administrator of the National Health Funding Pool, are primarily focussed on the efficient funding and productivity of the health system.

The proposed merger of the above bodies to form the Health Productivity and Performance Commission may compromise the core business of the ACSQHC. Conflicts of interest are likely to arise when merging an organisation with a focus on safety and quality in health with organisations focussed on efficient funding and health system productivity.

Recommendation:

7. The Commonwealth Government should maintain separation of ACSQHC from organisations whose focus is on the efficient funding and productivity of the health system.

[11] Source: "Senate Select Committee on Health: First interim report", Commonwealth of Australia 2014, Page 29.
[12] Source: "Senate Select Committee on Health: First interim report", Commonwealth of Australia 2014, Page 30.
[13] Source: "Australian Commission on Safety and Quality in Health Care", ACSQHC 2014, http://www.safetyandquality.gov.au/ accessed 5/12/2014

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5. Information and Communication Technology

The 2014-15 Commonwealth Budget committed $140.6m for the ongoing roll-out of a national eHealth and Personally Controlled Electronic Health Record (PCEHR) system. The PCEHR is an electronic summary of an individual's health records, which was rolled out nationally in 2012. It has been introduced as an "opt-in" system, and to date approximately 1.2 million Australians have registered for the system[14].

In order to be effective, the PCEHR must be utilised by a critical mass of the population and be compatible with the systems used by health services involved in consumers' care. A 2013 review of the PCEHR, commissioned by the Commonwealth, recommended that the PCEHR be transitioned to an "opt-out" system by 1 January 2015 to facilitate greater uptake of the system[15]. Furthermore, the PCEHR must be able to interface with the information and communication technology systems of a range of health services including hospitals and community health services, to be able to create an effective eHealth system.

Poor uptake of the PCEHR to date means a limited applicability of the system across the Australian population. Without a critical mass of the population utilising the PCEHR, the utility of such a system is restricted. Additionally, no support is currently available for health services such as hospitals and community health centres to dedicate time and resources to upgrade their information and communication technology systems to enable effective interface and integration with the PCEHR.

The VHA commends the introduction of a streamlined single electronic record with the ability to support the provision of seamless care across providers and to share information and interoperability. The VHA recommends that the PCEHR be transitioned to an "opt-out" model, and that funding support should be provided to health services, particularly hospitals and community health services.

Recommendations:

8. The Commonwealth Government should accelerate uptake of the PCEHR by committing to an opt-out approach for all Australians.
9. The 2015-16 Commonwealth Budget should allocate funding to support hospitals and community health services to upgrade existing information and communication technologies to be compatible with the PCEHR.

6. Reducing the Regulatory Burden

Accreditation against rigorous standards is critical to ensuring the safety and quality of healthcare. All accreditation should result in clear quality and safety benefits to service users. Australian public health services must undergo a number of accreditation procedures against rigorous standards to ensure the safety and quality of the healthcare they deliver. This accreditation is often required in order to receive

[14] Source: "Review of the Personally Controlled Electronic Health Record", Department of Health 2013, Page 6.
[15] Source: Ibid, Page 29.

public funding for a particular program, or to continue providing a particular service. In the case of the ten National Safety and Quality Health Service (NSQHS) standards, failure to achieve accreditation can ultimately lead to withdrawal of a provider's license to operate. Many of Victoria's health services provide multiple services across the health, aged and community care spectrum, and consequently must achieve accreditation against multiple, often overlapping, standards. In particular, accreditation standards such as corporate policy, governance and management processes are often repeated with each accreditation body.

Multiple accreditation in public healthcare is placing an unnecessary regulatory and administrative burden on public health services, thus affecting efficiency. Multiple accreditation of individual organisations, services or terms should be avoided where it does not improve service provision.

Governments should explore opportunities for streamlining accreditation to reduce duplication. This could lead to a hierarchy of accreditation, with organisations first accredited against a core set of standards, and then specific service standards, avoiding multiple assessments in areas such as corporate policy, governance or management processes.

Recommendation:

10. The Commonwealth Government should move towards a unified and streamlined accreditation process for health services ensuring quality and safety benefits to users, to avoid overlap and duplication in the accreditation process.

7. Funding of Multi-Purpose Services

Multi-Purpose Services (MPSs) provide a range of health services across the spectrum of health care to local, often isolated, communities. They are funded via a flexible funding model under a tripartite arrangement to provide a range of services, including aged care services.

However, the way MPSs are funded and the distribution of funding for some services is affecting the sustainability of provision of services through these organisations in Victoria.

Specifically:

- The price in the MPS funding model for aged care has not been adjusted for complexity

  MPSs are funded for aged care services using a flexible funding model that was established more than 15 years ago. The funding model used to determine the price for low and high care beds preceded the current ACFI model. There is no evidence that the price in the MPS funding model has been adjusted for complexity since development despite changes to the ACFI price.

  Modelling of a Victorian MPS showed that for high care residents, the current price per place received by this MPS is $118 per day. However, if they were funded under the ACFI rate, then the MPS would receive $137.90 per day per resident.

- MPSs are ineligible for accommodation supplements

  MPSs are ineligible for Commonwealth accommodation supplements for residents assessed as fully or partially supported, and MPSs cannot receive an accommodation contribution for residents assessed as partially or not supported. As a consequence MPSs don't access funding that is provided to other aged care services (including public aged care services).

  This is affecting the viability of these services. Modelling of aged care funding to MPS services showed that without the accommodation supplement and contributions by residents, then MPS residential aged care services must run at a loss once they exceed 70% occupancy.

- Rural Primary Health Service (RPHS) funding

  Six of the seven Victorian MPSs and many small rural health services are not receiving this funding due to the way the Medicare Locals are distributing these funds. In addition it is reported that Medicare Locals are taking an administration fee before distributing funds.

  This is acting to reduce funding to MPSs and is affecting the sustainability of the service and their capacity to provide primary health services. The introduction of larger PHNs is likely to continue the administrative role of the primary health organisation, with ongoing funding losses through the extra level of distribution via the PHNs.

Recommendations:

11. The Commonwealth Government should review the funding model for multi-purpose services and ensure consistency of funding models across the services they provide with that of funding received for services by other providers.
12. The Commonwealth Government should review the distribution of Rural Primary Health Service funding to ensure funds are used for service provision and that they are distributed directly to the organisations that need these funds to provide primary health services in their communities.

8. Provision of Home and Community Care Services

Home and Community Care (HACC) services provide a comprehensive range of integrated home and community care for consumers, which support them to remain at home, and avoid premature or inappropriate admission to long term residential care. The Victorian HACC service system is characterised by strong partnerships with local government and primary care services, as well as public health services. Victorians receive excellent care through the HACC program including robust assessment procedures, and high quality and availability of HACC services. Such programs are critical for the long term financial sustainability of the health care system. The Commonwealth will assume responsibility for the delivery of these home based services under the Commonwealth Home

Support Program (CHSP) from 1 July 2015[16]. The CHSP will consolidate the HACC Program, the National Respite for Carers Program, the Day Therapy Centres Program and potentially the Assistance with Care and Housing for the Aged Program. The CHSP will link with consumers via the "MyAgedCare" website.

In the transition process, existing consumers may be vulnerable to potential gaps in service provision. Furthermore, service providers will require support to develop IT infrastructure within their own systems to be able to link to the centralised "MyAgedCare" system.

Recommendation:

13. The Commonwealth Government should ensure, through budgetary and other measures that the strengths of the existing HACC system are not lost, that existing consumers are not left vulnerable through the transition to services under Commonwealth control, and that sufficient support is provided to service providers to ensure a smooth transition.

9. Access to Community Based Services – National Disability Insurance Scheme

The Commonwealth funded National Disability Insurance Scheme (NDIS) was launched across a number of trial sites from July 2013. The NDIS is designed to enhance the quality of life and increase economic and social participation for people with disability, through community linkages and individualised planning to access the most appropriate supports[17]. Eligibility criteria includes individuals with a permanent and significant disability who need assistance with everyday activities.

The VHA applauds the introduction of the landmark NDIS. However, current eligibility criteria for the NDIS exclude some population groups requiring care which has previously been provided by state funded programs. As an example, patients with mental health needs are a particular population group at risk of losing funding for services which have previously been provided by the Mental Health Community Support Services (MHCSS) program. If such services have their funding ceased under the assumption consumers will be able to access services and support through the NDIS when they cannot, vulnerable population groups will miss out on vital services, which has the potential to lead to crisis-type situations.

Recommendation:

14. The Commonwealth Government should ensure through budgetary and other measures that the transition to services under Commonwealth control such as the NDIS, does not adversely impact consumer access to services, or the quality of care provided in Victoria.

[16] Source: "Commonwealth Home Support Programme", Department of Social Services last updated 4 August 2014, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/reforms-by-topic/commonwealth-home-support-programme accessed 5/12/2014.

[17] Source: "National Disability Insurance Scheme", http://www.ndis.gov.au/ accessed 5/12/2014

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10. Access to Dental Health Services

Good oral health is essential for general health and evidence shows that Australia's lowest income-earners are more likely to experience complete tooth loss, live with toothache, or avoid food due to pain. This pain will usually worsens, until sufferers with preventable dental disease visit their GP or the Emergency Department of local hospitals which are generally not equipped to offer dental care.

Increased funding through the National Partnership Agreement (NPA) for treating more public patients saw access to public dental services for the Victorian community reduced by over 32% for general care in 2014 and wait times down to as low as 8.8 months during March 2014[18].

However, there are concerns that the NPA for treating more public patients and the Child Dental Benefits Schedule (CDBS) will not be accessible for providers of public dental services beyond 30 June 2015. Additionally the VHA is keen to see the commencement of the NPA on adult public dental services (deferred for one year in the previous budget).

Recommendations:

15. The Commonwealth and State Governments should continue to fund the National Partnership Agreement for treating more public patients.
16. The Commonwealth Government should continue the Child Dental Benefits Schedule and allow public dental providers to continue to access the program.
17. The Commonwealth and State Governments should proceed with the National Partnership Agreement on adult public dental services.

Further Information

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[18] Dental Health Services Victoria Annual Report 2013/14, Page 7