SUBMISSION

Victorian Healthcare Association Pre-Budget Submission: 2016-17 Commonwealth Budget

The Victorian Healthcare Association (VHA) welcomes the opportunity to contribute to the development of the 2016-17 Commonwealth Budget. The priorities and discussion presented in this document reflect the highest aim of the public health sector; that all Victorians, regardless of socio-economic status or place of residence, should be able to access safe, high-quality healthcare when it is needed. The recommendations we provide will, if implemented, ensure access is maintained and public health services are able to continue to provide the quality healthcare they are renowned for.

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.

Summary of recommendations

1. Partner with States and Territories to address the ongoing financial implications of adjustments to the acute hospital funding formula to take effect from 2017-18.
2. Deliver funding to prevention programs and increase investment in prevention and primary healthcare measures across Australia.
3. Utilise primary healthcare consultations and reform agendas as a means of improving the delivery and performance of the primary healthcare system.
4. Continue the Child Dental Benefits Schedule and allow public dental providers to continue to access the program.
5. Ensure the National Partnership Agreement on Adult Public Dental Services remains funded.
6. Retain the existing capped fringe benefits tax exemptions for staff of public and not-for-profit hospitals and public benevolent institutions and introduce a fair indexation to the caps.
7. Allocate funding to support hospitals and community health services to implement and update information and communication technologies to be compatible with My Health Record.
8. Move towards a unified and streamlined accreditation process for health services to ensure quality and safety benefits to users and to avoid overlap and duplication in the accreditation process.
9. Prioritise small aged care providers in rural areas requiring additional beds to reach operational economies of scale in the Aged Care Approvals Round process.
10. Include flexible and mixed funding approaches in rural areas where a competitive, market-based and individualised funding model alone will not be sustainable.
11. Ensure the funding rate for multi-purpose services is reflective of increased resident acuity and increasing costs of service provision.
12. Reverse the departmental determination and allow multi-purpose services to charge partially-supported residential accommodation contributions.
13. Incorporate Accommodation Supplements into the multi-purpose service funding model.
14. Through budgetary and other measures ensure 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.

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SUBMISSION

Victorian Healthcare Association

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 is 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]

The Commonwealth budget delivered in May 2014 resulted in changes to health funding under the NHRA which saw Victoria receive $676m less over the following three years compared to original agreements under the NHRA funding guarantee. While substantial, this figure does not include losses to funding through the earlier cessation of programs related to the National Partnership on Improving Public Hospital Services, which previously funded the provision of sub-acute beds. Additionally the changes in indexation from 2017-18 will further reduce funding. After this time 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 growth. These growth measures will not match the growth in cost of care in Victoria.

We support the identification of savings in the health portfolio and the opportunities this creates for smarter health spending, so long as health access and outcomes are not negatively affected and any savings achieved are reinvested in the health portfolio. As a basic principle, we maintain 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.

We emphasise the importance of the Government honouring its commitment not to reduce net funding to health.

Recommendation:

1. Partner with States and Territories to address the ongoing financial implications of adjustments to the acute hospital funding formula to take effect from 2017-18.

The Commonwealth's commitment to prevention and primary healthcare

Prevention and primary healthcare are the foundations of a system where healthcare demands are increasing. This demand is related to increasing prevalence of chronic disease and lifestyle risk factors, as well as an ageing population.[3] Changes in health technology and models of care mean some care can be delivered more effectively in the community compared to hospital settings. Effective

[1] Council of Australian Governments 2011, *National Health Reform Agreement*
[2] Ibid
[3] Australian Institute of Health and Welfare 2014, *Australia's Health 2014, Page 32*

prevention and primary healthcare can prevent avoidable hospital admissions, delivering net benefits to both State and Commonwealth health expenditure and better access to care for individuals.

Investment in prevention and primary healthcare

A prevention system that is coordinated, responsive, sustainable, and that complements the healthcare system is needed in order to reduce the prevalence of preventable chronic disease and to create lasting improvements in the health and wellbeing of people and communities. Funding is an essential component required to support such a system. Research[4,5] demonstrates the significant and long-term 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.[6] In Victoria, a wide range of health services offer prevention 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, we recommend that the Commonwealth Government clearly demonstrates its commitment to prevention and primary care through greater investment in providing the most cost-effective care and preventing avoidable hospital admissions. The reduced Commonwealth contribution to hospital funding further highlights the need for investment in preventative and primary healthcare services to keep people well and in their community, and avoid increasing reliance on more expensive hospital-based services.

Recommendation:

2. Deliver funding to prevention programs, and increase investment in prevention and primary healthcare measures across Australia.

Primary healthcare

There are a range of reforms and sector consultations currently being undertaken by the Commonwealth, each of which carries significant potential to alter the funding and delivery of primary healthcare services. While these consultations, including the Medicare Benefits Schedule Review, the Inquiry into Chronic Disease Prevention and Management in Primary Health Care and the Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care, are welcomed by the health sector as a means of potentially delivering meaningful change to the planning and delivery of public healthcare, they present a complex policy environment against a broader government objective to reduce expenditure.

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

SUBMISSION

These consultations and reform opportunities should be viewed holistically and as a vehicle primarily for improving primary healthcare; rather than an opportunity to deliver further efficiencies and cuts to the health system.

Recommendation:

3. Utilise primary healthcare consultations and reform agendas as a means of improving the delivery and performance of the primary healthcare system.

Access to public dental services

Oral health is an indicator of an individual's overall physical health. Poor oral health negatively affects speech, social and psychological wellbeing, self-esteem and productivity. 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.[7] This pain will usually worsen, until sufferers with preventable dental disease seek treatment by which time it may be too late to save their natural teeth. Instead of seeking care at their local dental clinic, sufferers will often visit their GP or hospital emergency department, settings that are generally not equipped to provide the most appropriate and cost effective care.

Victoria's public dental services have contributed significantly to the overall health and wellbeing of the community, providing care to 382,942 people in 2014-15 including 164,785 children, many of whom were treated through the Child Dental Benefits Schedule.[8] This number has significantly decreased from the previous year due to the deferral and decreased funding contribution to the National Partnership Agreement on Adult Public Dental Services. The National Partnership Agreement deferral and decreased funding contribution also saw public dental waiting times and waitlist numbers balloon.

A large percentage of the eligible population is not being reached. The backlog of untreated dental disease in adults and low levels of oral health literacy cannot be resolved with short term and disjointed programs. More sustainable funding of the public dental sector is required in order to reduce waiting times for care and integrate a preventive approach to disease management.

Continued and increased access to public dental services is absolutely essential and must be supported by a joint commitment to ensuring appropriate funding measures are in place and are not ceased, deferred or changed prior to the expiry of the agreed contractual terms.

Recommendations:

4. Continue the Child Dental Benefits Schedule and allow public dental providers to continue to access the program.
5. Ensure the National Partnership Agreement on Adult Public Dental Services remains funded.

[7] Australian Institute of Health and Welfare 2007, *Social determinants of oral health: conditions linked to socioeconomic inequalities in oral health and the Australian population.* http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129546502
[8] Dental Health Services Victoria Annual Report 14/15, https://www.dhsv.org.au/__data/assets/pdf_file/0016/51118/annual-report-2015.pdf

SUBMISSION

Victorian Healthcare Association

Fringe benefits tax exemptions for public hospital and public benevolent institution staff

The 2015-16 Commonwealth Budget introduced changes to meal entertainment (ME) and entertainment facility leasing (EFL) fringe benefits tax (FBT) concessions. These include the introduction of a single $5,000 grossed-up cap on ME and EFL expenses; and the removal of the reporting exclusion for salary packaged entertainment benefits.

The changes will take effect from 1 April 2016 and carry with them a risk to public hospitals' ability to provide competitive employment packages, particularly for senior clinical and management staff. We acknowledge the Government's decision to retain a $5,000 grossed up cap rather than removing all access to salary packaged ME and EFL fringe benefits.

Public and not-for-profit hospital and public benevolent institution staff are currently able to salary package $17,667 and $31,177 respectively. These benefits are highly valued and are an effective means of attracting and retaining qualified nursing, clinical and management staff. While the benefits serve an important role, their real value continues to be eroded each year, as the exemption caps have not been permanently indexed since their introduction.

The exemptions' ongoing importance to public health services cannot be understated and as such, we recommend the introduction of indexation to the general FBT exemption caps so that they remain commensurate with increases to the cost of living.

Recommendation:

6. Retain the existing capped FBT exemptions for staff of public and NFP hospitals and PBIs and introduce a fair indexation to the caps.

Information and communication technology

The 2015-16 Commonwealth Budget introduced significant changes to the structure of the Personally Controlled Electronic Health Record system. In addition to $485.1 million over four years, the eHealth record has been renamed My Health Record and the agency previously tasked with its rollout, the National E-Health Transition Authority, has had its responsibilities transferred to the Australian Commission for eHealth. The uptake of My Health Record has been slow, and in Victoria it was characterised by a limited number of major public hospitals introducing the necessary systems and hardware. A key criticism of the slow public uptake was the continued insistence on an "opt-in" model. We have advocated for an "opt-out" model and are pleased that the government will be trialing opt-out sites. Hopefully this proves to be the catalyst required to drive broad adoption of My Health Records.

In addition to achieving a critical mass of public use, My Health Record 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 and integrated eHealth system.

The relatively slow uptake of My Health Record to date means a limited applicability of the system across the Australian population. Without a critical mass of the population utilising My Health Record,

the utility of such a system is restricted. Additionally, insufficient support is currently available for health services such as hospitals and community health centres to dedicate time and resources to implement and upgrade their information and communication technology systems to effectively interface and integrate with My Health Record.

We commend 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, and importantly the decision to trial opt-out measures to drive uptake.

Recommendation:

7. Allocate funding to support hospitals and community health services to implement and update information and communication technologies to be compatible with My Health Record.

Reducing the regulatory burden on health services

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. Victorian public health services must undergo a number of accreditation procedures to ensure the safety and quality of the healthcare they deliver. This accreditation is required in order to receive 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, disability and community care spectrum, and must achieve accreditation against multiple, often overlapping, standards. In particular, accreditation standards such as corporate policy, governance and management processes are often repeated in each accreditation process.

This places an unnecessary regulatory and administrative burden on public health services, thus affecting efficiency. As a fundamental principle, we believe that multiple accreditation of individual organisations or programs should be avoided where it does not improve service provision.

The Commonwealth should explore opportunities for streamlining accreditation to reduce duplication. This could include, for example, 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.

We consider accreditation a core strength of public hospitals and community health services' offering to the public. The high levels of achievement across the sector demonstrate a commitment to quality and safe health services and should be recognised and applauded. However, progress in improving the burden of achieving accreditation should be adopted by the Commonwealth Government in line with its commitment to reducing red tape across the public and private sectors.

Recommendation:

8. Move towards a unified and streamlined accreditation process for health services to ensure quality and safety benefits to users and to avoid overlap and duplication in the accreditation process.

SUBMISSION

Aged care

Almost all public health services in Victoria also provide aged care services, including residential and community-based aged care. The majority of public sector services in Victoria are located in regional and rural areas.

Nationally, the public sector makes up 11 per cent of residential aged care providers and five per cent of places. However, the majority of these are in Victoria[9], where the public sector makes up 24 per cent of residential aged care facilities and 12 per cent of places.[10] In Victoria, there are 77 public sector health services that also provide residential aged care across 182 facilities. Of these facilities, 162 (89 per cent) are located in regional and rural areas.[11]

Nationally the public sector provides nine per cent of operational Home Care Packages. In Victoria however, the public sector provides 27 per cent of operational Home Care Packages.[12]

In Victoria, public hospitals and community health services provide 45 per cent of Home and Community Care (HACC) funded services and represent 28 per cent of funded HACC organisations. Of the 132 Victorian health services that provide HACC services, 99 or 75 per cent are in rural areas.[13]

Public sector providers of aged care are often co-located with acute services, and strive to provide integrated, holistic care and service provision. Public sector providers will frequently provide services to complex consumers with high care needs.

By operating largely in regional and rural areas and providing higher acuity care to complex consumers, the public service acts as a safety net for Victorians who may otherwise struggle to access aged care services that meet their needs in, or near, their homes, families and communities.

The Aged Care Approval Round (ACAR) provides a 'priority' system to certain geographic locations and special needs groups. The ACAR should also give priority to small providers in rural areas (where there is adequate demand for residential aged care in their communities) that require additional beds in order to reach operational economies of scale.

The unique demands of service provision in rural and regional areas, including the challenges highlighted above, have seen the development of different approaches to service delivery.[14]

In Victoria, this has involved delivering aged care by public hospitals to ensure provision of aged care in locations where other private for profit and not-for-profit organisations will not operate, resulting in

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[9] ACFA 2015a, *Third report of the Funding and Financing of the Aged Care Sector,* Aged Care Financing Authority, Department of Social Services, Canberra.

[10] Australian Institute of Health and Welfare 2012, *Service Outlets for Residential Aged Care,* Canberra, http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/services-and-places/

[11] Department of Health and Human Services Website 2015, *List of PSRACS Facilities,* March 2015 http://www.health.vic.gov.au/agedcare/services/residential.htm

[12] ACFA 2015a

[13] State Government of Victoria 2014, *Who gets HACC 2010-2011, A Statistical Overview of the Home and Community Care Program in Victoria in 2010-2011*

[14] Baldwin et al. 2013

market failure. This is often the case in rural area, which underscores the importance of public residential aged care.

By pooling funding for core services and applying a more flexible funding model (including block funding and/or mixed models) than traditional activity-based or individualised models, rural communities can retain financially sustainable public sector organisations capable of delivering services where there is limited or fluctuating demand.

The benefits of this approach are considerable and include:

- Ensuring access to aged care services in rural communities.
- A more integrated and holistic service offering for consumers.
- A restorative and wellness based approach to care.
- Higher levels of qualified staff and higher quality of clinical care provision.
- Keeping services local.
- Services acting as a key driver of financial sustainability for their towns, often acting as one of the largest employers.

However, as the aged care reforms continue to move the aged care sector to a more competitive and market-based system, the continued provision of aged care services in rural areas is at risk.

A safety-net system must be in place in areas where a fully competitive, market-based and individualised funding model will not operate effectively.

In the Caring for Older Australians Report, the Productivity Commission recognised that a competition model would not work for specialised services or in rural and remote areas. The Productivity Commission concluded that a funding structure would need to include supplements and/or block funding to ensure that consumers in rural areas would continue to have access to the care they need.[15]

Recommendations:

9. Prioritise small providers in rural areas requiring additional beds to reach operational economies of scale in the ACAR process.
10. Include flexible and mixed funding approaches in rural areas where a competitive, market-based and individualised funding model alone will not be sustainable.

Multi-purpose services

Multi-purpose services (MPS) provide integrated health and aged care services for small, rural and often isolated communities. Victoria has seven MPS operating in 11 communities, and in 10 of these they are the sole provider of residential aged care. In order to provide appropriate, flexible, integrated and cost effective services in these rural areas, MPS are funded via a flexible funding model under a tripartite agreement between the MPS, the State and the Commonwealth.

[15] Productivity Commission 2011, *Caring for Older Australians*

The MPS model successfully ensures that these communities have access to health, aged and disability services in areas of market failure. However, the funding of MPS and the distribution of funding for some services is affecting the sustainability these organisations in Victoria.

MPS are funded for aged care services at a rate that has not been increased since their establishment, more than 15 years ago. The price in the MPS funding model has not been adjusted for the increasing cost of service delivery or to reflect the increased acuity of residential aged care consumers despite the significant changes to the Aged Care Funding Instrument (ACFI) price over this time.

Modelling of the seven Victorian MPS shows a shortfall of $2,191,341 in 2014-15 when compared to equivalent ACFI rates.

MPS are ineligible for Commonwealth accommodation supplements for residents assessed as fully or partially supported, and since July 2014 have not been able to charge partially supported residents for accommodation contributions. This is particularly problematic for MPS as they operate in communities that have much higher than average numbers of supported residents, which in many cases equates to 50% more than the regional averages. As a consequence MPS do not have access to the accommodation income that is provided to other aged care services, including other public residential aged care services.

Modelling of Victoria's seven MPSs shows an accommodation contribution and supplement short fall of $474,483 in 2014-15. This also means that the Significant Refurbishment incentives do not apply to MPSs. Modelling shows that if Significant Refurbishment is taken into account this shortfall increases to $1,180,840.

The MPS model is a highly effective way to ensure service access in rural and isolated communities, however the funding rates in the MPS model must be increased to reflect current service delivery costs.

Recommendations:

11. Ensure the funding rate for MPSs is reflective of increased resident acuity and increasing costs of service provision.
12. Reverse the departmental determination and allow MPS to charge partially-supported residential accommodation contributions.
13. Incorporate Accommodation Supplements into the MPS funding model.

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 has been 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.[16] Eligibility criteria include individuals with a permanent and significant disability who need assistance with everyday activities.

The interface between the NDIS and public health services remains a concern, with eligibility criteria, poorly aligned catchment boundaries and NDIS packages that do not contain the full range of health and allied health services required by clients creating potential issues as the full scheme rolls out across Victoria.

By way of example, one Victorian public health services provides 26 clients with podiatry as part of their disability support. All of these clients have transitioned to the NDIS; however only three have podiatry included in their NDIS plan. For the remaining 23, NDIA planners determined that their disabilities did not "directly impact" their feet and therefore their podiatry support was to be provided outside of the NDIS, despite these clients requiring podiatry as part of their disability support. Several are wheel-chair bound, vascularly compromised and are unable to provide self-care for their feet. As the full scheme rolls out, it is essential that the Commonwealth Government remains aware of eligibility gaps and the risk this poses to clients who may be forced to interact between a number of different providers and jurisdictions.

We applaud 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 Victorian Mental Health Community Support Services 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.

Recommendation:

14. 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] National Disability Insurance Scheme 2015, http://www.ndis.gov.au/

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Further Information

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The Victorian Healthcare Association

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 bush nursing hospitals and centres. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.