MEMBER BULLETIN

Victorian Healthcare Association

Victorian Health Policy and Funding Guidelines 2016-17

7 July 2016

The Victorian Department of Health and Human Services (the Department) has today released the statewide *Health Policy and Funding Guidelines 2016-17* (the Guidelines).

Its introduction refers to the Royal Commission into Family Violence, the Hazelwood Mine Fire Inquiry, the Kruk Prevention Investment Review and the Duckett Review and identifies four strategic directions:

- Person centered services and care
- Local solutions
- Earlier and more connected support
- Advancing quality, safety and innovation

It also states that the Government's reforms of health and community health services will be shaped by the central themes of the Royal Commission; being the integration and coordination of targeted services. The Guidelines note that in doing so, the Department will 'shift away from prescriptive program guidelines.

A substantial component of volume two, chapter 1 of the Guidelines is dedicated to providing a useful overview of key government areas of focus and activities over 2016-17. These have already been announced and therefore will not be summarised in this bulletin.

A summary of key funding changes is set out below.

Modelled funding allocations for FY 2016-17

- The Victorian Government's funding of activity funded public hospitals and health services[1] will increase by **6.2%**
- Funding for small rural health services, including MPS, will increase by **2.8%**
- Mental health funding[2] will increase by **8.2%**
- Funding for registered community health services[3] will increase by **2.2%.**

Health system funding

There is a range of funding and policy changes that will have a material impact – both directly and indirectly – on health service budgets. Some of these are the result of Victorian Government policy

[1] Includes metropolitan and regional public health services, and subregional and local public hospitals
[2] Statewide funding for all hospitals
[3] Limited to DHHS programs

priorities and adjustments to the funding pricing models for healthcare; others are national and reflect commonwealth government and COAG priorities.

Commonwealth funding measures

National Health Reform Agreement

Public hospital funding is a shared responsibility between the commonwealth and state and territory governments.

On 1 April COAG signed a Heads of Agreement which rolls over the National Health Reform Agreement arrangements from 201718, ending a long period of uncertainty as to the make-up of the Commonwealth Government's contribution to public hospital funding. The Heads of Agreement commits to:

- delivering reforms designed to improve health outcomes for patients and decrease avoidable demand for public hospital services
- introducing models to integrate quality and safety into hospital funding and pricing and reduce avoidable readmission rates in conjunction with the Australian Commission on Safety and Quality in Health Care and the Independent Hospital Pricing Authority
- cooperative development of a longer-term public hospital agreement for COAG consideration before September 2018 and commencement by 1 July 2020.

Under the new arrangements, commonwealth funding growth for public hospital services – previously unlimited and based on activity – will be capped at 6.5 per cent annually, and the commonwealth contribution to efficient growth funding will remain at 45 per cent of the efficient growth, rather than moving to the 50 per cent under the original NHRA.

According to DHHS, modelling indicates that the new agreement will deliver "substantially more funding" for public hospitals, compared to the arrangements set out in the commonwealth's 2014-15 budget, which announced the original departure from the NHRA.

Child and Adult Public Dental Scheme

On April 23 the Commonwealth Minister for Health announced a new Child and Adult Public Dental Scheme would be included in the 2015-16 commonwealth budget and would commence on 1 July 2016. Key changes to the previous arrangements include the replacement of the NPA on Adult Public Dental Services and the Child Dental Benefits Schedule, both of which were due to cease on 39 June 2016.

Funding for the new scheme was capped nationally at $415.6 million, but as it was to be based on activity levels it was unclear as to the total quantum Victorian could expect to receive.

The implementation of these reforms required legislative change, and due to the recent election the relevant bills were unable to pass both houses of parliament prior to the enacting of caretaker mode.

As an interim measure, the existing NPA and CDBS will be extended for six months to allow passage of legislation and the development of formal agreements between the commonwealth and states.

Victorian funding measures

Note: the following summarises key changes to funding policy in 2016-17. Further detail is presented in PFG Volume 2, Chapter 2: Funding arrangements for Victoria's health system.

HealthLinks: Chronic Care

DHHS will trial the HealthLinks: Chronic Care (HLCC) funding model in 2016-17, which will promote select health services to respond to the needs of patients with chronic and complex health needs in community settings. The HLCC funding model allows the conversion of existing WIES funding into an HLCC grant, which will result in a high-risk cohort of patients (often those frequently requiring a more costly admission) to be treated in more appropriate settings.

Single TAC and DVA price

DHHS will pay a single price for TAC and DVA admissions, replacing the existing structure of three or four prices that were based on the location and the size of the health service. These changes will effectively deliver an efficiency dividend from health services.

DHHS will match its price paid to health services with the target cost recovery proportion. For TAC funded activity, DHHS' set price provides approximately 90 per cent cost recovery; for DVA funded activity, DHHS' set price delivers approximately 95 per cent cost recovery.

The proportion of the DVA and TAC price received by DHHS that is not passed onto health services has now been earmarked for use in capital, teaching and training expenditure.

Renal dialysis

Victoria's hub and satellite service structure for renal dialysis includes a mandated payment from satellites to hubs for specialist support, equipment and consumables. From 2016-17, new arrangements will impact pathology testing and introduce greater flexibility for satellite providers to order (and finance) tests. The key change will be the removal of the mandatory cross-charge which required satellite providers to pay hub providers $8 of the mandatory payment to cover pathology testing. These changes align responsibility for ordering and financing of renal pathology testing with the provider of dialysis.

Admitted subacute – episodic funding model

The progressive reform of subacute funding will continue in 2016-17 with the introduction of an episodic funding model for rehabilitation and geriatric evaluation and management admitted activity. Palliative care and maintenance care will retain bed-day funding in 2016-17 with progression to an episodic model in the future.

Mental health – input based funding

In 2014-15 and 2015-16, funding for acute admitted mental health activity was distributed to health services using a weighted model that allocated a higher weight for some admitted inpatient care. This approach is not being continued in 2016-17.

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DHHS will instead fund acute inpatient mental health on an input basis. Health services will be funded based on their capacity to provide inpatient mental health care, with the number of bed days available. Adult, child and aged bed types will receive the same price regardless of the location of the health service. Specialist bed types will also receive the same price.

A transition grant will be provided to health services where the new funding is less than the funding currently received in 2015-16.

Admitted extended care and non-admitted acute mental health care (e.g. ambulatory, subacute and residential aged mental health services) will continue via a mix of input (per day or service hour) and block grants.

Lithotripsy

The arrangement of the statewide provider and network of designated satellite providers will be retained in 2016-17. In addition to the existing block grants paid to St Vincent's Hospital Melbourne, DHHS will set the WIES cost weight for lithotripsy activity (L42Z) to zero for all length of stay types. This is intended to preserve the statewide provider responsibilities of St Vincent's Hospital.

Total parenteral nutrition

For 2016-17 health services will no longer be funded through a specific grant. Instead, health services will be paid according to actual activity per patient per month, with recall and funding above throughput applied at the end of 2016-17.

Home enteral nutrition

Funding for home enteral nutrition will be within one funding line in 2016–17 and will be allocated to health services based on the amount of activity that is reported to the department. All activity reported will be funded based on the published price.

Single WIES price – changes in 2016-17

In 2015–16 the WIES price for health services in the metropolitan and large regional pay group received $233 less funding for each WIES compared to health services in the regional and rural pay group. In 2016–17, the department will continue to reduce the gap in prices, with the eventual aim that all health services will receive the same funding for the same diagnosis treated and there is an equivalent level of cost recovery across health services in each pay group.

Pricing for quality

In 2014–15 Victoria implemented a 'pricing for quality' scheme, providing an opportunity to link funding allocations to discrete performance measures that demonstrate a health service's success in reducing preventable harm and improving the quality of care.

In 2016–17, in addition to the existing programs underway in the pricing for quality program, there will be a new focus on unplanned readmissions. The department will focus on a specific cohort of

unplanned readmission rates in 2016–17, with further details on the thresholds for eligibility payments to be provided during 2016–17.

Supply and funding of cornea and sclera

Commencing on 1 July 2016, health services will be funded for the cost of purchasing eye tissue (cornea and sclera) through the Weighted Inlier Equivalent Separation model. For WIES23 and WIES24, the cost weights have been manually adjusted to recognise the additional costs.

Previously, the costs have been incurred by the Department of Health and Human Services Victoria through a block grant to the supplier, the Lions Eye Donation Service. With this change, health services will be invoiced by the supplier for product ordered and supplied.

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