

# Commonwealth pre-budget submission 2019-2020

**January 2019**

## Introduction

The Victorian Healthcare Association (VHA) welcomes the opportunity to contribute to the development of the 2019-20 Commonwealth Budget.

The Victorian Healthcare Association is the peak body supporting Victoria's health services to deliver high quality care. Established in 1938, the VHA represents 96 per cent of the \$19.4b Victorian public healthcare sector including public hospitals and community health services.

The VHA supports Victoria's healthcare providers to respond to system reform, shape policy and advocate on key issues.

In addition, the VHA assists its members with the implementation of major system reform and strategic business support and provides networking opportunities through topical and informative events on vital issues.

The VHA, in its submission, calls on the Australian Government to focus on key areas of health policy that will enable the healthcare system to better ensure that patients receive the right care, in the right place, at the right time. Opportunities to reduce the burden on the healthcare system, particularly hospitals, are being missed; taking them will lead to better care, better outcomes and lower healthcare costs.

The VHA calls on the Australian government to focus health investment in the 2019-20 budget on the following five areas:

- **Promotion and prevention**
- **Aged care**
- **Rural health**
- **Dental**
- **National Disability Insurance Scheme**
- **Data**

The suggested recommendations will, if implemented, ensure access is maintained and public health services and community health organisations are able to continue to provide the quality healthcare for which they are renowned. These are expanded upon in the following pages.



**Content**

<b>Summary of recommendations</b>	<b>3</b>
<b>Promotion and prevention</b>	<b>5</b>
<b>Aged care</b>	<b>7</b>
<b>Rural health</b>	<b>9</b>
<b>Dental</b>	<b>12</b>
<b>National Disability Insurance Scheme</b>	<b>14</b>
<b>Data</b>	<b>16</b>

## Summary of recommendations

### Promotion and prevention

- The development and implementation of a National Obesity Strategy to reduce ever-increasing demand on public health services.
- Funding a national prevention strategy, combined with key programs to improve hospital utilisation.
- Development of a 'shared-risk' funding model with states and territories that rewards health services that can reduce their acute separations for targeted patients, while delivering care in settings better-suited to patient needs, such as community health services.
- Establish a national set of quality indicators for cardiac rehabilitation services, as set out at the National Improving Cardiac Rehabilitation Measurement Think Tank, to reduce the impact of repeat cardiac events on public health services.

### Aged care

- Funding the implementation of the strategic actions set out in the strategy, *A Matter of Care –Australia's Aged Care Workforce Strategy*, developed by the Aged Care Workforce Strategy Taskforce to encourage higher quality and safer care.
- Ensuring that future Aged Care Funding Instrument reform adequately reflects the true cost of providing care for older people, and incentivise better health outcomes for older people.

### Rural health

- Introduction of changes to MBS billing items to help facilitate telehealth in rural and remote areas, with nurse practitioners, rural and isolated practice endorsed registered nurses, and allied health practitioners given telehealth item numbers to enable telehealth consultation in an attempt to manage workforce shortages and increase equity of access to care in rural areas.
- Introduction of changes to MBS billing items so that nurse practitioners are a more viable staffing option for rural and regional health providers, able to bill for chronic health management plans, mental health care plans, advanced care directives, and telehealth. This will enable nurse practitioners to overcome workforce shortages, particularly in regards to attracting and retaining doctors in rural and regional areas.
- Implementation of all 19 recommendations of the National Rural Generalist Taskforce's report, *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*, to create a sustainable rural generalist pathway, which should lead to a viable route to rural and regional practice and help to mitigate rural workforce shortages.

### Dental

- Fund and support the active promotion of the Child Dental Benefits Schedule to eligible families, so the public health system benefits from a preventative approach to poor oral health.
- Creation of an Aged Pensioner Dental Benefits Schedule, with similarities to the Child Dental Benefits Schedule, to lessen the impact that poor oral health, which lead to more acute conditions, has on hospitals.
- Recognition that continuation of funding based purely on outputs will only encourage providers to focus their services on delivering greater outputs. A portion of funding needs to

be quarantined to reward services that achieve great outcomes for clients including preventative work.

- Return funding for public dental services through the National Partnership Agreement (NPA) on Adult Public Dental Services to at least 2016 levels.
- Support for longer term funding agreements (e.g. five to seven years) that match demand for services and enable providers to plan for and develop more innovative service provision.

#### **National Disability Insurance Scheme**

- Provision for a funding supplement for public health services providing care in acute care settings to people with disability due to the fact they cannot be discharged and are awaiting implementation of a National Disability Insurance Scheme plan.
- Development of a market strategy for managing natural monopoly markets in regional and rural areas where a 'thin market' may develop and inhibit service, with proposals developed to: support sole allied health providers in a market; provide rural allowances for increased costs and lack of scale; create a geographic classification for loadings based on participant population and coverage; create principles to guide decision making for transport arrangements and funding that supports provider sustainability; outline principles for a standard of allied health service access in small towns.

#### **Data**

- Development of a Primary Health Care National Minimum Data Set to map and chronicle primary healthcare, like other healthcare areas, so that patient outcomes and usage can be analysed, which should enable health services to improve healthcare provision. This should be developed with the creation of a national data governance framework to guide the Primary Health Care National Minimum Data Set and other national data sets so that they can be used together to generate more knowledge about the Australian health system. All primary health care services, including community health services, must be a part of data collection for the Primary Health Care National Minimum Data Set, so that the full spectrum of primary care can be analysed.
- Increased reporting commitments for the Primary Health Care National Minimum Data Set to be matched with funding increases, so that responsibility is not passed onto already stretched parts of the Australian health system.

## Promotion and prevention

### Situation

Three quarters of all Australians over the age of 65 have at least one chronic condition<sup>1</sup>. While the cost of preventable hospitalisations attributed to chronic conditions is estimated to be at least \$322 million per year<sup>2</sup>, funding for prevention and early intervention activities has gone backwards.

While the Australian Government has taken steps to tackle the burden of chronic disease, including development of the National Chronic Disease Framework, more needs to be done to improve the health and wellbeing of Australians and keep them out of overstretched public hospitals.

While all chronic disease should be a priority, cardiovascular disease continues to be the leading cause of death and most expensive disease to treat in Australia<sup>3</sup>, with \$8.8 billion spent annually in direct healthcare expenses<sup>4</sup>. Admissions due to cardiovascular disease, which are mostly preventable<sup>5</sup>, put a huge strain on public hospitals.

Poor secondary prevention means that our public hospitals are continually treating patients, with a third of people admitted for heart attack having been previously treated for the condition before<sup>6</sup>. With only 30 per cent of patients taking part in cardiac rehabilitation after a cardiovascular event, the potential for additional adverse events is increased along with the potential for further costly hospitalisations<sup>7</sup>. Poor data also inhibits the ability to improve outcomes for patients across Australia, which was the focus of the recent National Improving Cardiac Rehabilitation Measurement Think Tank, a partnership between the South Australian Academic Health Science and Translation Centre, the Australian Cardiovascular Health and Rehabilitation Association and the National Heart Foundation of Australia.

The Australian Government must support keeping people well and out of public hospitals, to reduce the overall burden on our public hospital system, reduce costs and to benefit the population.

### Recommendations

To combat and mitigate the impact of cardiovascular disease on the health system, the government must fund a range of holistic prevention and promotion initiatives. These include:

- The development and implementation of a National Obesity Strategy, as set out at the COAG Health Council on 12 October 2018, with a focus on supporting wellness promotion in these areas:

<sup>1</sup> Swerissen, H., Duckett, S., 2016, *Chronic failure in primary care*, Grattan Institute (<https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf>)

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Stroke Foundation, 2018, *Time for action on heart disease and stroke*, Stroke Foundation, Media release (<https://strokefoundation.org.au/Media-Releases/2018/10/29/02/56/Time-for-action-on-heart-disease-and-stroke>)

<sup>5</sup> Ibid.

<sup>6</sup> Heart Foundation, 2016, *Cardiac Rehabilitation Factsheet*, National Heart Foundation of Australia ([https://www.heartfoundation.org.au/images/uploads/publications/HF.Cardiac\\_Rehab\\_Factsheet\\_WEBH\\_R.pdf](https://www.heartfoundation.org.au/images/uploads/publications/HF.Cardiac_Rehab_Factsheet_WEBH_R.pdf))

<sup>7</sup> Ibid.

- healthy eating
- smoking cessation
- exercise campaigns
- Funding a national prevention strategy, combined with key programs to improve hospital utilisation.
- A move to a 'shared-risk' funding model with states and territories that rewards health services that can reduce their acute separations for targeted patients, while delivering care in settings better-suited to patient needs, such as community health services.
- Establish a national set of quality indicators for cardiac rehabilitation services, strengthening secondary prevention to lessen readmissions to hospital and lower healthcare costs. This was set out at the National Improving Cardiac Rehabilitation Measurement Think Tank forum in September 2018<sup>8</sup>.

---

<sup>8</sup> National Improving Cardiac Rehabilitation Measurement in Australia Think Tank, 2018, *Improving Cardiac Rehabilitation Measurement in Australia Think Tank Communique*, SA Translation Centre, the Australian Cardiovascular Health and Rehabilitation Association and the National Heart Foundation of Australia

([https://www.heartfoundation.org.au/images/uploads/main/241018\\_Communique\\_FINAL.pdf](https://www.heartfoundation.org.au/images/uploads/main/241018_Communique_FINAL.pdf))

## Aged care

### Situation

Australia's population is ageing and demand for aged care services is predicted to increase significantly at a time when aged care providers are struggling to attract an adequate workforce.

The demographic challenges facing the aged care system are well documented and understood. In its 2011 *Caring for Older Australians* report, the Productivity Commission found that by 2050 the aged care workforce will need to quadruple to meet demand<sup>9</sup>. The Productivity Commission also concluded that labour participation rates will likely fall from 65 per cent in 2012 to 60 per cent in 2060, with overall labour supply per capita contracting to 5 per cent<sup>10</sup>.

This is a major issue, particularly in Victoria, which has the majority of Australia's residential aged care providers<sup>11</sup>, where the public sector makes up 24 per cent of residential aged care facilities and 12 per cent of places<sup>12</sup>. 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<sup>13</sup>.

The process to rectify this major issue has begun, with the development and publication of a national aged care workforce strategy, *A Matter of Care –Australia's Aged Care Workforce Strategy* as well as the recent launch of the Royal Commission into Aged Care Quality and Safety.

*A Matter of Care –Australia's Aged Care Workforce Strategy*, developed by Professor John Pollaers OAM, set out 14 strategic actions to provide industry with the tools needed to improve aged care and ensure that the workforce is ready for the future direction of aged care. These strategic actions include:

- Creation of a social change campaign to reframe caring and promote the workforce
- Voluntary industry code of practice
- Implementing new attraction and retention strategies for the workforce
- Strengthening the interface between aged care and primary/acute care
- Establishing a remote accord
- Establishing an Aged Care Centre for Growth and Translational Research

While the strategic actions contained within *A Matter of Care –Australia's Aged Care Workforce Strategy*, have received strong government support, no funding has been committed. The strategy, if fully implemented, would grow and sustain the workforce providing aged care services and support

<sup>9</sup> Productivity Commission, 2011, *Caring For Older Australians, Report No. 55, Final Inquiry Report*, Australian Government

<sup>10</sup> Productivity Commission, 2013, *An Ageing Australia: Preparing for the Future, Commission Research Paper*, Australian Government

<sup>11</sup> ACFA 2015, *Third report of the Funding and Financing of the Aged Care Sector*, Aged Care Financing Authority, Department of Social Services, Australian Government

<sup>12</sup> Australian Institute of Health and Welfare, 2012, *Service Outlets for Residential Aged Care*, Australian Institute of Health and Welfare (<http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/services-and-places/>)

<sup>13</sup> Department of Health and Human Services, 2015, *List of PSRACS Facilities*, March 2015, Victorian Government (<http://www.health.vic.gov.au/agedcare/services/residential.htm>)



for older people, to meet their care needs in a variety of settings across Australia. The Royal Commission into Aged Care Quality and Safety has already begun to highlight the importance of a high-quality, well-trained workforce to the quality and safety of care. While responsibility for implementation largely rests with industry, no funding has been made available.

**Recommendations**

- The Australian Government must commit to support and fund the implementation of all the strategic actions included in *A Matter of Care –Australia’s Aged Care Workforce Strategy*, as developed by the Aged Care Workforce Strategy Taskforce, to enable aged care services to deliver higher quality and safer care for older people.
- The Australian Government must ensure that Aged Care Funding Instrument reform adequately reflects the true cost of providing care for older people, and incentivise better health outcomes for older people.



## Rural health

### Situation

People in rural and regional areas continue to have lower life expectancy, greater difficulty accessing health services and worse outcomes on leading indicators of health when compared with people living in metropolitan areas<sup>14</sup>. One reason for these outcomes is workforce shortages which hinder ability to access care<sup>15</sup>. This has led to higher rates of potentially preventable hospitalisations<sup>16</sup>, placing further strain on the health system.

Rural generalists practitioners have been identified a potential solution to workforce shortages. Rural generalists learn the specific skills to work in rural and regional areas while being taught in a rural and regional setting, which has been found to contribute to health professionals being more likely to practice in country areas<sup>17</sup>. This led to the December 2018 publication of the National Rural Generalist Taskforce's report, *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*, which set out 19 recommendations for the creation of an education and professional development pathway for practitioners wanting to work in rural and regional areas<sup>18</sup>. The recommendations include the adoption of the proposed National Rural Generalist Training Pathway, a rural loading for all clinical services, and recognising rural hospital teaching and research in the hospital funding agreements.

Distance is another barrier to rural care, but digital technology can overcome this. Telehealth has also long been identified by the Australian Government as a potential solution to the complexities of rural healthcare. Since the 1990s, the Australian Government has invested in telehealth programs or made billing changes to encourage uptake<sup>19</sup>; recent changes to the criteria for Better Access to Mental Health Care Medicare rebates were to increase access to mental health services via telehealth for people in rural and remote regions. The Australian Government must, however, make

<sup>14</sup> Australian Institute of Health and Welfare, 2017, *Rural and remote health*, Australian Institute of Health and Welfare (<https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health>)

<sup>15</sup> National Rural Health Alliance, 2015, *Cardiovascular disease in rural Australia*, Fact Sheet – May 2015 2015, National Rural Health Alliance and Heart Foundation (<http://ruralhealth.org.au/sites/default/files/publications/cardiovascular-disease-fact-sheet-may-2015.pdf>)

<sup>16</sup> Australian Institute of Health and Welfare, 2016, *Australia's health 2016*, Australia's health series no.15, Australian Institute of Health and Welfare (<https://www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx>)

<sup>17</sup> Playford, D., Ngo, H., Gupta, S., Puddey, I., 2017, *Opting for rural practice: the influence of medical student origin, intention and immersion experience*, MJA 207 (4), Medical Journal of Australia ([https://www.mja.com.au/system/files/issues/207\\_04/10.5694mja16.01322.pdf](https://www.mja.com.au/system/files/issues/207_04/10.5694mja16.01322.pdf))

<sup>18</sup> National Rural Generalist Taskforce, 2018, *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*, National Rural Health Commissioner ([http://www.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/\\$File/Advice-to-the-National-Rural-Health-Commissioner-on-the-Development-of-the-National-Rural-Generalist-Pathway.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/Advice-to-the-National-Rural-Health-Commissioner-on-the-Development-of-the-National-Rural-Generalist-Pathway.pdf))

<sup>19</sup> Health and Community Services Committee, 2014, *Inquiry into telehealth services in Queensland*, Report No.55, Parliament of Queensland (<https://www.parliament.qld.gov.au/documents/committees/H CSC/2014/InquiryTelehealth/rep-055-12Sep2014.pdf>)

sure that telehealth regulations are up to date with the reality in rural areas. With access to care worse in rural and regional areas, due to workforce and distance pressures, it is essential that a range of health professionals are enabled to deliver care via telehealth. Nurse practitioners, rural and isolated practice endorsed registered nurses (RIPERN), and allied health practitioners require telehealth billing codes if they are able to be a viable staffing option to ensure that rural and regional patients have greater access to care. The current requirement to have a medical specialist to be present at the consultation inhibits their ability to deliver benefits for the system and patients.

Nurse practitioners, similarly, also need to be enabled to play a greater role in rural and regional healthcare. Nurse practitioners deliver care across the health care spectrum from primary through to acute care; fulfilling different, but equally important roles, in the health system. Nurse practitioners, in particular, are a cost-effective and successful solution to addressing rural and regional workforce issues, and help overcome challenges around attracting and retaining general practitioners. Despite this, there are barriers in the system for their utilisation; they are unable to claim against Medicare Benefits Scheme (MBS) item numbers for chronic health management plans<sup>20</sup>, mental health care plans<sup>21</sup>, and for the completion of an advance care directive<sup>22</sup>. They are unable to autonomously work under MBS telehealth item numbers, requiring a medical specialist to be present at the consultation, severely impacting delivery of care in rural settings.

To support improved health inequity, the Australian Government must enable innovative models of service delivery, such as nurse-led outpatient models, improved use of telehealth and approaches to attracting and retaining health professionals in rural locations.

#### **Recommendations**

- The Australian Government must make changes to MBS billing items to help facilitate telehealth in rural and remote areas. Nurse practitioners, RIPERN nurses, and allied health practitioners need to be eligible for telehealth item numbers to enable telehealth consultation in an attempt to manage workforce shortages and increase equity of access to care in rural areas.
- The Australian Government must commit to make changes to MBS billing items to enable nurse practitioners to bill for chronic health management plans, mental health care plans, advanced care directives, and telehealth item numbers. This will make nurse practitioners a more viable staffing option for rural and regional health providers, removing restrictions on their ability to care for patients, to help overcome workforce shortages, particularly in regards to attracting and retaining doctors in rural and regional areas.
- The Australian Government must implement all 19 recommendations of the National Rural Generalist Taskforce's report, *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*. This would be delivered as a staged

<sup>20</sup> Department of Health, 2014, *Chronic Disease Management (formerly Enhanced Primary Care or EPC) — GP services*, Australian Government

(<http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement>)

<sup>21</sup> Healthdirect Australia, 2017, *Mental health care plan*, Australian Government

(<https://www.healthdirect.gov.au/mental-health-care-plan>)

<sup>22</sup> Better Health, 2018, *Advance care plans*, Victorian Government

(<https://www.betterhealth.vic.gov.au/health/servicesandsupport/advance-care-plans>)



implementation plan, with ongoing consultation and funding support. This pathway is a crucial step to overcoming long-term and systemic workforce issues in rural and regional areas which have long inhibited the quality of care that patients can receive.

## Dental

### Situation

Oral health is an important determinant of overall health and wellbeing with poor oral health connected to a range of chronic conditions including obesity, cardiovascular disease and Type 2 diabetes<sup>23</sup>. There are long waiting times for access to public dental services, in some cases up to two years in Victoria, while the high cost of care was last year identified by over half a million people as the reason they did not access care<sup>24</sup>. This leads to delays in people receiving treatment resulting in further deterioration of dental health and compounding the issue. In 2015-16 there were 67,266 potentially preventable hospitalisations for oral health problems and almost one-third of these were children under the age of nine years<sup>25</sup>.

Poor oral health has the second highest disease expenditure in Australia<sup>26</sup>. The benefits of inhibiting poor oral healthcare from developing into other costly medical issues are clear from the disease expenditure and preventable admissions, with a national approach required to limit the need for avoidable hospitalisation. With the Australia's demographics getting older, and nearly 20 per cent of adults aged over 65 having no natural teeth<sup>27</sup> and a three-quarters having a chronic disease<sup>28</sup>, it is important that steps are taken to limit this growing burden on public health services.

While the Australian Government funds the Child Dental Benefits Schedule, only 30 per cent of the 3.4 million children eligible to be treated on the Child Dental Benefits Schedule have accessed it<sup>29</sup>; this signals a clear requirement to improve awareness and drive uptake. Driving prevention at an early age will lessen the need for invasive and expensive treatments under general anaesthetic down the track.

The Australian Government must support preventative dental healthcare initiatives, which will lead to improved clinical outcomes for patients, reduce the burden on public hospitals, and mitigate health system costs.

<sup>23</sup> Dental Health Services Victoria, 2011, *Links between oral health and general health - the case for action*, Dental Health Services Victoria ([https://www.dhsv.org.au/\\_data/assets/pdf\\_file/0013/2515/links-between-oral-health-and-general-health-the-case-for-action.pdf](https://www.dhsv.org.au/_data/assets/pdf_file/0013/2515/links-between-oral-health-and-general-health-the-case-for-action.pdf))

<sup>24</sup> Duckett, S., 2018, *The tooth hurts but Victoria's public dental system is broken*, 11.11.2018, The Age (<https://grattan.edu.au/news/the-tooth-hurts-but-victorias-public-dental-system-is-broken/>)

<sup>25</sup> Australian Health Policy Collaboration, 2018, *Nothing to smile about - oral health report*, Australia's Oral Health Tracker, Victoria University and Australian Dental Association (<https://www.vu.edu.au/about-vu/news-events/news/nothing-to-smile-about-oral-health-report>)

<sup>26</sup> Swerissen, H., Duckett, S., 2016, *Chronic failure in primary care*, Grattan Institute (<https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf>)

<sup>27</sup> Chrisopoulos, S., Harford, J.E., and Ellershaw, A., 2016, *Oral health and dental care in Australia: key facts and figures 2015*, Australian Institute of Health and Welfare (<https://www.aihw.gov.au/getmedia/57922dca-62f3-4bf7-9ddc-6d8e550c7c58/19000.pdf.aspx?inline=true>)

<sup>28</sup> Swerissen, H., Duckett, S., 2016, *Chronic failure in primary care*, Grattan Institute (<https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf>)

<sup>29</sup> Public Health Association Australia, 2018, *Top 10 public health successes over the last 20 years*, PHAA Monograph Series No. 2, Public Health Association Australia (<https://www.phaa.net.au/documents/item/3241>)

**Recommendations**

- The Australian Government must fund and support the active promotion of the Child Dental Benefits Schedule to eligible families,<sup>30</sup> so that the public health system may benefit from a greater preventative approach to dental care.
- The Australian Government must support dental healthcare initiatives to lessen the impact of poor oral health, leading to more acute conditions, on hospitals, including an extension of the Child Dental Benefits Schedule to an Aged Pensioner Dental Benefits Schedule, with eligibility confined to a specific age and concession card status.
- The Australian Government must recognise that continuation of funding based purely on outputs will only encourage providers to focus their services on delivering greater outputs. A portion of funding needs to be quarantined to reward services that achieve great outcomes for clients including preventative work.
- The Australian Government must return funding for public dental services through the National Partnership Agreement (NPA) on Adult Public Dental Services to at least 2016 levels
- The Australian Government must support longer term funding agreements (e.g. five to seven years) that match demand for services and enable providers to plan for and develop more innovative service provision.

---

<sup>30</sup> Australian Healthcare and Hospitals Association, 2019, *2019-20 Pre-budget submission to Treasury*, Australian Healthcare and Hospitals Association ([https://ahha.asn.au/system/files/docs/publications/ahha\\_pre-budget\\_2019-20\\_submission\\_to\\_treasury.pdf](https://ahha.asn.au/system/files/docs/publications/ahha_pre-budget_2019-20_submission_to_treasury.pdf))

## National Disability Insurance Scheme

### Situation

The VHA and its members are committed to ensuring that the National Disability Insurance Scheme (NDIS) is able to deliver the best possible care for those that need it, however there are gaps in the system that are inhibiting access and leading to inefficiencies in care.

Consumers are regularly forced to stay in the care of a hospital for an extended period, at great cost to the system, while they await an NDIS plan evaluation. Public hospitals are not funded to look after those who cannot be discharged nor are they funded to compile the evidence that is necessary for NDIS access requests. A 2018 report by the Summer Foundation found that hospitals require additional staff resources to meet NDIS system demands, while longer stays in acute beds is impacting on ability to meet incoming demand<sup>31</sup>.

In many areas of rural Australia, there is high potential for market failure where allied health services and supports are not available for purchase by NDIS participants. Any geographic area with a dispersed population and insufficient demand to support a monopoly provider, known as a 'thin market', will drive significant gaps for participants. Fee for service pricing is creating complex challenges in thin markets for providers to achieve sustainability and viability for many NDIS services.

Recent analysis carried out by the VHA has shown that no small town allied health provider in Victoria is likely to 'break-even' on any NDIS market scenario, while a number of large towns will struggle to offer a choice of service providers<sup>32</sup>. There is growing concern and conjecture in the sector around the viability of NDIS services under the National Disability Insurance Agency (NDIA) funding model.

### Recommendations

- The Australian Government must deliver a 'presumptive positive' funding supplement for public health services providing care in acute care settings to people with disability due to the fact they cannot be discharged and are awaiting implementation of a NDIS plan. This should be funded to the equivalent of an acute bed day for each day the person is in hospital awaiting an NDIS plan, enabling hospitals to deliver the care required.
- The Australian Government must ensure that the NDIA develops a market strategy for managing natural monopoly markets in regional and rural areas that considers:
  - funding sustainable NDIS allied health services where they are the sole provider of allied health services in that market
  - benchmarking provider efficiency in a remote and rural service environment, with allowances for increased overheads and employment costs due to lack of scale
  - the development of a purpose-built NDIS geographic classification based on service coverage areas, mapping geographic classifications based on participant population and coverage, so appropriate loadings can be applied to the price controls

<sup>31</sup> George Taleporos, Inquiry into the implementation of the National Disability Insurance Scheme and the provision of disability services in New South Wales, Summer Foundation, August 2018 (<https://www.parliament.nsw.gov.au/lcdocs/submissions/61381/0204%20Summer%20Foundation.pdf>)

<sup>32</sup> Defined as having a population of less than 10,000 people.

- developing a set of principles that will guide decision making for transport arrangements and funding that balances the NDIS goals of 'reasonable and necessary' with 'choice and control' and that also supports provider sustainability
- principles outlining a standard of allied health service access in small towns.

## Data

### Situation

Better utilisation of data is seen globally as the future basis of good decision-making in healthcare; it is also the basis for emerging digital healthcare capabilities and a growing focus on patient outcomes.

Currently in the Australian healthcare sector there are over ten national minimum data sets (NMDS) which includes admitted and non-admitted patient care in hospitals, elective surgery waiting times, and community mental health care. These NMDS provide valuable evidence-base that is intrinsic to decisions made at all levels of healthcare.

Despite significant investment in providing primary health care services, which in 2016-17 constituted approximately 34 per cent of total Commonwealth health expenditure<sup>33</sup>, little is known about what services are being delivered, where they are being delivered, who they are being delivered to and what the outcomes are. Central collection and collation of primary health data is now essential, with the potential to result in a better understanding of what drives best patient outcomes and areas for service improvement.

There have been recent positive steps towards this. The Australian Government funded the Australian Institute of Health and Welfare to establish a Primary Health Care Data Unit and to develop a National Primary Health Care Data Asset in the 2018-2019 budget. While the Data Asset is an improvement on current data knowledge, the Australian Government needs to pursue a NMDS that will provide more useful knowledge on outcomes and usage to improve services. To be effective, the Australian Government must also recognise that some primary health care settings will need support to provide the data required for a NMDS; responsibility cannot be allowed to fall solely on already stressed parts of the healthcare system.

### Recommendations

The VHA echoes the calls of the Australian Healthcare and Hospitals Association for the creation of a national minimum data set for primary health<sup>34</sup>. The Australian Government must build on its National Primary Health Care Data Asset commitment by:

- supporting the Australian Institute of Health and Welfare to lead the development of a Primary Health Care National Minimum Data Set to map and chronicle primary healthcare, like other healthcare areas, so that patient outcomes and usage can be analysed, which should enable health services to improve healthcare provision
- ensuring alignment with other national data sets in health through a national data governance framework, to chronicle the entire health experience in Australia which will lead to service improvements
- ensuring that other aspects of primary health care services, such as community health

<sup>33</sup> Thorpe, M., Sweeney, S., 2019, *Call for the establishment of a primary health care national minimum data set*, Deeble Institute Issues Brief No. 29, Deeble Institute for Health Policy Research ([https://ahha.asn.au/system/files/docs/publications/deeble\\_issues\\_brief\\_no\\_29\\_primary\\_healthcare\\_nmds.pdf](https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_no_29_primary_healthcare_nmds.pdf))

<sup>34</sup> Australian Healthcare and Hospitals Association, 2019, *We need a national primary healthcare data set*, Media release, Australian Healthcare and Hospitals Association (<https://ahha.asn.au/news/we-need-national-primary-healthcare-data-set>)





services, are a key focus of data collection, and not just general practice, so that the full spectrum of primary care can be analysed

- ensuring that any increased reporting commitments on primary care services are reflected in funding increases, so that responsibility is not passed onto already stretched parts of the Australian health system.

**For more information, contact:**

Tom Symondson  
Chief Executive Officer  
[tom.symondson@vha.org.au](mailto:tom.symondson@vha.org.au)  
03 9094 7777

Emma Liepa  
Director of Policy and Strategy  
Email: [emma.liepa@vha.org.au](mailto:emma.liepa@vha.org.au)  
Phone: 03 9094 7777