COMMONWEALTH BUDGET 2017-18

Victorian Healthcare Association
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Victorian Healthcare Association Pre-Budget Submission:

2017-18 Commonwealth Budget

January 2017

Introduction

About the VHA

The Victorian Healthcare Association (VHA) welcomes the opportunity to contribute to the development of the 2017-18 Commonwealth Budget.

The VHA is the not-for-profit peak body supporting Victoria's public health services to deliver quality care. We represent public sector health services, hospitals, registered community health services, multi-purpose services, and bush nursing services.

The priorities and discussion presented in this document reflect the highest aim of the Victorian public health sector; that all Australians, regardless of socio-economic status or place of residence, can access safe, high-quality health, aged, disability and community care where and when they need it.

The recommendations we provide 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.

Summary of Recommendations

1. Reduce Unnecessary Admissions to Hospital

Prevention – Keeping People Well:

1. *Develop a long term National Prevention Strategy and provide adequate long term funding for prevention activities.*

Public Dental – Protecting Access for People in Need:

2. *Restore funding for the National Partnership Agreement for Adult Dental Services to at least pre-2016 levels.*

3. *Restore the $1000 cap for dental care for children under the Child Dental Benefits Scheme.*

4. *Commit to a long term funding deal (i.e. five years or greater) for Commonwealth funding of public dental services.*

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Health Care Homes – Improving Co-ordination of Care:

5. *Adequately fund the Health Care Homes trial to support the provision of coordinated and comprehensive care.*

6. *Allocate contingency funding beyond 30 June 2019 to extend the Health Care Homes initiative if successful.*

7. *Recognise the expertise of community health services in providing chronic disease management and engage them as partners in innovative chronic disease management projects including Health Care Homes.*

Residential Aged Care – Better Outcomes for Residents:

8. *Develop, implement and fund a strategy to reduce avoidable hospital admissions from residential aged care, which includes defining levels of appropriate clinical expertise in residential aged care settings.*

2. Match Funding to the Real Costs of Service Provision

Hospitals Beyond 2020 – Keeping Our Acute System Strong:

9. *Provide certainty of funding for public hospitals beyond 2020 in this year's budget as an interim step.*

10. *Commit to co-designing and securing long term funding arrangements for public hospitals with state and territory governments.*

Adequate NDIS Pricing – Retaining Quality Services:

11. *Revise the NDIS price caps to reflect the true cost of providing quality NDIS supports.*

Residential Aged Care Funding – A Fair & Transparent Model:

12. *Reverse its 2016 cuts to the Complex Health Care Domain of the Aged Care Financing Instrument.*

13. *Ensure that the review of the Aged Care Financing Instrument prioritises adequate funding that reflects the true costs of providing care and incentivises better health outcomes for older people.*

3. Address the Risks of Market Failure

The NDIS & Aged Care Reforms – Rural Areas & Complex Consumers:

14. *Develop a strategy to mitigate against the risk of market failure in aged care and NDIS services, particularly in rural areas and for people with complex or specialised service needs.*

15. *Implement mixed or block funding, as well as provider incentives, in areas of thin NDIS and aged care markets, particularly in rural areas or for providers that target and support complex and vulnerable clients.*

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Public Sector Health & Aged Care Services – An Alternate Approach:

16. *Increase aged care funding to explicitly meet the additional costs of operating services in rural areas, including travel costs.*

Multi-Purpose Services – Keeping Services in Rural & Isolated Communities:

17. *Increase aged care funding to multi-purpose services to match current day resident acuity, the costs of current day service provision, and equivalent rates received by mainstream residential aged care providers.*

18. *Allow multi-purpose services to charge partially supported residents accommodation contributions.*

19. *Pay multi-purpose services accommodation supplements, including the increased rate for significantly refurbished facilities.*

4. Align Sector Interfaces

Establishing a Mechanism to Resolve Interface Issues - Putting People at the Centre of Care:

20. *Develop and fund a co-designed strategy to address the needs of consumers and organisations across the health, aged, community and disability care sectors to ensure the interfaces between these sectors support better patient outcomes.*

NDIS Interface with Health - Improving Health Outcomes for People with a Disability:

21. *Allow and fund the continued inclusion of all services within current individual support plans for people transitioning to the NDIS.*

22. *Establish a mechanism to monitor the impacts of the NDIS on health services and to address interface concerns between all levels of government and relevant sector stakeholders.*

Mental Health Services – Right of Access for Those Not Eligible for the NDIS:

23. *Guarantee access to, and provide ongoing funding for, community mental health support services for those not eligible for the NDIS.*

5. Improve Data & Service Access

My Health Record – Supporting Seamless Provision of Health Care:

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

My Aged Care – Facilitating Better Access to Aged Care:

25. *Invest in the evaluation and improvement of the My Aged Care system to prevent unintended consequences and ensure better outcomes for consumers.*

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26. *Continue to fund and expand sector outreach and support roles that operate alongside the My Aged Care system to ensure access to aged care services for vulnerable consumers and those with particularly complex needs*.

6. Allow Health Services to Focus on Care

Streamlining Accreditation – Reducing Red Tape:

27. *Introduce and fund the implementation of mutual recognition of accreditation standards to remove unnecessary duplication and reduce regulatory burden for health services that provide a range of funded services.*

7. Ensure Patient Choice

Private Health Insurance – Protecting the Right to Choose:

28. *Commit to retain patient choice for privately insured Australians who elect admission in public hospitals as part of its review into private health insurance.*

1. Reducing Unnecessary Admissions to Hospital

The VHA believes in providing the right care at the right time and in the right place.

Unnecessary hospital admissions lead to poorer outcomes for patients and an inflated price tag for taxpayers. In a time of fiscal constraint, rapidly increasing demand for health care[1] and a growing emphasis on patient choice, high rates of avoidable hospital admissions are unacceptable.

By reducing unnecessary admissions we have an opportunity to improve system efficiencies, reduce cost, ease pressure on our hospitals and provide better care with less disruption to the lives of consumers.[2]

To keep people well and out of hospital Australia needs well-functioning and adequately resourced prevention, primary health, dental and aged care systems.

1.1 Prevention – Keeping People Well

It is essential to develop a highly functioning, coordinated preventive healthcare system in order to reduce the prevalence of chronic disease, prevent avoidable hospital admissions and improve the overall health of the community.[3]

Funding for preventative health produces significant health benefits and research demonstrates the substantial and long term returns on investment and cost savings of prevention activities.[4] [5]

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[1] AIHW 2014, *Australia's Health 2014,* Australian Health Series No. 14, Australian Institute of Health and Welfare, Canberra, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548150

[2] Katterl et al. 2012, *Potentially Avoidable Hospitalisations in Australia: Causes for Hospitalisation and Primary Health Care Interventions*, Primary Health Care Research & Information Service, http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_8388.pdf

[3] Wutzke, S. et al. 2016, *What Will it Take to Improve Prevention of Chronic Diseases in Australia? A Case Study of Two National Approaches,* Australian Health Review, www.publish.csiro.au/AH/pdf/AH16002

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The fact is that too many hospital admissions are attributed to avoidable illnesses and chronic disease.[6] It is clear that preventative health approaches can lower the rates of such illnesses and in turn lead to better outcomes for Australians and a decrease in overall health spending. For example, efforts to reduce smoking rates between 1975 and 1995 saved 400,000 lives and over $8 billion, more than 50 times the amount spent on smoking reduction activities.[7]

A 2008 study reported that for every dollar invested in proven community based disease prevention programs, such as 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.[8]

Commonwealth, state and territory governments need to work together to reduce the burden of chronic disease by developing strategic directions using an 'equity lens' to ensure that disadvantaged groups and communities are supported.

The Commonwealth Government has a vital role in setting national targets for health outcomes, and providing leadership and funding for preventive health. It should develop a long term approach to supporting preventive health underpinned by a National Prevention Strategy similar to the ceased National Partnership Agreement on Preventive Health (NPAPH).

The NPAPH, which was ceased in the 2014-15 Commonwealth Budget, provided a platform for directing prevention efforts across a range of areas and was well supported in the health sector. Some of its benefits included the provision of a forum for agencies to interact directly with the Commonwealth Government on prevention matters, the support and expansion of multi-faceted programs, improved coordination, and the development of improved data sets, evaluation, governance and upskilling of the prevention workforce.[9]

The Development of a new National Prevention Strategy must have significant long term funding arrangements that extend beyond one election cycle to ensure its success.[10]

Recommendations:

1. *Develop a long term National Prevention Strategy and provide adequate long term funding for prevention activities.*

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[4] Trust for America's Health, 2008, *Prevention for a healthier America, Investments in Disease Prevention Yield Significant Savings, Stronger Communities,* www.healthyamericans.org/reports/prevention08/Prevention08.pdf Returns on investment in public health: an epidemiological and economic analysis.
[5] Taylor, R. & Clements, M. 2001, *Returns on Investment in Public Health – An Epidemiological and Economic Analysis*, prepared for the Department of Health and Ageing, Canberra, 2003.
[6] Katterl et al. 2012
[7] Preventative Health Taskforce. 2009, *Australia: The Healthiest Country by 2020, National Preventative Health Strategy – The Roadmap for Action*, Commonwealth of Australian, Canberra, 2009 http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/CCD7323311E358BECA2575FD000859E1/$File/nphs-roadmap.pdf
[8] Trust for America's Health, 2008
[9] Wutzke, S. et al. 2016
[10] Ibid

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1.2 Public Dental – Protecting Access for People in Need

Oral health has a significant impact on a person's overall wellbeing and is a predictor of general health. Poor oral health negatively affects speech, social and psychological wellbeing, self-esteem and productivity.[11] Dental problems are also the second largest cause of avoidable hospital admissions in Victoria and the highest for Victorians aged under 25 years.[12]

Dental problems are preventable[13] but 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.[14]

In 2014-15 publically funded dental agencies treated more than 380,000 Victorians including 160,000 for emergency care[15] and also provided a wide range of other services including preventative health.

However, unlike other areas of health care, access to public dental health services in Victoria is not universal and as of June 2015, only one quarter of the 41 per cent of people eligible for public dental services access services.[16]

We are concerned that further cuts to public dental funding announced in December 2016 will lead to poorer oral health for vulnerable people who cannot afford private dental care.

The decisions by the former Health Minister Sussan Ley to reduce funding through the NPA to $320 million over three years (down from $155 million in 2016) and to decrease the cap for dental care for children under the CDBS from $1000 to $700 will reduce dentistry services available for disadvantaged and vulnerable adults and children.

To prevent this, funding for the National Partnership Agreement for Adult Dental Services (NPA), and the Child Dental Benefits Schedule (CDBS) should be returned to at least pre-2016 levels.

Long term funding arrangements for adult and child public dental are also required so that clients, public dental care providers and clinicians can have certainty of dental service provision and that the large proportion of the population that is not currently being reached can receive treatment.

The sector cannot operate effectively in an environment where funding is provided on an inconsistent, short term basis with no longer term certainty and the possibility of cuts to funding with only a few weeks' notice. More sustainable funding of the public dental

[11] Katterl et al. 2012
[12] Taylor. R & Clements, M. 2001
[13] Victorian Auditor General, 2016, *Access to Public Dental Services in Victoria,* Paper No 227, Session 2014-16, December 2016
[14] Saunders, A. 2007, *Social Determinants of Oral Health: Conditions Linked to Socioeconomic Inequalities in Oral Health in the Australian Population,* Australian Research Centre for Population, Oral Health, Australian Institute of Health and Welfare, 2007
[15] Dental Health Services Victoria, 2015, *Dental Health Services Victoria Annual Report 2014/15*, https://www.dhsv.org.au/__data/assets/pdf_file/0016/51118/annual-report-2015.pdf
[16] Victorian Auditor General, 2016

sector is required in order to reduce waiting times for care, reduce unnecessary hospital admissions, and provide clients with a preventive approach to dental care.

Recommendations:

2. *Restore funding for the National Partnership Agreement for Adult Dental Services to at least pre-2016 levels.*

3. *Restore the $1000 cap for dental care for children under the Child Dental Benefits Scheme.*

4. *Commit to a long term funding deal (i.e. five years or greater) for Commonwealth funding of public dental services.*

1.3 Health Care Homes – Improving Coordination of Care

The VHA welcomes the Government's Health Care Homes initiative and believes patient enrolment and bundled payments for those with chronic disease may provide an answer to managing the growing burden of chronic disease and preventing avoidable hospital admissions.[17] [18] However, this trial must be adequately resourced and the VHA has concerns that current funding levels may be setting the trial up to fail.

The burden of chronic disease is extremely significant. Approximately 35 per cent of people have at least one chronic condition[19] and in 2008-09 chronic disease was conservatively estimated to cost $27 billion to the health system.[20]

In 2013-14, 285,000 possibly avoidable hospital presentations were attributable to chronic conditions.[21] Some estimates indicate that the cost of potentially preventable hospital admissions due to chronic disease could be up to $2 billion per year and even conservative estimates indicate a cost of over $320 million annually.[22]

The current fee-for-service Medicare payment arrangements are appropriate for episodic management of acute conditions but do not support best practice management of chronic disease. Fee-for-service models fail to encourage coordination or innovative in practice and do not incentivise general practitioners to make better use of nurses, allied health and other disciplines.[23]

The VHA considers that optimal management of chronic disease, characterised by care coordination is required to address the burden of chronic disease and to improve the health and wellbeing of the Australian population.

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[17] Kalucy, L. Katterl, R. Jackson-Bowers, E. & Hordacre, A-L. 2009, *Models of patient enrolment: Policy issues review*, Primary Health Care Research & Information Service, Adelaide.
[18] Australian Government, Department of Health, 2015, *Better Outcomes For People With Chronic and Complex Health Conditions,Report of the Primary Health Car Advisory Group*, Commonwealth of Australian, 2016
[19] AIHW 2014
[20] Ibid
[21] Ibid
[22] Swerissen, H. & Duckett, S. 2016, *Chronic failure in primary care*, Report No. 20126-2, Grattan Institute, March 2016
[23] Ibid

The trial of Health Care Homes will provide an important opportunity to evaluate the impact of patient enrolment and bundled payments on care coordination and patient outcomes.[24]

Both Primary Health Networks and participating practices must be adequately funded for the time and expertise required to coordinate care, develop strategic partnerships and provide comprehensive treatment.

Additionally, we note that no funding has been committed beyond the conclusion of the trial on 30 June 2019 and we recommend that Government allocate contingency funding beyond this point to ensure its continuation if successful.

Furthermore, we encourage the Commonwealth to partner with Victorian community health services that have already implemented sophisticated, coordinated care models and are ideally placed to trial and deliver innovative chronic disease management programs, such as Health Care Homes.

Recommendations:

5. *Adequately fund the Health Care Homes trial to support the provision of coordinated and comprehensive care.*

6. *Allocate contingency funding beyond 30 June 2019 to extend the Health Care Homes initiative if successful.*

7. *Recognise the expertise of community health services in providing chronic disease management and engage them as partners in innovative chronic disease management projects including Health Care Homes.*

1.4 Residential Aged Care – Better Outcomes for Residents

Older people receiving aged care have the same rights to access the public healthcare system (including hospitals and emergency departments) as any other member of our society. It is also true that residential aged care facilities are peoples' homes and should not feel like an acute health setting.

However, to respond to rising trends in acuity and complexity, aged care services require a highly skilled and interdisciplinary aged care workforce inclusive of registered and enrolled nurses, allied health professionals, and general practitioners to deliver the appropriate level and quality of care.

The negative impacts of transferring older people living in residential aged care to hospital emergency departments are well known and include increased risk of delirium and other iatrogenic events such as falls, medication errors, pressure injuries, deconditioning and death.[25] The benefits of minimising unnecessary transfers to emergency departments, for both the resident and the healthcare system include:

[24] Ibid
[25] Hulick et al. 2016, 'Emergency Department Transfers and Hospital Admissions from Residential Aged Care Facilities: A Controlled Pre-Post Design Study', *Bio Med Central Geriatrics,* Vol. 16, No. 102,

- reduced morbidity and mortality of older people;
- reduction in costs associated with emergency transport; and
- increased ability of emergency department staff to more effectively and efficiently manage emergency patients.[26]

Residential facilities report that the factors influencing staff to transfer residents to emergency departments include:

- delays to review by a general practitioner (GP);
- limited operating hours of primary care services; and
- limitations in residential aged care facility services such as staff skill mix and inadequate equipment.[27]

Public sector residential aged care facilities provide nurse-led, clinically focused care that does not exist in the private or community sectors. In fact, the public sector spends over three and a half times more on care management than the community sector and over five times more than the private sector.[28]

Despite the accepted benefits of providing clinical care at residential facilities and preventing unnecessary hospital admissions, avoidable hospital transfers from private and community sector residential aged care facilities continue to increase.

The Commonwealth should take the lead and work with state and territory governments to develop and implement a strategy to reduce avoidable hospital admissions of aged care residents.

This strategy should aim to improve the health and wellbeing outcomes of older Australians and ensure they are receiving the care they need in their preferred setting.

Such a strategy should investigate the barriers to GP involvement in residential aged care and address how the GP workforce can be financially incentivised to deliver appropriate care to older people regardless of where they are living.

It should also consider requirements for an appropriate level of clinical expertise and quality of care in residential aged care facilities to reduce the avoidable transfers of residents to emergency departments in order to reduce the burden on the public health sector and improve health outcomes for older people.

Recommendation:

8. *Develop, implement and fund a strategy to reduce avoidable hospital admissions from residential aged care, which includes defining levels of appropriate clinical expertise in residential aged care settings.*

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http://web.a.ebscohost.com.ezproxy-b.deakin.edu.au/ehost/pdfviewer/pdfviewer?sid=ae14f8b4-9d34-4dc3-8252-62731e7fc4b5%40sessionmgr4008&vid=0&hid=4112

[26] Ibid

[27] Morphet et al. 2015, 'Resident transfers from aged care facilities to emergency departments: can they be avoided?', *Journal of Emergency Medicine Australasia, Vol.* 27, No. 5, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4745031/

[28] ACFA 2016b

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2. Matching Funding to the Real Costs of Service Provision

2.1 Hospitals Beyond 2020 – Keeping Our Acute System Strong

The VHA supports universal healthcare and welcomes the sharing of this core priority between the Commonwealth, states and territories. We also recognise the key role that the Commonwealth plays in the leadership and resourcing of this important public asset.

We welcomed the re-commitment from the Commonwealth in last year's Heads of Agreement to activity based funding. We also supported its budget commitment for hospital funding of $17.9 billion in 2016-17 rising to $21.1 billion by 2019-20. However, we consider that more needs to be done to fund public health adequately and provide long-term certainty.

Victorian health services are a significant part of the public and not-for-profit sectors and employ well in excess of 80,000 people state wide. It is essential that health services have full confidence that the healthcare to which they dedicate time and resources will have long term funding certainty. Long term funding arrangements are also required to allow health services to plan for any changes to their workforce and service provision arrangements.

Members of the public reasonably expect a high level of service provision, reliability, and system performance. Funding changes and short term funding arrangements can jeopardise the standards of health service delivery, impact performance and ultimately impact patients.

As a principle all funding arrangements should be negotiated with state and territory governments and no unilateral funding decisions should be made by the Commonwealth, particularly where it translates to a reduction or halting of its contributions as this has the effect of cost shifting to state and territories or forcing health services to reduce capacity and service delivery.

The current funding agreement for public hospitals will last until 2020. The COAG Heads of Agreement anticipates the development of a long term public hospital funding agreement from 1 July 2020, which is to be considered by COAG before September 2018.

However, in the interim, certainty of the Commonwealth's commitment to the public health system is required in this year's budget in order to allow public hospitals to plan their services into the future. We urge the Commonwealth to extend the funding agreement for public hospitals beyond 2020 as a matter of urgency.

Once this immediate certainty is provided, all long term funding agreements should be co-designed between the Commonwealth, state and territory governments and be protected from unilateral decisions by the Commonwealth.

Recommendations:

9. *Provide certainty of funding for public hospitals beyond 2020 in this year's budget as an interim step.*

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10. *Commit to co-designing and securing long term funding arrangements for public hospitals with state and territory governments.*

2.2 Adequate NDIS Pricing – Retaining Quality Services

The National Disability Insurance Scheme (NDIS) represents a significant milestone for people living with disability and will drive real and positive change in disability services.

It is widely labelled as the most significant reform since the introduction of Medicare and will present significant and complex challenges for the disability, health and community services sectors.

It is crucial that this major reform builds upon the existing quality service system and improves services available to people with a disability. To achieve this, rates under the NDIS pricing framework must be adequate to support high quality service delivery.

The stated aim of the price caps for NDIS support services set by the National Disability Insurance Agency (NDIA) is to ensure the sustainability of the scheme whilst balancing a reasonable price for supports.

However, the VHA is concerned that some of the key price caps in the metropolitan, rural and very remote price guides fail to adequately cover the costs of providing quality supports, particularly to people with complex needs and when travelling over long distances.

If providers are not able to operate within the published price caps, there is a risk that long standing service providers will not be financially viable under the NDIS and may opt-out of service provision, leaving vulnerable clients stranded.

There is no evidence to support the assumptions that underpin the price caps set by the NDIA[29] and if the levels of these caps are not revisited there is a risk that the prices will undermine the availability, quality and diversity of supports available to people with disabilities.

The NDIA acknowledges the variability of costs by applying increased price loadings for the delivery of supports to participants in remote and very remote parts of Australia.[30] However, in many cases these loadings do not meet the costs of providing support, particularly to people with complex needs.[31] Additionally, there are no allowances for areas of potentially thin markets in regional and metropolitan areas.

The VHA is concerned that in environments which are financially constrained, services will not be incentivised to seek out the most disadvantaged clients and may instead look

[29] National Disability Services 2016, *Human Services: Identifying sectors for Reform Submission to the Productivity Commission,* NDS, http://www.pc.gov.au/__data/assets/pdf_file/0013/205123/sub262-human-services-identifying-reform.pdf
[30] National Disability Insurance Agency, 2016, *2016/17 Price Guide for NDIS Service Providers,* Pricing and payment website section, accessed 7 December 2016, https://www.ndis.gov.au/providers/pricing-and-payment.html
[31] National Disability Services 2016

to manage clients who provide the least barriers to positive outcomes,[32] leaving vulnerable people at risk.

To support providers to deliver quality services to all Australians that require them, the NDIS price guides must reflect the true costs of providing disability care across rural, remote and metropolitan areas. An analysis of these costs should be undertaken in order to update the NDIS price caps.

Recommendation:

11. *Revise the NDIS price caps to reflect the true cost of providing quality NDIS supports.*

2.3 Residential Aged Care Funding – A Fair & Transparent Model

Last year's Commonwealth Budget introduced measures, in addition to those announced in the Mid-Year Economic and Fiscal Outlook Report 2015-16, to reduce the growth in Aged Care Financing Instrument expenditure.

Even noting the modest concessions announced by the Department of Health on 7 December 2016,[33] the VHA believes that an across the board cut such as this, penalises all providers because of the actions of a few and will have significant implications for the public sector's ongoing viability.[34]

The nature of the proposed changes – particularly the action to stem growth in the Aged Care Financing Instrument rates by targeting the Complex Health Care domain – will disproportionately affect public sector providers whose service model is underpinned by a focus on quality clinical care for complex and disadvantaged residents requiring a highly qualified and skilled workforce.

While the VHA understands the need for budget repair, the impacts of funding changes must be fairly distributed so that public sector providers of residential aged care can continue to deliver the level of care older people deserve.

The VHA understands that there is a long term review of the funding instrument underway, which will seek to prioritise transparency and independence. The development of such an instrument is complex and involves many variables. However, it also presents a clear opportunity to explore approaches that incentivise reablement and improvement in the health outcomes of older people in residential aged care. Whilst it is crucial to ensure funding levels match the true cost of providing complex health care services, the new residential funding approach should as a matter of priority incentivise better outcomes for older people.

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[32] Queensland Council of Social Services, 2016, *Competition in the Human Services, Safeguarding Access for the Most Vulnerable Clients, A QCOSS Discussion Paper,* September 0215, https://www.qcoss.org.au/what-are-your-thoughts-about-competition-human-services

[33] Australian Government 2016, *Fact Sheet Changes to Residential Aged Care funding Arrangements – 1 January 2017,* Department of Health, 7 December 2016, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/12_2016/changes_to_residential_aged_care_funding_arrangements_1_january_2017.pdf

[34] ACFA, 2016, *Fourth report on the Funding and Financing of the Aged Care Sector*, Aged Care Funding Authority, July 2016, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2016/ 2016_report_on_the_funding_and_financing_of_the_aged_care_industry.pdf

Recommendations:

12. *Reverse its 2016 cuts to the Complex Health Care Domain of the Aged Care Financing Instrument.*

13. *Ensure that the review of the Aged Care Financing Instrument prioritises adequate funding that reflects the true costs of providing care and incentivises better health outcomes for older people.*

3. Addressing the Risks of Market Failure

3.1 Aged Care & NDIS Reforms – Rural Areas & Complex Consumers

The aged care reforms and the NDIS have introduced individualised funding models. Individualised funding models paid in arrears are less stable than other funding approaches and require that providers operate with sufficient economies of scale to be sustainable. This presents obvious risks in situations where there is not adequate demand to allow providers to reach economy of scale.

The VHA is particularly concerned for rural communities and for people with very complex or specific service requirements, as it is likely that in these situations there will not be adequate demand to viably run an organisation and to 'keep the doors open'.

The Productivity Commission has recognised that a competition model based on individualised funding would not work for specialised services or in rural and remote areas. For this reason, it concluded that the 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.[35]

Similarly, the NDIA itself has acknowledged that 'weak' or 'thin' markets will continue to exist, primarily in rural, regional and remote areas due to insufficient local demand, limited service delivery, workforce shortages and lack of infrastructure.

Importantly, the Australian Auditor General has concluded that the Department of Social Services and the NDIA must continue to have a role in identifying and resolving market gaps and risks for many years to come.[36]

People in rural areas have a right to access services they require including home care, residential aged care and disability services. If alternate funding arrangements are not built into the system the result will be poorer outcomes for participants including less choice, service gaps, higher prices and/or lower quality supports and services.[37]

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[35] Productivity Commission, 2011, *Caring for Older Australians,* Australian Government, Canberra
[36] Auditor-General, 2016, *National Disability Insurance Scheme – Management of the Transition of the Disability Services Market, Department of Social Service, National Disability Insurance Agency*, Australian National Audit Office, Report No.24 2016-17, Performance Audit, Commonwealth of Australia, Canberra
[37] National Disability Insurance Agency, 2016, *NDIS Market Approach: Statement of Opportunity and Intent,* NDIA, November 2016

To date, little has been done to address these challenges and mitigate against the risk of market thinning and failure. The Government must invest in measures to protect Australians' right to access the care they need in or nearby their local communities.

In order to ensure the continuation of a wide range of services that are reflective of consumer need, the Government should put in place protections that allow public providers and smaller, specialist services the opportunity to participate and contribute to a diverse marketplace.

A strategy should be co-designed with the sector to mitigate risks and put in place a safety-net system where a fully competitive, market-based and individualised funding model will not operate effectively.

Alternate funding models (including fixed or block funding) should be made available in both geographical areas of thin and failing markets; and for service tailoured for complex consumers requiring specialised services.

Additionally, incentives should be introduced into provider payment systems to ensure that the most vulnerable clients can access services, rather than be abandoned because their often complex needs are not adequately catered for by a poorly regulated market.

Recommendations:

14. *Develop a strategy to mitigate against the risk of market failure in aged care and NDIS services, particularly in rural areas and for people with complex or specialised service needs.*

15. *Implement mixed or block funding, as well as provider incentives, in areas of thin NDIS and aged care markets, particularly in rural areas or for providers that target and support complex and vulnerable clients.*

3.2 Public Sector Health & Aged Care Services – An Alternate Approach

The unique demands of service provision in rural and regional areas, including the challenges highlighted above, have generated different approaches to service delivery.[38]

In Victoria, for example, it has seen public health services deliver aged care services to secure provision of aged care in locations where other private for profit and not-for-profit organisations opt not to operate.

These public sector health services and aged care facilities have remained sustainable despite low demand because of this co-location of services and the application of a more flexible funding model.

The benefits are considerable and include:

- ensuring access to aged care services in rural communities;

[38] Baldwin et al. 2013

- 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; and
- services acting as a key driver of financial sustainability for their towns, often acting as one of the largest employers.

However, for this model to be sustainable into the future, aged care funding rates must be commensurate with the full cost of rural service provision. Rural providers face an array of additional expenses including:

- higher workforce costs to engage, develop, retain and manage staff across greater distances;
- higher travel, freight and fuel costs;
- higher set operational costs such as administration, hotel services, catering, linen and facility services.[39]

To support public sector providers of aged care services to deliver affordable, accessible and sustainable services in rural areas, aged care funding models must reflect the true costs of providing care in rural areas.

Recommendation:

16. *Increase aged care funding to explicitly meet the additional costs of operating services in rural areas, including travel costs.*

3.3 Multi-Purpose Services – Keeping Services in Rural & Isolated Communities

Multi-purpose services are integrated health, aged and community care services. They provide flexible and sustainable service options for small rural and remote communities that due to likely market failure, would not otherwise receive these crucial services. Victoria has seven multi-purpose services collectively operating campuses in eleven different communities and acting as the sole provider of residential aged care in ten of these.[40]

Multi-purpose services are frequently the main employer in the communities in which they are located. In fact the seven multi-purpose services in Victoria employ almost 1000 people in medical, nursing and ancillary jobs. Multi-Purpose Services are therefore also key local economic drivers, playing a pivotal role in keeping the entire community sustainable.

Commonwealth and state funds for health and aged care services are pooled to allow multi-purpose services to coordinate and tailor their services and staffing models in a flexible manner. Multi-purpose services are able to gain some scale by amalgamating health, disability and aged care services and their service flexibility means they are able to be highly responsive to community need.[41] This significantly expands the range of

[39] Ibid
[40] DHHS 2015, *Victorian Multipurpose Services, Aged Care Funding: Preliminary Financial Modelling*, Department of Health & Human Services, Ageing & Aged Care Branch, State Government of Victoria.

services available in these areas, particularly for community and primary health services.[42]

An evaluation undertaken for the Commonwealth Department of Health has described multi-purpose services as an *exemplar* model of health service delivery for small rural communities and concluded that they deliver significant benefits to communities and clients, improve service availability and responsiveness, and are more cost-effective than other service structures.[43]

The aged care funding component for multi-purpose services is treated differently to funding provided to other mainstream aged care providers. Unfortunately, funding rates for residential aged care delivered by multi-purpose services have not been altered or reviewed since their inception more than 20 years ago and fail to reflect current day costs of care. While funding for mainstream services has increased substantially over this time, the rate of Commonwealth funding for multi-purpose services has not increased to reflect rising resident acuity, or the increasing costs of providing aged care services.[44]

Modelling comparing multi-purpose services to equivalent Victorian public sector rural services, indicates that, on average, Victorian multi-purpose services are receiving $25 per resident per day (or 18 per cent) less in federal funding for their residential high care beds, and $57 per day (or 65 per cent) less for their low care beds.[45] By way of example, one service with 24 high care beds and 30 low care beds is currently being underfunded by over $930,000 annually. Across the state the funding shortfall represents a gap of almost $5 million per year across the seven multi-purpose services.

The VHA is concerned that despite their vital role, the Commonwealth aged care funding contribution for multi-purpose services has failed to keep pace with need. To keep these valuable services in rural and isolated communities, funding rates must be reviewed and fully funded as a matter of urgency.

Furthermore, the Commonwealth prevents multi-purpose services from charging accommodation contributions from partially supported residents and does not provide multi-purpose services with accommodation supplements for fully and partially supported residents. This is inconsistent with funding arrangements for all other aged care providers and prevents multi-purpose services from reaping the benefits of the increased supplement rate for significantly refurbished or newly built facilities.

These determinations are inconsistent with the direction of the aged care reforms, discourage service delivery to residents with limited financial means and mean that multi-purpose services have limited resources and no incentive to upgrade their infrastructure.

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[41] Anderson & Malone 2014, *Suitability of the Multi-Purpose Service Model for Rural and Remote Communities of Australia,* Asia Pacific Journal of Health Management, 9:3
[42] Sach & Associates, 2000, *Multi-Purpose Services Program Evaluation (Victoria),* prepared in association with Centre for Applied Gerontology, Prepared for Commonwealth Department of Health and Aged Care & the Victorian Department of Human Services, November 2000
[43] Ibid
[44] DHHS 2015
[45] DHHS 2015

Recommendations:

17. *Increase aged care funding to multi-purpose services to match current day resident acuity, the costs of current day service provision, and equivalent rates received by mainstream residential aged care providers.*

18. *Allow multi-purpose services to charge partially supported residents accommodation contributions.*

19. *Pay multi-purpose services accommodation supplements, including the increased rate for significantly refurbished facilities.*

4. Aligning Sector Interfaces

4.1 Establishing a Mechanism to Resolve Interface Issues - Putting People at the Centre of Care

People access services from a range of sectors across their life span. It is also common for people to receive multiple services from multiple systems at the same time.

For example the majority of consumers of aged care also require health services. Many others will also require disability, community services and eventually palliative care. This results in multiple transitions between service settings and the engagement of multiple systems by consumers at any given time.

Therefore policies and strategies are required to ensure people can receive care and support in the most appropriate setting, are supported to transition between service settings, and are able to receive services from multiple sectors in an integrated way.

To support this, payment arrangements and service delivery models must promote service flexibility and innovation, and aim to dissolve funding and program silos.

Policy changes in one sector must not lead to unintended consequences in another and the risk of this increases with the roll-out of major reform agendas such as national aged care reforms, the NDIS, and the Health Care Homes initiative.

Given the complex reforms taking place, it must be the Commonwealth that takes the lead to initiate, in discussion with its state and territory counterparts, solutions to address interface issues.

A strategy is required to address the needs of consumers and organisations across the health, aged, community and disability care sectors.
The strategy should seek to ensure the provision of effective and equitable service outcomes for people receiving services and must start from a shared understanding and purpose between health, aged care and disability sectors, as well as between state and federal governments.[46]

[46] AHHA 2016, *Cross-Sector Care Simulation, Reform Processes and the Interface between Disability Services, Aged Care and Health,* Australian Healthcare & Hospitals Association, November 2016

Recommendations:

20. *Develop and fund a co-designed strategy to address the needs of consumers and organisations across the health, aged, community and disability care sectors to ensure the interfaces between these sectors support better patient outcomes.*

4.2 NDIS Interface with Health - Improving Health Outcomes for People with a Disability

The smooth transition to the NDIS relies on successful collaboration within and across governments and effective support for people with a disability, families, carers and service providers to transition to the NDIS.

It is essential that the Government monitors the NDIS as it rolls out to ensure that the health, aged care, mental health and disability needs of Victorians continue to be met.

The NDIS will intersect with the health system on a number of levels, including:

- NDIS participants will continue to require clinical treatment, health and rehabilitation services;
- healthcare providers will have an important role in navigation and support role in assisting people access the scheme; and
- many healthcare providers may also decide to become NDIS providers.

Despite this clear overlap, the roll-out of the NDIS has in some cases created artificial barriers between 'health' and 'disability' needs, which actively work against the provision of integrated and holistic care.

It will be crucial to monitor the scheme's interface with the health system to ensure that:

- perverse incentives are not created that work against the wellness and recovery approach; and
- service delivery for NDIS participants is outcome focused and responsive to individual goals, rather than on cost shifting between the NDIS and state health systems.[47]

We are particularly concerned about Victorians who currently receive disability services and individual support plans via state programs and that have health services included as a core part of their care packages. These crucial services must be continued for this cohort who cannot afford to have their health services discontinued or be made to wait as part of their transition to the NDIS.

The VHA recommends that the Commonwealth establishes a clear mechanism for different levels of government, the NDIA, healthcare providers and the disability sector to work collaboratively to address interface issues in a collaborative way and resolve gaps, overlaps, inconsistencies and tensions where they exist.

[47] Deeble Institute, 2014, *Implications of the National Disability Insurance Scheme for health service delivery*, Deeble Institute Issues Brief, No.NLCG-5, Australian Healthcare and Hospitals Association, 23 June 2014, Canberra.

Recommendations:

21. *Allow and fund the continued inclusion of all services within current individual support plans for people transitioning to the NDIS.*

22. *Establish a mechanism to monitor the impacts of the NDIS on health services and to address interface concerns between all levels of government and relevant sector stakeholders.*

4.3 Mental Health Services – Right of Access for Those Not Eligible for the NDIS

As part of the transition to the NDIS, Victoria has committed all of the funding previously used to deliver community based mental health services. Victoria is the only state that has done this, and it means that there will be a significant gap and risk for Victorians that require mental health services but who may not be eligible for the NDIS.
It is currently estimated that as many as 10,000 Victorians living with mental illness will be unable to access an appropriate service in the NDIS full scheme environment.[48]

We are concerned that these Victorians - many of whom are currently receiving care through the mental health community support services program - will find themselves without access to an equivalent support.

The VHA is also concerned that these people may then end up requiring higher acuity health services, such as emergency hospital care or acute inpatient mental health care. This would lead to poorer outcomes for Victorians as well as a much higher financial impact to the health system. This is a significant risk to both clients and health services and must be addressed as a matter of priority.

In this context, we welcome the Joint Standing Committee on the NDIS *Inquiry into the Provision of NDIS Services for People with Psychosocial Disabilities*.

In particular we support the inclusion in the terms of reference of 'the transition to the NDIS of all commonwealth and state government funded services, in particular whether they will continue to be provided for people who are ineligible for the NDIS'.

Regardless of the outcome of the inquiry we strongly advocate that access to community mental health services for those that require them but are not eligible for the NDIS be guaranteed and adequately funded.

Recommendation:

23. *Guarantee access to, and provide ongoing funding for, community mental health support services for those not eligible for the NDIS.*

[48] VICSERV 2016, *State Budget Submission 2017-18 Towards a Responsive Mental Health System in Victoria,* Psychiatric Disability Services of Victoria

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5. Improving Data & Service Access

5.1 My Health Record – Supporting Seamless Provision of Health Care

The VHA commends the introduction of a streamlined single electronic record with the ability to support the provision of care across providers and to share information.

However, the uptake of My Health Record has been slow. The VHA welcomed the trials of an 'opt-out' model and believes it should be expanded in order to drive broad adoption of My Health Records.

For My Health Record to create an effective and integrated eHealth system, it must be interoperable with the ICT systems of a range of health services including hospitals and community health services.

Currently, there is insufficient support for health services to dedicate time and resources to implementing and upgrading their ICT systems to effectively interface and integrate with My Health Record. Investment is required to support health providers to introduce the necessary systems and hardware.

Recommendation:

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

5.2 My Aged Care – Facilitating Better Access to Aged Care

The VHA fully supports the intent of My Aged Care to provide a central, identifiable entry point through which older people, their families and carers can easily access information and locate services available to them.

However a number of issues require further attention in order to ensure that My Aged Care achieves its intended outcomes. Issues that have been raised with the VHA have been numerous and while many can be attributed to transition adjustments, others point to a system design that creates unnecessary barriers to service access, as well as between health and aged care services. They relate to:

- accessibility of the new system to consumers, particularly those with complex needs;
- people falling through the cracks and failing to access required services;
- barriers for vulnerable and hard to reach consumers that approach their local integrated health services or other community services directly;[49]
- the lack of interface with the health system and confusion in the health sector about how to engage with the system;
- incompatibility with the multitude of other client management systems operating across health services;
- interruption to well-functioning and established networks that promote better consumer outcomes;

[49] Queensland Council of Social Services 2016

- disruption to hospital discharge planning; and
- longer assessment waitlists and higher risk of readmission or deterioration as consumers await assessment and the timely commencement of services.

More investment is needed in the evaluation and improvement of the My Aged Care system to overcome these unintended consequences and ensure it can fulfil its intended purpose.

It is equally important to understand that a centralised intake system will simply not work for everyone.

Health services have reported to the VHA that, based on previous experience with central intake systems and their impact on vulnerable cohorts, they anticipate a proportion of their community will choose to opt out of the new system and instead rely on family and other informal supports until they reach crisis point. This will lead to substantially poorer outcomes for these individuals and their families, and result in the need for more expensive and invasive supports and care.

To prevent this, outreach and supported entry to My Aged Care for these cohorts must be funded and implemented. Service approaches must also be more flexible so as to give providers the ability to engage when people present, ensuring a 'no-wrong-door' approach.

Recommendations:

25. *Invest in the evaluation and improvement of the My Aged Care system to prevent unintended consequences and ensure better outcomes for consumers.*

26. *Continue to fund and expand sector outreach and support roles that operate alongside the My Aged Care system to ensure access to aged care services for vulnerable consumers and those with particularly complex needs*.

6. Allowing Health Services to Focus on Care

6.1 Streamlining Accreditation – Reducing Red Tape

Accreditation against quality standards is a crucial element of ensuring the high quality of government funded services.

However, the VHA considers that all accreditation should result in clear quality and safety benefits to service users and must not be designed and implemented in a way that imposes unnecessary administrative burden or waste of public funds.

As many of Victoria's health services and community health organisations provide multiple services across the health, aged, disability and community care spectrum, they are currently required to 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.

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This represents a significant resource and cost impost and specific issues include:

- Multiple accreditation of individual services;

  Some service types are subject to accreditation by multiple bodies and against multiple standards. In some cases, this can lead to a single service being subjected to numerous reviews by separate bodies.

  In addition, services may also be subject to state accreditation in areas such as community care, child and family services and disability services.

- Variation;

  While many accreditation processes assess overlapping areas these areas are assessed against differing standards, requiring significant duplication of effort on the part of services.

- Timelines;

  Most accreditation is carried out on a three yearly basis, however each set of standards has differing requirements for mid-cycle updates or re-accreditation, and accreditations by different organisations are not generally synchronised. This can lead to multiple accreditations taking place over a short period of time.

- Resources burden; and

  The number of processes, for health services who typically provide multiple accredited services, places an enormous financial and time burden on the management and staff of those services.

  By way of example quality compliance requires a Victorian small rural service with a total 80 EFT to allocate greater than 2 EFT to Quality Coordination, with 1 EFT dedicated to continuous documentation of self-assessment processes.

- Staffing.

  Personnel with specialised knowledge and experience are required to work effectively in quality roles and health services report that they are increasingly experiencing difficulties (particularly in rural areas) in recruiting and retaining people in these positions due to the increasing complexity and stress.

The Commonwealth should implement mutual recognition of accreditation standards to reduce overlap and duplication and to save public funds.

Mutual recognition would allow organisations that provide a range of services to have their accreditation against overlapping standards recognised, then only if required, be assessed for specific service types (e.g. residential care). This would avoid multiple assessments of similar areas such as corporate policy or management processes and significantly reduce the current regulatory impost.

Some start-up funding would be required to support trials and implementation of mutual recognition, but would ultimately result in reduced costs for both government and health services.

Recommendation:

27. *Introduce and fund the implementation of mutual recognition of accreditation standards to remove unnecessary duplication and reduce regulatory burden for health services that provide a range of funded services.*

7. Ensuring Patient Choice

7.1 Private Health Insurance – Protecting the Right to Choose

The VHA is a staunch advocate on behalf of the public health system and its hospitals. However, we also recognise that for many Australians, private health is a personal preference.

It is important that those people who opt to take out private health insurance policies receive fair benefits for their investment, particularly when health insurance premiums are rising at rates far exceeding CPI.

There is currently much debate surrounding private health insurance and the value it delivers to policy holders in Australia. In 2015-16 the proportion of the Australian population with private hospital treatment coverage declined for the first time since 2010, reducing to 46.9 per cent.[50]

Additionally, the Private Health Insurance Ombudsman received 4,265 complaints in 2014-15. This represents a 24 per cent increase from the previous year, which increased again in 2015-16 to 4,416 complaints.[51]

The VHA has also been particularly concerned by reports that some private health funds have been advising their members against using their health cover in public hospitals.

This is particularly problematic for Australians living in rural areas where accessing healthcare can be difficult and long distances between health services force people to travel outside their region when specialist or complex care is needed.

In many rural areas the local public hospitals operate as the sole provider of acute and community based care. This means that those in rural areas who wish to use their private insurance are therefore forced to either elect to be admitted as private patients in their local public hospital or travel long distances to the closest regional or metropolitan private hospital.

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[50] Australian Prudential Regulation Authority, 2016, *Statistics, Private Health Insurance Membership and Coverage,* November 2016, Sydney http://www.apra.gov.au/PHI/Publications/Documents/1611-MemCov-20160930.pdf

[51] Private Health Insurance Ombudsman, 2016, *Private Health Insurance Ombudsman Additional Information for 2015-16,* Commonwealth Ombudsman, http://www.ombudsman.gov.au/__data/assets/pdf_file/0020/41672/PHIO-Annual-Report-2015-16-additional-information.pdf

We welcome the Government's review into private health insurance and support the right to choice for people with private health insurance. In this context, it is critical that no new restrictions are applied to patients who elect to be admitted to public hospitals using their private health cover.

Recommendation:

28. *Commit to retain patient choice for privately insured Australians who elect admission in public hospitals as part of its review into private health insurance.*

Further information

For further information, please contact:

Nina Bowes
Manager of Member Projects & Policy Advisor
Victorian Healthcare Association
Nina.Bowes@vha.org.au
03 9094 7777

Tom Symondson
Chief Executive Officer
Victorian Healthcare Association
Tom.Symondson@vha.org.au
03 9094 7777