2020-2021
COMMONWEALTH BUDGET SUBMISSION

The Victorian Healthcare Association is the peak body supporting Victoria's health services to deliver high quality care. Established in 1938, the VHA represents the Victorian $20 billion 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, delivering vision, value and voice for the Victorian health sector. In addition, the VHA assists its members with the implementation of major system reform.

While our healthcare system delivers some of the highest quality care of any system anywhere in the world, it is under pressure due to a number of well-established factors.

The VHA's submission to the Royal Commission into Aged Care Quality and Safety highlighted that providers are struggling with increased demand and acuity and residents in public sector facilities receive inequitable funding when compared with their private counterparts. Participants of the National Disability Insurance Scheme (NDIS) are also unfairly hampered by geography and insufficient support for providers, limiting their access to care in areas of thin market in Victoria and in regions that are remote, but not sufficiently remote to qualify for the funds needed to deliver care.

This budget offers an opportunity to create change that ensures equitable access to health and disability care for all Australians.

• Remove the Adjusted Subsidy Reduction to create equity for public residents

Policy area

Aged care

Cost

$14.7 million

Background

Residents in public sector aged care beds experience significant inequity as they receive less Commonwealth funding for their care and accommodation than those in non-government services. This funding shortfall also seriously impacts on the viability of public sector aged care services.

The Adjusted Subsidy Reduction, which applies to aged care services operated by state/territory governments, applies a reduction of $13.39 per day per resident and results in approximately a nine per cent reduction of the average Aged Care Funding Instrument (ACFI) subsidy for public residents.

Each resident in a public sector aged care bed receives approximately $4,800 less per year than a resident in a non-government bed.

The recent Australian National Aged Care Classification fixed cost analysis concluded that the ASR should be discontinued and the public sector funded the same as non-government.

• Increase Flexible Care Subsidy for multi-purpose services

Policy area

Aged care

Cost

To increase funding by 30 per cent would require additional expenditure of approximately $50 million per year; by 40 per cent, to $67 million per year.

Background

The multi-purpose service (MPS) model is a joint state/Commonwealth initiative that enables the delivery of integrated health, community and aged care in small rural communities. At the time of establishment of the model in the 1990s, the Flexible Care Subsidy, which funds MPS aged care beds, was based on an 'average rate' of funding for 'low' and 'high care'. ACFI data shows the stark growth in acuity, with residents assessed as 'high' for complex health care growing from 12.7 per cent in 2008-09 to 53 per cent in 2017-18.

MPS beds remain funded at this frozen rate while the complexity and acuity of residents has increased significantly, this has led to a shortfall for MPS agencies struggling to meet increasing resident care needs. In Victoria there were 378 MPS places funded at $15 million through the Flexible Care Subsidy (2017-18), equating to approximately $39,600 per resident per year. In comparison, average ACFI funding for residents in non-government services averaged at $67,000 per year.

- ## Extend the eligibility criteria so all PSRACS can apply for Commonwealth capital grants

Policy area

Aged care

Cost

No cost

Background

Extending the eligibility criteria to all public sector residential aged care providers to apply for Commonwealth capital grants would enable funding equity and improve resident experiences.

Under the current framework, it is the responsibility of aged care providers to fund construction, maintenance and upgrade works to aged care facilities through operating revenues or Commonwealth subsidies and resident charges.

However, state/territory aged care providers are not eligible for these Commonwealth capital grants, creating a significant disadvantage when compared with the non-government sector.

This funding inequity has limited the ability of public sector providers to upgrade facilities and deliver new models of care to meet resident need and align with modern community expectations.

- ## Allow public sector providers the ability to claim the accommodation supplement and/or contributions to maintain capital infrastructure

Policy area

Aged care

Cost

No cost

Background

Residents in MPS agencies are not required to pay the accommodation contribution or payment which limits income to refurbish or upgrade facilities for resident comfort and in line with community expectation.

- ## Continue the 9.5 per cent ACFI funding uplift until a decision is made on a new residential care funding tool

Policy area

Aged care

Cost

$215 million annually

Background

Extend the short-term 9.5 per cent funding injection into residential care, tied to investing in staffing, training and other workforce matters based on local and organisational needs, until the Royal Commission's broader recommendations can be implemented.

The uplift announced in February 2019 was $320 million over 18 months. The $320 million residential aged care component equates to approximately $1,800 per permanent resident and would provide additional support to the sector, over the next 18-months, to deliver quality aged care services while the Government considers longer-term reform funding options.

- ## Introduce a 20 per cent loading for therapeutic supports in participant plans for those living in Modified Monash Model (MMM) Regions four and five.

- ## Invest in developing 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

Policy area

Disability

Cost

$40 million

Background

People with a disability often experience problems accessing public services, including the NDIS. These problems are exacerbated in rural Australia, where the existence of thin markets is placing the viability of NDIS providers at risk.

The NDIS provides funding to participants, enabling them to purchase the services they require. For those living in remote areas, their funding receives a boost of up to 50 per cent, recognising the higher costs of providing these participants with access to care. For those living in rural areas, their funding is essentially identical to those living in big cities, despite the higher costs associated with providing services.

The bulk of regional Victoria is classified as Modified Monash Model 4 and 5, meaning these services do not benefit from the 50 per cent boost despite increased costs and distances.

This means that people living in rural areas who rely on the NDIS are at risk of losing local access to essential services, forcing them to either travel long distances to seek care or foregoing care altogether.

• Urgently fund a market strategy for managing thin markets in regional and rural areas.

Policy area

Disability

Cost

$5 million

Background

While public hospitals and community health services have traditionally offered allied healthcare and support to people with disability, the funding for these services has been re-allocated to the NDIS, leading to the cessation of these predecessor programs. Any remaining allied health capacity is accessible to the broader local population, and is not tailored to the individual needs of NDIS participants.

Following consistent reports regarding the challenges of maintaining a financially viable service, the VHA undertook a review of the delivery of therapeutic supports under the NDIS.

The location, potential participant population requiring NDIS allied health services, the corresponding funding allocated across packages, and the costs to provide the service, including employment and overheads were assessed for all public hospitals and community health services in Victoria. This was overlaid with the geographic coverage area to calculate the potential impact on the number of appointments staff could attend throughout each day, including travel reimbursements. This model enabled the VHA to determine if providers could 'break-even'.

The key findings of this work revealed that:

/ No service provider in a small town (population fewer than 10,000) would be able to break-even under any NDIS market scenario. While NDIS services may contribute to cost recovery activities and provide necessary volume in small towns, any contribution NDIS services make to a small rural health service's business will be at a financial loss to the health service, and the diversity of allied health disciplines is likely to be reduced.

/ Large towns such as Geelong, Albury, Shepparton, Wangaratta and Ballarat will struggle to offer a choice of service providers; being 'natural monopoly' markets, breaking-even in these markets will only be possible if substantial improvements to efficiency are delivered.

/ Metropolitan Melbourne is the only Victorian market that has the sufficient size or scale to support competition, however, even in this area the current travel reimbursement framework advantages providers with multiple locations, and disadvantages or limits the coverage area in which travel can be reimbursed.

/ The use of the MMM as the core geographic classification to determine participant funding is not detailed enough to support the principles of the existing efficient price model.

While this study was conducted using modelled data, a parallel survey of public hospitals and community health services delivering NDIS supports was undertaken, which found that only 16 per cent of respondents had been able to deliver a surplus financial result, and worryingly, 95 per cent of respondents indicated that continuing financial losses would either prompt their organisation to review their participation, or withdraw from offering NDIS supports.

The system risk posed by ongoing provider deficits is real, and if left unaddressed, could see a large number of providers elect to withdraw from delivering NDIS supports in rural Victoria.