Submission to the

Senate Economics Legislation Committee's Inquiry into the *Budget Savings (Omnibus) Bill 2016*

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Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission as part of the Senate Economics Legislation Committee's inquiry into the *Budget Savings (Omnibus) Bill 2016*.

AHHA is Australia's national peak body for public and not-for-profit hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high quality healthcare to benefit the whole community.

Pausing the indexation of income thresholds for the Private Health Insurance Rebate and Medicare Levy Surcharge

AHHA has previously submitted our support for the Commonwealth government to abolish or better target the Private Health Insurance Rebate, with this support being conditional on any savings in expenditure on the Rebate being fully redirected to other parts of the public healthcare system.[1] While AHHA does not object to pausing the indexation of income thresholds for the Private Health Insurance Rebate as proposed in the *Budget Savings (Omnibus) Bill 2016* (a measure carried over from the 2014–15 Budget), AHHA does not support the savings generated from this measure being used for fiscal repair or other policy priorities of the government. Any savings generated from this measure should instead be redirected into public healthcare. AHHA also does not object to the pause on indexation of the income thresholds for the Medicare Levy Surcharge, although we do note that this Levy is more regressive than raising revenue through personal income taxes.

However, AHHA notes that pausing the indexation of income thresholds could have the effect of increasing individuals' share of total health funding. In 2013–14, individuals paid $27.506 billion of total health expenditure. This represents 17.8 per cent of total health expenditure and 55.2 per cent of all non-government spending in 2013–14. This share of funding by individuals is up from a three year low of 17.0 per cent in 2011–12.[2] Additionally, to the extent that affected individuals chose to pay the Medicare Levy Surcharge rather than take-up private health insurance, this will increase their average rate of tax.

To the extent that the incidence of this measure falls on vulnerable individuals or families, this will affect a group already known to have on average worse health outcomes.[3]

Abolishing the National Health Performance Authority

It is noted that the reporting activities of the National Health Performance Authority (NHPA) have already been transferred to the Australian Institute of Health and Welfare and the Australian

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1 Australian Healthcare and Hospitals Association *Private Health Insurance Consultation Submission*, 4 December 2015.

2 Australian Institute of Health and Welfare (AIHW). 2015. Health Expenditure Australia 2013–14. Health and Welfare Expenditure Series No 54. Cat No HWE 63. Canberra, AIHW.

3 Australian Institute of Health and Welfare (AIHW). 2014. Australia's Health 2014. Australia's Health Series No 14. Cat No AUS 178. Canberra, AIHW.

Commission on Safety and Quality in Health Care with effect from 1 July 2016 (with NHPA staff and resources moving to these two agencies in the first half of 2016[4]).

AHHA calls on the Commonwealth to continue providing appropriate funding for these former NHPA activities to build on the evidence base that has been assembled and the tools developed to increase transparency around variation in clinical care across local communities.

Child and Adult Public Dental Scheme

AHHA welcomed the Commonwealth's 23 April 2016 announcement of a Public Dental Scheme for children and adults through one single national agreement with the states and territories. However the funding is neither as generous as suggested in the announcement, nor will it underpin equitable access to care.

Following the 2016 budget, the Commonwealth government moved a Bill to terminate the Child Dental Benefits Schedule, and it indicated the 12 month National Partnership Agreements with states and territories for additional Commonwealth funding for public dental services for eligible adults (primarily those with Health Care Cards or Pensioner Concession Cards) would end as agreed on 30 June 2016. The Commonwealth proposed that the two programs would be replaced by one program, the Child and Adult Public Dental Scheme to be funded by the Commonwealth but managed by the states and territories. The proposed legislation was introduced into the Australian House of Representatives prior to the 2016 federal election; however, post-election, the legislative process has to be recommenced.

Schedule 9 to the *Budget Savings (Omnibus) Bill 2016* amends the *Dental Benefits Act 2008* to close the Child Dental Benefits Schedule from 31 December 2016 and establish a framework for agreements between Commonwealth, state and territory governments to underpin a Child and Adult Public Dental Scheme.

Australians should have access to affordable dental care because good oral health is important for health and wellbeing. However, affordability challenges mean many people miss out. Whether the Child and Adult Public Dental Scheme assists in addressing these challenges will be highly dependent on policy details and implementation.

There is a risk that establishing a framework for agreements between Commonwealth, state and territory governments to underpin a Child and Adult Public Dental Scheme may not be completed by 31 December 2016. This puts at risk the availability of post 1 January 2017 Commonwealth funding for public dental services provided by the states and territories. AHHA calls on the Commonwealth to guarantee post 1 January 2017 Commonwealth contingency funding for its share of public dental services in the event the framework for agreements has not been established.

Many of the people who will be eligible for the new program are already eligible for public dental services but face long waits for care. The proposed funding model needs to include measures to address these long waiting times in order to ensure equitable access to services.

The funding stream from the Commonwealth may contribute to easing waiting times, but it will be dependent on the calculation methodology for the efficient price the Commonwealth has indicated it will pay, and the capacity of the states and territories to meet co-funding requirements. The agreed

[4] National Health Performance Authority. 2016. Report from the Chief Executive Officer – 2015-16.

upon funding model must reflect variable costs similar to the activity based funding model for public hospital services (e.g. loadings for regional and remote health consumers, Aboriginal and Torres Strait Islander health consumers, etc.), and attention should be paid to the real risk of variation across Australia in the availability of care.

Children requiring preventive care will be competing for publicly funded care with adults with high immediate needs for dental treatment as a result of the move away from the previous scheme which promoted better dental care in childhood. Preventive oral care for children is at serious risk, given that past experience suggests that the limited funding will be prioritised toward adults with urgent treatment requirements (i.e. in acute pain) over children. This could be addressed by designating sub-targeted populations or specific minimum funding allocations for both children and adults

Administrative processes will need to align with service requirements and support access to care, particularly for vulnerable population groups and to ensure that children remain in scope for care. The administrative cost of the Child Dental Benefit Schedule was borne primarily by the Commonwealth. As the Child and Adult Public Dental Scheme will shift this responsibility and cost to the states and territories, funding models will need to reflect the shift in administrative costs between the jurisdictions. Funding models must also consider financial support needed for infrastructure to support access and capacity growth.

It is also important to ensure clarity around the quantum of funding for this initiative. This funding measure is a step forward in recognising that dental care must be part of the public-funded health system.

The proposed Child and Adult Public Dental Scheme does not focus adequately on outcomes and health indicators, despite these being more important than focusing on throughput. As a starting point, the Commonwealth, state and territory governments could develop outcomes and indicators that reflect the guiding principles of Australia's National Oral Health Plan and its targeted strategies in six Foundation Areas and across four Priority Populations.[5]

Finally, while the establishment of the Child and Adult Public Dental Scheme via the *Budget Savings (Omnibus) Bill 2016* can be viewed as a budget savings measure, the Commonwealth should commit to working with the states and territories for a longer-term vision of oral healthcare whereby Australians access oral healthcare in a similar manner to that in which they currently access primary and acute care.

Conclusion

While AHHA does not object to pausing the indexation of income thresholds for the Private Health Insurance Rebate and the Medicare Levy Surcharge as proposed in the *Budget Savings (Omnibus) Bill 2016*, any savings generated from these measure should be redirected into public healthcare and not used for fiscal repair or other policy priorities.

The reporting activities of the NHPA have already been transferred to the Australian Institute of Health and Welfare and the Australian Commission on Safety and Quality in Health Care with effect from 1 July 2016. As a result, AHHA calls on the Government to continue providing appropriate funding for these former NHPA activities to build on the evidence base that has been assembled and

[5] COAG Health Council. Australian Government. 2015. *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*.

the tools developed to increase transparency around variation in clinical care across local communities.

While AHHA welcomed the Commonwealth's 23 April 2016 announcement of a Public Dental Scheme for children and adults through one single national agreement with the states and territories, the funding is neither as generous as suggested in the announcement, nor will it underpin equitable access to care. The implementation details of the Scheme will be key in determining its success, and governments should commit to the development of oral health outcomes and indicators that reflect the guiding principles of Australia's National Oral Health Plan. In addition, governments should commit to working with the states and territories for a longer-term vision of oral healthcare whereby Australians access oral healthcare in a similar manner to that in which they currently access primary and acute care.

The AHHA advocates for health reforms that maintain and improve health outcomes, and support equity, accessibility and sustainability of the broader Australian health system to the benefit of the whole community.