Chapter 3

Health measures

3.1 The bill contains four measures that relate to health expenditure:

- a pause on indexing the income thresholds for the Medicare Levy Surcharge (MLS) and private health insurance rebate for a further three years (schedule 6);
- the abolition of the National Health Performance Authority (schedule 7);
- a measure to improve compliance in aged-care providers, by enhancing the Secretary's compliance powers and creating civil penalties for aged care providers who engage in certain behaviours (schedule 8); and
- the closure of the Child Dental Benefits Schedule (schedule 9).

3.2 This chapter provides an overview of the submitter views on these measures.

Schedule 6: Indexation of the private health insurance thresholds

3.3 Schedule 6 to the bill pauses the income thresholds that determine the tiers for the MLS and the Australian Government Rebate (the Rebate) on private health insurance at the 2014–15 rates until 2020–21.[1]

3.4 The MLS is levied on Australian taxpayers who do not have an appropriate level of private hospital insurance and who earn above a certain income. The base income threshold (under which you are not liable to pay the MLS) is $90,000 for singles and $180,000 for families. [2]

3.5 The private health insurance rebate is a means-tested contribution from the Australian Government towards the cost of paying for private hospital health insurance premiums.[3]

3.6 The Explanatory Memorandum notes that individuals who do not currently pay the MLS may become liable to as their income increases. The Australian

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1 Explanatory Memorandum, p. 47.

2 Australian Taxation Office, *Medicare Levy Surcharge*, https://www.ato.gov.au/Individuals/Medicare-levy/Medicare-levy-surcharge/ (accessed: 8 September 2016).

3 Australian Taxation Office, *Private Health Insurance Rebate*, https://www.ato.gov.au/individuals/medicare-levy/private-health-insurance-rebate/ (accessed: 8 September 2016).

Government anticipates that more people will be encouraged to take up private hospital insurance as their income increases.[4]

Views on schedule 6

3.7 The Consumers Health Forum of Australia (CHF) and the Public Health Association of Australia (PHAA) noted concerns that inflation-induced income increases will push people into requiring private hospital insurance although their capacity to pay has not increased.[5] The CHF and the Australian Healthcare and Hospitals Association (AHHA) also expressed concerns about what they regarded as the regressive character of the measure.[6]

3.8 The committee was also reminded of general concerns among stakeholders regarding the balance between public and private funding in healthcare. The AHHA argued that pausing the indexation of income thresholds could have the effect of increasing individuals' share of total health funding.[7] The PHAA reiterated its longstanding position that private health insurance rebates are an inefficient means to deliver quality healthcare to the population, and questioned the policy objective of pushing people into private health insurance.[8] The Australian Council of Trade Unions, observing the above-inflation increases in insurance policies, queried the value for money proposition of private health insurance.[9]

Schedule 7: Abolishing the National Health Performance Authority

3.9 Schedule 7 of the bill has the effect of transferring the responsibilities of the National Health Performance Authority (NHPA) to the Australian Institute of Health and Welfare (AIHW). The Explanatory Memorandum outlines the rationale for this administrative change:

> The responsibilities of the [NHPA] overlap with those of the [AIHW] in terms of the collection and dissemination of accurate, relevant and useful information on the performance of Australia's health system and services. The overlap resulted in the duplication of functions and an uncoordinated approach to reporting. The closure of the NHPA and the rationalisation of functions across the two agencies will strengthen AIHW's national

4 Explanatory Memorandum, p. 47.

5 Consumers Health Forum of Australia, *Submission 114*, p. 4; Public Health Association of Australia, *Submission 133*, p. 5.

6 Consumers Health Forum of Australia, *Submission 114*, p. 4; Australian Healthcare and Hospitals Association, *Submission 120*, p. 2.

7 Australian Healthcare and Hospitals Association, *Submission 120*, p. 2.

8 Public Health Association of Australia, *Submission 133*, p. 5.

9 Australian Council of Trade Unions, *Submission 177*, p. 16.

> leadership role in the collection and publication of health information and statistics.[10]

3.10 This measure is anticipated to save $88.6 million over the forward estimates.

Views on schedule 7

3.11 The Consumers Health Forum of Australia (CHF) noted general support for the streamlining of the delivery of government services through reducing the number of smaller, separate entities.[11] The Australian Healthcare and Hospitals Association (AHHA) pointed out that the reporting activities and staff of the NHPA has moved to the AIHW in the first half of 2016.[12]

3.12 It was reported to the committee that the NHPA's work was of a very high standard and could prove to be an asset to the AIHW if the two can successfully integrate. The CHFA advised the committee:

> [T]he NHPA established a high benchmark for both frequency and standard of health system performance reporting, particularly with the work it did at the regional level, including for Primary Health Networks and Local Hospital Networks.
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> …
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> The NHPA has an annual work program and was consultative in its approach to what it should be reporting on and how and CHF believes that the AIHW could benefit from taking on board more of this approach.[13]

3.13 The AHHA noted the importance of the work done by the NHPA in developing tools to 'increase transparency around variation in clinical care across local communities', and emphasized the importance of continuing this work.[14] Catholic Health Australia similarly called for the work of NHPA to continue.[15]

Schedule 8: Aged care

3.14 Schedule 8 to the bill seeks to amend the *Aged Care Act 1997* (the Aged Care Act) to create civil penalties for approved providers of aged care who engage in certain behaviours, and provides new powers for the Secretary of the Department (currently, the Secretary of the Department of Health).

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10 Explanatory Memorandum, pp. 9–10.

11 Consumers Health Forum of Australia, *Submission 114*, p. 5.

12 Australian Healthcare and Hospitals Association, *Submission 120*, p. 1.

13 Consumers Health Forum of Australia, *Submission 114*, p. 5.

14 Australian Healthcare and Hospitals Association, *Submission 120*, p. 2.

15 Catholic Health Australia, *Submission 154*, p. 1.

Background

3.15 There are several parts to this measure. As the subsidy the government pays to approved providers will be affected by appraisals of care recipients' care needs, the schedule introduces a civil penalty if approved providers give false, misleading or inaccurate information in connection with an appraisal or reappraisal on more than one occasion within a two year period.

3.16 The amendments will make it easier for the Secretary of the Department of Health (Secretary) to require an approved provider to re-appraise its care recipients or suspend it from making further appraisals if the provider gives false, misleading or inaccurate information in connection with an appraisal or reappraisal. Also, if the Secretary suspects on reasonable grounds that a care recipient's care needs have decreased significantly, the Secretary has the power to require the approved provider to re-appraise the care recipient.

3.17 The schedule changes the date that a change in classification is taken to have effect. This will allow the Secretary to recover overpayments of subsidy from the date the care recipient was originally classified. Currently, the Secretary can only recover overpayments for a maximum of six months before a change in classification.

3.18 The schedule also amends the Aged Care Act to allow for the charging of a fee if an approved provider seeks reconsideration by the Secretary of a classification downgrade.

3.19 Other amendments in the schedule allow the Secretary to take into account the manner in which care is provided to a care recipient, the abolition of adviser and administration boards so approved providers can choose their own advisers and administrators, and for approved providers to notify the Secretary of changes to any of its key personnel that do not materially affect the provider's suitability as a provider of aged care.

Views on schedule 8

3.20 The committee received four submissions that addressed schedule 8.

3.21 Several submissions raised concerns about the measure enabling the Secretary to require an approved provider to undertake a care recipient reappraisal where the Secretary reasonably suspects that the care needs of the recipient have decreased significantly. According to Catholic Health Australia (CHA), this measure would be contrary to the policy objective of encouraging providers to deliver programs that will assist in restoring function.[16] Both Leading Age Service Australia (LASA) and CHA reasoned that the inclusion of this measure would be a retrograde action as it would be

16 Catholic Health Australia, *Submission 154*, p. 2.

a 'disincentive to encourage the care recipient (and staff) to improve the level of care needed and does not recognise the support needed to maintain improvements.'[17]

3.22 Another concern related to the application of a civil penalty to 'inaccurate' information arising from genuine mistakes. LASA proposed that the adjective 'inaccurate' be removed from this part of the Bill.[18]

3.23 According to the Salvation Army, the proposed amendments will place further financial pressure on approved providers of aged care, particularly in relation to the proposal to recover overpayments of subsidy from the date the care recipient was originally classified, which may be backdated several years.[19] As noted by LASA, it does not acknowledge that care and services had already been delivered to the care recipient.[20]

3.24 Other concerns included the need for clarification concerning the definition of 'significant decrease' in reference to subsection (3B)[21] and in relation to the application of a fee by the Department of Health for reconsideration of a decision to downgrade a client's classification. COTA noted that 'some providers may slip clauses into their client agreements allowing them to on charge these fees onto clients without their consent to each reconsideration request.'[22] COTA also noted that it may be 'necessary to assess whether the decreased care needs [were] due to the intervention being provided, and not simply an independent decrease in care needs'.[23] LASA and the Salvation Army added that this section of the bill would deny natural justice for the provider, as the fee would also be a disincentive to providers to question a downgrade.[24]

Schedule 9: Dental services

3.25 Schedule 9 to the bill seeks to amend the *Dental Benefits Act 2008* (the Act) to close the Child Dental Benefits Schedule from 31 December 2016.

3.26 The Explanatory Memorandum notes that the current Australian Government funding arrangements for dental services are provided for children through the Child

17 Catholic Health Australia, *Submission 154*, p. 2; Leading Age Services Australia, *Submission 157*, p. 6.

18 Leading Age Services Australia, *Submission 157*, p. 5.

19 Salvation Army Australia, *Submission, 155*, p. 3.

20 Leading Age Services Australia, *Submission 157*, p. 6.

21 Catholic Health Australia, *Submission 154*, p. 2.

22 COTA Australia, *Submission 180*, p.3.

23 COTA Australia, *Submission 180*, p.3.

24 Leading Age Services Australia, *Submission 157*, p. 6; Salvation Army Australia, *Submission 155*, p. 3.

Dental Benefits Schedule (CDBS) and adults through the National Partnership Agreement (NPA) on Adult Public Dental Services (APDS).

3.27 Under the current CDBS, eligible children can receive up to $1,000 worth of dental treatment, capped over two calendar years. Under the APDS NPA, $155.0 million is being provided to the states and territories during 2015–16 for the treatment of 178,000 additional public dental patients. Both adults on concession cards and all children will be eligible to receive public dental services under the new Child and Adult Public Dental Scheme (CaAPDS).[25]

3.28 The measure's Regulatory Impact Statement notes that low participation rates are a significant reason for the change to the Act. Presently around only one third of eligible children utilise the CDBS, stating that 'the existing Commonwealth funded Child Dental Benefits Schedule is poorly targeted as children already had good visiting patterns prior to its commencement.'[26] Additionally, the number of private dentists accessing public dental services is limited under existing arrangements.

3.29 As such, the government is proposing to improve access to public dental services by establishing an ongoing capped special appropriation under the *Dental Benefits Act 2008*. Funding grants would be made available to the states and territories via NPAs for an initial five year period.[27] It is anticipated that after the fourth year a review of the program will occur to inform the next NPA.

3.30 The Explanatory Memorandum notes that the Commonwealth contribution will be set at 40 per cent of the 'efficient price' of provision of dental services with the states and territories meeting the balance of the provision. The states will also retain the ability to contract private providers to deliver public dental services where required. It is also noted that through the provision of long-term Australian Government funding, the states will potentially put greater investment in infrastructure and general dental services.[28]

Views on schedule 9

Equitable access and impact on children's services

3.31 Equitable access to dental care, particularly in rural and regional public dental services, was raised as a shortcoming of the measure in a number of submissions. A number of submitters have stated that the amalgamation of child dental in the measure

25 Department of Health, Report on the Review of the Dental Benefits Act 2008, http://www.health.gov.au/internet/publications/publishing.nsf/Content/Report_+Review_DBAct~Report_+Review_DBAct_bground~Report_+Review_DBAct_DBA

26 Explanatory Memorandum, p. 78.

27 Explanatory Memorandum, p. 74.

28 Explanatory Memorandum, p. 12.

will impact negatively on children and the achievements gained in recent years.[29] For example, the NSW Council of Social Service submitted:

> The proposed Child and Adult Public Dental Scheme (CaAPDS) is not an equitable replacement for the Child Dental Benefit Scheme. The changes not only represent an overall decrease in funding, but will make savings by impacting most heavily on the low-income and vulnerable children who are most in need of support. We are particularly concerned about the likely impact on children and families in rural and regional areas, and Aboriginal and Torres Strait Islander children.[30]

Waiting times and overloading

3.32 The Australian Council of Social Service (ACOSS) and Consumer Health Forum of Australia (CHFA) stated that there is a risk that the expanded eligibility criteria will place further pressure on existing overloaded state public dental systems, increasing waiting times and reducing services. In a similar vein, the Australian Healthcare and Hospitals Association (AHHA) suggested that the funding model should attempt to address long waiting times in the public dental system.[31]

National Partnership Agreements and State funding

3.33 The major funding share in this measure rests with the state and territories. The AHHA notes that the ability of the states and territories to meet this share of the funding poses a potential risk to the successful establishment of the new scheme:

> 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 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.[32]

3.34 A number of submitters raised questions related to the commencement of the scheme and the introduction of the NPAs. Cohealth advocated for a delay to the introduction of the scheme until such time as details of the proposed CaAPDS replacement are finalised and can be assessed. The ADA considered that the eligible

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29 NSW Council of Social Service (NCOSS), *Submission 122*, p. 2; Consumers Health Forum of Australia *Submission 114*, p. 2; Dr Niraj Lal, *Submission 113*, p.6; Australian Dental Association, *Submission 175*, p.1.

30 NSW Council of Social Service (NCOSS), *Submission 122*, p. 2.

31 Australian Healthcare and Hospitals Association, *Submission 86*, pp. 3–4.

32 Australian Healthcare and Hospitals Association, *Submission 120*, p.3; Australian Dental Association, *Submission 175*, p.1.

population size needs to be identified with associated equitable distribution of funding including the introduction of productivity targets.[33]

COAG outcomes and health indicators

3.35 Both the AHHA and Australian Dental Association noted the need for greater recognition of the COAG National oral health plan and the need to ensure that the NPAs keep focus on outcomes and health indicators rather than just people through. The AHHA submitted that, 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.[34]

Private Dentists

3.36 In contrast to the Explanatory Memorandum's statements of possible greater opportunities for private dentists in the state-run services, a number of submitters raised concerns regarding the impact of this measure on private dentists.

> The new public dental funding mechanism will have a significant negative impact on private dental practitioners, as the changes proposed in the Bill direct funding away from private sector providers, in favour of public clinics. Given that all children would then be eligible for the CaAPDS, more than 4.4 million children could be directed away from private dentists annually, and funneled into an already strained public dental system, where they will likely need to wait longer to receive the care that they need. Directing all children away from private dental services would certainly have an impact on private dentists.[35]

Committee view

3.37 The committee notes the need to restrain growth in Health expenditure, so that it can ultimately be targeted to where it is needed most and can be most effective. The committee considers the measures in the bill consistent with this objective.

3.38 With regard to schedule 9 (dental services) specifically, the committee is cognisant of the need to balance resources yet provide the widest possible provision of dental services nationally. The committee further notes the challenges that the new Child and Adult Public Dental Scheme's expanded eligibility criteria may pose for state-based dental systems. Nevertheless, with the certainty of ongoing funding, the committee has confidence in the scheme.

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33 Australian Dental Association, *Submission 175*, p. 3; cohealth, *Submission 131*, p. 6.

34 Australian Healthcare and Hospitals Association, *Submission 120*, p. 2; Australian Dental Association, *Submission 175*, p. 3.

35 Australian Dental Association *Submission 175*, pp. 3–4.