27 January 2023

The Hon Dr Jim Chalmers MP
Treasurer
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Via email: prebudgetsubs@treasury.gov.au
CC: The Hon Mark Butler MP Mark.Butler.MP@aph.gov.au

Dear Treasurer

Pre-budget submission for 2023–24 Commonwealth Budget

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for about 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian State and in the ACT, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care. CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health and care system that is person-centred in its delivery of care.

CHA appreciates the opportunity to provide input into the federal Budget's priorities for 2023-24, and looks forward to continuing to work constructively with the new government in the execution of our joint commitment to imprioving health and aged care outcomes nationally.

While the community enjoys a Summer now largely unaffected by COVID-19, this is not the case for hospitals and those who work there. COVID-19 is no longer leading news and its associated funding has severely diminished, but the post-pandemic impacts and costs for hospitals have not. There is an ongoing financial shortfall and hospitals are simply not back to business as usual as we once knew it. Strategies are now required to manage the pre-existing significant and widespread workforce issues that COVID-19 has exacerbated. COVID-19 costs are ongoing for hospitals who have, for example, stepped down screening but need to maintain its infrastructure lest they expose staff and patients to unacceptable risk. There is no funding for this, and other, non-activity generating activity that strains already stretched budgets. The 2023-24 Budget process must be informed by consideration of how healthcare services operate both during and after the pandemic.

Recommendations:

The following recommendations are provided as CHA's priority recommendations for the health sector, extracted from the complete submission which follows:

1. **Workforce**

a. National leadership be restored to health workforce planning through the re-establishment of Health Workforce Australia;
b. Rent subsidisation up to a specified ceiling be exempted from the salary packing ceiling, for nurses renting within a certain proximity to their work;
c. The Commonwealth hosts cross-sector discussion to debate changes that could be made to undergraduate nursing programs to improve the attractiveness of nursing as a career proposition in both the short and long term;
d. The creation of a national 'Health & Care Worker Passport' to centralise and align compliance checks for hospital, aged, and disability care workers;
e. Funding support to hospitals to provide additional nursing supervisor capacity; and
f. An Allied Health Strategy be developed, including:
    i. Examination of incentive structures and the effects these are having on workforce participation;
    ii. The introduction of a Diploma in Allied Health to aid in filling allied health workforce gaps; and
    iii. Capitalising on Allied Health Assistants by further defining their roles and career pathways.

2. Mental health

a. Including community based mental health care provided by or on behalf of a hospital in all private health insurance hospital products via an extension of default benefit arrangements;
b. Including accredited, digital mental health care in all private health insurance hospital products for people 30 years of age or under. This could include:
    i. 24/7 phone or online mental health crisis support;
    ii. Next day follow-up service from an accredited mental health service provider; and/or
    iii. Evidence based digital cognitive behavioural therapy (iCBT) programs.
c. Tweaking of the mental health waiting period exemption to remove all waiting periods for people 30 years of age or under to receive mental health care;
d. Removing the requirement in the *Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care* that patients are required to be admitted under the care of a hospital credentialed psychiatrist in order to access mental health day programs provided by that hospital;
e. The Medicare Benefits Schedule rebates for psychiatric services are increased; and
f. The Commonwealth host a cross-sector discussion to debate what a redesigned mental health care system with consumers at the centre would look like, and to discuss the best pathway forward to see that system become a reality.

3. Improving the value of Private Health Insurance

a. Extending *default benefit* arrangements to cover out of hospital services provided by or on behalf of hospitals.

4. Funding for Medicare ineligible patients

a. A risk-sharing regime be adopted across public hospitals to cover the cost of care for Medicare ineligible patients.

b. Additional Commonwealth funding for Medicare ineligible patients to access primary care through primary health networks and Urgent Care Clinics to prevent avoidable hospitalisations.

5. **Sensible, whole-of-system reform of the private health sector**
    a. Direct the Productivity Commission to conduct an independent, whole-of-system review that can provide recommendations on how best to ensure a sustainable, efficient and high-quality private health care sector into the future.

Workforce

Challenges in recruiting and retaining healthcare workers is the key issue for CHA member hospitals nationally.

CHA appreciates the extensive work the government and Department of Health and Aged Care (the Department) have undertaken recently to understand the workforce issues health care providers face, and the progress that has been made towards remedying these. CHA notes that issues our member hospitals were facing six or so months ago regarding visa processing times have dramatically reduced since the Jobs and Skills Summit in August 2022.

Workforce challenges nevertheless continue and will be ongoing until the numbers of locals training, graduating and working in the health and care sectors increase dramatically. No single solution will get us there, but implementing an assortment of short, medium and long term changes such as those outlined below, will help to move the dial on this problem on a variety of fronts.

1. **Restoration of Health Workforce Australia**

The health, care and disability sectors face a structural deficit of available workforce participants, with every provider competing for a limited pool of potential staff. This problem is replicated globally.

Locally, no central agency has sufficient oversight of either current or future workforce needs in Australia's health and care sectors. It is impossible to train adequate numbers of staff in the disciplines that will be required in the future without an understanding of the composition and attributes of the current workforce and a view of what is over the horizon. This structural deficiency has led to our current state; State and territory governments have been announcing workforce incentives and development initiatives without a clear idea of how additional promised health care workers will materialise. Further, this is being done without cognisance that, in the short term, workers will inevitably be poached from other jurisdictions or the private sector, shifting workforce gaps around rather than filling them.

CHA recommends the reconstitution of Health Workforce Australia (HWA) or similar. The Council of Australian Governments established HWA in 2008 to act as the national agency to address health workforce reform including understanding the skills and volume of workers needed, and where in the country they will need to be distributed. This included developing national workforce projections for doctors, nurses and midwives through to 2025. A reconstituted HWA should add disability support workers to the list of roles it develops workforce plans for.

HWA was abolished in 2014 by the Commonwealth Government, citing the perception HWA was additional bureaucracy, and alleged confusion regarding the division of roles between HWA and the Department. Ostensibly HWA's functions were rolled into the Department, however given the sector is now experiencing a workforce crisis with no line of sight into where health workforce gaps are and will be, it is clear that HWA's full remit of work was not successfully adopted by the Department.

In the absence of an accurate picture on the scale of the workforce challenges facing the sector, CHA commissioned research to identify the current vacancy rate for key health care roles nationally. That research, conducted by CHA and Notre Dame University in 2022, indicated a national health and care workforce shortage of over 82,000 staff, including over 11% of enrolled nurse and 6% of registered nurse positions being vacant. This is in addition to an absentee rate of approximately 10% each day in CHA member hospitals, as health care workers battle burnout and illness themselves.

A reconstituted HWA would bring together critical workforce research as well as planning and development functions under one roof at a national level. It would collaborate with states, territories, and the private sector to understand workforce needs, coordinate appropriate levels of training, incentivise greater participation in the health workforce and provide recommendations to the Commonwealth government on where further skilled immigration is appropriate. HWA would also help maximise the use of the current workforce by researching, collating and disseminating successful improvements to scope of practice, uses of digital technologies to improve workforce productivity and exploration of other models of care.

NURSES AT ONE CHA MEMBER HOSPITAL GROUP TRAVEL ON AVERAGE FOR 1 HOUR EACH WAY TO AND FROM WORK. OFTEN THEY ARE DRIVING PAST 2 OTHER OUTER HOSPITALS ON THE WAY.

CHA recommends: National leadership be restored to health workforce planning through the re-establishment of HWA.

2. Affordable housing for nursing staff

Due to historic geographical factors, most long-established hospitals in metropolitan areas are clustered in suburbs where affordable housing and rental properties are not available. As a consequence, nurses and other workers need to travel significant distances to get to work each day.

While the changes in work patterns brought about by COVID-19 have meant many sectors of the workforce have enjoyed opportunities to work from home, nurses have simultaneously suffered at the coalface of COVID-19 prevention and treatment, while also enjoying none of the benefits of working from home which COVID-19 offered. It is the experience of CHA member hospitals that many nurses are opting to reduce their hours because of long days and long commutes.

To counter this, CHA would like to see changes made to promote and subsidise suitable accommodation close to where nurses need to work in a similar way to how Nurses' Homes once provided this advantage. Specifically, rent subsidisation may be considered by exempting from salary packaging caps, rental deductions up to a certain limit, for properties located within a certain proximity to work.

Such a change may mean a small reduction in taxation revenue, however, the benefit for frontline staff would help to offset inequitable housing access that is impacting workforce shortages for many hospitals. This

investment from the Commonwealth Government would deliver a pay advantage to a workforce that is falling behind general market rates for equivalent university graduate roles and is struggling to attract new entrants. It would also alleviate a key barrier that not-for-profit healthcare providers face in recruiting staff.

HOSPITALS HAVE PREVIOUSLY PROVIDED STUDIO ACCOMMODATION TO UNDER-GRAD NURSES AND HOSPITAL FLATS FOR POSTGRAD NURSES AT REDUCED RENT AND WITHIN WALKING DISTANCE OF WORK

Investors may be induced to consider acquiring apartment complexes that would operate as quasi 'Nurses' Homes' in geographical locations with high barriers to entry. Aside from the obvious employment and financial benefits, the social benefits of Nurses' Homes could once again be significant, as they were in previous decades when Nurses' Homes were standard practice at many teaching hospitals nationally. Due to proximity, staff can more easily build camaraderie with both junior and senior colleagues outside of their immediate work area. Informal debriefing occurred socially especially after particularly tough shifts, building support networks and resilience. Resilience and burnout factors remain prevalent in this workforce with solutions requiring a multifactorial approach – housing considerations is one step in a range of many that will be necessary for sustainability of a high quality health care system.

CHA recommends rent subsidisation up to a specified ceiling be exempted from salary packaging caps, for nurses renting within a certain proximity to their work.

3. **Introducing a hybrid workforce model for undergraduate nurses**

This change could be coupled with other tweaks to undergraduate nurse training and incentive structures to further encourage new entrants to the sector, and to retain those who have chosen a career in nursing.

Underpinning such changes would be a reimagining of undergraduates as a paid workforce. Undergraduates could attend university for *blocks* of intensive education, for example, five days each week for four weeks at a time, after which a two-month rotation would occur as a matter of course in their workplace. Minimum theory hours would be retained across the duration of the undergraduate degree, but these would be interspersed with practical on the job paid experience at the same workplace across the years of their degree. Exemptions and options could be offered if key specialties were not possible, with alternative placement plans being made available in such cases.

Initially, a six or so week block of intensive learning would cover the basic principles of care delivery to ensure cohorts were *job ready* with each intensive theory block after that building upon specialty areas. Practical paid placements could then happen under a team nursing model with undergraduates paired with a qualified member of staff under a ratio of patients of, for example, 1:6 (rather than the typical 1:4 per individual nurse). CHA believes that such changes would result in lower dropout rates as undergraduates become part of a supportive team, build relationships over the course of the degree, while also earning income. Coupled with subsidised housing closer to the workplace, such changes would fundamentally alter the appeal of entering the nursing profession.

CHA recommends the Commonwealth hosts cross-sector discussion to explore changes that could be made to undergraduate nursing programs to improve the attractiveness of nursing as a career proposition in both the short and long term.

4. **'Health & Care Worker Passport' to centralise and align compliance checks for hospital, aged, and disability care workers**

Compliance requirements for workers across the health, disability and aged care sector vary across the sectors and by jurisdiction. This is both an unnecessary cost burden and an unnecessary bottleneck when it comes to recruiting and on-boarding new staff. A streamlined approach at the federal level for care industry workers would make a tangible difference to industry. It is also important that compliance checks cover **both** registered and unregistered providers on a mandatory basis.

Appendix A includes a snapshot of some these compliance checks, highlighting the differences across jurisdictions and between caring professions, and the costs associated with each. Most of these compliance checks draw information from the same databases, and rather than these databases being accessed separately and repeatedly by different agencies and departments, a 'Health & Care Worker Passport' or equivalent would reduce on-boarding times and cost, and would allow better scalability across the available health and care workforce. Over time, additional on-boarding requirements such as proof of immunisation could be added to the Health & Care Worker Passport to provide further efficiencies.

CHA recommends the creation of a national 'Health & Care Worker Passport' to centralise and align compliance checks for hospital, aged, and disability care workers.

5. **Increasing nursing supervisor capacity to increase the number of new nurses able to start working in the sector**

The nursing capacity that has been lost during COVID-19 due to early retirement, departing the sector for other work, cutting back of hours, and the migration halt requires a multipronged solution. The immigration program is back in full swing and hospitals are advertising heavily in international markets for nursing positions. However, jurisdictions continue to compete with one another to attract nurses by offering new and, at a macro level, counterproductive, sweeteners. Health and care stakeholders nationally agree that a domestic suite of work to *grow our own* is required if we are to have enough nurses to fill vacant health and care roles.

While tertiary education facilities can continue to increase the number of nursing courses, a blockage remains in the system once these students require a hospital placement to complete their training.

The current system utilises a preceptor model in which experienced nurses exclusively supervise these students for approximately five weeks. Each preceptor supervises three to four students for the five-week period and, importantly, this supervision must be dedicated supernumerary. This means for each three to four students a hospital places in their training program, a senior nurse is precluded from seeing patients for five weeks, with that nurses' wage/salary having to be paid from the bottom line and their typical shifts needing to be divided between other staff.

CHA member hospitals are proud to offer training placements to hundreds of nursing graduates each year, and have been doing so for decades, funding these placements from their own bottom line.

This work will continue. However, with some dedicated funding support for additional preceptor rotations, CHA member hospitals could expand their existing training places to offer placements to even more nursing students to help bolster the nursing workforce more quickly than would otherwise be possible.

The funding support required would not be significant. Large hospital groups are able to offer placements to approximately 200 nursing students each year. To double this would require funding of approximately $400k. 200 students / 4 students per preceptor = 50 student groups annually. Each group requires a preceptor for 5 weeks. 50 groups * 5 weeks = 250 weeks' supervision. @$90,000/year, 250 weeks' salary = $433,000.

CHA recommends funding support to hospitals to provide additional nursing supervisor capacity, which will increase the number of new nursing graduates able to start work as soon as possible.

6. Develop an Allied Health Workforce Strategy

The hospital sector is experiencing a serious issue in the recruitment and retention of qualified allied health professionals. As above, there is a workforce shortage, but this shortage is exacerbated by significant wage distortions in the market and by high barriers to entry for those wanting to train as allied health professionals. Both these distortions require attention.

Hospitals are haemorrhaging qualified allied health professionals as significantly higher remuneration is increasingly offered in other settings, particularly disability services. As an indicative example, a physio graduate could expect to earn about $53/hour for an entry level hospital position, while the NDIA offers about $170/hour for the same entry level positions. Senior positions can earn even more again, and hospitals simply cannot complete.

This is compounded by the extremely high barriers to entry to train to be an allied health professional, hampering efforts to *grow our own* workforce. Again, as an indicative example, entry to an undergraduate physiotherapy course requires an average ATAR of 94, but up to over 99 at some universities. With the immigration skills list already including most allied health positions, the solution to filling the significant workforce shortages that already exist must come from within Australia, yet the marks required for tertiary study preclude most school leavers from these courses.

The introduction of a diploma level qualification would assist in meeting demand for allied health professionals and would open the doors to more possible candidates to study in this field.

Currently, Allied Health Assistants can work under the supervision of an allied health professional but cannot work independently. Diploma level qualified allied health workers could be inserted in between these two levels, not performing the same scope of work as degree qualified workers, but able to work more autonomously than Certificate level qualified Allied Health Assistants. Diploma qualified Allied Health workers could, for example, lead mobility exercise programs or perform rehabilitation in the home sessions. The diploma would also serve as a pathway to allied health professional degrees – an option not afforded to certificate-level graduates.

CHA recommends an Allied Health Strategy be developed, including considerations such as:

i. **Examination of incentive structures and the effects these are having on workforce participation;**
ii. **Introducing a Diploma of Allied Health to aid in filling allied health workforce gaps; and**
iii. **Capitalising on Allied Health Assistants by further defining their roles and career pathways.**

Mental health

CHA members provide significant mental health services across Australia including outpatient care, care in the community, digital mental health solutions, as well as traditional acute and sub-acute care in public and private hospitals.

The most vulnerable populations are often those most poorly served by the mental health system. CHA members report unprecedented demand for their mental health services, particularly crisis services, and are straining more than ever to provide services within a system that is not well designed to provide the best care, in the best place, at the best time.

The structure of the system and how different types of care are funded is impacting greatly on equity of access. A workforce shortage of mental health workers and significant changes to the types of work many mental health professionals are performing is adding pressure to an already fragmented system under significant strain. There is no single easy answer to remedy this, but small, considered steps in the short and medium term will realise immediate improvements while also laying the groundwork for longer-term system level improvements.

7. Improving access to mental health care for young people with private health insurance

Ensuring all age groups participate in private health insurance (PHI) ensures the survival of our community rated system. With young people typically not requiring hospital services to the same extent as older age groups, keeping young Australians interested in retaining their PHI is critical to preserving the risk pool.

One key area of concern for young people is access to quality, affordable mental health care. The leading causes of illness for younger Australians are anxiety disorders, depressive disorders, suicide, self-harm, and alcohol misuse. All of these are amenable to treatment through mental health services. Improving the value that PHI offers in these areas is important to keeping young people healthy, and to ensure they continue to see value in PHI.

To assist with this **CHA recommends:**

i. **Including community based mental health care provided by or on behalf of a hospital in all PHI hospital products via an extension of default benefit arrangements.** This could include day programs, outreach or hospital substitution services, with minimum requirements of service such as specified periods of community care, follow up, and/or post-discharge care linked to a hospital admission.

ii. **Including accredited, digital mental health care in all PHI hospital products for people 30 years of age or under.** This could include:

   a. 24/7 phone or online mental health crisis support;

b. Next-day follow-up service from an accredited mental health service provider;

c. Evidence based digital cognitive behavioural therapy (iCBT) programs such as This Way Up.

iii. **Tweaking of the mental health waiting period exemption to remove all waiting periods for people 30 years of age or under to receive mental health care.**

iv. **Removing the requirement in the Guidelines for Determining Benefits for Private Health Insurance Purposes for Private Mental Health Care (last updated in 2015) that patients are required to be admitted under the care of a hospital credentialed psychiatrist in order to access to mental health day programs provided by that hospital.** This is an artificial handbrake on access to much needed mental health programs and has no meaningful role in the provision of care. Instead, treating psychiatrists, psychologists or GPs should be able to refer a patient to into a mental health day program, that patient be assessed by one of the hospitals' psychology or therapy team, and then if assessed as suitable, commence in the program as soon as possible with progress updates provided regularly to the referring clinician.

8. Realigned remuneration of specialist psychiatric work to recognise complexity and acuity of care delivered

CHA member hospitals have seen a decline in psychiatrists wanting to work in in-patient settings. This decline has accelerated since 2020 when COVID-19 quickly disrupted typical expectations of receiving healthcare face-to-face. In addition, the incentives (both financial and otherwise) to work in settings other than hospitals are immense, with in-patient care retaining the most acute and complex patients and requiring shift work. The clinicians choosing this difficult and important work are not remunerated at a higher rate than what they would receive working 9-5 in an outpatient setting seeing lower acuity clients. This is because Australia's mental health system is agnostic to patient complexity and acuity when remunerating mental health professionals for the care they deliver. This is artificially distorting care delivery by financially rewarding lower acuity and/or less complex care to the same degree has higher intensity care. This must be remedied to ensure scarce human resources are appropriately incentivised to deliver care where that care is most needed.

Many other distortions exist in the mental health system. General Practitioners (GPs) are paid less per minute for mental health consultations than for other types of consultations. Hospitals are funded to deliver overnight or day mental health programs, but are not funded to carry over care to patients in between programs, with patients experiencing a hard stop to care delivery once they are discharged unless they book (and usually self-fund) a community mental health appointment. With graduate mental health professionals able to choose where they would like to work, we have created a supply-driven rather than needs-driven paradigm in which there is an inverse relationship between need and spend. Disadvantaged communities receive less per capita funding than more affluent areas. Over time we have tried to combat this by financially incentivising work in rural and remote locations, but we have not simultaneously reduced the financial incentives to work in metro areas which has stymied the impact this change could otherwise have had. In addition to the toll this plays on those requiring mental health care, this has also come at a huge financial cost both to individuals and to the system. Compounding this, we have not sought to measure either impact or outcomes at scale. Additional funding continues to pour into bespoke mental health programs, but we are unable to gauge the impact these cash injections have had, or will have, in future.

These distortions, which are created by a system designed around those who work in it, rather than those who need to access it, are best fixed as part of a wider redesign of the mental health system. A series of roundtables, for example, in which experts and decision makers debate how we would ideally like the mental health system to behave, which outcomes we want to see and measure in patients, and then how the mental health system needs to be structured in order to deliver on these goals. How this system is to be funded should come at the end of this process, once the desired care model has been agreed. Such a re-engineering of the mental health care system is required to truly deliver improved population mental health.

In the more immediate term, incentive structures must be rebalanced so we appropriately remunerate complexity and acuity of care delivered. This would assist greatly in ensuring the system as a whole is not unwittingly directing the limited pool of practising psychiatrists to exit some parts of the system *en masse*. Delivering in-patient mental health care must be at least as financially rewarding as seeing private out-patients, writing work-cover reports or offering professional opinions for medico-legal cases. This is vital to ensure access to mental health care. This is not about speed of access or choice of provider, but simply about access full stop. The private hospital system offers care that is largely not available in the public system where capacity constraints mean beds are preserved for those at extreme risk or with acute illness. The private hospital sector has the infrastructure, skills and the experienced teams of professionals with capacity to assist. What is required is a mechanism to attract psychiatrists back to the sector so it can continue to provide access to mental health care for the millions of Australians who require it. In the short term, an increase in the MBS rebates for psychiatric services would fill this need, while longer term, a wider discussion and funding review is undertaken to ensure the system is delivering optimal and efficient outcomes.

CHA recommends:

a. **The Medicare Benefits Schedule (MBS) rebates for psychiatric services are increased; and**
b. **A cross-sector discussion is had to debate what a redesigned mental health care system with consumers at the centre would look like, and to discuss the best pathway forward to see that system become a reality.**

New models of care

9. Bring PHI into the 21st Century by extending funding to cover out of hospital and virtual health services

Private health insurance funding should facilitate the provision of care in the most appropriate setting based on patients' preferences and clinical needs. Unfortunately the current regulatory environment limits guaranteed funding to care delivered in hospital. Models of care have evolved, but funding models have not. In practice, this means patients who would have preferred to receive care at home or in the community are forced into more expensive hospital care simply because that is what is funded under their PHI product. Achieving the widespread provision of care in the most appropriate setting for each patient requires a change to PHI legislation to expand funding to cover out of hospital (OOH) care. Specifically, an expansion of default benefit arrangements.

Default benefits are a key instrument in the private health insurance regulatory landscape, incentivising private health insurers and hospitals to agree productive contracting arrangements to deliver care to insured patients, while offering a safety net to patients in the event such a contract cannot be reached. Currently, default benefits only apply if members receive treatment in a bricks and mortar hospital.

There are significant opportunities to expand the value of private health care by incorporating OOH services such as virtual care into default benefits arrangements. OOH models of care are an opportunity to address pressure on the health system and meet patient preferences for more flexible care. Compared to traditional inpatient care for medically stable patients, OOH care can often be more efficient and effective, with lower readmission rates, length of stay, mortality, and increased patient satisfaction.[1] [2]

THE RESULTS OF AN INNOVATIVE PALLIATIVE CARE PROGRAM DEVELOPED AND FUNDED BY ST VINCENT'S PRIVATE HOSPITAL BRISBANE AND BUPA HAVE BEEN PUBLISHED IN A PEER REVIEWED JOURNAL AND SHOW THE PROGRAM ENABLES PATIENTS TO CHOOSE WHERE THEY WOULD LIKE TO BE CARED FOR, AND WHERE THEY WOULD LIKE TO DIE, WHILE ALSO GENERATING COST EFFICIENCIES.

CHA MEMBER HOSPITALS DELIVER MANY OUT OF HOSPITAL PROGRAMS AT LOWER COST THAN HOSPITAL DELIVERED EQUIVALENT CARE. IN INSTANCES IN WHICH PATIENTS WOULD PREFER TO RECEIVE CARE AT HOME, THESE PROGRAMS SHOULD BE AVAILABLE TO THEM, NOT BE CONSTRAINED BY THE WHIMS OF THEIR HEALTH INSURER.

A number of treatments and care types such as dialysis, chemotherapy, rehabilitation, and palliative care that previously needed to take place within a hospital can now, in certain circumstances, safely take place in other settings. Where a patient prefers to receive care at home and clinical assessment deems it appropriate, health insurance funding should logically follow. Provided that treatment is efficacious, safe, cost-effective, and meets the requirements and preferences of the patient and their treating clinician, the existence or otherwise of private health insurance funding should not be the determining factor as to where treatment takes place.

Default benefit arrangements must evolve to fix this oversight that is restricting patient access to clinically effective, cost effective, patient centric care, while ensuring safety and quality remain paramount. Services would not be permitted to move from a hospital to another setting which has lower standards of safety and quality. Hospitals impose accreditation and scope of practice limits on practitioners who work in their

[1] https://www.cha.org.au/wp-content/uploads/2021/03/6-CHA-Report-J170720.pdf

[2] Cross, J., et al (2020). 'Supporting choice: an innovative model of integrated palliative care funded by a private health insurer.' *Internal Medicine Journal,* 50(8), pp.931-937.

facilities, which are over and above the requirements of State/Territory legislation. Hospitals also impose strict infection control standards and policies, have rigorous incident reporting and management protocols, and can ensure continuity of care and back-up in the event of an adverse outcome. A less regulated environment could provide an opportunity for corners to be cut and patient care to suffer. For these reasons, default benefit arrangements should only be extended to OOH care performed by or on behalf of a hospital.

With the advancement of technology, changes in surgical approach, the advent of new medicines and changing patient preferences, there continues to be a shift from overnight to same day care and to out of hospital admitted and non-admitted care. Unlike the public sector, private hospitals are often restricted from providing 'the right care in the right location' simply because funding is not agreed or it is not permitted under current legislation. While some health insurers fund these services, many do not support hospital in the home services outside those they are able to provide themselves either directly or via a subcontractor. Others do not contract with hospitals for these services citing concerns around benefit outlay, quality considerations, and/or necessity. The disparity in care with the public system, where patients ordinarily have access to a range of acute and subacute home-based treatments, is often significant.

IN FINANCIAL YEAR 2022, TWO CHA MEMBER PUBLIC HOSPITALS ALONE WROTE OFF $2MILLION IN UNPAID INVOICES FROM TREATING MEDICARE INELIGIBLE PATIENTS.

A default benefit for the provision of hospital in the home and hospital substitutive services would assist all providers in establishing care paths for patients that are not disrupted by funding idiosyncrasies and regulatory barriers. OOH care has the potential to fundamentally improve the capability and efficiency of the private health system. However, economies of scale can only be achieved with the funding certainty for hospitals to invest broadly and deeply into these services, which can be delivered through an expansion of default benefit arrangements.

CHA recommends default benefit arrangements are extended to cover out of hospital services provided by or on behalf of private hospitals, noting:

- **Clinical standards and regulations should be consistent with hospital delivered care; and**
- **Gradual introduction across clinical categories will give the sector time to adapt.**

Equity in funding Medicare ineligible patients

Rules need to be changed so Medicare ineligible patients are funded for treatment at public hospitals.

Governments do not fund the total cost of public hospital services. Some services are funded in part by PHI or by various compensation schemes for workplace and transport related injuries. Some services to some patients receive no government funding at all, such as non-Australians without PHI. This places a burden on hospitals who care for large numbers of these so-called 'Medicare ineligible patients' who often cannot afford the cost of care provided. This burden tends to fall on a small number of hospitals (many of whom are

CHA member hospitals) and there is no current risk equalisation process within any state or territory to share the risk of this arbitrary cost.

CHA member hospitals treat many Medicare ineligible patients each year, and write off millions of dollars in unpaid invoices as a result. CHA member hospitals treat these patients because they need treatment and there is nowhere else they can go to receive it. It is unconscionable that there is no formal pathway to receive healthcare for Medicare ineligible patients unless they can afford to pay the full cost of that healthcare themselves as an out of pocket. For context, a single overnight admission is on average multiple thousands of dollars. Maternity care can easily reach tens of thousands of dollars.

CHA member hospitals will continue to treat these patients, but it is only fair that a risk-sharing regime be adopted across public hospitals for these Medicare ineligible patients both to ensure these patients are not turned away from receiving healthcare if they cannot afford it, and to share the cost of this care provision in an equitable manner.

CHA recommends a risk-sharing regime be adopted across public hospitals to cover the cost of care for Medicare ineligible patients.

Whole-of-system PHI reform

Currently the Commonwealth Department of Health is conducting multiple reviews of various policy levers impacting private health care provision including:

- The Medicare Levy Surcharge
- Default and minimum benefits
- Risk equalisation
- Lifetime Health Cover Loading

While it is appropriate to regularly review all policy instruments that impact the availability of health services to Australian residents, adjusting any single instrument can have unintended consequences. This approach to consultation also makes it challenging for stakeholders to provide constructive input, as individual consultants engaged by the Department of Health lack the context and detail on each specific instrument of reform.

Based on previous reviews the estimated cost of this initiative is under $20 million. The benefits of implementing the review's recommendations would accrue to patients and taxpayers, and are certain to be billions in enhanced productivity and improved future patient outcomes.

Background

The value proposition of private hospitals in financial terms alone is compelling. More than two out of every five hospital admissions in Australia are to a private hospital.[3] Two out of three elective surgeries in Australia from 2019–2021 were performed in private hospitals. In 2019–20, 71 per cent of the $17.1 billion spent on

[3] https://www.healthdirect.gov.au/understanding-the-public-and-private-hospital-systems

private hospitals (some $11.5 billion) was funded by non-government sources. For $5.6 billion, Australian governments saw two fifths of hospital admittances and two thirds of elective surgeries delivered, before accounting for any of the other enormous benefits provided by private hospitals. This is a bargain by any measure. For comparison, governments collectively spent some $60 billion on public hospital services.[4]

For patients, the value proposition is just as clear. Patients can choose to purchase high quality care via self-funding or insurance that is both accessible quickly and at a hospital and with a doctor of their choosing. This stands in contrast to ever-increasing wait times in public hospitals for elective surgery. Worryingly, this includes growing numbers of patients in the public system facing delays longer than their clinically recommended waiting period.[5] This can lead to the exacerbation of the original health concern and worse health outcomes.

And yet, as compelling as this value proposition is, the private hospital sector is experiencing immense financial hardship, with its long-term viability threatened. Private hospitals have suffered through the COVID-19 pandemic and governments' response to it, exacerbating structural and regulatory challenges already present in the sector. The most immediate financial challenges include:

- Health inflation
- Workforce shortages (and associated wage inflation)
- Pandemic-related costs such as personal protection equipment (PPE)
- Increasing and unfunded cost burdens resulting from government regulation such as the recent critical infrastructure bill

CHA recommends the Commonwealth direct the Productivity Commission to conduct an independent, whole-of-system review that can provide recommendations on how best to ensure a sustainable, efficient and high-quality private health care sector into the future.

Thank you for considering our submission. If you or your staff wish to discuss any of the issues or solutions raised, please contact our Director of Health Policy, Caitlin O'Dea, at caitlino@cha.org.au or 0416 918 144.

Yours sincerely,

Pat Garcia
Chief Executive Officer
Catholic Health Australia

[4] https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance/contents/spending-on-hospitals
[5] https://www.finder.com.au/private-vs-public-hospitals-wait-times-and-safety

APPENDIX A. EXAMPLES OF COMPLIANCE CHECK DEFINITIONS, COVERAGE AND COST

Compliance Check	Definition	Applicable State/ Territory	Cost of Check
National Criminal Record Check	The National Criminal Record Check involves comparing an individual's details (such as name and date of birth) against a central index of names using a name matching algorithm to determine if the name and date of birth combination of that individual matches any others who have police history information. The name will then be vetted by police personnel to determine what information may be disclosed, subject to relevant spent conviction legislation and/or information release policies.	All States	$36.20
International Criminal Record Check	The requirement for an International Criminal Record Check (ICRC) applies where candidates are providing direct care/client-facing services to clients/patients funded by the Department of Health & Human Services (DHHS). The ICRC is a requirement for preferred applicants who have resided overseas for 12 months or more in one country in the last 10 years since turning sixteen. The ICRC is not required to be obtained from countries where the applicant has travelled for shorter periods. Some countries will not release information regarding an individual for personal or third party purposes. In these extenuating cases, where an international police record check cannot be obtained a statutory declaration and character reference checks must be conducted with at least two individuals who personally knew the individual while they were residing in the other country.	VIC (as required per individual/service/role)	$80 approx. Varies depending on the country
Working Rights Check	A Working Rights Check may reveal the following information: • Disclose whether a non-citizen has unrestricted work entitlements, limited work entitlements or no work entitlements • Visa expiry date (if applicable) • Information on maximum hours and the type of work permitted under relevant legislation	All States (as required per individual)	Free via Department of Immigration Website. $3 via Fit2Work

			with base line monitoring.
Bankruptcy & Insolvency Check	A Bankruptcy and Insolvency check is a broad search and check of the financial solvency and credit history of an individual.	VIC NSW SA TAS QLD ACT (as required per service/role)	$60.50
NDIS Worker Screening Check	The NDIS Worker Screening Check is an assessment of whether a person who works, or seeks to work, with people with disability, poses a risk to them. The assessment determines whether a person is cleared or excluded from working in certain roles with people with disability. The NDIS Worker Screening Check is conducted by the Worker Screening Unit in the state or territory where a person applies for it. The Worker Screening Unit also decides whether a person is cleared or excluded. Registered NDIS providers are required to ensure that they only engage workers who have been cleared in certain roles, called risk assessed roles.	VIC NSW SA TAS QLD NT (as required per service/role)	$123.20 - VIC $80 – NSW $115 – SA $119 – TAS $129 – QLD $127 - NT
Working with Children Check	The Working With Children Check (WWCC) is a requirement for anyone who works or volunteers in child-related work*. It involves a risk assessment based on applicant's criminal history, non-conviction information, relevant professional conduct and any other relevant information. WWCC's are more extensive, but also more targeted than Police Checks The outcome of a check is either a clearance to work with children or a bar against working with children.	VIC SA NSW WA	$123.20 – VIC $119.90- SA $80 – NSW

	Eligibility: -anyone aged 18 or older -anyone whose role involves direct contact with children ***Child-related work** (including voluntary work) is: providing services for under 18s where the work normally involves being in direct contact**with children where contact with children is more than incidental to the work. E.g. work as a health practitioner providing health services if the work includes the provision of health services to under 18 year olds, health practitioners include non-registrable staff who provide health services, work by persons (other than health practitioners) who provide health and care services in paediatric or adolescent health services, respite care or other support services for children with a disability. Relevant for those who work in Paediatric wards of hospitals. ****Direct contact** means – physical contact or face to face contact, or written (including postal), oral or electronic communication. **NSW** – Check may also be requested if positions handle sensitive personal information about children. **SA** – Health services for children includes allied health services for children, medical professionals, counselling and support services, paediatric wards in any kind of hospital or hospice. Disability Services for children includes Medical professionals, Allied health services, Transport services, Respite carers, Recreation providers.	NT (Ochre Card) (as required per service/role)	$87 – WA $76 - NT
Working with Vulnerable People Check	This registration functions as a background check that aims to help reduce the risk of harm or neglect of vulnerable people* in the ACT and TAS. Required for people- - over 16 years of age; and - who work or volunteer with vulnerable people to have a background check and be registered. - would be expected to have more than incidental contact** with a vulnerable person as normal part of their duties	ACT TAS (as required per service/role)	$135 - ACT $119 - TAS

	*In **ACT**- A vulnerable person is a child, or an adult who is disadvantaged and accessing a regulated activity*** in relation to the disadvantage. Examples of disadvantage include- physical/mental disability, social/financial hardship, difficulty communicating in English. **ACT Exclusions** – Registered health practitioners and staff member/ volunteer of an approved provider under the Aged Care Act 1997 *In **TAS** – a vulnerable person is a child under the age of 18 or an adult who is accessing a regulated activity. ****Contact** is that which would reasonably be expected as a normal part of engaging in the activity. For example, physical (including working in the same place as the vulnerable person), oral and written communication (including electronic communication or dealing with a record relating to the vulnerable person either face-to-face or over the telephone) or, making a decision about the vulnerable person. Contact is defined broadly to cover situations where a vulnerable person may be harmed directly through the misuse of information or power. ***** **Regulated Activities include** – counselling & support services, mental health services, community services, disability services, respite care service, emergency service, public transport for vulnerable people, **Registration** involves risk assessment by the commissioner of whether the person poses an unacceptable risk of harm to a vulnerable person. Examples of harm include sexual, physical, emotional, financial. Risk Assessment involves checking the applicant's criminal history, non-conviction information and any other information about the applicant that may be relevant in deciding the application. Information may be sought from any entity in relation to the applicant. Employer of applicant (if named) can be contacted in relation to status of the applicant's application or registration. Application involves written statement by applicant regarding whether the applicant has been convicted or found guilty of a relevant offence outside Australia and details of the offences.		