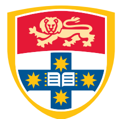
Menzies Centre for

Health Policy



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BUDGET 2009-10: A HEALTHY MID YEAR ECONOMIC AND FISCAL OUTLOOK?

November 2009

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Foreword

The purpose of the MYEFO report is to provide updated information to allow the assessment of the Government's fiscal performance against the fiscal strategy set out in the current Budget Papers.

The Treasurer must publicly release and table a Mid-year Economic and Fiscal Outlook (MYEFO) report by the end of January in each year, or within 6 months after the last budget, whichever is later. Typically, the MYEFO is released in November each year. This year it was released on November 2.

Over the past 12 months the global economic conditions have seriously impacted the fiscal outlook so this year the MYEFO was anxiously anticipated.

Angela Beaton

Lesley Russell

Introduction

The Charter of Budget Honesty Act 1998 requires the Treasurer to publicly release and table a Mid-year Economic and Fiscal Outlook (MYEFO) report by the end of January in each year, or within 6 months after the last budget, whichever is later. Typically, MYEFO is released in November each year. This year it was released on November 2.

The purpose of the MYEFO report is to provide updated information to allow the assessment of the Government's fiscal performance against the fiscal strategy set out in the current Budget Papers. Over the past 12 months the global economic conditions have seriously impacted the fiscal outlook so this year the MYEFO was anxiously anticipated.

Overview

While the Australian economy has performed better than expected, it is likely to remain below capacity for some time. The 2009-10 Budget projected an underlying cash deficit of $57.6 billion (4.9 per cent of GDP). The revised forecast underlying cash deficit for 2009-10 is $57.7 billion (4.7 per cent of GDP), essentially unchanged from the May forecast.

The Budget deficit is an inevitable consequence of the global recession, which has resulted in downward revisions to revenue of around $210 billion since the 2008-09 Budget.

Policy decisions since the 2009-10 Budget have increased estimated expenses by $49 million in 2009-10, but have reduced expenses by $2.1 billion over the forward estimates.

Parameter and other variations since Budget have resulted in an increase in expenses of $1.9 billion in 2009-10 (and $9.7 billion across the forward estimates).

The Government has invested $22 billion to improve infrastructure, of which, $3.2 billion was invested in health and hospital infrastructure. The Government will also provide $4.2 million over four years to fund a business case (to be completed early 2010) for establishing a national individual electronic health record system.

	2009-10		**2010-11**		**2011-12**		**2012-13**	
	Budget	**MYEFO**	**Budget**	**MYEFO**	**Budget**	**MYEFO**	**Budget**	**MYEFO**
Commonwealth health budget ($m)	51,223	52,355	53,201	53,933	55,619	56,611	57,628	59,482

Table 1: Changes in Commonwealth Health Budget 2009-10 to 2012-13 since 2009-10 Budget

Health Measures Which Have Affected Budget Forecast

Overall, the MYEFO shows that policy decisions since the 2009-10 Budget have increased estimated expenses by **$49 million** in 2009-10, but have reduced expenses by **$2.1 billion** over the forward estimates (Table 1). While a number of expense measures were listed, no major health policy decisions affecting expenditure were discussed.

Parameter and other variations since Budget have resulted in an increase in health expenses of **$1.9 billion** in 2009-10 (and **$9.7 billion** across the forward estimates) reflecting:

- A **$276 million ($1.1 billion over four years)** increase in Private Health Insurance Rebate expenses primarily reflecting higher than expected take-up of private health insurance[1];
- A **$266 million ($1.4 billion over four years)** increase in forecast Medicare expenses largely reflecting higher than anticipated spending on GP consultations and the implementation of a new forecasting method[2];
- A **$248 million** increase in forecast expenses for the Chronic Disease Dental Scheme (CDDS) reflecting higher than anticipated expenditure for the period 1 July to 31 December 2009 and the continuation of this scheme until 31 March 2010. The Government announced this scheme would cease in the 2008-09 Budget; however, the determination to cease the CDDS was disallowed by Parliament. Cessation of the CDDS remains the Government's policy; and
- A **$221 million ($1.8 billion over four years)** increase in pharmaceutical and pharmaceutical services expenses to reflect increased demand for some drug groups which is expected to be sustained over the forward estimates period.

The MYEFO includes two savings measures for health:

- **the creation of three new 'therapeutic groups' under the PBS** - under which the Government will pay the same amount for medicines that deliver a similar health outcome (because the price at which the Government subsidises the cheapest medicine in the group are used as the basis for pricing the other medicines in that group). The new therapeutic groups, being created on the advice of the independent Pharmaceutical Benefits Advisory Council (PBAC), will result in a saving to the PBS of **$48.2 million over the next four years**. Changes in the price paid by the Government for these medications will not affect the majority of patients as their prescriber will choose the cheaper alternative medicine; and
- **promoting the better use of selected spinal X-ray items on the Medicare Benefits Schedule**, by encouraging practitioners to request region-specific X-rays for particular clinical indications and limit requesting rights for allied health practitioners in relation to three and four region spinal X-rays to one per patient per calendar year. This measure, which will also reduce the risk of unnecessary patient exposure to radiation, will result in a saving to the Medicare Benefits Schedule of **$17.1m over the next four years**.

The only major policy decision affecting revenue in the health portfolio in the MYEFO in 2009-10 was the modification to the 2009-10 Budget measures modifying the Pharmaceutical Benefits Scheme viz. chemotherapy drugs (deferred implementation); listing of Revlimid® (lenalidomide); and minor new listings (figures were not provided, listed as not for publication).

However, a number of other budget measures have not yet been enacted, were significantly delayed, or have been deferred, which is likely to affect revenue/savings:

- *Customs Tariff Amendment* to increase the customs duty rate applying to certain alcoholic beverages ('alcopops') – DELAYED; passed by Senate, August 2009.

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1 Despite these proposed changes, there was a $276 million ($1.1 billion over four years) increase in Private Health Insurance Rebate expenses, as discussed earlier, primarily reflecting higher than expected take-up of private health insurance. The MYEFO projects continued growth in expenditure on the PHI rebate due to the continued growth in private health insurance membership.

2 The projected increase in Medicare costs is also likely to reflect continued blow-outs in the cost of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS) program. Please refer to 'Trends affecting future health expenditure and impact on consumers' in this document for a further explanation.

- *Responsible Economic Management — Chemotherapy Drugs — more efficient arrangements* budget measure[3] – DEFERRED.
- Withdrawal of the *Medicare Chronic Disease Dental Scheme (CDDS)* in favour of the *Commonwealth Dental Health Program* – DELAYED.
- Package of three bills to effect three private health insurance tiers (– DELAYED; re-introduced to Senate November 2009):
    - **Fairer Private Health Insurance Incentives Bill 2009 -** The bill amends the **Income Tax Assessment Act 1936** , **Income Tax Assessment Act 1997** , **Private Health Insurance Act 2007** , **Taxation Administration Act 1953** and **Taxation (Interest on Overpayments and Early Payments) Act 1983** to reduce the amount of private health insurance rebate (PHI rebate) eligible taxpayers with complying private health insurance are entitled to when their income for surcharge purposes is above the relevant Medicare levy surcharge (MLS) threshold.
    - **Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 -** The bill amends the **Medicare Levy Act 1986** to increase the rate of MLS for certain taxpayers who do not have complying health insurance and whose income for surcharge purposes is above the relevant MLS threshold.
    - **Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009 -** The bill amends the **A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Act 1999** to increase the rate of MLS for taxpayers who do not have complying health insurance and whose income (including reportable fringe benefits) for surcharge purposes is above the relevant MLS threshold.

Specific Purpose and National Partnership Payments

Payments for specific purposes have been rationalized to five, including one Specific Purpose Payment (SPP) for health care. National Partnership Payments (NPPs) will be used to facilitate reforms, support specific projects and reward the achievement of reform-based performance benchmarks. Existing payments for specific purposes and election commitments have become National Partnership project payments. They support national objectives or provide a financial contribution to the States to deliver specific projects.

Each National SPP, including for health, is associated with a National Agreement that contains the objectives, outcomes, outputs and performance indicators, and clarifies the roles and responsibilities that will guide the Commonwealth and States in the delivery of services across the relevant sectors.

Implementation plans for some, but not all, of the National Partnerships for Health are available at: http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health.aspx

3 The Government will defer the implementation of this Budget measure that, when implemented, will fund chemotherapy drugs listed on the PBS and under the Chemotherapy Pharmaceuticals Access Program according to the amount of active ingredient used, rather than the number of vials used. The deferral will allow further consultation with industry stakeholders to address implementation issues. The deferral will reduce savings to the PBS and RPBS Scheme by $36.3 million in 2009-10.

Of the $335.47 million for facilitation payments, and $307.47 million for reward payments (as outlined in the National Partnership Agreement on Preventive Health), it is estimated that as little as $4.1 million will be distributed to states in 2009-10.

Ministerial Council for Federal Financial Relations: Performance reporting for national agreements

The COAG Reform Council will be the independent assessor of whether pre-determined milestones and performance benchmarks have been achieved before an incentive payment to reward nationally significant reforms or service delivery improvements under a National Partnership reward payment is made. The final decision on payments will be made by the Commonwealth. To assist the COAG Reform Council, the agreements underpinning each National Partnership reward payment will clearly set out the milestones and performance benchmarks that must be achieved for each jurisdiction to be eligible for a payment.

Available at: http://www.federalfinancialrelations.gov.au/content/performance_reporting.aspx

Trends affecting future health expenditure and impact on consumers

Medicare Benefits Scheme

The projected increase in Medicare costs is likely to in part reflect continued blow-outs in the cost of the *Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS)* program. An analysis of data from 2006 to 2009 shows the total cost of the *Better Access* program to June 2009 is $841.2 million. On this basis, the total cost of this program over the 4 years since its introduction is predicted to be around $1.4 billion.

The rapid rate of increase in the uptake of all services continues, including out-patient services (Table 2), with the exception of GP-provided Focused Psychological Strategies services which are constant, perhaps even declining slightly.

In 2007-08, a maximum of 664,419 people had a GP management plan. These people received a total of 2,518,759 mental health services from GPs, psychologists, social workers and occupational therapists – an average of 3.8 services/person.

In 2008-09, a maximum of 821,925 people had a GP management plan. These people received a total of 3,389,243 mental health services from GPs, psychologists, social workers and occupational therapists – an average of 4.1 services/person. The number of plans being reviewed has increased substantially.

For psychiatric services in 2008-09, a maximum of 14,323 patients had a management plan, an increase of 29 per cent over the previous year; and 82,524 initial consultations were billed, an increase of 7 per cent over the previous year.

Table 2: Out-patient psychiatric services: Summary of number of services and total cost.

		2004-05	2005-06	2006-07	2007-08	2008-09
Items 291, 293 Management plans	**Services**	86	1,902	6,057	11,119	14,323
	Cost	$0.01m	$0.4m	$1.8m	$3.7m	$4.8m
Items 296, 299 Initial Consultations	**Services**	-	-	43,392	77,212	82,524
	Cost	-	-	$8.6m	$15.6m	$17.1m
Items 300-319 Consultations	**Services**	1,723,178	1,706,753	1,629,485	1,537,876	1,519,188
	Cost	$193.8m	$197.7m	$196.4m	$194.3m	$197.7m
Items 353 – 361 Telepsychiatry	**Services**	202	351	646	1,081	1,336
	Cost	$0.02m	$0.04m	$0.07m	$0.10m	$0.14m

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

There has also been a considerable increase in Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) scripts and costs over the decade from financial year 1998-99 to 2008-09 (Figure 1). Over this time, the cost of the PBS and RPBS has grown by 140 per cent (which equates to $4.4 billion); the number of scripts has grown by 41 per cent.

Combining the data (using the relevant Anatomical Therapeutic Chemical (ATC) Codes) for anti-neoplastic and immuno-modulating agents as a proxy for cancer pharmaceuticals, for the decade from financial year 1998-99 to 2008-09, the cost for this group of pharmaceuticals has increased nearly seven-fold (which equates to $1.1 billion) and script numbers have grown by 170 per cent. This accounts for 25 per cent of growth in PBS and RPBS costs.

The average cost per script for all pharmaceuticals (excluding cancer pharmaceuticals) has increased from $20.74 in 1998-99 to $31.88 in 2008-09. For cancer drugs the average cost per script has increased from $225.71 to $644.21. If PBS and RPBS had grown at same rate post 2004-05 as the average rate up until that time, costs would have reached $9.33 billion per year. So on that basis alone, without savings from generics, the Government has saved $5.4 billion - considerably more than the $1.9 billion the previous Treasurer Peter Costello predicted in the 2002-03 Budget.

Perhaps more worrying, about 96 million fewer prescriptions were delivered through the PBS and RPBS since 2004-05[4] than might have been expected on the basis of annual rates of increase prior to that time (Figure 2). We know little about what sort of scripts these were, but previous work[5] suggests that one group that may have suffered were general patients taking medicines for mental health conditions.

While it is not within the scope of this report to analyse the likely impact of the current capacity of the Australian economy on the household budgets of Australian families, we can expect that there will be a considerable effect on the ability of many to afford needed health care.

4 PBS co-payments increased by 21 per cent in January 2005.

5 Hynd A & Russell L. Recession and depression; an analysis of the effect of co-payment increases on the use of PBS depression medications. February 2009. This paper was the subject of an opinion piece and a news article for the Health section of The Australian, 28 February 2009.

Figure 1: Total cost of PBS and RPBS services compared with cancer-related PBS and RPBS services per financial year, in the years beginning June 1998-2008.

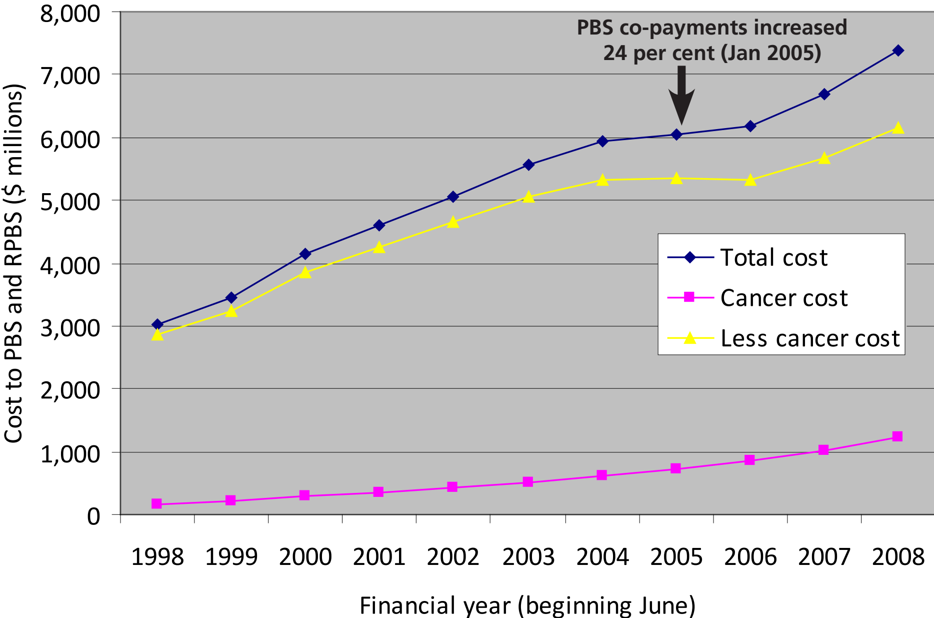
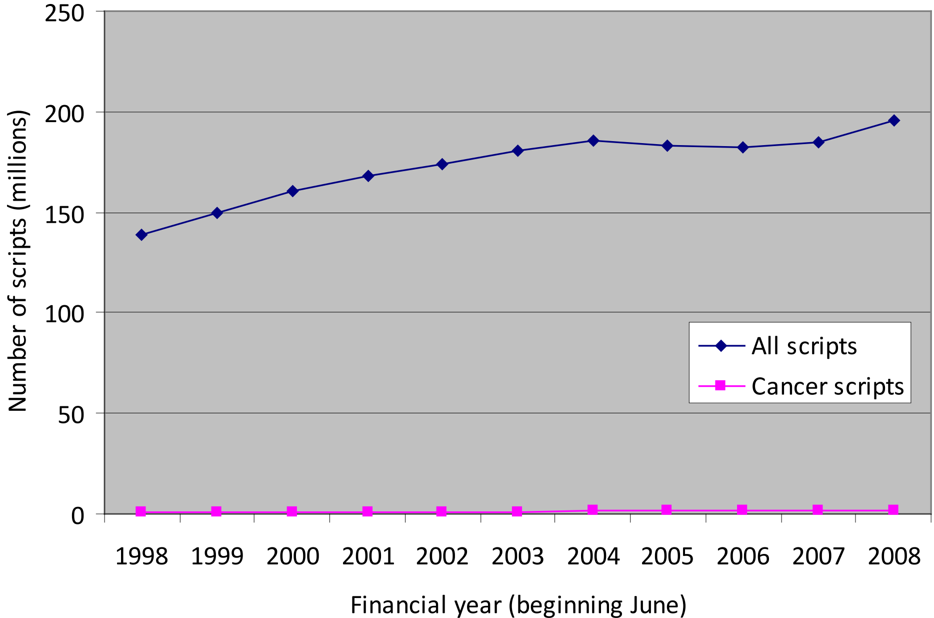


Figure 2: Total number of scripts compared with number of cancer scripts delivered through PBS and RPBS per financial year, in the years beginning June 1998 – 2008.



Biographical Notes

Dr Angela Beaton is a Research Officer at the Menzies Centre for Health Policy, working with Professor Stephen Leeder and Dr Lesley Russell.

After completing her PhD in genetics at the University of Waikato (New Zealand) and a postdoctoral fellowship in reproductive technologies, Angela worked as a Clinical Embryologist and Preimplantation Genetic Diagnosis Scientist at Fertility Associates (NZ) and Sydney IVF (Australia).

Angela has held a conjoint academic appointment at the University of Sydney, contributing to the FRACP training program for Paediatric Medical Trainees and coordinating an ongoing education program at The Children's Hospital at Westmead, and other teaching within the School of Public Health and Sydney Medical School. More recently, Angela played a key role in the development of the University of Sydney Cancer Research Network.

Angela is currently enrolled in a Graduate Certificate in Health Policy at the University of Sydney.

Dr Lesley Russell has more than 20 years' experience working in health policy in the government, private and not-for-profit sectors, both in Australia and internationally.

Most recently Dr Russell was Policy Advisor to Julia Gillard, MP in her role as Federal Shadow Minister for Health and Manager of Opposition Business in the House of Representatives. Prior to this she was part of the Policy Unit in the office of the Hon Simon Crean, MP, when he was Leader of the Federal Opposition, with responsibilities for health and ageing, disabilities, immigration, indigenous affairs and the status of women.

Dr Russell has also worked in policy, communication and lobbying roles for the pharmaceutical industry, the Cancer Council and the National Breast Cancer Centre and in the lead-up to the 2000 Sydney Olympic Games, she worked in communications and media for both SOCOG and Telstra.

Dr Russell is currently in Washington DC where she is part of the health team at the Center for American Progress, a Democrat think tank, and a Visiting Professor in the Department of Health Policy at George Washington University.

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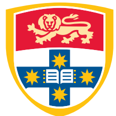
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Menzies Centre for Health Policy

The Menzies Centre for Health Policy is a collaborative centre between The Australian National University and the University of Sydney. The Centre encourages informed debate about how Australians can influence health policy to ensure that it is consistent with their values and priorities and is able to deliver safe, high quality health care that is sustainable in the long term.

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