

ANALYSIS OF THE 2009-10 HEALTH BUDGET

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NOTES

This analysis looks at the health and ageing and related provisions in the 2009-10 Commonwealth Budget in the context of current and past strategies, policies, programs and funding support.

The opinions expressed are those of the author who takes sole responsibility for them and for any inadvertent errors.

The Budget measures aimed at 'Closing the Gap' in Indigenous disadvantage have been analysed separately, and can be found on the website of the Menzies Centre for Health Policy, along with Budget analyses from previous years.

See http://www.menzieshealthpolicy.edu.au/MCHP_V3/site/budgetelectioncomm.php

The rounding errors for funds used in this paper are those used in the Budget Papers.

FORWARD

Increasingly the annual Federal Budget has been the vehicle for the announcement of new government policies and spending proposals. Whether the Budget is the proper mechanism for the introduction of health care reforms is an open question, although reforms inevitably necessitate fiscal and legislative changes, which in turn require budgetary input.

The exigencies of the global financial crisis and its consequences always meant that the 2009-10 Budget was going to be more about targeted new spending and lots of budget cuts in current programs, but such times can offer a unique opportunity to refocus and recast old policies and spending to achieve better value and better outcomes.

The drive to do this has never been greater. The Rudd Government has yet to deliver on the substantial reforms promised to tackle the prevention and better management of chronic diseases, to provide the outreach, team work and coordination that is needed to ensure physical and mental health and wellbeing, and to address the inequalities and inequities that are inherent in the current system.

However this year an examination of the Health Budget shows that this opportunity has been missed. The bean counters clearly won out over the policy wonks, and to the extent that new policy is made, it seems that this was done by Finance and Treasury, not Health.

This is demonstrated most obviously in the proposal to means test the private health insurance rebate, which is arguably the biggest policy change in the Budget. While this measure was aimed at reigning in expenditure, which now is almost \$4 billion annually, increasing the Medicare levy surcharge to help persuade higher income earners to continue to purchase private health cover takes steps (deliberately or inadvertently) towards new policy about the role of the private system in health care.

In effect, this proposal presages the Government's response to the financing reform recommendations that will be in the report from the National Health and Hospitals Commission (NHHRC), due at the end of June.

In fact there are a number of reports on health reform from advisory bodies due within the next few months. However there are no measures in the Budget to provide the resources that will be needed to facilitate analysis and implementation of the recommendations from these reports from the NHHRC, the National Preventative Health Taskforce, and the National Primary Health Care Strategy External Reference Group.

The Budget does have some welcome new spending, most notably on infrastructure for health services and research (albeit without the recurrent costs that will also be needed), the provision of new maternity services led by midwives, and to allow nurse practitioners access to Medicare items and prescribing rights.

There is \$232 million to initiatives to help close the gap in Indigenous health, although the majority of these funds will go to the Northern Territory. Despite the huge unmet need, Indigenous health programs are not immune from budget cuts, losing \$25 million.

The total spending in health over the five years 2008-09 to 2012-13 is \$4.7 billion. This includes spending on Indigenous health but does not include aged care or sport and recreation. New spending, \$3.0 billion of which is from the Health and Hospitals Fund for infrastructure, is off-set by savings totaling \$3.3 billion.

Analysing the 2009-10 Health Budget and tracking the funding commitments is particularly difficult exercise this year. The Budget Papers and Portfolio Budget Statements provide a lot of information, but nowhere is there a statement about the total amount of new spending or the total savings made from current programs. Funding commitments are bolstered by constant references to funding already provided through the Council of Australian Governments (COAG) and to funding commitments that extend well beyond the forward estimates.

Last year the raft of budget cuts were gathered together under the rubric of 'responsible economic management'. This year the euphemisms are about 'modernising Medicare', 'improved targeting' or 'further efficiencies'.

Substantial new spending was never a realistic possibility for this Budget, and in many ways, the Health Budget is better than might have been predicted on the basis of new funding commitments.

However the failure of this Budget to link the need make savings to health policy reforms - for example, not to just redress the blow-outs in the cost of the Medicare safety net and the Better Access mental health program but to improve the functioning of these programs and the health of patients - means that inevitably it must be judged harshly.

At budget time next year, with an election looming, the Rudd Government may lament this wasted opportunity.

HEALTH CARE BUDGET PROVISIONS

BACKGROUND

The total spending in health over the five years 2008-09 to 2012-13 is **\$4.7 billion**. This includes spending on Indigenous health but does not include aged care or sport and recreation. New spending, **\$3.0 billion** of which is from the Health and Hospitals Fund for infrastructure, is off-set by savings totaling **\$3.3 billion**.

There is **\$232 million** to initiatives to help close the gap in Indigenous health, although the majority of these funds will go to the Northern Territory. Despite the huge unmet need, Indigenous health programs are not immune from budget cuts, losing **\$25 million**.

It should not go unnoticed that included in the Health Budget spending is **\$85 million / 4 years** to Medicare Australia, of which **\$51.4 million** is for management and administration costs and **\$33.6 million** is for related capital costs.

COAG COMMITMENTS

Central to the COAG reforms agreed to in 2008 were five new National Specific Purpose Payments (SPPs), including a National Healthcare SPP with funding of **\$60.5 billion / 5 years** (this was increased to **\$64.4 billion** in November 2008). The new SPPs will be central to achieving delivery improvements and reforms.

New National Partnership (NP) payments will be used by the Australian Government to fund specific projects and to facilitate and / or reward States that deliver on nationally significant reforms.

There are currently four NPs in health:

- Hospitals and Health Workforce Reform (**\$1.7 billion / 5 years**);
- Preventative Health (**\$448.1 billion / 4 years**);
- Taking Pressure off Public Hospitals (**\$750 million in 2008-09**);
- Indigenous Health (**\$1.6 billion / 4 years**).

Some documents also include the e-health NP (NeHTA) with federal funding of **\$108.9 million / 3 years**.

These NPs were effective 1 January 2009.

ANALYSIS OF BUDGET INITIATIVES

1. Workforce

According to the 2009–10 Budget Papers, the Government has developed an agenda for reform which will make the health system *'more responsive, coherent and efficient'* by using the skills of all health workers better.

However despite this claim, the 2008-09 Budget is a mixed bag as far as workforce is concerned. While there are some workforce innovations in the Budget, many of the measures announced are about rearranging or continuing with current programs. Overall this Budget spends **\$396.7 million / 4 years** on workforce provisions, but at the same time makes savings of **\$75.4 million**.

There is funding for two innovative initiatives - expanding the role of nurse practitioners in the delivery of health care by providing them with access to the MBS and PBS, and expanding Medicare and indemnity support for midwives - along with continued funding at quite modest levels for the rural health workforce, and additional funds for prevocational training for GPs and for the Divisions of General Practice.

There is also some infrastructure funding that will support clinical education and training, primarily for new medical and dental schools.

There is what purports to be a new Rural Workforce Strategy but for the most part this is a continuation of renamed and, in some cases consolidated programs, with little or no increase in funding. The new geographical classifications system that will replace the current RRMA classification and the boost in rural relocation payments for GPs will undoubtedly help some towns and regions that are currently struggling to recruit GPs, but any scheme that involves decisions made on the basis of boundaries will inevitably have winners and losers. The weakness of the new rural workforce strategy is that it is focused almost entirely on GPs.

It is disappointing to see the Public Health Education and Research Program (PHERP) summarily discontinued, apparently without any consideration of the recent review of public health research conducted by Professor Don Nutbeam, which remains, to the frustration of Nutbeam and many others, unreleased. Commissioning reviews and then ignoring them is no way to make evidence-based policy.

There is nothing to tackle continuing workforce problems in areas such as aged care nursing, mental health nursing, public dental services and specialist services outside metropolitan areas, and indeed some programs in these areas have had budget cuts, without any effort to see if they could be improved or replaced with better programs.

Table 1.1 Summary of workforce initiatives

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
<i>Workforce – spending provisions</i>						
Prevocational training for GPs	-	\$8.9m	\$10.4m	\$10.5m	\$11.4m	\$41.2m
Expansion of MBS schedule to NPs	-	\$11.5m	\$13.2m	\$17.4m	\$17.6m	\$59.7m
New funding formula for DGP	-	\$1.9m	\$3.1m	\$2.6m	-	\$7.5m
Improving maternity services	-	\$14.2m	\$25.4m	\$30.5m	\$50.4m	\$120.5m
Rural health workforce strategy	-	\$26.7m	\$32.7m	\$35.0m	\$40.0m	\$134.4m
Rural multidisciplinary training	-	\$2.7m	\$2.7m	\$2.8m	\$2.8m	\$10.9m
Pathology and diagnostic imaging	-					\$22.5m
<i>Total spending</i>	-	\$65.9m	\$87.5m	\$98.8m	\$122.2m	\$396.7m
<i>Workforce – savings provisions</i>						
Nursing education and recruitment	-	-\$0.6m	-\$0.6m	-\$0.6m	-\$0.6m	-\$2.3m
Practice incentive payments	-	\$2.1m	\$0.6m	-\$13.7m	-\$14.8m	-\$25.8m
Support for specialists to re-enter workforce	-	-\$0.6m	-\$0.6m	-\$0.7m	-\$0.7m	-\$2.6m
GPET	-	-\$0.2m	-\$0.8m	-\$0.8m	-\$0.8m	-\$2.6m
GP training – rural placements	-	-	-\$0.2m	-\$0.3m	-\$0.3m	-\$0.8m
Consolidating regional training providers	-	-\$1.5m	-\$3.0m	-\$3.0m	-\$3.0m	-\$10.3m
Workforce program efficiency savings	-	-\$0.4m	-\$0.4m	-\$0.4m	-\$0.4m	-\$1.5m
Discontinuation of PHERP	-	-	-\$6.6m	-\$11.3m	-\$11.5m	-\$29.5m
<i>Total cuts</i>	-	-\$1.3m	-\$11.6m	-\$30.7m	-\$32.1m	-\$75.4m

1.1 Improving maternity services package

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$8.8m	\$24.7m	\$29.7m	\$49.5m	\$112.7m
Medicare Australia	-	\$2.4m +\$3.1m*	\$0.7m	\$0.8m	\$0.9m	\$7.9m
<i>Total</i>	-	\$14.3m	\$25.4m	\$30.5m	\$50.5m	\$120.5m

* Related capital costs

This innovative initiative responds in a timely fashion to the recommendations of the recent report on maternity services from the Commonwealth Chief Nursing and Midwifery Officer. The Government has committed \$120.5 million / 4 years for the introduction of Medicare-supported midwifery services and other measures to provide women with greater choice of care during pregnancy, birthing and post-partum.

The Budget Papers and accompanying media release provide some outline of the measures that will be included in this package, but much detail is lacking and presumably remains to be worked out. Full implementation will not begin until November 2010.

The package includes:

- Access to MBS and PBS benefits for services provided by eligible midwives working in collaboration with doctors.
- A Government-supported professional indemnity insurance scheme for eligible midwives.
- An expansion of the Medical Specialist Outreach Assistance Program (MSOAP) to provide integrated teams that will include midwives, obstetricians, GPs, pediatricians, AHWs to under-serviced areas.
- Extra scholarships for GPs and midwives to expand the maternity workforce, especially in rural and remote areas.
- Professional development programs for midwives and to encourage GPs to undertake additional training in obstetrics and anaesthesiology.
- A new 24/7 telephone helpline and information services to provide information and support before and after birth.
- The development of a quality and safety framework, professional guidelines and advanced midwifery credentialing.

There is also a commitment to agreement with the States and Territories on a National Maternity Services Plan.

The main thrust of this initiative is that midwives will now be able to work as private practitioners (something previously limited in large part by the difficulty in obtaining professional indemnity cover), have their services subsidised by the MBS and prescribe medications under the PBS.

There are limitations imposed in that the Budget Papers refer to 'eligible' midwives (presumably those with agreed post-graduate qualifications and experience) and the services must be carried out in 'collaborative arrangements' with hospitals, healthcare settings and doctors. It's not clear how easy it will be for midwives to meet these criteria and how cooperative doctors, in particular, will be. It's also not clear how many midwives currently forced to work in salaried positions in hospitals and birthing centres will be attracted away from this sector into private work: this could impact adversely on publicly funded maternity services.

The expansion of MSOAP requires that there is spare capacity for maternity care health professionals to do this work and that they are willing to work together in the proposed integrated teams.

It is interesting to speculate whether the proposed 24/7 hotline represents a reworking of the controversial and under-utilised Pregnancy Counselling Hotline.

These provisions alone will not be sufficient to address the current problems in the availability (and affordability) maternity services, many of which relate to over-stretched public hospital facilities. The development of a quality and safety framework will help here, along with national agreed guidelines for risk management. (See http://www.menzieshealthpolicy.edu.au/MCHP_V3/site/other%20tops/Position%20paper%20%20Reforming%20maternity%20service%20in%20Australia.pdf)

1.2 Medicare Benefits Schedule – nurse practitioner workforce – expansion

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$1.5m	\$10.8m	\$16.8m	\$16.9m	\$46.0m
Medicare Australia	-	\$8.9m +\$1.0m*	\$2.1m +\$0.3m*	\$0.6m	\$0.6m	\$13.5m
<i>Total</i>	-	\$11.5m	\$13.2m	\$17.4m	\$17.5m	\$59.7m

The provision will help provide for the development of a model for the more effective use of nurse practitioners in the health workforce by expanding their role and allowing them access to the MBS and the PBS from November 2010. This should help with workforce issues in rural and remote areas.

This measure has been criticised by the Royal Australian College of General Practitioners which has argued that, unlike funding for practice nurses, the funding provided to support the expansion of the role of specialist nurse practitioners does not meet the workforce needs of GPs, presumably because nurse practitioners work in independent practice and are not supervised by medical practitioners. This type of criticism highlights how difficult it is to implement new workforce programs with new roles for the various professions.

Measures like this also give some indication of the high cost of administration of Medicare and the PBS by Medicare Australia. In this case Medicare Australia gets 27% of the program funding.

1.3 Divisions of General Practice program – new funding formula

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$1.9m	\$3.1m	\$2.6m	-	\$7.6m
Current funding*	\$79.5m	\$81.2m	\$82.7m	-	-	

* from 2007-08 budget

This additional funding will go, via a new funding formula based on the new classification system for remoteness areas, to those DGPs where there has been significant population growth. Longer term funding arrangements are to be considered prior to the expiry of the current new funding agreements on 30 June 2012.

It appears that no provision has been made for the funding of Divisions from Jan-June 2012.

1.4 Prevocational training for doctors in general practice

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$8.9m	\$10.4m	\$10.5m	\$11.4m	\$41.2m

This funding will provide 160 additional places / 4 years in the Prevocational General Practice Placement Program (PGPPP), bringing the total number of annual places in 2012-2013 to 410.

This program provides voluntary general practice placements for junior doctors undertaking hospital training but not yet enrolled in a speciality as a way of encouraging them to become GPs. Interns and international medical graduates are also able to participate in this program, which currently provides up to 280 placements annually. The program is currently managed by the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners.

A separate provision in the Budget makes savings of \$2.6 million / 4 years in this program by transferring its administration to General Practice Education and Training (GPET).

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.2m	-\$0.8m	-\$0.8m	-\$0.8m	-\$2.6m

A national internal evaluation of the PGPPP was undertaken in 2007. The evaluation covered outer urban, regional, rural and remote placements undertaken by junior doctors in the PGPPP from January 2005 to June 2007. During this time there were 244 placements, 75% in rural and remote areas.

These data, admittedly now several year's old, suggest that this program is not currently operating at maximum capacity. It is not clear how moving this to GPET will save funds.

1.5 General practice training – consolidating regional training providers – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$1.5m	-\$3.0m	-\$3.0m	-\$3.0m	-\$10.4m

The Australian General Practice Training Program (AGPT) is managed by General Practice Education and Training Limited (GPET), set up in 2001, on behalf of the Australian Government. The vocational endpoints of training are Fellowship of the Australian College of Rural and Remote Medicine and Fellowship of the Royal Australian College of General Practitioners, either of which is required for vocational recognition under the *Health Insurance Act*.

GPET has a regionalised system of general practice education and training, currently delivered through 20 regional training providers (RTPs) across Australia, which promotes horizontal and vertical integration of general practice education and training. The RTPs are distributed as follows:

- NSW – 9 (including one shared with Victoria)
- Northern Territory – 1
- Queensland – 3
- South Australia – 3 (including one shared with Victoria)
- Tasmania – 1
- Western Australia – 1
- Victoria 0 2 (including 2 shared with other states)

It is not clear if any of these can be consolidated without inconvenience and increased travel requirements for GPs in training.

1.6 General practice training – extension of time for rural placements

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$0.2m	-\$0.3m	-\$0.3m	-\$0.8m

This measure will extend the time of a rural placement for trainee GP specialists from six to 12 months. The rationale given is that this will ensure greater medical continuity in the community. The savings are made by a (presumed) reduction in the number of relocation subsidies paid under the program. It is not clear if a 12month rural placement now becomes mandatory or is optional.

1.7 Practice Incentive Payments – quality and administrative improvements – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$4.9m	-\$1.3m	-\$14.1m	-\$15.2m	-\$35.5m
Medicare Australia	-	\$2.3m +\$4.7m*	\$0.7m +\$1.2m*	\$0.4m	\$0.3m	\$9.6m
<i>Total</i>	-	-\$2.1m	\$0.6m	-\$13.7m	-\$14.9m	-\$25.8m

* related capital costs

These changes are described as improving quality and safety and simplifying administrative changes, although establishing how these aims will be achieved is not easy from the information provided in the Budget Papers.

For example, the simplification of administration is achieved only at a cost of \$9.6 million to Medicare Australia.

The provision that will require non-accredited practices to adhere to proper vaccine storage and handling processes is important for quality and safety, but only achieves savings if a reasonable proportion of the 750 practices no longer qualify for the GP Immunisation Incentive.

It is not clear how these new requirements for the payment of practice incentives will impact on GPs red tape, paper work and cash flows.

1.8 Nursing education and recruitment – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.6m	-\$0.6m	-\$0.6m	-\$0.6m	-\$2.3m

Savings are made by consolidation of five existing programs:

- Bringing Nurses Back into the Workforce;
- Rural Nurse Initiative (Nurse Scholarship program);
- Retraining Scholarships for More Practice Nurses and Allied Workers in Metropolitan Areas:
- Additional Practice Nurses for Rural Australia: and
- The Mental Health Postgraduate Scholarship Scheme.

It would be an interesting exercise to see if this consolidation does result in \$2.3 million in savings as a consequence of administrative efficiencies.

1.9 Workforce program – realising efficiency savings from consolidation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.4m	-\$0.4m	-\$0.4m	-\$0.4m	-\$1.5m

This is yet another Budget provision that aims to make savings by consolidation of programs. In this specific case, savings might actually result, but it is unlikely we will ever know.

Eighteen elements of the current workforce program will be consolidated into three sub-programs:

- Health Workforce Innovation and Reform;
- Medical Training and Supply; and

- Nursing and Allied Health Training and Supply.

These programs have an average funding of \$401.4million / year across the forward estimates.

1.10 Support for specialists to re-enter the workforce - cessation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.6m	-\$0.6m	-\$0.7m	-\$0.7m	\$2.6m

The Specialist Re-entry Program was established in 2003 as part of the Fairer Medicare package to provide support to assist medical practitioners to re-enter the workforce following career interruptions. Re-entering medical practitioners participating in this program are eligible for three months refresher support including a supported clinical placement (where this occurs in a private practice, services attract the Medicare rebate).

The Budget Papers state that the uptake of this program has been low (it has not been possible to find publicly available information about the uptake) and the program is no longer considered a cost-effective means of encouraging the re-entry of specialists into clinical practice.

1.11 Public Health Education and Research Program – discontinuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$6.6m	-\$11.3m	-\$11.5m	-\$29.5m

The Public Health Education and Research Program (PHERP) aims to strengthen national capacity to educate and train Australia's public health workforce. PHERP assists tertiary institutions across Australia to offer a range of postgraduate public health education programs, including research training. The program has been reviewed several times, in 1999, 2005 and 2008.

The Budget Papers state that *'the most recent review of the program [it's not clear which review is being referred to] concluded that successive government investments have increased the public health workforce capacity to address population health issues.'*

Evidence to Senate Estimates indicates that cutting PHERP was purely a cost-saving measure that did not reflect the performance of the program or any review of research and education needs.

In response to the fact that the 2008 NHMRC Review of Public Health Funding in Australia (Nutbeam Review) has yet to be released, Professor Nutbeam took the unusual step of writing a public letter to the Minister (see <http://blogs.crikey.com.au/croakey/2009/05/28/roxon-to-face-anger-over-blocked-public-health-report/>). In that letter he said *'This Program [PHERP] was regularly referred to*

in our consultations and in the Report as one of the factors that has supported success in public health research in Australia. We appear to be going backwards not forwards in response to the success of public health research in Australia.'

The rural health workforce provisions are analysed in Section 3: Rural Health.

The pathology and diagnostic imaging workforce provisions are analysed in Section 8: Pathology and Diagnostic Imaging.

2. Infrastructure

The 2009-10 Budget will be remembered for the major contribution to health and biomedical infrastructure, an investment that will benefit Australia well into the future.

The Budget commits **\$3.3 billion / 7 years** from the Health and Hospital Fund established in 2008-09 to infrastructure. There is some confusion around the actual spending of these funds and it seems that not all have been committed, or that some funds are being held by DoHA for administration expenses.

For example:

- There is \$9.2 million allocated for health care infrastructure in rural Australia under the provision headed 'Health and Hospitals Fund – hospital infrastructure and other projects'. The media release from the Minister for Health on 12 May 2009, announces \$13.9 million for 40 rural and regional projects, although when totaled, the spending on the listed projects is only \$11.62 million. It is not clear if these are references to the same spending or to a different commitment.
- The actual detailed spending on hospital infrastructure and other projects totals \$1,215 million (assuming the \$9.2 million for rural projects) – some \$300 million less than the stated commitment.

These commitments can be assessed in a number of ways, and a clear breakdown of spending is not possible because some projects involve simultaneous commitments to building, new equipment and opportunities for workforce training. Table 2.1 provides one cut of these commitments.

Table 2.1 How infrastructure funds are spent

Hospital infra-structure	Research	Clinics/ health centres	Clinical education / training	Medical equipmt	Medical/ comm services	Total	Un-accounted
\$1,856m	\$610m	\$47m*	\$189m	\$120m	\$152m	\$3,000m	\$300m

* assume rural infrastructure spending of \$11.6m

The States and Territories have been keen to scrutinise this spending to see who benefited most. Again, there are different ways to look at this. Table 2.2 analyses the spending by category and State / Territory, but omits those provisions which benefit more than one jurisdiction. It's interesting that the clear winner on a population basis is WA – the only jurisdiction where Labor is not in power.

Table 2.2 Allocation of infrastructure spending by State and Territory

	Vic	NSW	Qld	SA	WA	Tas	NT	ACT
Hospitals	\$426m	\$266m	\$76m	-	\$444m	\$42m	\$32m	\$28m
Research	\$130m	\$82m	\$40m	\$200m	-	\$45m	\$34m	\$60m
Rural clinics etc	\$3.5m	\$30.5m	\$1.0m	\$0.8m	\$10.7m	\$0.5m	\$0.8m	-
Clinical edn / training	\$11.4m	\$46.2m	\$104m	-	-	-	\$27.8m	-
<i>Total</i>	\$571m	\$425m	\$221m	\$201m	\$455m	\$88m	\$95m	\$88m

2.1 Health and Hospitals Fund – hospital infrastructure and other projects

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	\$100.0m	\$383.7m	\$273.5m	\$307.2m	\$287.0m	\$1,351.4m

This funding is for \$1.5 billion / 7 years (it includes \$104.1 million in 2013-14 and \$10 million in 2014-15) from the Health and Hospital Fund established in 2008-09.

However the total sum of the projects listed is only \$1,215.5 million. It is not clear where or if the remainder of these funds has been committed.

While it appears that there may have been some consultation and discussion through the COAG/AHMC process about the funding of most of these projects, it is not clear how the range of health infrastructure projects in rural areas were selected.

Projects to be funded:

Project	Funding	Comments
ARC Blood Service principal site development (Vic)	\$120m / 2 years	Construction due to begin in 2009 and completed by April 2011.
Donor Tissue Bank of Victoria (Vic)	\$13m / 3years	Supplies tissue to 170 hospitals. Construction expected to begin in March 2010 and completed by September 2011.
Narrabri District Health Service Centre, Griffith (NSW)	\$27.0m	Funding is for an integrated district health service, bringing together hospital, primary and community health services. Narrabri has a 38-bed acute facility with services in obstetrics and surgery.
Clinical School and Research Centre, Blacktown (NSW)	\$17.6m	Part of School of Medicine, UWS at Blacktown Hospital. Note that there is also funding of \$17.2m for a Nepean Clinical School.

Nepean Health Services Redevelopment (NSW)	\$96.4m / 5years	Will provide new East Block, expansion of in-centre renal dialysis stations, mental and dental health services and the Intensive Care Unit, and major equipment upgrades. Budget also provides \$17.2m for Nepean Clinical School.
Expansion of Rockhampton Hospital (Qld)	\$76.0m	50% of cost of 30 new beds and 2 new theatres.
Oral Health Centre, University of Queensland (Qld)	\$104.0m	To be Australia's largest OHC – 187 chairs across 11 clinics will treat about 17,000 dental and cancer patients each year. To be operational in 2012.
Health and Medical Research Institute (SA)	\$200m	For up to 675 researchers. To be completed by 2012, next door to RAH.
Replacement of rehabilitation unit at Fiona Stanley Hospital (WA)	\$255.7m/6 years	Rebuilding of State Rehabilitation Centre at FSH which is currently being built. Due for completion 2013.
Midland Health Campus (WA)	\$180.1m	In March 2009 the WA Health Minister announced that construction of this campus was delayed until 2014. Previous State Govt committed \$350m.
Expansion of Kimberley Renal Service (WA)	\$8.6m	The Kimberley Satellite Dialysis Centre (KSDC) is provided by the Broome Regional AMS. Opened 2002.
Replacement of pediatrics unit in Broome (WA)	\$7.9m	Broome Hospital has 36 beds (including six nursing home beds) and is in the process of being upgraded to provide more regional services
Acute medical and surgical service unit, Launceston General Hospital (Tas)	\$40.0m	Money is in addition to \$45m current rebuilding program; will provide for refurbishment of all surgical and medical wards, improved hospital infection control and fire prevention requirements.
Emergency Department, Alice Spring Hospital (NT)	\$13.6m	ED handles 30,000 presentations and 10,000 admissions / year. NT Govt 2007-08 Budget had \$6m to build new ED but this work has not started.
NT medical program through Charles Darwin and Flinders Universities (NT)	\$27.8m + \$4.4m / 3 years from 2020-11	Funding is for a medical school building so NT medical students can be educated in NT. Additional funds are provided from 2010-11 for recurrent costs.
Short-term patient accommodation Royal Darwin Hospital (NT)	\$18.6m	50 units at RDH for patients and their carers. NT Govt 2009-10 budget has \$2m for accommodation for radiation oncology patients and their carers.
Health care infrastructure in rural Australia*	\$9.2m	Minister's media release states \$13.9m for 40 rural and regional projects. Difference not clear.

The breakdown of the infrastructure in rural Australia follows. This was taken from a media release from the Minister for Health, dated 12 May 2009 which announces spending of \$13.9 million for 40 rural and regional projects. However the sum of these projects is only \$11.62 million.

Some of these projects look as if they were sourced very quickly. For example: \$500,000 is provided to the Barwon DGP to *'design a one-stop primary health care facility'* for Gunnedah, and Dubbo Private Hospital received \$155,205 to, in part, *'develop a plan that can be implemented over time which will benefit the people of Dubbo'* [sic]. Some projects are funded to the last dollar, others are provided with a round half a million dollars.

Projects to be funded:

Location	Organisation	Project	Funding
Ararat (Vic)	Ararat Medical Centre	Extension of existing building with additional consulting rooms, waiting area, meeting rooms and teaching area.	\$500,000
Beechworth (Vic)	Beechworth Surgery	Replacement and upgrade of computer system and hardware.	\$50,000
Camperdown (Vic)	Camperdown Clinic Trust	Extensions to the current medical clinic and purchase of clinical, diagnostic and procedural equipment.	\$432,987
Kerang (Vic)	Fitzroy Street Medical Clinic	Build and equip new consulting rooms for practice use and training of medical students and GP registrars.	\$261,990
Merino (Vic)	Glenelg Shire Council	Redevelopment of the Bush Nursing Centre.	\$500,000
Murchison (Vic)	Goulburn Valley Division of General Practice	Refurbishment and upgrade of facilities.	\$499,059
Charlton (Vic)	Charlton Medical	Refurbishment of medical practice facility and equipment to attract staff.	\$218,407
Cobram (Vic)	Moira Shire Council	Construction of integrated primary care facility to include medical and dental..	\$500,000
Inglewood (Vic)	Loddon Shire Council	Construction of accommodation to attract another GP to the area.	\$390,000

Nathalia (Vic)	Nathalia Medical Clinic	Equip new medical clinic with medical equipment, to remain part of the medical clinic.	\$115,100
Ouyen (Vic)	Mallee Division of General Practice	Extension for a dental sterilisation facility.	\$57,272
Bombala (NSW)	Bombala Council	Construction of house for use by GP.	\$260,000
Dubbo (NSW)	Dubbo Private Hospital	Purchase urology and imaging equipment; develop a plan to be implemented over time to benefit the people of Dubbo.	\$155,205
Forbes (NSW)	Forbes Shire Council	Construction of walk-in / walk-out medical service in Forbes.	\$500,000
Forbes (NSW)	Joma Consulting Services Pty Ltd	Renovation of existing building and construction of annex building for professional consulting rooms.	\$498,388
Gilgandra (NSW)	Gilgandra Shire Council	Build a private GP clinic in the grounds of the Gilgandra MPS.	\$240,000
Gunnedah (NSW)	Barwon Division of General Practice Ltd	Design a one-stop integrated primary health care facility with capacity for training, retaining and developing medical and allied health services.	\$500,000
Rylstone (NSW)	Mid-West Regional Council	Purchase of residential property to attract and retain GPs and other health professionals.	\$300,000
Scone (NSW)	Upper Hunter Shire Council	Increase capacity of Scone Medical Practice to accommodate multidisciplinary health services.	\$500,000
Taree (NSW)	Intalink Therapy Solutions	Expand allied health services.	\$261,176

Urbenville (NSW)	Tenterfield Shire Council	Renovate and equip the existing Urbenville Medical Practice.	\$295,455
Inglewood (Qld)	Goondiwindi Regional Council	Capital works to establish a new medical centre.	\$500,000
Nebo (Qld)	Isaac Regional Council - Nebo Business Unit	Capital works to construct a new medical centre practice facility.	\$454,545
Roma (Qld)	Maranoa Medical Centre	Refurbishment to provide new consulting room; purchase of medical equipment.	\$55,389
Cummins (SA)	District Council of Lower Eyre Peninsula	Extensions for additional consulting rooms, waiting area, meeting rooms and teaching area.	\$130,000
Padthway (SA)	Tatiara District Council	Extension to the indoor sporting facility to include a new medical centre.	\$86,292
Tanunda (SA)	Tanunda Medical Centre	Refurbishment of building for study area, meeting area, video-conferencing room and staff amenities.	\$102,748
Tumby Bay (SA)	District Council of Tumby Bay	Enhance existing medical practice and allied health services to increase the range of health services available through visiting specialists.	\$500,000
Kalgoorlie (WA)	Eastern Goldfields Medical Div of GP (Goldfields Esperance GP Network)	Purchase of vehicle for mobile medical team; early detection and treatment for people with diabetes.	\$470,000
Donnybrook (WA)	Shire of Donnybrook-Balingup	Construction of new medical facility for general medical practice, pathology, specialised nurse treatment, allied health and training of rural medical staff.	\$500,000

Northam (WA)	Central Wheatbelt Division of General Practice Ltd	Capital works to support counselling and Allied Health Services.	\$500,000
Scottsdale (Tas)	Division of General Practice Northern Tasmania Inc	Construction of multidisciplinary primary care centre.	\$500,000
Dhalinbuy (NT)	Laynhapuy Homelands Association Inc	Build facility to deliver health care in clinically and culturally appropriate manner.	\$295,441
Alyangula, Groote Eylandt (NT)	Anindilyakwa Land Council	Accommodation for junior doctors and medical students.	\$496,000

2.2 Health and Hospitals Fund – translational research and workforce training

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	\$46.0m	\$40.0m	\$159.0m	\$170.0m	\$14.0m	\$429.0m

This initiative provides \$430.3 million / 6 years (including \$1.3 million in 2013-14) from the Health and Hospitals Fund to support infrastructure for translational medical research initiatives.

The Budget papers state that the projects listed are subject to their meeting the requirements of the HHF Advisory Board.

The majority of the spending (\$342.1m) is for facilities for translational research, and 30% of this is specifically for the neurosciences. There is \$88.2 million for new clinical schools. This is in addition to \$149.4 million provided elsewhere in the budget for clinical and dental schools.

Projects to be funded:

Project	Funding	Comments
Monash Health Research Precinct translation facility, Clayton (Vic)	\$71.0m	Facility will have four partners - Southern Health, Monash University, Prince Henry's Institute and the Monash Institute for Medical Research.
The Melbourne Neuroscience Project (Vic)	\$39.8m	Two sites – at Parkville and at Austin Hospital. Partners are Florey Neurosciences Institute, Mental Health Research Institute and University of Melbourne.

Academic and research precinct, Northern Hospital, Epping (Vic)	\$14.0m	La Trobe University and The University of Melbourne have each committed \$7.2m and Vic Govt has contributed \$3 million towards planning and development.
Children's Bioresource Centre, Murdoch Children's Research Institute (Vic)	\$4.7m	Collaboration with Royal Children's Hospital and University of Melbourne Department of Paediatrics.
Clinical medical teaching and research facilities University of Notre Dame (Vic and NSW)	\$22.8m	ND University has clinical schools affiliated with a number of hospitals in Sydney and Melbourne and surrounding areas.
Nepean Clinical School, Nepean Hospital (NSW)	\$17.2m	One of 6 University of Sydney clinical schools, established 2006.
Ingham Health Research Institute facilities, Liverpool Hospital (NSW)	\$46.9m	The Institute was created by consolidation and restructure of Health Research Foundation, Sydney South West in 2007.
Hunter Medical Research Institute, Newcastle (NSW)	\$35.0m	Established in 1998. Building to cost \$90m.
Smart Therapies Institute, Princess Alexandra Hospital, (Qld)	\$40.0m	Established in 2007 with State Govt funding.
Stage 2, Menzies Research Institute, Royal Hobart Hospital (Tas)	\$44.7m	Matching support from the University of Tasmania, State Government, and US-based Atlantic Philanthropies. Building will house MRI and the clinical research facilities of the RHH.
Eccles Institute at JCSMR, ANU (ACT)	\$60.0m	Eccles Institute of Neuroscience was established in 2007. It hosts several major centres including the Centre for Mental Health Research, the Centre for Visual Sciences and the ARC Centre of Excellence in Vision Science.
Research and Training Facility, Darwin (NT)	\$34.2m	To build Centre of Excellence in Indigenous Health and Education. Linked to RDH and Menzies Health Centre.

2.3 Health Infrastructure projects in Tasmania

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Treasury	-	\$0.9m	\$0.9m	\$0.6m	-	\$2.4m

These funds will go to the Tasmanian Government to provide:

- An upgrade to the chemotherapy unit and the purchase of additional chemotherapy chairs at the Burnie Hospital;
- Funding to upgrade the Mersey Hospital chemotherapy unit;
- The provision of a mobile chemotherapy / day procedure unit for the west coast;
- \$1.0 million for family style units in patient accommodation in Launceston.

This seems like rather a lot to accomplish with \$2.4 million.

2.4 Health and Hospitals Fund – national cancer statement

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	\$40.0m	\$42.0m	\$415.0m	\$336.0m	\$342.0m	\$1,175.0m

This initiative provides \$1.3 billion / 6 years (including \$101.1 million in 2013-14) from the Health and Hospitals Fund to deliver infrastructure for cancer care.

This investment will fund:

- Two integrated cancer centre focused on treating rare and complex cancers;
 - ⇒ Lifehouse at RPAH (NSW) \$100 million
 - ⇒ Parkville Comprehensive Cancer Centre (Vic) \$426.1 million
- A network of 11 regional cancer centres (\$560 million)
 - ⇒ Integrated cancer centre (ACT) \$27.9 million
- Garvan /St Vincent’s Campus Cancer Centre (NSW) \$70 million
- Digital mammography equipment for BreastScreen Australia \$120 million

2.5 Health and hospital reform – establishment of the National Institute for Virology

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$20.0m

The new National Institute for Virology, which will support the National Centre in HIV Epidemiological and Clinical Research (NCHECR) at UNSW, will be established at St Vincent’s Hospital in Sydney.

The cost of this measure will be met from \$389.5 million / 5 years provided in the 2008-09 Budget for grants and recurrent funding for medical technology such as MRIs, upgrading and expanding hospital and community health facilities, and medical training infrastructure. A significant amount of this funding had previously been allocated in election commitments.

3. Rural health

This Budget has **\$228.1 million / 4 years** to fund new and ongoing initiatives in rural health. There is new spending of around **\$11.6 million**¹ for rural infrastructure, and **\$59.7 million** for expansion of the role of nurse practitioners, a measure which can reasonably be viewed as a provision impacting the rural health workforce. The remaining funds are for continuing programs, some of them rebadged or consolidated. It should be noted that it appears that the cost of the implementation of the new rural classification system is around **\$25 million / 2 years**.

Even allowing for the different ways in which different Governments package and brand their Budget proposals, the 2009-10 commitment for rural and regional health can be seen as considerably less than previous commitments:

- The 2000-01 Budget contained a \$562 million Country Health Package;
- The Rural Health Strategy was reauthorized to 2007-08 in the 2004-05 budget, at \$830.2 million / 4 years. This represented funding at the 2003-04 level with indexing in the out years. At that time the package was also ‘broadbanded’ – so that States and Territories were given some flexibility with the funding of the measures within the package.

The provisions that formed part of the previous Rural Health Strategy were:

- New GP Registrars;
- Enhanced Rural Assistance to medical Undergraduate Students;
- HECS Reimbursement Scheme;
- Bonded Scholarships for Medical Students to Practice in Rural Areas;
- Medical Training – University Departments of Rural Health;
- Medical Training – Rural Medical Training Clinical Schools;
- Rural Specialist Support Program (previously Medical Specialist Outreach Assistance)
- Workforce Support for Rural GPs;
- Rural Primary Health Program (previously More Allied Health Services and Regional Health Services);
- Rural Primary Health Program – Primary Health Projects (previously Rural Chronic Disease Initiative);
- Enhanced Rural and Remote Pharmacy Package;
- Rural Private Access Program (previously Bush Nursing, Small Community and Regional Private Hospitals);
- Aged Care – Adjustment Grants for Small Rural Facilities: and
- Communications Strategy.

¹ It is not clear exactly how much new spending is in the budget for rural health infrastructure. See Section 2: Infrastructure for further discussion of this matter. In this section the figure of \$11.6 million is used.

It's a difficult and time-consuming task to track the current fate and funding for these programs, but it appears that most, if not all, are still operational in some form or another. The question of whether they are funded in the forward estimates at increased or decreased levels over previous years remains open. However in the past five years almost \$100 million has been spent on the Rural Retention Program. Now this program will be consolidated with the Registrars Rural Incentive Payments Scheme into a new General Practice Rural Incentives Program, with total funding of \$64.3 million / 4 years. Other measures, such as the commitment to increase locum relief to doctors in rural and remote areas, are not substantially different to existing arrangements.

While this Budget delivers on the Rudd Government's commitment to reforming the remoteness classification structure (RRMA) to ensure that incentives and rural health policies respond to current population figures and real need, the actual evidence to support the move from RRMA to the ABS's Australian Standard Geographical Classification (ASGC) system has not been made public.

Neither has the promised review of all existing programs that support rural health professionals. It is known that an evaluation of the Rural Clinical Schools Program and the University Departments of Rural Health Program was done by the consultancy Urbis. Their report assessed the effectiveness and workforce implications of the two programs and made 25 recommendations about their future development. Urbis has been quoted as saying: *'The report was well received by the Department and the sector and has been influential in guiding policy direction in rural health education.'*

A web search reveals recent letters from the AMA and the RDAA to DoHA commenting on an issues paper on rural health programs. The RDAA's letter states in part: *'whilst this paper is a good start at identifying the overall themes we look forward to a more comprehensive paper being produced that explores in more significantly more detail the programs under each of the themes and their relative benefits and costs. It is difficult for the RDAA to comment in detail without this detailed information on each of the programs covered under the review. We would also suggest that this paper and any subsequent papers be made available to other stakeholder organisations as soon as possible for wider comment.'*

3.1 Rural Health Workforce Strategy

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$4.7m + \$1.3m*	\$28.6m +\$0.2m*	\$34.0m	\$39.0m	\$107.8m
Medicare Australia	-	\$6.5m +\$14.3m*	\$1.9m +\$2.1m*	\$0.9m	\$1.0m	\$26.7m
<i>Total</i>	-	\$26.8m	\$32.8m	\$34.9m	\$40.0m	\$134.4m

There are four major components to this Strategy:

1. A new geographical classification system, the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).

ASGC-RA has been developed by the Australian Bureau of Statistics using 2006 Census data, and is widely used by a number of Commonwealth and State agencies. It has five area categories: major cities; inner regional; outer regional; remote; and very remote. All areas other than major cities will be eligible for rural medical workforce programs. The Budget Papers state that this means more than 2,400 GPs and 500 communities will become eligible for rural medical workforce programs.

The new classification system will be phased in from July 2009.

2. The new General Practice Rural Incentives Program (\$64.3 million / 4 years)

This is formed by consolidation of the Rural Retention Program (RRP) and the Registrars Rural Incentive Payments Scheme. Retention and relocation payments will now be geared to the level of remoteness. According to the Minister's media release, a GP relocating from a major city to a regional centre will receive a \$15,000 grant, a GP relocating to a very remote area will receive \$120,000. Many of the more than 260 doctors who practice in the most remote locations will potentially have their maximum retention incentives increased from \$25,000 per year to \$47,000 per year.

The AMA says that while the RRP has been relatively successful in retaining GPs in rural and remote areas but it has failed to attract new doctors. It remains to be seen if this proposal will do that.

3. Changes in service obligations (\$47.5 million / 4 years)

Overseas trained doctors with restrictions on where they can practice will be able to discharge their obligations sooner if they work in rural and remote communities. In addition, the rate of reimbursement of debt under the HECS Reimbursement Scheme will be adjusted according to remoteness.

4. Increase in locum relief (\$22.6 million / 4 years)

Locum relief will be available to doctors working in remote and rural locations. The Minister's media release says more than 400 locum placements are planned (over 4 years?) to enable rural GPs to take a holiday or undertake further education and training. More than 150 urban doctors will be up-skilled in exchange for undertaking four-week locum placements in rural and remote communities.

The Rural Locum Relief Program currently allows overseas trained doctors who are not otherwise eligible to gain a Medicare provider number. It is assumed that this will continue. It is not known how many current locum placements are made under this program which is operated by the various State and Territory workforce agencies. Some States also contribute funding to this scheme.

3.2 Rural Health Workforce – maintaining rural multidisciplinary care

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.7m	\$2.7m	\$2.8m	\$2.8m	\$10.9m

Increased funding of \$10.9 million / 4 years is provided to two existing rural training programs:

- Additional funding of \$6.8 million to the University Departments of Rural Health program to provide opportunities for students of medicine, nursing and other health professions to practice their clinical skills in a rural environment; and
- Additional funding of \$4.1 million to allow 30 annual placements for dental students to undertake clinical training in rural areas.

The rural infrastructure measures are discussed in Section 2: Infrastructure.

4. Access to medicines

This Budget continues the recent trend with respect to the Pharmaceutical Benefits Scheme – some significant spending on the listing of expensive new medicines, primarily for cancer treatment; the claw-back of significant savings by expansion of ‘reform’ measures around reference pricing, therapeutic groups, and automatic pricing decreases when generic products come on to the market; and further spending measures for pharmacy activities (surprising considering that pharmacy already gets almost a quarter of the PBS budget) and Quality Use of Medicines (a good investment).

The Budget spends **\$1 billion / 5 years** on PBS measure, and takes savings of **\$230.6 million**. Of this spending, **\$970.7 million** is for new or expanded PBS listings, although some of this new spending may be offset by pricing arrangements which are acknowledged but not detailed in the Budget Papers. Initiatives to change PBS prices will achieve savings of **\$175 million**.

Arguably the best investment is the increased funding for the National Prescribing Service (NPS) which will save \$3.65 for ever \$1 spent.

Table 4.1 Pharmaceutical Benefits Scheme – new and extended listings

Drug	Indication	Cost
Plavix and Isocover (clopidogrel)	Extension of listing to patients who are also on aspirin. Used to treat Acute Coronary Syndrome.	\$101.3 million / 5 years
Avastin (bevacizumab)	For treatment of metastatic bowel cancer.	\$314.1 million / 4 years
Sutent (sunitinib)	For treatment of renal cell carcinoma.	\$131.1 million / 5 years
Minor new listings, including: Aclasta Vfend Nexavar Pegatron	Treatment of osteoporosis Treatment of fungal infections Treatment of primary liver cancer Treatment of hepatitis C	\$256.2 million / 5 years
<i>Total</i>		\$802.7 million

For two of these expensive new medicines (Avastin and Sutent), the Government has negotiated pricing agreements that potentially will see some cost reduction (not specified in the Budget) to the Government. It is assumed that these are either price /volume agreements or agreements to reimburse when treatment is not deemed successful.

Some discounts have also been negotiated for some of the minor new listings; again, these are not disclosed for commercial reasons.

4.1 Breast cancer treatment – continuation of funding for the Herceptin program

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$168.0m
Medicare Australia	-	-	-	-	-	-

The Budget papers state that \$168.0 million / 4 years will be provided to continue this program which provides free access to Herceptin for patients with late-stage metastatic breast cancer.

This program was introduced in December 2001, as a consequence of intensive lobbying before the 2001 federal election and after the PBAC had three times rejected appeals to have the drug listed for late stage cancer patients on the grounds that it was not cost-effective.

	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Funding*	\$6.8m	\$13.2m	\$14.5m	\$15.9m	\$38.1m	\$41.9m	NA	NA
Number patients*					750		1000	1000

* from previous budgets and DoHA annual reports

Future funding levels, at \$42 million / year, echo the funding levels in 2006-07. In the time since, a number of other breast cancer treatment drugs have become available, which may influence the number of women being treated under this program.

The most recent statistics on the Medicare Australia website are dated June 2008. They show that since its inception the program has served a total of 3072 women, of whom 2080 have either died or withdrawn, leaving 992 patients receiving Herceptin at June 2008. In 2007-08, 396 new patients were added to the program.

In 2006, after further heavy lobbying, Herceptin was added to the PBS for treatment of early stage HER+ breast cancer. It is not clear whether the 'rule of rescue' was invoked by the PBAC when this decision was made, but in any case this PBS listing does beg the question of why Herceptin for late-stage breast cancer is not now provided under the PBS.

4.2 Pharmaceutical Benefits Scheme – enhancements to the National Prescribing Service

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$9.1m	-\$12.1m	-\$13.6m	-\$16.2m	-\$51.0m
DVA	-	-\$1.1m	-\$1.1m	-\$1.2m	-\$1.3m	-\$4.7m
<i>Total</i>	-	-\$10.2m	-\$13.2m	-\$14.8m	-\$17.8m	-\$55.6m

The Budget provides an additional \$21.0 million / 4 years to the NPS for work that is described as focusing on services to medical practitioners.

This would appear to take the current NPS Budget to \$115.6 million / 4 years.

The NPS was established in the 1997-98 Budget and aims to improve health outcomes by improving the quality of prescribing, while at the same time reducing growth in the PBS. The 2001-02 Budget provided \$22 million / 4 years for an expansion of NPS activities which were expected to result in savings over the same period of \$59 million – a net saving of \$37 million.

The 2005-06 Budget provided on-going appropriations of \$94.6 million / 4 years to the NPS, which was an increase of \$30.6 million. An additional \$6.3million / 4 years was provided for the National Return of Unwanted Medicines initiative via the National Medicines Disposal Program.

The NPS Evaluation Report No.11 (February 2009) states that under the funding agreement with the Government (July 2005 to June 2009) NPS must deliver savings of \$40 million each year to the PBS. The estimated savings claim for 2006-07 was well over \$18 million in excess of contractual requirements. This translates as a saving of \$2.32 for every dollar spent.

The current budget numbers suggest that the Government is now looking for an even greater return on its investment – around \$3.65 per dollar invested.

4.3 National Return and Disposal of Unwanted Medicines program – additional funding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	\$0.3m	\$0.5m	\$0.6m	\$0.7m	\$0.8m	\$2.9m

This measure increases the funding for this program to \$2.1 million / year. There has been an increase in demand for this service, which enables consumers to return unwanted or out-of-date medicines to pharmacies and ensures they are disposed of correctly.

4.4 Pharmaceutical Benefits Scheme – chemotherapy drugs – delayed implementation of more efficient program

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$5.3m	-	-	-	-
DVA	-	\$0.5m	-	-	-	-
<i>Total</i>		\$5.9m				

This measure was in the 2008-09 Budget, with savings of \$105.4 million / 4 years as below:

	2007-08	2008-09	2009-10	2010-11	2011-12	Total
DoHA	-	\$4.4m	-\$31.9m	-\$33.6m	-\$35.8m	-\$96.9m
DVA	-	-	-\$3.3m	-\$3.2m	-\$3.4m	-\$9.9m
Medicare Australia	-	\$0.6m +\$0.8m	\$0.1m	-	-	-
<i>Total</i>	-	\$5.8m	-\$35.1m	-\$36.8m	-\$39.2m	\$105.4m

This budget provision proposed changes the basis on which the pharmacist is funded for the preparation and dispensing of chemotherapy drugs from a per vial basis to the amount of active ingredient used plus a \$40 fee for preparing infusions. The purported aim was to reduce wastage of costly drug ingredients, estimated at \$150 million / year.

However pharmacists have objected to this provision, claiming that the Government wants pharmacists to dispense 'left-over' cancer drugs.

For the moment there is a stand-off. This issue may end up being addressed within the context of the Fifth Pharmacy Agreement.

4.5 Pharmaceutical Benefits Scheme – extending the therapeutic group premium policy

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$12.5m	-\$28.5m	-\$29.7m	-\$40.9m	-\$111.6m
DVA	-	-\$0.7m	-\$1.5m	-\$1.5m	-\$1.5m	-\$5.2m
Medicare Australia	-	\$0.5m	\$0.8m	\$0.8m	\$0.9m	\$3.0m
<i>Total</i>	-	-\$12.7m	-\$29.3m	-\$30.4m	-\$41.5m	-\$113.8m

This provision eliminates the exemption from the PBS reference pricing scheme which the manufacturers of the cholesterol-lowering drugs Lipitor and Crestor had previously carved out for their products on the basis that they were different (ie better) than other statins. Now the Government proposes to create a new therapeutic group for Lipitor and Crestorm in addition to the therapeutic group for statins.

This action will see the price to the Government of Crestor (currently \$69.48 / month for 10 mg tablets) reduced, presumably to that of Lipitor (currently \$42.27 / month or 10mg tablets). However it is not clear from the Budget Papers whether the Government will negotiate a price with the manufacturers of both products or if the price of Crestor will be automatically reduced.

It should be noted that the manufacturer does not have to accept the price paid by Government and can charge a premium which is borne by the consumer.

In 2008, Lipitor accounted for 10.5 million scripts and Crestor for 2.2 million scripts. Lipitor, which will be off patent in 2011, is one of the most prescribed medicines on the PBS, and prescribing rates for Crestor are increasing rapidly.

4.6 Pharmaceutical Benefits Scheme – extending the PBS reference pricing policies to all non-exempt pharmaceutical items

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$8.8m	-\$18.0m	-\$16.7m	-\$16.3m	-\$59.8m
DVA	-	-\$0.7m	-\$1.4m	-\$1.3m	-\$1.2m	-\$4.6m
Medicare Australia	-	\$0.6m	\$0.8m	\$0.9m	\$0.9m	\$3.2m
<i>Total</i>	-	-\$9.0m	-\$18.6m	-\$17.0m	-\$16.6m	-\$61.2m

The Budget includes another measure that is designed to correct some of the anomalies in the reference pricing system. Although the Budget Papers note that this measure will extend the reference pricing policies to all ‘*non-exempt pharmaceutical items in a therapeutic group*’, it is not clear which drugs will be affected by the measure. Reference pricing arrangements extend to seven groups of drugs on the PBS and presumably, the products affected by this measure are those which are not currently captured by these arrangements. Nexium would seem to be the prime candidate here.

If manufacturers disagree with the new pricing arrangements, it is likely that one outcome of this measure will be an even greater increase in the number of PBS medicines with a premium that will add to patients’ out-of-pocket costs.

4.7 Pharmaceutical benefits Scheme – increased uptake of PBS Online

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$6.8m

This provision provides \$6.8 million / 5 years from funds within the Fourth Pharmacy Agreement to fund increased uptake of PBS Online. This system enables pharmacists to claim PBS payments direct from Medicare Australia at the time a medicine is supplied, and allows real time checking of PBS eligibility and customer concessional status.

While initial uptake of PBS Online was slow, new incentives in 2006-07 saw a dramatic increase in uptake.

This new funding will be allocated to:

- \$2.6 million to public hospitals which will get a \$0.40 script incentive to process through PBS Online;
- \$3.5 million for the installation of online processing software in community pharmacies’ and

- \$0.6 million for the installation of online processing software in public hospitals.

The lead-up to the Budget, the Pharmacy Guild was urging the Government (DHS) to reconsider its decision to discontinue payments to dispensing software vendors to support PBS Online. Vendors had indicated that they will have no choice but to introduce PBS Online levies in addition to normal fees in order to continue their current high levels of service. It is not clear if the \$3.5 million allocation in this budget addresses this problem or not.

4.8 Pharmaceutical Benefits Scheme – interim increase in the handling fees under the Section 100 Remote Aboriginal Health Service Program

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$3.1m

\$3.1 million / 2 years will be provided from 2008-09 to give an interim increase of \$1.55 in the handling fee paid to pharmacists per prescription under the Remote Aboriginal Health Service Program for Section 100 drugs (funding taken from within the Fourth Pharmacy Agreement). This increase will take the handling fee to \$2.69. It will be back-dated to 1 January 2009 and continue until 30 June 2010. The ongoing handling of the program will be determined by a review due for completion in mid 2009.

4.9 Epidermolysis bullosa – national dressing scheme

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.0m	\$4.6m	\$4.8m	\$5.0m	\$16.4m

The national dressing scheme will provide assistance to help eligible patients with Epidermolysis bullosa meet the high cost of treatment. Criteria for eligibility will be developed in consultation with clinical experts.

The Budget Papers estimate that there are approximately 250 patients requiring these specialized dressings, which can cost more than \$5,000 / month in severe cases. On the basis of the above funding, the average patient would receive around \$1,600 /month.

5. Indigenous health

The 2009-10 Budget contains **\$1.271 billion / 5 years** in new spending for Indigenous initiatives. Of this new spending, **\$807.4 million** is allocated to initiatives in the Northern Territory. The Northern Territory Emergency Response (NTER) spending is allocated over three years (2009-10 to 2011-12), reflecting a commitment to review these policies in 2011-12.

Only **\$232 million** of this new spending is in the health portfolio, virtually all of this for activities in the Northern Territory or rural and remote areas. The budget also takes savings of **\$25 million** from Indigenous health programs. This means that new health spending to help close the gap is less than **\$50 million / year**, and there is almost no new spending for national programs. This spending allocation denies the fact that just over half the Indigenous population lives in major cities or inner regional areas and only one-quarter of the population lives in remote and very remote areas.

While the 2009-10 Budget, when taken in isolation, provides no sense that the Government is driving forward its commitments to improving Indigenous health, the recently announced COAG National Partnerships (NPs) do reveal a substantial new investment in health spending to be done in partnership with the States and Territories.

It is apparently the Government's intention to funnel most new spending on Indigenous health through the COAG NP. This is the best means of ensuring an integrated approach across both levels of government, but it does mean that, unless new reporting provisions are put in place, there is less transparency around the roll-out of funding commitments from governments and about the effectiveness of programs. There are some areas where it is unclear whether previous Commonwealth spending commitments have now been included in the NPs.

However a major concern continues to be the heavy focus on the NT, which has only 11% of the Australia's Indigenous population.

The DoHA Portfolio Budget Statement (PBS) for Outcome 8, Indigenous Health, clearly states that the Government is committed to increasing access to Indigenous-specific comprehensive primary health care services in the NT through the Expanding Health Services Delivery initiative. However it is not clear what approaches the Government and DoHA are taking to ensuring that Indigenous people living outside the NT also have access to such services.

Indeed one provision in the Budget cuts funding and will limit the number of urban brokerage sites that were proposed in 2006-07 as a means of improving Indigenous access to mainstream primary health care services. There is no publicly available information about how well the current brokerage services (there are three) are performing, and there have been some concerns expressed about this approach, but there is no effort to put in place other initiatives to help Indigenous people in metropolitan and

regional areas have access to mainstream services and to ensure that these are culturally sensitive.

The forward estimates predict large increases in spending on medical services and the PBS for Indigenous patients, but this is unlikely to occur without an expansion in the number and capacity of Aboriginal and Community Controlled Services and Aboriginal Medical Services. These services are used by at least 50% of Indigenous Australians, particularly those with complex disease conditions. A large part of improving access to culturally sensitive health services is ensuring an increase in the number of Indigenous people working at all levels in the health workforce. There are no new initiatives to promote an increase in the Indigenous health workforce in the Budget.

The focus also needs to be beyond primary care services. There is growing evidence that Indigenous people do not get the same access as non-Indigenous people to acute care services, cancer screening and treatment, and rehabilitation services. Indigenous hospital patients are less likely to get diagnostic and therapeutic procedures such as angioplasty and bypass surgery and less likely to attend a cardiac rehabilitation program when they leave hospital.

Work is urgently needed to characterise and address the nature, level, sources and consequences of institutional and interpersonal discrimination in the health care system in order to reduce unfair treatment, ensure equitable care and improve outcomes for Indigenous patients.

The ability to do this is aggravated by the paucity of data that are available to measure the effectiveness of any interventions. The identification of Indigenous people in hospital and primary care records and in death registrations is a significant problem; reliable information about Indigenous hospital admittances and outcomes are not available in all states; and long-term national data on heart disease incidence and survival for Indigenous people are lacking.

The Australian Institute of Health and Welfare has for some time drawn attention to the relatively poor quality of the data on the health of Indigenous people, and the fact that comprehensive comparisons between States and Territories are not possible. This situation cannot continue if the Government is serious about closing the mortality gap. It is therefore pleasing to see that funding is provided (in the Contingency Fund) to meet the COAG decision to invest in closing Indigenous data gaps.

This year's Health Portfolio Budget Statement outlines quantitative deliverables, and having such targets, however vague, will enable some measurement of progress. However as pointed out in a recent paper in the *Medical Journal of Australia*², reaching these goals in the timeframe of the Prime Minister's commitment will be very difficult, if not impossible. To avoid failure by specifying unattainable goals, emphasis should be given to shorter-term process measures that will lead to better outcomes.

² Hoy WE. "Closing the gap" by 2030: aspiration versus reality in Indigenous health. *MJA* 2009; 190 (10):542-544,

It is self-evident that sustained changes in health status will also require better nutrition, public health initiatives such as safe, fluoridated drinking water, education, housing, economic and employment opportunities, and social justice and healing.

Table 5.1 Summary of Indigenous health initiatives

Indigenous health measure	Focus of activity	Budget cost
Closing the Gap – Indigenous health and related services	NTER	\$131.1m/3 years
Closing the Gap – improving eye and ear health	Remote communities	\$58.3m/4 years
Closing the gap – Indigenous dental services	Rural and regional areas	\$11.0m/4 years
Closing the Gap – expanding Link-Up services for the Stolen Generation	National	\$13.8m/3 years
Closing the Gap – quality assurance for the Aboriginal Medical Services program	National	\$3.8m/4years
Torres Strait protection strategy	Torres Strait islands	\$13.8m/4years
<i>New spending</i>		<i>\$232m</i>
Reduction of business management training initiative	National	-\$4.7m/4years
Shared Responsibility and Regional Partnership Agreements	Regional	-\$10.0m/4years
Indigenous access to health services	Urban	-\$10.3m/4years
<i>Budget cuts</i>		<i>-\$25.0m</i>
Total		\$207m/4years

COAG commitments - National Partnership on Closing the Gap in Indigenous Health Outcomes

Over the past 12 months, through COAG, the Australian Government and the States and Territories have committed a total of **\$4.6 billion** through National Partnerships (NPs) to initiatives to close the gap on Indigenous disadvantage. This includes **\$1.6 billion / 4 years** for Indigenous health.

The NP on Closing the Gap in Indigenous Health Outcomes, announced by COAG on 29 November 2008, is funded at **\$1.6 billion / 4 years**, with the Commonwealth contributing \$806 million and the States \$772 million.

The proposal includes expanded primary health care and targeted prevention activities to reduce the burden of chronic disease in Indigenous people through:

- reduced smoking rates;
- increased uptake of Medicare Benefits Schedule-funded primary care services to Indigenous people with half of the adult population (15-65 years) receiving two adult health checks over the next four years;

- significantly improved coordination of care across the care continuum; and
- over time, a reduction in the average length of hospital stay and reduction in readmissions.

Around \$470 million of the \$1.6 billion will be provided to improve chronic disease management and \$171 million will be provided to increase the capacity of the health workforce

The COAG commitment is that over a five-year period, around 55 per cent of the adult Indigenous population (around 155,000 people) will receive a health check with about 600,000 chronic disease services delivered. More than 90,000 Indigenous people with a chronic disease will be provided with a self-management program, while around 74,500 Indigenous people will receive financial assistance to improve access to Pharmaceutical Benefits Scheme medicines.

This NP is described as a ‘down payment’ on the significant investment needed by both levels of government to close the unacceptable gap in health and other outcomes between Indigenous and non-Indigenous Australians

Table 5.2 Commonwealth expenses in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, by subfunction
(from Budget Paper No.1)

	Estimates		Projections	
	2009-10	2010-11	2011-12	2012-13
Medical services and benefits	\$7m	\$19m	\$50m	\$67m
Pharmaceutical services and benefits	\$5m	\$22m	\$36m	\$47m
Aboriginal and Torres Strait Islander Health	\$26m	\$39m	\$27m	\$27m
Health services	\$6m	\$28m	\$50m	\$65m
General administration	\$33m	\$51m	\$87m	\$112m
<i>Total</i>	\$77m	\$159m	\$250m	\$319m

Table 5.2 shows a significant increase in Commonwealth spending on Indigenous health, with annual average real growth of 57.2% across the forward estimates. This is due primarily to growth in MBS, PBS and health services. Spending in the Aboriginal and Torres Strait Islander sub-function grows in 2009-10 and 2010-11, but then decline. Budget Paper No 1 states that expenses in this sub-function are forecast to decline in 2012-13 as funding for the NTER in this year is yet to be determined.

It is worth noting that administrative expenses are high (43% of expenditure in 2009-10, and an average of 36% of expenditure each year over the forward estimates). If State and Territory administration costs are also of this level, then a significant part of the upfront investment in health care (as much as \$580 million / 4 years) is spent on bureaucracy, red tape, regulation and oversight.

5.1 Closing the Gap – NTER – Indigenous health and related services

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Treasury	-	\$8.0m	\$5.0m	\$5.0m	-	\$18.0m
DoHA	-	\$6.5m	\$52.5m	\$54.1m	-	\$113.1m
<i>Total</i>	-	\$14.5m	\$57.5m	\$59.1m	-	\$131.1m

This funding includes:

- \$99.3 million for the continuation of expanded primary health care services in remote locations. This component also provides for the Remote Area Health Corps.
- \$15.7 million for dental, hearing and ENT specialist services arising from the child health checks.
- \$11.0 million for the continuation of the sexual assault mobile outreach services (note that when this was announced last year \$11.5 million was allocated).
- \$5.1 million for substance abuse rehabilitation and treatment services.
- \$18.0 million to the NT to assist in the delivery of these services.

The funding for follow-ups to health checks seems to be woefully inadequate, given the available evidence about the need. In last year's budget \$13.6 million was provided for 2008-09, and the new funding is considerably less – around \$5 million / year.

5.2 Closing the Gap – expanding link-up services for the Stolen Generation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.3m	\$5.5m	\$6.1m	-	\$13.8m

This funding provides an additional \$13.8 million / 3 years to address the recommendations of the Bringing Them Home report. This funding will provide an additional 11 Link-Up caseworkers and other support staff.

The 2008-09 Budget provided \$15.7 million / 4years in additional funds for the Bringing Them Home and Link-Up programs.

An independent evaluation of the Link-Up Program undertaken by Urbis Keys Young for OATSIH in 2007 found that there was a significant level of unmet demand for the services, services were under-resourced for the high workloads currently experienced, and the demand for services was likely to continue to be at least the same level for the foreseeable future. There is no information publicly available to show whether the increased resources in recent years have helped address these issues.

It is not clear why funding for this program is only for 3 years as this is not part of the NTER and therefore will not be part of the NTER review in 2011-12.

5.3 Closing the Gap – Indigenous dental services in rural and regional areas

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$1.3m	\$2.9m	\$3.4m	\$3.4m	\$11.0m

The Budget provides \$11.0 million / 4 years to deliver dental treatment and prevention services to Indigenous people in rural and regional areas. The Budget Papers state that this will be done using transportable dental facilities serviced by dental health professionals. The funding also provides for an evaluation of this initiative, including cost-effectiveness and equity.

Indigenous people experience significantly poorer oral health than the general population. Average rates of tooth decay in Indigenous children are twice as high as in non-Indigenous children and have worsened in recent years. This is due to more dental disease, lack of timely access to dental services, and diets that are high in sugar. ABS data from 2004-05 showed that 11% of Indigenous people aged 15 years and over had never visited a dentist or other health professional about their teeth.

Historically, the uptake of dental services by Indigenous children has been spasmodic due to staffing issues, low school attendance, difficulty in gaining consent to treatment, infrequent service to clinics, and no services to some of the more remote communities. Indigenous people currently have little or no access to the Medicare Enhanced Primary Care dental program, the Teen Dental Plan and the private health insurance rebate for dental services.

The dental checks by Australian Government Intervention (AGI) teams have been performed under much less than ideal examining conditions and have been carried out by non-dental health professionals who are likely to have considerably under-estimated the prevalence of dental diseases. Furthermore, the AGI teams have not provided any details on the burden of oral and dental diseases.

In their submission to the NHHRC, the Australian Dental Association (ADA) stated that the only sure way to ensure that the burden of dental diseases is lifted from the child population is to institute a comprehensive examination followed by preventive and restorative services targeting all remote Indigenous children.

ADA recommended that mobile AGI Dental teams should comprise of a dentist, dental hygienist or dental therapist, dental assistant, an administrator and a local Indigenous community liaison worker. Provision needs to be made for substantially increasing access to general anaesthetic procedures.

It is unfortunate that this new initiative does not come accompanied by any funding or incentives to improve the dental health workforce providing Indigenous dental services as this will surely prove to be a limiting factor in the successful implementation of this initiative.

5.4 Closing the Gap – Improving eye and ear health services for Indigenous Australians

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$6.2m	\$15.4m	\$18.3m	\$18.5m	\$58.3m

This funding, announced in February, will provide:

- At least 1,000 additional ear and eye surgical procedures;
- At least 10 regional teams to treat and help prevent trachoma;
- Expansion of the Visiting Optometrist Scheme, to provide new and increased numbers of optometrist visits to remote and very remote communities;
- Increased ear health workforce training;
- Investments in hearing medical equipment including audiometers, tympanometers, and video-otoscopes; and
- Hearing-health promotion to reduce hearing loss in Indigenous communities.

This funding represents a long-overdue response to the urgent problems of trachoma and ear infections in Indigenous populations, especially those in remote communities. The problems are so serious that it is imperative that this funding is rolled out quickly and effectively.

Trachoma is an infectious eye disease now found only in the poorest countries and that, untreated, leads to blindness. It is our shame that Australia is the only developed country among the 57 trachoma-endemic countries listed by the World Health Organisation. Trachoma was eliminated from the non-Indigenous population in northern Australia during the 1930s. It continues to be a threat to the Indigenous communities in the remote desert areas of northern Australia because of their poor living conditions, poverty and lack of access to water.

Results published late last year highlight the continuing deplorable standards of eye health in trachoma-endemic areas of the Northern Territory, South Australia and Western Australia. The study found the overall rate of active and infectious trachoma in children under 10 years of age in screened communities was nearly 20%, well above the 10% level at which the disease is deemed endemic.

The prevalence of corneal scarring in people aged 20 years and over was 32%, with the youngest person to bear scars derived from the active stage of the disease being just seven years old. More than 2% of adults aged 40 and over were identified with trichiasis (ingrown eyelashes) requiring urgent ophthalmological attention to prevent the onset of blindness.

More recent data highlight the facts that: only 65% of communities with active trachoma are receiving antibiotic treatment; routine screening and reporting of the disease need to be strengthened; and adherence to the national treatment guidelines is very low. Increased resources from the NTER have not improved prevention, treatment or reporting in the Territory.

Chronic middle ear infection is a major cause of hearing impairment among Australian Indigenous children living in remote communities. In 2007, 90% of Aboriginal children in the NT were found to have severe ear infections, and 25% had perforated eardrums. At that time, the Royal Australian College of Surgeons said that \$10 million / year was needed in the NT to tackle this problem.

5.5 Closing the Gap – quality assurance for the Aboriginal and Torres Strait Islander Medical Services pathology program

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.8m	\$0.9m	\$1.0m	\$1.1m	\$3.8m

This funding will enable the extension and expansion of the Quality Assurance for Aboriginal Medical Services (QAAMS) program beyond the current expiry date of 31 July 2009.

The QAAMS program uses Point of Care Testing (POCT) technology to conduct pathology tests on Aboriginal and Torres Strait Islander people with diabetes in the offices of the medical practitioner at the time of consultation. Two tests are performed for patients in the QAAMS Program: glycosylated haemoglobin (HbA1c) and Albumin/Creatinine Ratio (ACR). The tests are generally performed by trained Indigenous health workers.

The QAAMS program has been funded since 1999. About 100 Aboriginal Medical Services / Aboriginal and Community Controlled Health Organisations in remote, rural and urban areas currently participate in the QAAMS program which is administered on behalf of DoHA by the Flinders University Rural Clinical School and the RCPA Quality Assurance Programs Pty Ltd.

There is published data to demonstrate that the QAAMS POCT model delivers a culturally sensitive and clinically effective service for diabetes management in Indigenous Australians.

5.6 Indigenous access to health care services – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$2.8m	-\$2.7m	-\$2.4m	-\$2.4m	-\$10.3m

This provision makes savings of \$10.3 million / 4 years by not proceeding with two further urban brokerage sites that were to be selected as part of the Improving Indigenous Access to Health Care Services measure included in the 2006-07 Budget.

Initially five brokerage services were to be set up to link up to 15,000 Indigenous people to GPs and other health professionals in urban and regional areas in Queensland, New South Wales, Victoria, and Western Australia. The brokerage services were to enlist, train and register GPs and allied health professionals who are interested in providing culturally and clinically appropriate care to Indigenous people.

There is little information available about this initiative. The DoHA Annual Report 2006-07 states that the Sydney South West Indigenous Community Health Brokerage Service was funded in June 2007 as the first urban brokerage service. The Annual Report 2007-08 states that during the year, the Canning Division of General Practice Limited (in partnership with the Derbarl Yerrigan Health Service Incorporated), was funded to become the second urban brokerage service, and that another funding round would be undertaken in 2008–09 to select the three remaining brokerage services under this initiative. The Budget Papers refer to three operating brokerage services, which will continue to be funded.

It appears that getting these services set up has been a slow process and there is no available information about how well these services are functioning. However arguably some mechanism is needed to help Indigenous patients interact better with mainstream services (and to help mainstream services become more attuned to the needs of Indigenous patients), so if the current brokerage services are not working, what will replace them?

5.7 Shared Responsibility and Regional Partnership Agreements

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$2.0m	-\$2.3m	-\$2.6m	-\$3.1m	-\$10.0m

The Budget Papers are quite cryptic about why these funding cuts have been made and where the savings will be directed.

Budget paper No.2 says this:

*'The Government will **redirect** [emphasis added] funding for the health components of Shared Responsibility Agreements and Regional Partnership Agreements. Following a **refocusing of priorities** [emphasis added], the Government will honour existing commitments, but will not make further investments in the health components of the initiatives.'*

To date \$21.4 million has been committed to these agreements. It is not clear what future commitments in this regard will be.

5.8 Reduction of the business management training initiative – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$1.0m	-\$1.2m	-\$1.3m	-\$1.3m	-\$4.7m

This provision was included in the 2007-08 Budget to provide for the upskilling and training of 100 business managers in order to enhance the business management capacity of ACCHOs through higher education, training and on-line resources. It appears that

this program is underway, as the Budget Papers state that existing commitments to train AMS business managers will be maintained.

It is hard to believe that this type of training and support is not needed. The Budget Papers refer to the plan that *'successful aspects of this initiative will be incorporated into a broader program focused on continuous quality improvement and accreditation.'* It is not clear what program this is, or if it yet to be established.

The provisions in the 2009-10 Budget that contribute to 'Closing the Gap' on Indigenous disadvantage are analysed in greater detail in *Analysis of the Australian Government's 2009-2010 Indigenous Budget.*

See

http://www.menzieshealthpolicy.edu.au/MCHP_V3/site/other%20tops/Russell%20May%2009%20Analysis%20of%20Indigenous%20Budget%202009-10.doc

6. Medicare costs

Taken together, the range of Medicare provisions in the 2009-10 Budget reflect the fact that this is a Budget developed at a time of economic prudence.

Aside from new Medicare spending as a consequence of allowing midwives and nurse practitioners access to the MBS (not quantifiable but of the order of \$75 million / 4 years), new Medicare spending in this budget is negligible, **\$10.7 million / 4 years**. On the other hand, significant savings are made, of the order of **\$604 million / 4 years**³.

Table 6.1 Medicare spending and savings

Initiative	2008-09	2009-10	2010-11	2012-12	2012-13	Total
<i>Spending</i>						
MBS new and revised listings	\$0.1m	\$0.2m	\$0.3m	\$0.4m	\$0.4m	\$1.4m
Quality framework for reviewing services	-	\$3.3m	\$6.0m	-	-	\$9.3m
<i>Total spending</i>	\$0.1m	\$3.5m	\$6.3m	\$0.4m	\$0.4m	\$10.7m
<i>Savings</i>						
Capping EMSN benefits for items with excessive fees	-	-\$19.0	-\$62.3m	-\$79.2m	-\$97.3m	-\$257.9m
Capping EMSN benefits for obstetrics services	-	\$0.2m	-\$48.7m	-\$62.9m	-\$82.3m	-\$193.7m
Better Access – continuing professional development	-	\$0.2m	\$0.6m	-\$20.0m	-\$2.2m	-\$21.4m
Better Access – improved targeting and better quality services	-	-\$7.4m	-\$17.2m	-\$6.1m	\$9.2m	-\$21.7m
Medicare pathology and diagnostic imaging services	-	\$43.7m	\$58.5m	-\$15.2m	-\$27.5m	\$59.5m
Ensuring appropriate use of clinical procedures and adjusting to modern technologies	-	-\$24.7m	-\$40.1m	-\$42.9m	-\$45.7m	-\$153.4m
Reversal of proposal to allow GPs to order MRI scans	-	-\$4.0m	-\$3.9m	-\$3.8m	-\$3.6m	-\$15.3m
<i>Total savings</i>	-	-\$7.0m	-\$113.1m	-\$230.1m	-\$267.8m	-\$603.9m

³ Caveat: The exact levels of Medicare spending and saving depend on which budget provisions are counted where.

The Government's stated focus is on *'modernising Medicare to ensure that rebates encourage higher quality, evidence-based practice and better reflect the time and complexity of service'* and on *'[supporting] the long term sustainability of the extended Medicare safety net by making sure public money is spent on reducing costs for patients, not on providing excessive windfalls for medical specialists.'*

There are indeed many efficiencies that can be introduced into the MBS to make it more reflective of modern practice, more rewarding of cognitive services, more cost-effective and therefore more sustainable. The measures in the Budget make some tentative steps at beginning this process, and funds are provided for its continuation.

However, as the row that has raged since the Budget announcement about reduced reimbursement for cataract surgery shows, unless these changes are made on the basis of the best evidence – evidence which is publicly available - then the Government will come under pressure to reverse these changes.

Sensibly, the Government did adopt this approach with the changes made to the extended Medicare safety net (EMSN), using a report prepared by the Centre for Health Economics, Research and Evaluation (CHERE) at the University of Technology, Sydney to support their case.

There are several measures in the Budget to control the blow-out in the cost of the EMSN, although the nature and extent of the caps to be imposed has not been made public. In 2007 the EMSN distributed some \$324 million to approximately 790,000 Australians to reduce their out-of-pocket costs (less than 1% of single people and 9% of families who received a Medicare service in that year). Most of this money went to better-off Australians - 55% of benefits went to the most economically advantage areas, and only 3.5% went to the least economically advantaged.

By 2008, expenditure on the EMSN was \$414.1 million, an increase of 29.7% over the previous year. EMSN benefits are highly concentrated in certain services. In 2007, over 30% helped fund obstetric services and 22% went to assisted reproductive services (ART).

The additional spending on EMSN benefits has not been matched by a drop in patients' out-of-pocket costs, and in many areas it appears that the safety net has encouraged providers to increase fees with little benefit to patients. The CHERE report finds that the EMSN is responsible for 70% of the increase in fees that has occurred since its inception.

Despite the measures taken in this Budget, concerns must remain about the inflationary nature of the EMSN and the fact that it is a poorly designed policy that fails to address one of the main barriers to accessing health care – cost – for many patients on low incomes.

Of further concern is the band aid approach taken to tackling the problems of the Better Access program in the absence of any evaluation, particularly around issues such as

whether this program contributes to improved access to mental health services, is appropriately targeted to those with the greatest need, and leads to improved mental health outcomes.

The other point to make is that it seems that the Government's focus remains steadfastly on fee-for-service from individual providers and the number of services delivered, despite the fact that other payments systems might encourage and reward a coordinate suite of services delivered by a multidisciplinary team that result in improved health outcomes.

Perhaps this issue might eventually be considered through the evidence-based framework for reviewing services listed on the MBS that this Budget funds.

6.1 Medicare Benefits Schedule – capping Extended Medicare Safety Net benefits for items with excessive fees

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$21.5m	-\$62.8m	-\$79.4m	-\$97.4m	-\$261.1m
Medicare Australia	-	\$1.6m +\$0.9m*	\$0.4m	\$0.2m	\$0.1m	\$3.2m
<i>Total</i>	-	-\$19.0m	-\$62.4m	-\$79.2m	-\$97.3m	-\$257.9m

* Related capital costs

The Budget introduces a cap on Medicare benefits payable under the EMSN for a range of items with excessive fees, including ART, treatment of varicose veins, hair transplants and cataract surgery. The caps will take effect from January 2010.

The items to be capped accounted for 28% of EMSN costs in 2008, and expenditure on these items has grown by around 50% in the past two years.

6.2 Medicare Benefits Schedule – capping Extended Medicare Safety Net benefits for items with excessive fees – obstetrics services

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$3.8m	-\$49.1m	-\$63.1m	-\$82.5m	-\$198.5m
Medicare Australia	-	\$2.4m +\$1.7m*	\$0.4m	\$0.2m	\$0.2m	\$4.9m
<i>Total</i>	-	-\$0.3m	-\$48.7m	-\$62.9m	-\$82.3m	-\$193.7m

Obstetrics-related items account for 30% of the cost of the EMSN. This situation is due to the introduction in 2004-05 of item 16590 for the planning and management of pregnancy (after 20 weeks). This item has largely taken the place of a booking fee for which no Medicare reimbursement was previously payable. It was introduced by the

Howard Government when it became clear that some obstetricians were gaming the Medicare safety net rules to enable their patients to claim this fee, which in July 2008 averaged \$1,980.51 but which can be as high as \$9,000. The recently released Discussion paper on Improving Maternity Services in Australia notes: *'Anecdotally, whereas the booking fee was an exception, it appears that the charging of a planning and management fee is now widespread'*

The introduction of a cap on all obstetrics items and some ultrasound items related to pregnancy will achieve savings of \$351.3 million / 4 years. At the same time, scheduled fees for the obstetrics items will be increased, at a cost of \$157.6 million / 4 years.

This may help counter the recent trend that has seen the increasing disuse of items 16519 (management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days) and 16520 (Caesarian section and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care) in favour of the highly reimbursed item 16522. This item requires that one or more pre-existing conditions are present, but given that these include glucose monitoring, a previous C-section, and prolonged labour, this requirement is presumably easily met.

(for further analysis see Russell, L. The increasing cost of private maternity services http://www.menzieshealthpolicy.edu.au/MCHP_V3/site/other%20tops/Medicare%20Observations%20services%20--%20explanation%20of%20data.doc)

6.3 Medicare Benefits Schedule – ensuring the appropriate use of clinical procedures and adjusting to modern technologies

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$23.2m	-\$37.9m	-\$40.8m	-\$43.7m	-\$145.6m
DVA	-	-\$1.2m	-\$1.9m	-\$1.7m	-\$1.7m	-\$6.5m
Medicare Australia	-	-\$0.2m	-\$0.3m	-\$0.3m	-\$0.4m	-\$1.2m
<i>Total</i>	-	-\$24.7m	-\$40.1m	-\$42.9m	-\$45.7m	-\$153.6m

The Government has indicated that it will amend the MBS fees for a number of procedural items, including cataract surgery and certain coronary angiography procedures, where technology improvements have meant that these services can be delivered more quickly and are less complex.

Already this provision has provoked concern from specialists, and it will be interesting to see if the Minister / DoHA is able to carry this through as outlined.

Media reports indicates that rebates for nine cataract procedures will be halved from November 2009; the scheduled fee for the most commonly claimed item (42702) will fall from \$831.60 to \$409.60. This procedure now takes 15 minutes to perform.

The caps that will be imposed on rebates under the EMSN will mean that private ophthalmologists will face pressure not to increase the cost to patients to compensate for this loss of income.

However if this provision does discourage these doctors for doing this surgery in remote communities, as mooted, then this needs further investigation.

6.4 Medicare Benefits Schedule – new and revised listings

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.2m	\$0.3m	\$0.4m	\$0.4m	\$1.3m
Medicare Australia	\$0.1m		-	-	-	\$0.2m
<i>Total</i>	\$0.1m	\$0.2m	\$0.3m	\$0.4m	\$0.4m	\$1.4m

This funding is for a number of new and revised listing added to the MBS since February 2009.

6.5 Medicare Benefits Schedule – reversal of proposal to fund magnetic resonance imaging scans of the knee or brain – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$4.0m	-\$3.9m	-\$3.9m	-\$3.6m	-\$15.3m

This measure was first announced in the 2007 PEFO but has never been implemented. It was to allow GPs to refer patients directly for MRI of the brain or knee without referral to a specialist.

It is not known why this measure was not implemented.

6.6 Medicare Benefits Schedule – a quality framework for reviewing services

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$3.3m	\$6.0m	-	-	\$9.3m

Funding of \$9.3 million / 2 years is provided to put in place an evidence-based framework for reviewing services listed on the MBS. The new framework will take effect from 1 January 2010.

The Budget Papers state that under this framework *'services will be evaluated and aligned with contemporary evidence to ensure clinical relevance and appropriate pricing. New services will be evaluated three years after being listed.'*

This is a long needed proposal, although exact details around the functioning and resourcing of this effort remain unclear at this point. There are certainly plenty of issues to be looked at; it is to be hoped that the focus is not just on numbers and cost but also on outcomes. This should be a continuing effort, arguably one conducted by experts outside of DoHA.

Other initiatives which impact on Medicare spending are analysed elsewhere, under Section 8: Pathology and Diagnostic Imaging and Section 11: Mental health.

7. Cancer services

This budget contains **\$1.95 billion / 6 years** in new cancer spending, most of which is for infrastructure and new PBS listings for chemotherapy medicines. There is other spending in the budget, such as that for pathology and diagnostic services and for research infrastructure that is also of benefit to people with cancer, although this cannot be directly quantified.

Table 7.1 Cancer spending

Initiative	New or continued funding	Funding level
National cancer statement Infrastructure and equipment	New (from HHF)	\$1.3 billion / 6 years
Chemotherapy - Herceptin - New and extended PBS listings - Other	Continued New (delayed implementation)	\$168 million / 4 years \$445.2 million / 4 years* \$5.9 million 2009-10
Data collection	New	\$11.0 million / 4 years
Cancer Networks	Continued	\$2.6 million / 4 years
Mentoring for regional hospitals and specialists	Continued	\$15.1 million
Medicare Benefits for PET scans	New (funds from 2008-09)	\$6.8 million / 4 years
Discontinuation of radiation therapy single unit trial	savings	-\$5.4 million / 4 years
<i>Total</i>		\$1.95 billion / 6 years

* some additional costs from new minor PBS listings not included

It is now four years since the Howard Government, in the 2005-06 Budget, put forward \$189.4 million for the Strengthening Cancer Care initiative, delivering on their 2004 election commitment.

This package provided funding to:

- develop and implement training courses for cancer nurses (\$4.1 million);
- improve professional development for cancer professionals, counsellors and general practitioners (\$3.3 million);
- develop and implement mentoring for regional cancer services (\$14.1 million);
- improve support for those newly diagnosed with breast cancer (\$1.0 million);
- increase cancer research (\$17.6 million);
- enhance cancer screening and awareness (\$45.4 million);
- support cancer clinical trials (\$21.7 million);
- build cancer support groups (\$3.1 million);

- provide MBS eligibility for a MRI unit at Sydney’s Children’s Hospital (\$5.1 million);
- support children with cancer and their families (\$2.0 million);
- enhance palliative care programs (\$23.1 million);
- improve the early detection and management of breast cancer (\$4.0 million);
- establish a new national cancer agency, Cancer Australia (\$13.7 million);
- establish a national research centre for asbestos related diseases (\$5.5 million);
- provide additional radiation therapy internships and undergraduate places (\$14.9 million);
- redevelop the children’s cancer ward at Royal Children’s Hospital in Melbourne (\$10.0 million); and
- evaluate the initiative in 2007-08 (\$1.2 million).

Only some of these initiatives, many of which were quite slow to be rolled out, have received ongoing funding. More particularly, there is no sign of the evaluation study which was to be done.

Arguably the most noticeable absence from this Budget is any Commonwealth commitment to strengthen the National Bowel Cancer Screening program; in particular, to ensure that people with positive FOBT tests are able to get timely and affordable access to colonoscopies. There is also no funding in the forward estimates to provide a second round of screening for people already tested.

7.1 Cancer Australia – improved lung cancer data and treatment guidelines

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Cancer Australia	-	\$0.9m	\$2.4m	\$1.7m	\$1.7m	\$6.8m

This funding is to support the collection of data to better measure clinical outcomes of lung cancer patients. It will also fund priority lung cancer research and support the development of best practice guidelines for the treatment of lung cancer patients.

Every year around 5,500 Australians are diagnosed with lung cancer. Five-year survival rates for lung cancer are very poor; around 10.7% for males and 14.0% for females. This cancer is often diagnosed late, and there has been a paucity of innovative new treatment modalities.

There is a set of Clinical Practice Guidelines (CPGs) for the prevention, Diagnosis and Management of Lung Cancer, which were approved by the NHRMC in March 2004. It is assumed that the funding provided is to enable the update of these CPGs.

7.2 World Class Cancer Care – Building Cancer Support Networks program – continuing funding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Cancer Australia	-	-	-	-	-	\$2.6m

Funding is provided in the forward estimates for the continuation of this program, which was initiated in the 2004-05 Budget. The original commitment was for \$3.1 million over five years from 2004-05. This program provides grants for information resources for people living with cancer and support for their carers.

7.3 World Class Cancer Care – Building Cancer Support Networks program – continuing funding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Cancer Australia	-	-	-	-	-	\$15.1m

Funding is provided in the forward estimates to continue this program, which encourages specialists to spend more time in rural and regional areas and to be available to confer with regional colleagues. This program was originally funded at \$14.1 million / 4 years.

This measure will also continue funding for the Cancer Services Network National Demonstration program which provides a mechanism to link regional and metropolitan cancer services.

7.4 World Class Cancer Care – cancer data to improve cancer survival

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
AIHW	-	\$0.5m	\$0.5m	\$0.5m	\$0.5m	\$2.0m
Cancer Australia	-	\$0.5m	\$0.5m	\$0.5m	\$0.6m	\$2.2m
<i>Total</i>	-	\$1.0m	\$1.1m	\$1.0m	\$1.1m	\$4.2m

This funding is to establish a national cancer monitoring centre. The majority of this work is currently done at the state level.

The monitoring centre will under take two pilot studies: one to collect data relating to distance spread of cancer at diagnosis and recurrence, and a second to benchmark clinical outcomes following cancer treatment.

7.5 Radiation Oncology – national radiotherapy single machine trial – discontinuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$1.3m	-\$1.3m	-\$1.4m	-\$1.4m	\$5.4m

The National Radiotherapy Single Machine Unit Trial program, announced in the 2000-01 Budget, was carried out in Victoria to evaluate the viability of single machine radiotherapy centres in the provision of services in rural and regional areas. The trial concluded in 2006-07, although apparently funding was continued in the years since then. The Budget Papers state that the results of the trial are currently being assessed.

However it seems that the results of this trial have already been published and show that that smaller single-machine unit radiotherapy facilities can provide safe, effective radiotherapy on par with that of the larger centres⁴. It's not clear what the delay is here, and what the consequences are for withdrawal of funds to support single unit services that have presumably been in place in country Victoria for the past eight years.

⁴ Shakespeare TP, Turner M, et al. Is rural radiation oncology practice quality as good as the big smoke? Results of the Australian radiotherapy single machine unit trial. *Australas Radiol* 2007;51:381-5

8. Pathology and Diagnostic Imaging

The Government has changed the way in which pathology and diagnostic imaging services are managed, abandoning the capped Memoranda of Understanding (MoUs) that governed funding, quality and accreditation.

Measures proposed in this Budget include introducing bulk billing incentives for pathology and diagnostic imaging, costing **\$948.4 million / 4 years**, to be partly funded through savings of around **\$763.4 million** achieved by lowering the collection fees - the fee for collecting pathology specimens - paid to pathology providers.

Overall the Budget spends **\$982.0 million / 4 years** on pathology and diagnostic imaging provisions, but almost all of this new spending is paid for by savings, which total **\$949.6 million / 4 years**.

Table 8.1 Summary of pathology and diagnostic provision that replace the previous Memoranda of Understanding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Bulk billing incentives and PEI fees	-	\$33.2m	\$47.1m	\$50.8m	\$54.3m	\$185.4m
Depreciated DI equipment	-	\$0.2m	\$0.5m	-\$64.7m	-\$70.6m	-\$134.5m
Improving competition	-	\$3.0m	\$0.1m	\$0.1m	\$0.1m	\$3.4m
Quality and workforce	-	\$5.5m	\$8.1m	-\$0.2m	-\$10.0m	\$3.5m
Rebalancing pathology fees	-	-\$0.6m	-\$0.9m	-\$1.2m	-\$1.5m	-\$4.1m
Reviews	-	\$2.4m	\$3.6m	-	-	\$6.0m
<i>Total</i>	-	\$43.7m	\$58.5m	-\$15.2m	-\$27.5m	\$59.5m

Previously there were four agreements between the Government and Diagnostic Imaging groups known as Quality and Outlays Memoranda of Understanding (MoUs). These MoUs commenced on 1 July 2003 and expired 30 June 2008.

The Pathology Quality and Outlays Memorandum of Understanding (MoU) between the Government and the Australian Association of Pathology Practices, the Royal College of Pathologists of Australasia and the National Coalition of Public Pathology will expire on 30 June 2009.

The Government undertook a Strategic Review of Future Funding Arrangements for Diagnostic Imaging and Pathology Services to consider options for the future funding of

these, including the impact of those arrangements on Government expenditure and the availability and affordability for patients of diagnostic imaging and pathology services. The DoHA website states that *'It is expected that the review will be considered by the Government in the lead up to the 2009-10 Budget'* but the review itself does not seem to be publicly available.

Medicare Australia data show significant increases in services and Medicare costs of pathology and diagnostic imaging services in recent years (see Table 8.1).

Other data show that over the period 2004-05 to 2007-08, the number of pathology tests requested by GPs grew by 75%. Approximately 60% of this growth is clearly linked to preventive health and chronic disease management (obesity, diabetes, cancers, heart disease, STDs). In 2007 pathology accounted for 34.4% of all Medicare services and 14.5% of all Medicare benefits.

Over the period of the recently-expired diagnostic imaging MoUs, GPs increased their ordering of these services from less than 14 services / 100 visits to over 15 services / 100 visits. However notwithstanding this growth in the demand for services, the 5% growth cap meant that Government funding of diagnostic imaging declined as a percentage of overall Medicare outlays, declining from 15.7% in 2002-03 to 14% in 2007-08.

There have been a number of drivers of these increases, including doctors' liability concerns, increases in preventive health checks, pathology requirements to ensure new cancer medicines are used appropriately, and new technologies.

These new changes give rise to a number of questions – will the new measures to increase competition actually do that to the benefit of patients; what will be the impact of these measures on public and private providers of pathology and diagnostic imaging services; will the bulk billing incentives offset the decrease in pathology collection fees or will patients end up paying more in out-of-pocket costs?

Perhaps the most important question is: will these changes (appropriately) control pathology and diagnostic imaging costs? The Budget flags a decrease in government funding for these services of 4% to 5%. However given growth in demand for pathology services of between 7% and 8%, this represents an overall increase in Medicare funding of around 3% / year. The expected ongoing growth in demand for diagnostic imaging services of 6% to 7% / year represents an overall increase in annual Medicare funding of over 10%.

Table 8.1 Growth in pathology and diagnostic imaging services and costs

	Pathology services		Diagnostic Imaging services	
	Mar qtr 2009	Mar qtr 2006	Mar qtr 2009	Mar qtr 2006
Number of services	26,125	20,998	4,265	3,673
Cost of services to Medicare	\$514m	\$416m	\$477m	\$393m
Bulk billing rate	87%	86%	67%	60%
Patient cost for non bulk billed service	\$18.36	\$12.20	\$71.23	\$55.26

8.1 Medicare Benefits Schedule – diagnostic and pathology services

This raft of measures makes the following changes to the way Medicare pays for pathology and diagnostic imaging services:

- Provides new bulk billing incentives;
- Reduces the fees paid for pathology collection fees; and
- Makes changes to the Medicare fees for a number of pathology services.

Overall this suite of six provisions spends \$982.0 million / 4 years and makes offsetting savings of \$922.7 million. This provides average annual new funding to address any increase in demand for services, quality, driving competition and workforce training of less than \$15 million / year.

8.1.1. Bulk billing incentives and rationalisation of PEI fees

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$34.7m	\$50.7m	\$54.1m	\$57.5m	\$197.0m
DVA	-	-\$2.4m	-\$3.7m	-\$3.5m	-\$3.4m	-\$13.0m
Medicare Australia	-	\$0.5m +\$0.4m*	\$0.1m	\$0.2m	\$0.2m	\$1.0m
Total	-	\$33.2m	\$47.1m	\$50.8m	\$54.3m	\$185.4m

* Related capital costs

This provision provides \$948.4 million / 4 years for bulk billing incentives.

In diagnostic imaging, out-of-hospital services that are bulk billed will receive an incentive payment of 10% of the MBS fee. This will commence 1 November 2009, and cost \$600.4 million

In pathology, these incentives will cost \$348.0 million. Bulk billing incentives will be available for MBS items for all Patient Episode Initiation (PEI) fees (the Medicare benefits paid for the collection of samples). These incentives will be an additional \$1.60 for collections by public providers and \$2-\$4 for collections by private pathology providers. This will cost \$348.0 million.

At the same time, PEI fees (except those for aged care homes, cancer specimens and patients unable to leave their homes) will be cut, at a savings of \$763.4 million.

On average, the Medicare benefits per pathology episode, including both collection and test fees will decrease from \$69.17 to \$66.26, a difference of \$2.91. This could see an increase in patients out-of-pocket costs, which already average \$18.36 for a pathology test which is not bulk billed.

It is not clear why the DVA has savings of \$13.0 million. It is possible that this provision renders inactive the fee changes introduced in November 2008 which under which the DVA pays 100% of the MBS fee for pathology and diagnostic imaging services.

8.1.2 Changes to fees for fully depreciated diagnostic imaging equipment

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.1m	\$0.1m	-\$64.7m	-\$68.7m	-\$133.2m
DVA	-	-	-	-	-\$1.9m	-\$1.9m
Medicare Australia	-	\$0.1m	\$0.4m	-	-	\$0.5m
Total	-	\$0.2m	\$0.5m	-\$64.7m	-\$70.6m	-\$134.5m

Where a service is rendered with a piece of capital equipment that is fully depreciated, the MBS fee for that service will be reduced by 50%. These arrangements have been in place for CTs since 1997 and for angiography since 2001.

The stated aim is to provide greater incentives to update capital equipment. There will be an exemption for remote areas. This measure will take effect on 1 July 2011.

8.1.3 Improving competition

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.1m	-	-	-	\$0.1m
Medicare Australia	-	\$0.5m + \$2.4m*	\$0.1m	\$0.1m	\$0.1m	\$3.2m
Total	-	\$3.0m	\$0.1m	\$0.1m	\$0.1m	\$3.4m

* Related capital costs

Currently there are limits on the number of Medicare-eligible collection centres a pathology provider can operate. An independent review conducted in 2005-06 by Phillips Fox found that these restrictions inhibit the growth of smaller providers and facilitate the growth of larger pathology services. From July 2010, there will be no limit on the number of collection centres a pathology service can operate and patients will be able to request Medicare-eligible pathology and diagnostic imaging services from any accredited provider, regardless of which service their doctor selects.

8.1.4 Improving the quality of services and addressing workforce shortages

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$5.4m	\$7.9m	\$0.3m	-\$8.8m	\$4.8m
DVA	-	-	-\$0.1m	-\$0.4m	-\$0.8m	-\$1.3m
Medicare Australia	-	\$0.1m	\$0.3m	-\$0.1m	-\$0.4m	-\$0.1m
<i>Total</i>	-	\$5.5m	\$8.1m	-\$0.2m	-\$10.0m	\$3.5m

There are currently serious workforce shortages in both pathology and diagnostic imaging. The Government will provide \$17.3 million / 4 years to increase the number of specialist pathology training places to 50, and offer financial support of \$100,000 / specialist / year. A rural loading of \$20,000/ year will be available for 20 of these places. It is not known if any of these training places will be in the private sector.

This provision also provides \$5.4 million for 15 additional training places for diagnostic imaging at a cost of \$100,000 / specialist / year.

\$1.5 million will be provided for initiatives to improve the quality of pathology services, including the development of guidelines for reporting cancer.

There is no explanation provided as to why this measure makes savings of \$10 million in 2012-13.

8.1.5 Rebalancing of pathology fees

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.7m	-\$0.9m	-\$1.2m	-\$1.5m	-\$4.3m
DVA	-	\$0.1m	-	-	-	\$0.1m
<i>Total</i>	-	-\$0.6m	-\$0.9m	-\$1.2m	-\$1.5m	-\$4.1m

The MBS will be modified for certain pathology items to better align fees with the level of expertise required and take the increasing automation of pathology into account.

The Budget Papers state that there will be increases in MBS fees for eight items, averaging \$53.00, and decreases, averaging \$0.56, for 259 items that are done mainly on an automated basis.

8.1.6 Reviews of pathology and diagnostic imaging items

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.4m	\$3.6m	-	-	\$6.0m

\$6.0 million is provided for detailed reviews of pathology and diagnostic imaging items listed on the MBS. The reviews will be undertaken by DoHA in consultation with industry.

This is an important and valuable measure, but there should be a structure for the constant oversight and review of all such MBS items, preferably done by an independent expert body, especially in view of the rapid advances in technology in these areas.

8.2 Medicare Benefits Schedule – access to PET services provided at Westmead and Royal North Shore Hospitals and Austin Health Services

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$6.8m

The Budget provides \$6.8 million / 4 years (taken from the Health and Hospitals Reform provision funded in the 2008-09 Budget) to give MBS access for PET services provided at Westmead and Royal North Shore Hospitals in Sydney and the Austin Health Services in Melbourne.

Access to PET has previously been limited while data was accumulated to support a MSAC decision. The MSCA report was delivered in late 2007.

8.3 Magnetic Resonance Imaging – transitional funding for Gippsland and South Eastern NSW Mobile unit

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.6m	\$0.9m	-	-	\$1.5m

Funding is provided for 2 years to extend this mobile MRI service which is currently funded as part of a trial that is due to cease October 2009. It is not clear if this means that there will be an evaluation of this trial before funding ceases on 30 June 2011.

8.4 Magnetic Resonance Imaging unit in NW Tasmania – redirection of funding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$1.2m	-\$1.2m	-\$1.2m	-\$1.2m	-\$4.8m

This MRI unit was promised as part of the 2007 federal election campaign and an Invitation to Apply process had been initiated. However the Launceston General Hospital is now to get upgraded services and this funding has been redirected.

See also access to PET services provision in Section 7: Cancer.

9. Preventive health

There are no spending provisions on preventive health in this budget (unless new mammography equipment counts) and many of the former Government's initiatives developed as the response to the COAG communiqué from February 2006 have been dismantled.

Hopefully the **\$125.6 million** in savings made in this area (the Government has clawed back half the 2006 commitment of **\$250 million**) will quickly be reinvested in new initiatives as recommended by the National Preventative Health Taskforce.

It is not known what the States and Territories, which in 2006 also committed to spending \$250 million on prevention and early intervention, are doing in this area.

It is possible to provide the Government with some laxity in this area if there is a genuine commitment to pick and quickly implement the recommendations of the reports on health reform which it will receive by the end of the 2008-09 financial year.

COAG Communiqué February 2006

Promoting Good Health, Disease Prevention and Early Intervention

COAG recognises the importance of good health, disease prevention and early intervention and has announced the Australian Better Health Initiative that will start to re-focus the health system and will see the Commonwealth and States and Territories working together, and with the community, to promote good health and tackle chronic disease. This component of the package is linked to the National Reform Agenda in that over time it will assist in raising productivity and workforce participation.

From 1 July 2006, \$500 million will be provided over four years, comprising \$250 million from the Commonwealth and \$250 million from States and Territories, for:

- promoting healthy lifestyles through nationally-consistent messages on health, implementing nationally-consistent school canteen guidelines and school-based and local programs to facilitate and support lifestyle changes;
- supporting early detection of lifestyle risks and chronic disease through a new Well Person's Health Check which will be available nationally people around 45 years old with one or more identifiable risks that lead to chronic disease;
- supporting lifestyle and risk modification through referral to services that assist people wanting to make changes to their lifestyle. Assistance could include nutritional advice, advice on weight management, support to give up smoking, and counselling;
- encouraging active self-management of chronic disease with services ranging from group-based courses to different forms of counselling; and
- improving integration and coordination of care so that people with chronic conditions can receive more flexible and innovative support.

2006-07 Budget Commitment for COAG Health Services — promoting good health, prevention and early intervention

	2006-07	2007-08	2008-09	2009-10	Total
DoHA	\$44.1m	\$67.8m	\$71.1m	\$66.7m	\$250.0m

This package funded a range of initiatives including health checks and multidisciplinary cancer case conferencing Medicare items, counselling and education services on lifestyle modification to be delivered by nurses and allied health workers, and professional development for general practitioners and other health professionals on chronic disease self management for patients. The funding also provide for information and training packages for primary care providers to improve the quality of advice regarding lifestyle risks, as well as establishing a health promotion fund to provide ongoing national media campaigns targeting chronic disease risk factors.

9.1 Australian Better Health Initiative – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$26.2m	-\$27.1m	-\$27.6m	-\$80.9m

Funding for this measure covering a range of initiatives including:

- supporting lifestyle and risk modification;
 - encouraging active self management of chronic disease; and
 - the Primary Care Incentive Fund;
- will cease, effective 30 June 2010.

The explanation given is that funding for similar outcomes is now provided through other initiatives such as the Australian Primary Care Collaboratives Program.

The 2008-09 Budget committed \$22.5m over four years to the Collaboratives Program, but in doing so cut the program by \$16.7 million over previous funding levels.

Phase One of the Collaboratives Program was implemented from July 2004 to December 2007 and was managed by Flinders University. The Program funded about 500 practices (8% of GP practices) in 42 Divisions of General Practice to participate in the Program. Phase Two commenced in January 2008 and is being managed by the Improvement Foundation (Australia). It is expected that another 500 practices will participate in Phase Two.

9.2 Australian Better Health Initiative – cease promotional activities for 45-year old health Check

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.9m	-\$0.8m	-\$0.9m	-\$0.9m	-\$3.5m

The 45-year old health check (MBS item 717) was introduced in November 2006. It is available as a once-only service to patients aged 45 to 49 years (inclusive) who are at risk of developing a chronic disease. The current rebate for the item is \$104.55.

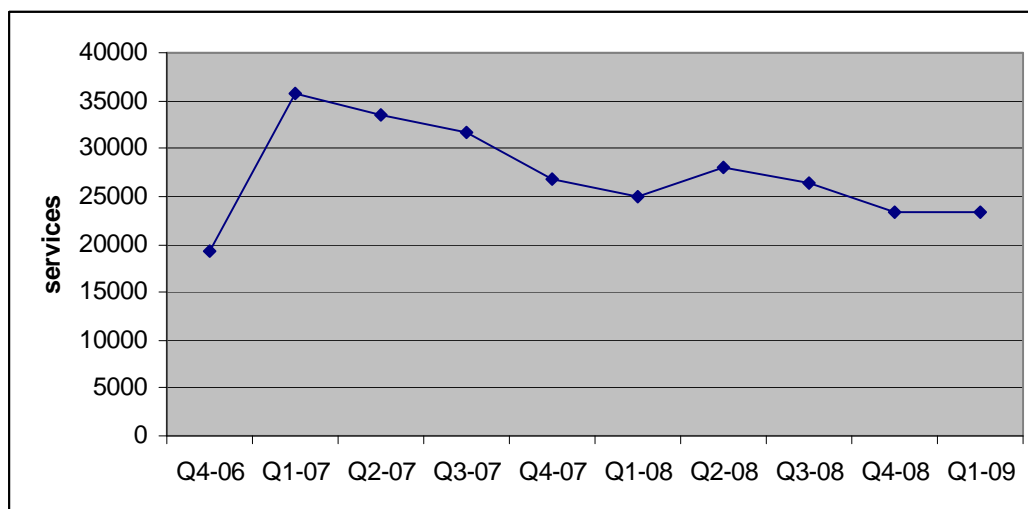
This health check was part of the COAG-agreed provisions on promoting good health, prevention and early intervention in the 2006-07 Budget. The anticipated cost to Medicare for this item was not given at the time.

The savings here of \$3.5 million / 4 years apparently accrue from ceasing the funding for promotion of this program. The Budget Papers state that *'The uptake rate of the 45 Year Old Health Check has been above original estimates, indicating that further promotional activities are no longer necessary.'*

However as the data in Figure 9.1 show, the promotional activities have not been a success as the use of this item has been in steady decline within 3 months of its introduction. Since its inception until April 2009, 280, 811 people have received a 45 year old health check, at a cost to Medicare of \$28.5 million.

There are about 1.1 million Australians aged 45-49, although not all of these people would be judged to be at risk of developing a chronic disease. It seems that about a quarter of this population have had a health check, but there are significant numbers of people moving into and out of this age cohort each year.

Figure 9.1 Uptake of 45 year old Health Check



9.3 Australian Better Health Initiatives – promoting healthy lifestyles – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$12.4m	-\$12.6m	-\$12.9m	-\$37.9m

This initiative was originally described as encouraging people to make informed lifestyle choices and reduce the risk of developing chronic disease. A particular focus was to be on getting agreement for simple, consistent messages between all jurisdictions so that all Australians can benefit from healthy lifestyle advice. These messages were to be used to support a national social marketing campaign to promote health and well-being.

The Measure Up public education campaign was introduced in late 2008. The campaign aims to raise appreciation of why people need to change their lifestyles, and includes supporting information on how to do this. The campaign primarily targets 25-50 year olds who have children, as parents' behaviour is likely to have an impact on their children's lifestyle behaviours. There is also an Indigenous version called Tomorrow People.

It is not known how much money was spent in the preparation of this campaign and its media sales and it is not clear whether the projected roll-out of this campaign will now be terminated.

The second part of this original initiative was the consideration by the States and Territories of the implementation of consistent school canteen guidelines across Australia. In May 2008 it was announced that Flinders University had secured the Government's \$1.25 million National Healthy Schools Canteen Project to develop a national food categorisation system, as well as training resources, to help school communities make appropriate menu choices. The plan was to make the system and resources available to the States and Territories for optional implementation in all government and non-government schools.

9.4 Grants for physical activity projects in the community – discontinuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.1m	-	-\$1.6m	-\$1.6m	-\$3.3m

This program has provided grants between \$10,000 and \$200,000 for projects of up to 18 months, to not-for-profit organisations to undertake healthy eating and physical activity initiatives at the local level. In October 2007 the then Minister for Health, Tony Abbott, announced grants totalling over \$37 million for 320 community organisations under the program. In August 2008, the current Minister for Health, Nicola Roxon, announced grants totaling over \$17.6 million for 190 schools and community organisations under the program.

There is no publicly available evidence about the benefits or otherwise of the programs funded to date, so no way to know whether the \$55 million spent has contributed to healthier eating and increased physical activity.

9.5 Investment in Preventive Health (Environmental Health) program – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.2m	-\$0.2m	-\$0.2m	-\$0.2m	-\$0.9m

The Budget Papers indicate that these savings are made by ceasing the component of the program that supports the development of environmental protection measures, thus addressing a duplication of responsibilities with the NHMRC.

Funding will continue to support the implementation of the National Environmental Health Strategy 2007-12, environmental health activities in Indigenous communities and the provision of environmental policy advice to the Government.

It’s interesting that this duplication of effort has apparently existed for some time and the work of the Preventive Health (Environment Health) program in the development of environmental protection measures was included as part of the National Environmental Health Strategy 2007-12.

National Environmental Health Strategy was first funded in the 1998-99 Budget. It was a collaborative effort with State and Territory Governments and under the auspices of the now defunct National Public Health Partnership. The aim of the Strategy is to improve assessment, prevention, control and management of environmental health hazards, including water borne diseases (such as hepatitis A and Cryptosporidium), the need for clean air, reducing the risks of vector borne diseases and the increasing incidence of asthma in the community. Evidence suggests that the need for this public health effort has increased rather than decreased over the past decade.

9.6 Primary care – Sharing Health Care Initiative – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$2.7m	-\$0.7m	-	-	-\$3.3m

The Sharing Health Care Initiative (SHCI) is designed to improve the health related quality of life for people with chronic diseases, to encourage people to use the health care system more effectively and to enhance collaboration between patients, carers and health care professionals in the management of chronic disease. The SCHI focus is on people over 50 years (or over 35 for those of Aboriginal or Torres Strait Islander descent) who have one or more of the following chronic or complex conditions:

- cardiovascular disease
- diabetes
- arthritis
- osteoporosis
- respiratory disorders
- depression, when this occurs with another condition

This program was originally part of the 1999-2000 Budget, and was funded at \$22.4 million / 4 years in the 2007-08 Budget.

It appears that the focus of this program will now narrow to Indigenous and CALD groups, which seems rather short-sighted given the needs of all people with chronic illness and the demonstrated success of this program in improving health status and symptom control and reducing GP visits and overnight hospital stays.

10. *Private health insurance*

The Government has proposed a number of changes to private health insurance (PHI) in this Budget, intended broadly to make private health insurance ‘more sustainable’. These include:

- Removal or reduction of the private health insurance rebate for higher income earners purchasing private cover;
- An increase in the Medicare levy surcharge for those higher income earners who do not purchase private cover;
- Changing Medibank Private from a ‘not for profit’ to a ‘for profit’ insurer; and
- Regulatory changes that affect how private health insurers can utilise surpluses.

These provisions signal a change in Labor’s approach to PHI and the PHI rebate, but manage to send a very confused message about what the Government’s policy will now be. Labor has previously resisted proposing changes to the PHI rebate, despite its growing cost to the Budget (now almost \$4 billion / year and expected to reach \$9.3 billion / year by 2019-20), but it seems that in this budget cycle the need to make savings triumphed over election commitments.

The main driver for the uptake of PHI has not been the 30% rebate, which has gone disproportionately to the better-off, or the penalty 1% tax surcharge for those on higher incomes who do not take out PHI. Indeed, counter to the dire predictions of the PHI funds, there has been an increase in uptake of PHI since changes last year to the thresholds for the Medicare levy surcharge.

The evidence suggests that those who take out private health insurance are not particularly sensitive to price. It was the introduction of the ‘lifetime’ cover provision in July 2000 which imposes a penalty for those who delay taking out private health insurance after the age of 30, that led to the major increase in proportion of the population with PHI, from 30% to 45%. It has hovered around the 42%-45% mark ever since.

There are arguably good reasons to cut back on the PHI rebate for people on higher incomes, while continuing to assist those on lower incomes, and despite the protests from the funds, this is unlikely to result in any major impact on the number of people who have PHI cover.. However the increased surcharge imposed on the well-to-do if they choose not to purchase PHI seems to indicate (deliberately or inadvertently) that the Government expects / requires these people to have (if not to use) PHI cover. It’s a very confused approach from a policy perspective, and it is clear that this is a case where the need for Budget savings won out over the drive for better health policy.

The Budget provisions on PHI, described as ‘*fair and sustainable support for the future*’, result in net savings of **\$1.9 billion / 5 years**. This will result in a decrease in the cost of the rebate to Government of an average of **\$630 million / year**, which represents about

16% of the total cost. However savings of this order will only result if the Government is able to get enacting legislation passed by the Senate.

In the 2008-09 Budget the Government proposed savings of **\$299.2 million / 4 years** by increasing the income thresholds at which the Medicare level surcharge kicks in from \$50,000 to \$100,000 a year for singles and from \$100,000 to \$150,000 a year for couples. The thresholds had not been indexed since the surcharge was introduced in 1997. However in order to get this passed by the Senate, the Government was forced to agree to income thresholds for single people of \$70,000 per year and \$140,000 per year for couples/families. The new thresholds are indexed annually to full-time adult average weekly ordinary time earnings.

10.1 Private health insurance – fair and sustainable support for the future

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$119.3m	-\$713.5m	-\$613.8m	-\$614.9m	-\$1822.9m
Medicare Australia	-	\$0.3m +\$0.3m*	-	-	-	\$0.6m
ATO	\$1.0m	\$4.8m	\$18.1m	\$33.6m +\$70.0m#	\$9.1m +\$75.0m#	\$66.6m -\$145.0m
<i>Total</i>	\$1.0m	\$124.7m	-\$695.4m	-\$650.2	-\$680.8m	-\$1900m

* Related capital costs

Related revenue

This measure will reduce the expenditure on the PHI rebate by \$1.8 billion / 4 years and will increase revenue through the surcharge by \$145.0 million.

It does this through the introduction, effective 1 July 2010, of three new 'Private Health Insurance Incentive Tiers'.

- Tier 1 will apply to singles with income between \$75,001 and \$90,000 (\$150,001 and \$180,000 for families). The PHI rebate will be 20%, increasing to 25% at 65 years of age, and to 30% at 70 years. The surcharge for not taking out complying private health insurance will remain at 1%..
- Tier 2 will apply to singles with income between \$90,001 and \$120,000 (\$180,001 and \$240,000 for families). The PHI rebate will be 10%, increasing to 15% at 65 years of age, and to 20% at 70 years. The surcharge for not taking out complying private health insurance will be increased to 1.25%.
- Tier 3 will apply to singles with income of more than \$120,000 (more than \$240,000 for families). No private health insurance rebate will be provided. The surcharge for not taking out complying private health insurance will be increased to 1.5%.

Existing arrangements will remain unchanged for singles with income of less than \$75,000 per annum and families with incomes of less than \$150,000 per annum.

The Budget Papers state (as always) that the financial impact of premium growth on the forward estimates for the PHI rebate is currently allocated in the Contingency Reserve.

10.2 Private health insurance – transparent premium setting

The Government will publish individual insurers' average PHI premium increases at the conclusion of each annual premium approval round, including details of the reasons provided by the insurers for the increases in premiums. This will not however include the Government's rationale for approving the premium increases that are given.

10.3 Medibank Private – change in status

The Budget includes an announcement that, towards the end of 2009, the Government will convert the status of Medibank Private from a 'not for profit' health insurer, to a 'for profit' health insurer, but will retain ownership in public hands.

The Government's stated intentions are to '*improve the competitive neutrality*' between Medibank Private and its 'for profit' competitors, by making Medibank Private liable to pay company tax and dividends which will help '*drive future efficiency gains*'. This will also benefit the Treasury coffers.

Although listed as a 'revenue' measure in the budget papers, the Government has not released estimates of the savings expected from the measure due to commercial sensitivities.

It is interesting to note that recent media reports have the Labor Party dropping the provision that states that Medibank Private will be kept in Government hands from the Party Platform document. This has inevitably led to speculation that Labor has plans for the sale of Medibank Private.

10.4 Regulatory changes

The Budget also announces that the Government intends to make legislative changes that would allow health insurers to 'spend surplus capital' to fund the provision of sporting and recreational activities for members and community-based health promotion activities. Under current arrangements, assets of 'not for profit' health insurers can only be used to meet liabilities (such as the payment of benefits for complying health insurance products) or other expenses, or make certain investments. Health insurers that operate on a 'for profit' basis do not have the same restrictions on their 'surplus capital' and they are free to allocate their profits where they choose.

11. Mental Health

This Budget, when viewed together with the 2008-09 Budget, will do little to assuage the concerns of the mental health community that the Government is not investing in, or even interested in, mental health services.

Last year's Budget cut **\$289.6 million** from mental health programs; this year's Budget makes further cuts of **\$63.1 million / 4 years**, and has new spending of only **\$11.9 million**. In reality, **\$6.7 million** of this 'new' spending is to restore some of the cuts made to mental health services for rural and remote areas in last year's budget; the remainder is to continue a program to deliver mental health services to drought-affected areas for another year.

It is particularly concerning that the Budget cuts almost one-third of the current funding allocation for progressing national mental health reform and improved national evaluation, accountability and reporting mechanisms.

11.1 Leadership in mental health reform – continuation and further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$5.0m	-\$5.0m	-\$5.0m	-\$5.0m	-\$20.0m

This particular provision might be the most egregious in the whole set of Budget Papers. At a time when there is enormous concern in the mental health sector about the Government's commitment to mental health reforms, almost one-third of the current budget of \$66.6 million / 4 years provided for progressing national mental health reform and improved national evaluation, accountability and reporting mechanisms is cut in the name of 'further efficiency'.

The Budget Papers simply state that less funding will be required over the forward estimates, "*reflecting the revised focus on key priorities*".

11.2 Medicare Benefits Schedule – Better Access Initiative – continuing professional development

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.2m	\$0.3m	-\$19.9m	-\$2.3m	-\$21.7m
Medicare Australia	-	-	\$0.3m	-	\$0.1m	\$0.4m
<i>Total</i>	-	\$0.2m	\$0.6m	-\$20.0m	-\$2.2m	-\$21.4m

This provision introduces additional mandatory mental health training requirements for general psychologists, social workers and occupational therapists who deliver services under the Better Access program. One-off support payments of \$200 will be provided to those who work in rural areas to assist them in undertaking these new training requirements (presumably the cost of this is the \$0.5 million provided in 2009-10 and 2010-11).

Basically the assumption is that this new requirement will be rejected, at least initially, by enough mental health professionals that savings of \$21.4 million will be made. If fewer services are being reimbursed, then presumably fewer patients with mental health needs are getting access to care.

11.3 Medicare Benefits Schedule – Better Access Initiative – improved targeting for the most in need and better quality of services

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$7.7m	-\$17.1m	-\$6.1m	\$9.1m	-\$21.8m
DVA	-	-\$0.1m	-\$0.1m	-\$0.1m	-\$0.1m	-\$0.4m
Medicare Australia	-	\$0.4m	-	-	\$0.1m	\$0.5m
<i>Total</i>	-	-\$7.4m	\$17.2m	-\$6.2m	\$9.1m	-\$21.7m

This provision is similar to that discussed above, wrapped in such a way as to be acceptable to the AMA, which previously claimed vociferously that GPs do not need mental health training. When the Better Access program was introduced in 2006 the AMA said this: *‘The Government is considering limiting access to the new items to GPs who have undertaken additional, prescriptive mental health training. GPs are already trained to provide mental health care and the people who will be disadvantaged by this move are mentally ill patients who will find their access to care severely limited. The AMA believes GPs should be encouraged to seek further training as required but does not believe the Government’s plan to enforce compulsory training will improve patient health outcomes under this initiative.’*

The key assumption underlying this provision is that GPs will resist getting the needed training, thus saving \$21 million / 4 years. The consequence is that the services they do deliver will be reimbursed at a lower rate which may or may not impact on their quality.

11.4 Mental health – continuation of existing services in rural and remote areas

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.7m	\$1.5m	\$1.2m	\$1.3m	\$6.7m

The Mental Health Services in Rural and Remote Areas Program is provided with an additional \$6.7 million /4 years in a move that restores some of the funding cut from this program in the 2008-09 Budget.

This program was part of the Australian Government’s 2006 COAG mental health package, where it was funded at \$55.5 million over five years (2006-07 to 2010-11). The 2008-09 Budget cut \$15.5 million from this program – clearly a move that was unwarranted.

In July and August 2007, the Government announced that 15 auspice organisations (including Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service) were funded to provide mental health services at a total cost of \$21 million. The 24 auspice organisations funded under stage two were announced on 10 October, 2008.

The DoHA website reports that in the first 12 months of operation, this Program provided over 9,600 services to over 2,700 clients by around 40 full-time equivalent allied and nursing mental health professionals.

11.5 Mental health – continuation of Mental Health Support for Drought-Affected Communities program

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$5.2m	-	-	-	\$5.2m

The 2007-08 Budget contained an additional \$20.6 million / 4 years to provide up to 114 allied health and/or mental health nursing professionals to drought-affected communities. There was also \$10.1 million / 2 years to provide Mental Health Support for Drought Affected Communities through funding up to 39 Divisions of General Practice (DGPs) in these areas, although this was reduced to \$7.4 million when the Government of the day announced the roll-out of funding in September 2007.

The additional funding in the 2009-10 Budget is to provide continued support to the DGPs.

12. e-Health

Over the years e-health has turned into an expensive Achilles heel for all Australian governments, as strategies and plans have come and gone, consultants' reports have accumulated, and monies have been allocated - but there are few concrete results to point to.

This Budget has just two provisions on e-health, and they serve to highlight the lack of strategic planning in this area. There is a small amount of funding for a local e-health network in NW Tasmania, which may or may not be viewed as compensation for the brouhaha over the takeover of the Mersey Hospital and the fact that Burnie Hospital will now not get a promised MRI machine. Northern Tasmania has previously been the site of one of five HealthConnect projects. And the final death knell is sounded for HealthConnect as the government claws back the last of its funds as savings. The Government's HealthConnect website has been archived since June 2008.

Overall the 2009-10 Budget spends **\$1.2 million / 3 years** on e-health and makes savings of **\$34.5 million**.

Late last year AHMC signed off on a National e-Health Strategy, prepared by consultants Deloitte. To date, only a brief executive summary of this report has been released. However media items suggest that the report finds the national e-health infrastructure needed will cost **\$1.5 billion / 5 years** or **\$2.6 billion / 10 years**. This is a relatively modest investment, given that the report also finds that tangible benefits from implementing the e-health strategy are in the order of **\$5.7 billion / 10 years**.

12.1 e-Health – electronic clinical information and communication for north-west Tasmania

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$0.3m	\$0.7m	\$0.2m	-	\$1.2m

This funding is for the development of a virtual network to link data from health care providers in NW Tasmania into a single integrated electronic clinical information and communication system. It is described as being between GPs and other health professionals (presumably specialists); it is not clear if hospitals are included.

The Burnie and Mersey Hospitals were part of a HealthConnect project set up in early 2006, but since abandoned. It is not known if this new project will build on this earlier work.

This provision is funded from savings made by not proceeding with a proposed MRI unit at Burnie.

12.2 e-Health program – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$9.7m	-\$12.1m	-\$13.0m	-	-\$34.5m

These savings apparently come from the wind-up of the ill-fated HealthConnect program and what are described as ‘further *efficiencies within the e-Health Implementation program*’.

The basis for these efficiencies is the information provided from the external review of NeHTA conducted last year by Deloitte but not publicly released. The Budget Papers state that none of these savings come from the Government’s funding commitment to NeHTA as agreed through COAG in November 2008.

13 Other health measures

There are a number of other measures in the 2009-10 Health Budget which do not fall readily into any of the specific categories analysed in this paper. This section includes only those measures where it is considered that there is a point to be made.

13.1 Hospital Accountability and Performance Program - continuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-	-	-	\$39.6m

Continued funding is provided for the Hospital Accountability and Performance program, previously known as the Hospital Information, Performance Information Program [sic].

This funding is for work on hospital-related patient classification systems on diagnoses and treatments, costing methods and minimum data sets. This work will be crucial in the Government's efforts to develop comparable performance measures for public and private hospitals across the country and to support activity-based hospital funding.

The 2006-06 PBS for DoHA makes some statements about this work:

As part of the [AHCAs], the Hospital Information and Performance Information program funds development of national classification systems for patients, their treatment and associated costs. These systems provide a basis for measuring and paying for hospital services. The contribution to this outcome is measured by the quality and timeliness of major data collections, reports and classification system developments. Annual revision of the Australian Refined Diagnosis Related Groups classification and additions to national data collections for emergency departments and outpatient services, are also undertaken.

The DoHA 2007-08 Annual Report states: *The Department completed the Hospital Information and Performance Program Review and the National Hospital Cost Data Collection Review. The reviews' recommendations are informing improvements in information about the hospital services and costs associated with those services, and in particular improving information on trends in hospital utilisation.*

These two reviews do not seem to be publicly available.

13.2 Hearing services – introduction of hearing threshold

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$9.7m	-\$12.0m	-\$12.8m	-\$34.5m
Medicare Australia	-	\$0.2m +\$0.4m*	-	-	-	\$0.6m
<i>Total</i>	-	\$0.6m	-\$9.7m	-\$12.0m	-\$12.8m	-\$33.9m

* Related capital costs

These savings are achieved by introduction of a minimum hearing threshold (a hearing loss of greater than 23 decibels) for eligibility for hearing devices through the Hearing Services Program. Unfortunately no evidence is provided to suggest that this is the appropriate minimum threshold, especially for children.

The 2007-08 Budget provided \$70.7 million / 4 years for hearing services. On this basis it appears that a major part of funds previously committed is being cut. In 2008-09 510,000 people received hearing services under this program. It would seem that a significant number of these people might now lose access to these services.

13.3 National Illicit Drug Strategy – a more strategic approach

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$3.3m	-\$5.7m	-\$6.1m	-\$9.6m	-\$24.7m

Funding for research projects under the National Illicit Drug Strategy (NIDS) will be cut to provide savings of \$24.7 million / 4 years. Funding to DoHA for NIDS was included in the 2007-08 Budget at \$111.6 million / 4 years. Some of the remaining funding will be redirected in the name of *'improved efficiencies and outcomes through a more strategic approach.'*

13.4 Stoma Appliance Scheme – implementing a new program approach

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.6m	-\$4.0m	-\$4.3m	-\$4.3m	-\$13.3m

The Government will review the Stoma Appliance Scheme and establish a revised program framework that will reduce the cost of the program by \$13.3 million / 4 years.

The concern is that a determination has been made about the level of savings to be achieved before the review has been completed. The information provided on the Scheme's website already indicates that the schedule of subsidised items is reviewed quarterly.

The Stoma Appliance Scheme provides stoma-related products (medicines and appliances) free of charge to members of stoma associations who have undergone either a temporary or permanent surgically created body opening (stoma). There are approximately 30,000 members nationally who receive products under the Scheme through approved volunteer stoma associations.

The Scheme has a schedule that lists products that have been approved by DoHA to be issued to eligible members. The schedule determines the maximum quantities, the price of the product and whether there are any restrictions. It is updated four times a year with new products, deleted products and any variations to products already listed.

13.5 Support for diabetes – remove duplication in research effort

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$7.7m	-\$7.9m	-\$8.0m	-\$8.2m	-\$31.9m

The 2004-05 MYEFO announced funding of \$32 million / 4 years to establish a research program into islet cell transplantation for Type 1 diabetes and the Lift for Life program to control Type 2 diabetes.

Most of this money (\$30 million?) was provided to the Juvenile Diabetes Research Foundation establish the Australian Global Centre of Excellence in islet cell transplantation. It's not clear if this funding was slow to be rolled out or was extended beyond 2007-08.

A report from the Australian and New Zealand Horizon Scanning Network in August 2008 made the following findings:

'The three included studies do not provide sufficient evidence to determine the safety and effectiveness of allogeneic pancreatic islet cell transplantation for the treatment of type 1 diabetes mellitus, particularly owing to the lack of high quality evidence available, as well as the insufficiency of follow-up duration. The technology appears to be effective in a subset of patients in the short-term (one to two years) only, and the adverse events and serious adverse events associated with the technique are far too frequent as the procedure stands, these may be reduced by further refinements of the treatment protocol.'

'Due to the lack of long-term benefits of allogenic pancreatic islet cell transplantation, further refinement of the technique is required. Considering the fact that high quality results will not be available for some time, it is recommended that allogenic pancreatic islet cell transplantation be archived.'

The current fate of the Global Centre of Excellence in islet transplantation is not known.

Regrettably these savings made in research money have not been reinvested in diabetes research. In 2007-08 the NHMRC directed a total of \$51.5 million towards diabetes related research.

13.6 Torres Strait health protection

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$3.8m	\$3.9m	\$1.2m	\$1.3m	\$10.2m
Treasury	-	\$0.9m	\$0.9m	\$0.9m	\$0.9m	\$3.6m
<i>Total</i>	-	\$4.7m	\$4.8m	\$2.1m	\$2.2m	\$13.8m

These funds are to protect the Torres Strait Islands from incursions of communicable disease that may occur through the cross-border movement of people in the Torres Strait Protected Zone.

\$9.2 million is provided for an upgrade and extension of the health clinic on Sabai Island to accommodate PNG patients seeking treatment and for a culturally appropriate sexual health education campaign.

\$4.5 million is for the continuation of mosquito control and eradication efforts and the appointment of a communications officer. \$3.6 million of this will go to the Queensland Government to assist in the delivery of the program.

Note that elsewhere in the Health Budget \$16.2 million / 4 years is provided to the Queensland Government for the provision of health care to PNG nationals in Queensland's public hospitals under the Torres Strait Treaty. This funding was previously provided under the Queensland AHCA and is now provided through a National Partnership Agreement.

14. Aged care

Arguably aged care was ignored in this Budget. There are no major new initiatives, no new spending that will benefit people receiving aged care, and some cuts in programs that help older Australians maintain their independence and quality of life.

The Australian Government currently spends about **\$10 billion / year** on aged and community care. In 2008-09 this included **\$6.8 billion** on residential aged care and **\$2.2 billion** on community care.

The 2009-10 budget papers outline **\$37.8 million / 4 years** in increased spending for existing programs (this includes **\$14.4 million** already included in the forward estimates for the National Palliative Care Strategy), and savings of **\$76.5 million / 4 years**. However **\$6.3 million** of these savings actually accrue to the DVA budget, and achieving these savings requires the expenditure of **\$4.1 million** by Medicare Australia.

The current aged care system is very complex in terms of its operation and funding, with responsibilities divided between the Commonwealth and State and Territory Governments, and most services delivered in a very regulated environment by the private and non-governmental operators. It is expected that changes in the way aged care services are funded and delivered will be a key focus on the final report from the NHRC.

14.1 Aged care viability supplements - increase

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.4m	\$11.0m	-	-	\$13.4m
DVA	-	\$0.3m	\$1.2m	-	-	\$1.5m

The viability supplement is a special payment made available under Section 44-29 of the *Aged Care Act 1997* to assist small residential aged care services in rural and remote areas with the extra costs of delivering services in those areas. The amount of viability supplement paid is determined by the location of the service, the number of occupied places, and the proportion of care recipients with special needs.

The current viability scheme came into effect from 1 January 2005, in response to issues raised in the Hogan Review. Eligibility and funding is based on points determined by:

- the remoteness of the aged care facility
- the number of occupied places in the facility
- whether 50% or more care recipients are people with special needs i.e. from Aboriginal and Torres Strait Islander communities; from non-English speaking backgrounds; veterans of the Australian Defence Force or of an allied defence force; or their spouse, widow or widower.

However there are grandparenting arrangements to ensure that facilities receiving a viability supplement under previous schemes established in 1997 and 2001 do not see a reduction in payments.

In 2007-08, 476 aged residential care services received \$15.1 million of this funding. Further funding went to 18 National Aboriginal and Torres Strait Islander Aged Care Strategy Flexible services (\$1.74 million) and 118 Multipurpose Services (\$6.5million). In all 612 services received \$23.3 million amounting to just over \$38,100 / facility. Altogether there are 1163 potentially eligible aged care services in regional and remote Australia.

The Budget Papers state that the Government will consider the long-term needs of the aged care system, taking into account the recommendations in the final report of the NHHRC. The viability supplement for community based aged care services is also due for review in 2010-11.

14.2 National Palliative Care Strategy – continuation of funding

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-		-	\$14.4m

Continued funding for the National Palliative Care Strategy (\$14.4 million / 4 years) has been provided in the forward estimates.

The National Palliative Care Strategy was agreed by the Australian Health Ministers' Advisory Council in 2000 and guides the National Palliative Care Program, which is funded by the Australian Government. Apparently it has not been reviewed or updated since 2000.

The Australian Government currently provides about \$100 million / year to support palliative care. The majority of these funds are provided to national initiatives through the National Palliative Care Program, but some funds are also provided to the states and territories (\$188 million under the 2003-08 Australian Health Care Agreements).

It is interesting to note that in a post-budget announcement on 27 May for Palliative Care Week, the Minister for Ageing announced this \$14.4 million package as providing for much more than funding the National Palliative Care Strategy:

- \$11 million / 2 years for local grants to help support palliative care patients and their families;
- More than \$2.9 million for equipment upgrades and research; and
- More than \$500,000 in one-off local grants for 2008-09.

14.3 Prudential regulation of aged care providers – not to proceed with cost recovery

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$2.2m	\$2.2m	\$2.1m	\$2.2m	\$8.6m

The Government oversees the prudential regulation of approved aged care providers who charge accommodation bonds for residents. In the Explanatory Memorandum to the *Aged Care Amendment (2005 Measures No1) Bill 2005*, which implemented the new prudential regulatory framework, it was stated that the Government would meet the costs of the new prudential regulatory framework for the first three years of operation (\$8.5 million / 3years).

The 2007-08 Portfolio Budget Statement said that 2007-08, DoHA would undertake a full cost analysis that would inform the development of a cost recovery mechanism. It is not known if this cost analysis was done.

The current funding level is less than that originally proposed by about \$0.7 million / year.

14.4 Assistive technology in community care – discontinuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$6.6m	-\$6.3m	-\$6.4m	-\$6.5m	-\$25.8m

This provision was originally funded in the 2007-08 Budget at \$21.4 million / 4 years. It was intended to increase the availability and use of ‘assistive technology’ - devices such as those which provide remote monitoring of vital signs, or help people remember to take their medications.

As introduced, the initiative had two components: (1) the establishment of an industry body to promote the use of assistive technology by community care providers, and to use the buying power of the large number of community care services to negotiate discounts on assistive technology and (2) starting in 2008-09, a grants program, totaling \$15.3 million / 3 years, to fund innovation in assistive technology.

It is not known how and to what extent this program has been rolled out.

The Budget Papers state that funding will cease for this program because ‘*the aged care industry is now aware of the availability and benefits of such technology*’, but it’s not clear how this statement about awareness corresponds to the aim of the provision which was about increasingly availability and use.

It is interesting to note that enhanced access to assistive technologies was one of the priorities for aging and aged care identified by the health stream at the 2020 Summit.

14.5 Contenance Aids Payment Scheme – more choice for users

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$3.2m	-\$7.8m	-\$5.4m	-\$4.6m	-\$14.6m
Medicare Australia	-	\$0.9m	\$0.6m +\$0.8m*	\$0.7m	\$0.8m	\$3.8m
<i>Total</i>	-	\$4.1m	-\$7.1m	-\$4.7m	-\$3.9m	-\$10.7m

* related capital expenses

The Contenance Aids Assistance Scheme (CAAS) assists eligible people who have permanent and severe incontinence to meet some of the costs of continence products. It is administered on behalf of the Australian Government by Intouch, the commercial arm of the Spinal Injuries Association Incorporated. CAAS clients receive a subsidy of up to \$479.40 / year on continence products ordered through Intouch.

From 1 July 2010, CAAS will be replaced with a Contenance Aids Payment Scheme that will enable those eligible a greater choice of products and suppliers. The savings are described as due to the fact that the Government will no longer pay administrative overheads to Intouch.

In the 2007-08 budget CAAS was expanded to include children from 5 to 15 years old; and older people (65 and over) with non-neurological causes of incontinence, provided they hold a Pensioner Concession Card. At that time the Scheme was described as costing \$98.5 million / 5 years.

14.6 Fairer income testing in residential aged care – ending the 28-day income test exemption

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$4.0m	-\$9.2m	-\$10.0m	-\$10.9m	-\$34.1m
Medicare Australia	-	\$0.3m	-	-	-	\$0.3m
DVA	-	-\$0.8m	-\$1.7m	-\$1.8m	-\$2.0m	-\$6.3m
<i>Total</i>	-	-\$4.5m	-\$10.9m	-\$11.8m	-\$12.9m	-\$40.0m

The income test for residential aged care will be applied from the day of entry, removing the current 28-day delay. This is described as ensuring ‘an equitable sharing of costs of residential care’. It achieves savings of \$40.0 million / 4 years (\$34.1 million to the DoHA budget).

Residents entering care may be asked to pay an income-tested fee based on their income and their level of care. Income is assessed using the same rules as for means-tested pensions. Income-testing of aged care residents started in March 1998.

15. Other portfolios

15.1 Department of Finance and Deregulation

Medibank Private

Medibank Private Ltd is converted to a 'for profit' government business enterprise. The revenue that will accrue to the Government as a result is not disclosed.

15.2 Australian Taxation Office

Increasing the Medicare levy thresholds

The Government will increase the Medicare levy low-income thresholds to \$17,794 for single individuals and \$30,025 for individuals in families with effect from 1 July 2008. This measure has an ongoing cost to revenue which is estimated to be \$205.0 million over the forward estimates.

The additional amount of threshold for each dependent child or student will increase to \$2,757 to take into account the movements in the CPI.

The Medicare levy threshold for pensioners below Age Pension age will increase to \$25,299 with effect from 1 July 2008, to ensure that these pensioners do not pay the Medicare levy when they do not have an income liability.

15.3 Department of Education, Employment and Workplace Relations

Increase in the maximum annual student contribution amount for education and nursing.

The Government will increase students contributions from \$4,162 in 2009 (National Priority Band) to \$5,201 in 2009 (Band 1), applying this to students who start study from 1 January 2010. This has been done to increase the funding available to the providers of these courses. Students will be compensated by HELP debt repayments for those who work in these professions following graduation.

Higher Education Loan Program (HELP) repayment reduction for education and nursing graduates

For education and nursing graduates HELP debts will be reduced by \$1,536 (indexed annually by the CPI) for each year in which year in which they work in these professions, up to a maximum of 5 years.

15.4 Department of Human Services

Fraud and compliance – matching MBS and PBS data

Data matching will be undertaken to help identify unusual patterns of health service activity. This measure will cost \$4.2 million / 4 years to implement and is expected to result in savings of \$15.4 million to DoHA.

15.5 Department of Innovation, Industry, Science and Research

Research

There are several funding commitments from the Education Investment Fund that are directly relevant to health.

- \$35 million for the establishment of collaborative infrastructure networks to support new drug discovery, novel cell therapies, development of nano-medicines, and integrated population health solutions through a collaboration of universities, non-profit research institutions, the CSIRO and private industry.
- \$15 million for the Australian Phenomics Network.
- \$10 million for the Population Health Research Centre hosted by the University of Western Australia.

There is also \$50.0 million / 4 years to establish a competitive grant program to facilitate research leading to the development of a functional bionic eye. This was a recommendation from the 2020 Summit.

15.6 Treasury

Organ transplantation services

The Commonwealth will meet future payment commitments to the States in respect of organ transplantation services by providing a single payment of \$16.1 million in 2009-10 and then ceasing future annual payments. The states will now be responsible for funding these services.

15.7 Department of Veterans' Affairs

Suicide prevention

\$9.5 million / 4 years is provided to fund the Government's response to the Independent Study into Suicide in the Ex-Service Community (Dunt Report, August 2008).