ANALYSIS OF THE 2010-2011 HEALTH AND AGEING BUDGET

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FOREWORD

The 2010-11 Budget and the raft of health care reform announcements that preceded it will supply the platform on which the Rudd Government will run in the forthcoming election. It deserves scrutiny to determine if it delivers on previous election commitments and to assess how well it reflects the recommendations provided by the National Health and Hospitals Reform Commission, the National Preventative Health Task Force, the National Primary Health Care Strategy External Reference Group, the Council of Australian Governments (COAG) Health and Ageing Working Group, the Maternity Services Review, and reviews of rural health and MBS items.

While the shape and extent of the Rudd Government's commitment to health care reform has now been revealed, the details are missing. And indeed, a response to many key issues – particularly mental health, dental health and Indigenous health - is also missing. The approach has been evolutionary rather than revolutionary, clearly designed to address short-term pressure points rather than needed long-term changes. Although the funding provided seems generous, on closer scrutiny funding for important new investments in health care delivery (as opposed to political and campaigning opportunities) is in fact quite limited.

The real reform elements are critically lacking. Hopefully they will emerge as the policy detail is developed.

As outlined, the plan to have the Commonwealth Government take over a significant part of hospital funding and oversight of how those funds are spent has the very real potential to address current problems with a fragmented system riddled with cost and blame shifting. But the focus is not on the patient, it's on governance and financing, on who pays for what, and on what basis. And while the Commonwealth Government will now fund 60 per cent of both recurrent and capital hospital expenditures, this falls far short of a complete takeover of public hospitals, as once mooted.

It's not even a particularly generous offer, given that the original deal for hospital funding was a fifty - fifty split between commonwealth and state and territory governments. Moreover, this Commonwealth Government largesse is funded largely through a claw-back of GST revenue from the states and territories.

Redirecting the funding of public hospitals directly to Local Hospital Networks, bypassing the state and territory government bureaucracies, should mean that regional health care delivery networks are more responsive to local needs. But it could also mean that they are prey to local politics. Careful oversight will be needed to ensure that areas of disadvantage and health care disparities get the additional resources they need and do not lose out to more powerful voices in better-off suburbs and regions.

There are a host of questions about what this new approach means for important issues such as equity of access to care, the integration of mental and physical health services, the better coordination of community, hospital, rehabilitation and residential care, and promised improvements in dental care. For real health care reform, these cannot be ignored.

There is a huge gap that should have been addressed in this plan, and that is the integration of private hospitals into the health care system; currently they apparently sit outside of the reforms. This is a serious omission, not least because of the significant federal subsidies which private patients in private facilities currently receive.

Realistically, hospital financing is an odd place to start a fundamental health reform, when all the prior consultations and reports make it quite clear that the real problems facing the health care system are those around prevention, better management of chronic illness, giving children the best start in life, and getting more health care professionals to work where they are most needed.

The other half of the equation is about reforming the way in which health care services are delivered and the need to move from paying for activity to paying for health outcomes. Our current reimbursement system rewards volume and not value, quantity and not quality.

Real reform should include a move away from fee-for-service and towards bundled payments which would ensure that patients get the complete suite of needed health care services. It would reward doctors and other health care providers for keeping patients as healthy as possible and avoiding preventable hospital admissions and readmissions. And it would tackle duplication and waste in the health care system, particularly in the areas of pathology testing, diagnostic imaging and prescribing of medications.

The real issues of needed investments and reforms in the health care system are now clearly on the table, increasing dramatically the possibility that these will be tackled and solved and not simply kicked forward into the future.

This analysis looks at the health and ageing and related provisions in the 2010-11 Commonwealth Budget. This is done in the light of current and past strategies, policies, programs and funding support. It does not include the provisions in the sports portfolio. While it includes Indigenous health provisions, the full range of budget measures aimed at 'Closing the Gap' in Indigenous disadvantage have been analysed separately.

Budget analyses from previous years, including summaries of the state and territory health budgets, can be found on the website of the Menzies Centre for Health Policy. See: http://www.menzieshealthpolicy.edu.au/hpa_budgetelectioncomm.php

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

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

INTRODUCTION

Total Commonwealth funding for health care is estimated to be **$56.88 billion** in 2010-11 and **$284.68 billion** / 4 years (see Table 1).

The significant increase in health care spending over the next four years is almost totally due to the new funding responsibilities assumed by the Commonwealth under the COAG National Health and Hospitals Network (NHHN) Agreement and increased funding commitments made to the states and territories for the provision of health care services since the Rudd Government came to office. These Commonwealth payments are made primarily through National Specific Purpose Payments (SPPs) and National Partnership (NP) payments.

Table 1: Estimates of health expenses (Budget Paper No 1)

$million

	Actual 2008-09	**Estimate 2009-10**	**Estimate 2010-11**	**Estimate 2011-12**	**Projected 2012-13**	**Projected 2013-14**
Medical services and benefits	20,767	22,251	22,893	22,595	24,087	25,534
Hospital services	3,023	2,198	3,025	2,609	2,714	2,701
Health care agreements	10,505	-	-	-	-	-
SPP/NHHN	-	11,224	12,036	26,575	28,695	30,959
Pharmaceutical services and benefits	9,210	9,808	10,248	10,762	11,076	11,740
ATSI health	523	642	711	707	678	701
Health services	3,720	5,045	6,002	6,322	5,859	5,840
General administration	1,291	1,619	1,963	2,388	2,652	2,611
(% total)	(2.6)	(3.1)	(3.5)	(3.3)	(3.5)	(3.3)
Total health	**49,039**	**52,786**	**56,880**	**71,958**	**75,761**	**80,085**

(It is not clear if Table 1 includes the funding provided under the NPs.)

Other than this NHHN spending, the Budget has savings of **$2.050 billion / 5 years** (to 2012-14) and new spending of **$408.5 million**. The majority of savings are made in the Pharmaceutical Benefits Scheme (PBS). Virtually all the spending is for the continuation or expansion of current programs.

NEW FUNDING ARRANGEMENTS FOR HEALTH

National Health and Hospitals Network

From 2011-12, Commonwealth payments to the states and territories for health will be modified to implement the National Health and Hospitals Network (NHHN). A new NHHN Fund will be established into which Commonwealth funding for the NHHN will be paid. The Commonwealth's 60% contribution for efficient hospital services will be delivered by an independent pricing authority.

The Rudd Government has committed **$7.3 billion / 5 years** to the NHHN – assuming a national roll-out in all states (Western Australia has yet to sign on). This includes **$3.8 billion** for a package of investments in health and hospitals. In addition, the Government has guaranteed to the states and territories no less than **$15.6 billion** between 2014-15 and 2019-20 in top-up payments for growth.

The NHHN Agreement establishes the financing and governance arrangements between the Commonwealth and the states and territories.
Under this agreement the Commonwealth will fund:

- 60% of the efficient price of every public hospital service provided to public patients
- 60% of recurrent expenditure on research and training undertaken in public hospitals
- 60% of capital expenditure, on a 'user cost of capital' basis where possible; and
- Over time, up to 100% of the efficient price of 'primary health care equivalent' outpatient services provided to the public.[1]

The Commonwealth will take on the full policy and funding responsibility for primary health care and aged care. The exceptions are that Victoria will continue to operate its immunisation programs and the Home and Community Care (HACC) program. A new National Partnership agreement consistent with the framework for federal financial relations will be agreed between the Commonwealth and Victoria to govern arrangements for the HACC program within Victoria from 1 July 2011.

The Commonwealth will fund its increased responsibilities through a combination of:

- Funding sourced from the current National Healthcare SPP;
- The Commonwealth retaining an agreed amount of GST to be dedicated to health and hospital services;
- From 2014-15, an additional top-up payment reflecting the increased responsibility for financing growth in health costs (guaranteed to be no less than $15.6 billion over the years 2014-15 to 2019-20)

The amount of GST retained by the Commonwealth and dedicated to the NHHN will be fixed in 2014-15, based on 2013-14 costs, and indexed at the rate of overall GST growth. The additional Commonwealth top-up payments are provided because

[1] It is not clear if this includes outpatient specialist services provided by hospitals.

hospital costs have been growing at close to 10% pa, and hospital costs are expected to outpace growth in GST and growth in the National Healthcare SPP. The additional GST funding, to be provided over 6 years, thus amounts to about 8% of annual funding, equivalent to about the current rate of growth of health care costs.

National Partnership payments for health

There are currently nine categories of NPs for health (see Table 2). These will provide **$9.68 billion / 5 years** for funding for health care services to the states and territories and local government. Not all of this is new funding.

Table 2: Total payments for specific purposes (including SPPs NPPs, and from 2011-12, National Health and Hospitals Network funding:

$million

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
National Healthcare SPP*	11,224	12,036	1,315	1,416	1,529
NHHN funding			25,261	27,279	29,429
NP payments	1,183	2,070	2,195	2,092	1,729
NHHN package	300	864	782	871	976
- 4 hr access target EDs#		*150*	*100*	*100*	*150*
- EDs capital funding	*100*	*50*	*50*	*50*	
- improving access to elective surgery#		*300*	*118*	*116*	*116*
- capital funding	*75*	*50*	*25*		
-new sub-acute beds		*233.8*	*317.6*	*446.6*	*625.5*
- flexible funding	*125*	*25*	*25*	*25*	
- mental health EPPIC		*5.9*	*5.9*	*5.9*	*5.9*
- aged care			*105.9*	*92.3*	*78.2*
- expanding MPS		*50.8*	*35*	*35*	
Health and workforce reform		41.4	55.5		
Preventive health		11	75	136	194
- healthy children#			*32.5*	*64.9*	*97.4*
- healthy workers#			*33.6*	*62.6*	*88.2*
- social marketing		*6*	*6*	*6*	*6*
- enabling infrastructure		*5*	*2.5*	*2.5*	*2.5*
Health and hospital fund	256	544	709	444	99
- hospital infrastructure	*220.7*	*280.7*	*320.7*	*141.4*	*77.6*
- national cancer system	*29.2*	*248.4*	*350.2*	*292.3*	*21.7*
- translational research & workforce training	*6.1*	*16.9*	*38*	*10*	
Closing the Gap -NT	8.9	4.9	4.9		
Health infrastructure	37	17	7	2	1

$million

	2009-10	2010-11	2011-12	2012-13	2013-14
Health services	84	81	83	81	82
- kids health check	*1.7*	*1.8*	*1.9*	*2.0*	*2.0*
- rheumatic fever ATSI kids	*2.3*	*2.4*	*2.5*	*2.5*	*2.6*
- bowel cancer screening	*2.0*	*2.0*			
- perinatal depression	*3.8*	*6.4*	*9.5*	*8.7*	*8.7*
- Vic cytology service	*7.0*	*7.3*	*7.7*	*8.1*	*8.2*
-OzFoodNet	*1.6*	*1.6*	*1.6*	*1.6*	*1.7*
-pneumococcal disease surveillance	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*
- vaccine preventable diseases surveillance	*0.6*	*0.6*	*0.6*	*0.6*	*0.6*
- human quarantine services	*0.1*	*0.1*	*0.1*	*0.1*	*0.1*
- Royal Darwin hospital incident readiness	*14.0*	*14.2*	*14.5*	*14.8*	*15.0*
- Torres Strait health	*4.7*	*4.9*	*5.1*	*5.3*	*5.3*
- NT sexual assault counselling remote areas	*1.4*	*1.4*	*1.5*		
- NT satellite renal dialysis	*1.0*	*0.3*	*0.1*		
- nurses returning to workforce	*6.2*	*0.7*			
- patients waiting for nursing homes	*37.5*	*37.5*	*37.5*	*37.5*	*37.5*
Local government programs	2	8	26	26	
Other payments	495	740	467	476	377
- E Kimberley development	*19.9*	*20.3*	*3.3*		
- repat hospitals	*14.3*				
- essential vaccines	*328.2*	*336.6*	*342.5*	*350.5*	*348.6*
- organ transplantation	*18.2*				
- NT medical school	*0.5*	*1.6*	*2.2*	*2.3*	
- elective surgery waiting lists#	*102*	*268*			
- Cmwlth Dental Health Program		*94.3*	*96.7*	*99.0*	
Indigenous early childhood development	*13.9*	*20.3*	*23*	*24*	*25.7*
Total	**12,406**	**14,307**	**28,770**	**30,786**	**32,687**

*payments in 2011-12 and beyond are to Western Australia, which is not a current signatory to the NHHN agreement.
includes incentive payments.

The way in which the NPs are organised is not particularly logical, and makes tracking the funding for indigenous health and continuing programs, such as those previously funded under the Public Health Outcomes Funding Agreements, difficult.

There has also been a significant increase in the number of National Partnerships. Last year's Budget papers showed 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 included the e-health NP (NeHTA) with federal funding of **$108.9 million / 3 years.**

1. NP for NHHN

The various initiatives included in the NHHN NP are outlined elsewhere in this paper, under the specific 2010-11 budget provisions.

2. NP for Health and Workforce Reform

The various initiatives included in the Health and Workforce NP are outlined elsewhere in this paper, under the specific 2010-11 budget provisions.

3. NP for Preventive Health

The Commonwealth will provide **$642.9 million / 6 years** for the NP on Preventive Health, which will address the issues such as smoking, nutrition, alcohol and physical activity outlined in the reports from the Preventative Health Task Force. However the Budget papers show that over the forward estimates only **$415.7 million** will be available, and with the exception of $11 million in 2010-11, this money does not start to flow until 2011-12.

It is assumed, that with a small variation in the funding level, this is the same NP as that outlined in last year's budget, which provided **$448.1 million / 4 years**.

Additional funding of **$61.7 million / 4 years** for community-based physical activity and healthy eating programs is provided in the NP for local government programs (see (7) below).

4. NP for Health and Hospitals Fund

The 2010-11 Budget allocates **$2.052 billion / 5 years** from the Health and Hospitals Fund for health infrastructure projects, the national cancer care system, and translational research and workforce training. It's not clear why this funding is separated out from that provided for health infrastructure (see (6) below). Note than in the Budget Papers this funding is described over a longer time frame (up to seven years) as **$3.23 billion**, although it is not clear from the budget outlays provided how these funds are spent in the out years. The ACT does not receive any of the funds for hospital infrastructure, and only Victoria receives funding for translational research and workforce training.

It is assumed that all of this funding is in addition to the **$3.3 billion / 7 years** committed from the Health and Hospitals Fund in the 2009-10 Budget.

Table 3: Health and Hospitals Fund payments to States and Territories

$ million	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Hospital Infrastructure	110.9	13.0	368.8	401.7	170	30	-	32.2	1,041
National cancer system	132	622.6	191	35.7	17.3	4	34.7	2.5	940
Translational research & workforce	-	71	-	-	-	-	-	-	71

5. NP for Closing the Gap – NT

An additional **$18.7 million / 3 years** is provided to the Northern Territory for Indigenous health and related services (these are not specified).

The NP for Indigenous Health is not included in this list.

6. NP for Health Infrastructure

A total of **$53.5million** is committed to a range of projects:

- **$17.5 million** for Tasmanian health package, including expanded radiation oncology services in North / North West Tasmania ($6.7 million / 4 years), increased patent transport and accommodation services in IPTAS ($5.8 million / 3 years), and investment in the Launceston Integrated Caner Care Centre ($5.0 million in 2009-10).
- **$11.1 million** for PET scanners for Royal Hobart hospital, Calvary Mater hospital in Newcastle, Westmead hospital in Sydney. ($1.3 million pa has previously been provided to Westmead for the PET scanner there.)
- **$10.0 million** for the Olivia Newton-John cancer centre in Melbourne, $12 million for the Children's cancer centre in Adelaide, $3.5 million fr the Lismore integrated cancer centre, $0.5 million for the Cairns base hospital chemotherapy centre, and $2.4 million to upgrade chemotherapy and cancer facilities at the northwest Regional hospital in Burnie and to upgrade a portion of the additional patient accommodation proposed for Launceston.

Note than in last year's budget $2.4 million was provided for an upgrade to the chemotherapy unit and the purchase of additional chemotherapy chairs at the Burnie Hospital and patient accommodation in Launceston.

It is not clear if this funding comes from the Health and Hospital Fund.

7. NP for Health Services

This NP is made up of a number of provisions, many of which have previously been Commonwealth responsibilities. A total of **$411.1 million / 5 years** is provided for

these provisions, not all of this money might be new costs to the Budget as some funding has previously been provided.

- **$9.4 million / 5 years** to strengthen linkage between the MBS healthy kids check and state-funded child health assessment services, and to promote the provision of health assessment services who are about to enter school.
- **$12.2 million / 5 years** to Queensland, Western Australia and the Northern Territory to support disease registers and control programming for rheumatic fever in Indigenous children. Funding of $11.2 million / 5 years was provided for this work in the 2008-09 Budget. Information about the roll-out of this program could not be found.
- **$4.0 million / 2 years** for follow-up of people who returned positive test results in the National Bowel Cancer Screening Program. This program is currently funded through to June 2011.
- **$36.9 million / 5 years** for the National Perinatal Depression Initiative. In November 2009, Australian health ministers agreed to the Framework for the National Perinatal Depression Initiative 2008-09 to 2012-13. The Australian Government committed $55 million over five years for this program: this was initially announced as $30 million to the states and territories, $20 million to the Access to Allied Psychological Services (ATAPS) program, and $5 million to beyondblue. An additional $30 million was to be provided by the states and territories over the five years, bringing the total to $85 million nationally.
- **$38.3 million / 5 years** to the Victorian cytology services, which is responsible for reporting cervical cytology tests.
- **$8.1 million / 5 years** for OzFoodNet, a collaborative initiative with state health authorities for food-borne disease surveillance.
- **$1.0 million / 5 years** for pneumococcal disease surveillance. It is not clear how and where these funds are to be provided; the Budget papers show $0.4 million to NSW over the years 2009-10 to 2012-13, and $0,1 million to NT in 2013-14.
- **$3.0 million / 5 years** to NSW, Victoria, Queensland, WA and SA for a surveillance program for vaccine preventable diseases.
- **$0.5 million / 5 years** for human quarantine services at Australia's international borders.
- **$72.5 million / 5 years** to the Royal Darwin Hospital to maintain it in a state of readiness to respond to major incidents in the geographical area. This is a continuation of funding previously provided in the 2008-09 Budget.
- **$20.8 million / 5 years** to Queensland towards the costs associated with the provision of health care to PNG national by the state health services. Funding of $16.4 / 4 years for this purpose was previously provided in the 2009-10 Budget. It is assumed that this is not additional funding.
- **$4.5 million / 5 years** to Queensland for Torres Strait Islander health protection strategy. Funding of $13.8 million / 4 years was provided for this purpose in the 2009-10 Budget, so this appears to be a reduction in funding.
- **$4.3 million / 3 years** for the NT mobile outreach service to assist Indigenous communities affected by sexual assault-related trauma. This program was established under the NTER, so it is not clear why it sits within this NP. These services commenced in 2007-08 and are set to continue through to 2011-12. The original budget was $6.2 million. It's not clear if the $0.2 million provided for 2009-10 and 2010-11 is additional funding. Tenders were called recently for the evaluation of this program.

- **$1.54 million / 3 years** for satellite dialysis services in remote NT communities. Labor had made an election commitment to provide $5 million to establish satellite renal dialysis facilities in remote communities. It's not clear if the money is this years budget is to supplement already existing programs to to build new ones.
- **$6.9 million / 2 years** for incentive payments and training programs to support nurses returning to the workforce**.** The Commonwealth is now unloading the remnants of this program to the states and territories. The 2009-10 Budget saw this program combined with a number of their nursing education and recruitment programs.
- **$187.5 million / 5 years** to provide a range of services to help public patients in public hospitals who are waiting for nursing homes. This program was part of an election commitment and was first introduced, at the current funding levels, in the 2008-09 budget.

8. NP for Local Government Programs

$61.7 million / 4 years is provided to support the roll-out of successful and effective community-based physical activity and healthy eating programs. Given the focus, it is not clear why this provision is separated out from others in the NP for preventive health.

9. Other payments

A total of **$2.550 billion / 5 years** is provided for an assortment of provisions.

- **$43.5 million / 3 years** to Western Australia for health infrastructure projects from the East Kimberley development package.
- **$14.3 million in 2009-10** to NSW, Victoria, South Australia and Tasmania for repatriation general hospitals. This is the final payment for repatriation hospitals. Previous payments have been of the order of $1.7 million /year.
- **$1.7 billion / 5 years** for essential vaccines included in the National Vaccine Schedule. However (with the current exception of Victoria) the Commonwealth is to take over this responsibility and this NP will transition to a Commonwealth Own Purpose Expense.
- **$18.2 million in 2009-10** to NSW and South Australia for organ and tissue transplantation services conducted by the Australian Red Cross Service. It appear that this is the last of such payments.
- **$6.6 million / 4 years** for recurrent costs of the NT medical school. $27.8 million / 3 years has previously been provided from the Health and Hospitals Fund for the establishment of the school.
- **$107 million / 5 years** for antenatal and reproductive health as part of the National Partnership on Indigenous early childhood development. It is unclear why this health care funding is not included as part of the NP for Indigenous health.
- **$370 million / 2 years** for the elective surgery waiting list reduction plan. This funding is in addition to the $650 million / 4 years provided through the NP for NHHN, and is to be used for systemic improvements such as the construction of additional operating theatres and the purchase of new surgical equipment. The funding allocated is somewhat at variance from that initially outlined for this

provision in the 2008-09 Budget and perhaps indicates that this program has been slow to roll out.

$million

	2007-08	2008-09	2009-10	2010-11
2008-09 budget	75	155	150	220
2010-11 budget	-	-	102	268

Funding of **$290 million / 3 years** is also included for the Commonwealth Dental Health Plan, which the government has been unable to implement because the Senate has refused to support the legislation to close the Medicare Chronic Disease Dental Scheme.

It's not clear where and how the funding for Highly Specialised Drugs is now provided.

2010-11 BUDGET PROVISIONS

The work of analysing the health and ageing and related provisions in the federal budget gets more complicated and more difficult each year. The task has been made doubly difficult in the past few years because of the raft of changes in how health care services are funded and who is responsible for delivering them. That of course is an essential part of reform, but there is little transparency here, and often, it seems, little logic. There are numerous examples of programs being bundled and unbundled, de-funded and funded again, with name changes and – dare I say it? – sometimes sleight of hand regarding what is new funding and what is ongoing funding commitments.

Tracking the fate and funding of particular programs through two or three budget cycles is almost impossible. Which makes me wonder how easy it is to track the outputs and outcomes, the cost effectiveness and the return on the investment, what works and what doesn't.

Many of the budget decision made, often individually involve puny amounts, although together these become significant, seem based more on meeting financial goals than on a coherent policy framework. Disinvestment from ineffective or inappropriately programs is a growing priority, but this requires an explicit focus on the potential for cost-savings coupled with improved quality of care.

In this light it is interesting and thought provoking to look at the provisions in the 2006-07 Budget which were funded through to June 2010, investigate (to the extent possible) how effective they have been, and see what has happened to the funding since.

National Health and Hospitals Network

Reform elements

The 2010-11 Budget provides **$641 million / 4 years** to implement and support the proposed health care reforms.

$466.7 million is for e-health – a crucial investment. It appears that after considerable sums of money have been spent and many years, Australia might finally be on the cusp of rolling out a national e-health program. This is essential if health care reforms such as better management and coordination of patients' care and improvements in quality and safety are to be realised.

There is also continued funding for the important work of the Australian Commission on Safety and Quality in Health Care, although it is not clear if this is sufficient for the growing workload of the Commission.

The new National Performance Authority, which will monitor and report on the performance of the health care system receives funding of **$109.5 million**.

And of course there is a large pot of funding - **$29.5 million**, for an advertising campaign to highlight the Rudd Government's commitment to and investment in health care reform.

Rebalancing financial responsibility in the federation

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	-	321.1	356.7	384.0
Treasury	-	-	-38.1	-61.7	-77.0
Total			**283.0**	**295.0**	**307.0**
Related revenue DoHA	-	-	*283.0*	*295.0*	*307.0*

The changes in responsibilities for Home and Community Care and related programs require the transfer of funding between the Commonwealth and State and Territory Governments as shown.

The reduced expenses for Treasury reflect that these changes are budget neutral over the forward estimates, funded through a reduction in the SPP. The increased spending for DoHA is to pay for people accessing HACC and specialist disability services under the National Disability Agreement. The related revenue is funding from the states and territories that they previously used to pay for these services.

eHealth – personally controlled electronic health records

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	185.6	281.2	-	-

$466.7 million / 2 years is provided to establish the key components of the personally controlled e-health record system. Access to the online system is promise by 2012-13.

Individual health care identifiers are expected to be introduced in 2010. Every Australian will be given a 16-digit electronic health number, which will only store a patient's name, address and date-of-birth. No clinical information will be stored on the number, which is separate to an electronic health record.

Implementation will initially target key groups in the community likely to receive the most immediate benefit, including those suffering from chronic and complex conditions, older Australians, Indigenous Australians and mothers and newborn children.

The Budget Papers state that "Subject to progress in rolling out the core e-Health infrastructure, the Government may consider future investments, as necessary, to expand on the range of functions delivered under an electronic health record system." Perhaps this tentativeness is in response to the slow roll-out of NeHTA's projects.

In 2008 NeHTA received COAG funding of $108.9 million / 3 years. From this three initiatives were to be funded:

- National clinical terminology ($32m)
- National individual identifier ($45m)
- National provider identifier ($53m).

The Budget Papers note that "in order to fully realise the significant benefits of the Commonwealth investment, State and Territory Governments will also need to continue their planned or expected investments in core information systems. The States and Territories will also need to provide the complementary investments to build their capacity in readiness for connection to this system."

National Performance Authority

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	22.3	23.6	29.4	34.2

$118.6 million / 4 years is provided to establish a National Performance Authority to monitor and report on the performance of Local Hospital Networks, Medicare Locals and public and private hospitals. Only **$109.5 million** of this is new money; $9.1 million is from adjusted funding for the Hospital Accountability and Performance Project.

The work of this Authority will show how Local Hospital Networks perform against new national standards and other performance indicators, including on:

- emergency department waiting times;
- elective surgery waiting times;
- adverse events in hospitals;
- quality of care (for instance through reporting on re-admission rates);
- patient satisfaction; and
- financial management.

Expansion of the Australian Commission on Safety and Quality in Health Care

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	0.7	7.2	11.6	12.7
NHMRC	-	-	1.0	1.0	1.0
Total	**-**	**0.7**	**8.2**	**12.6**	**13.7**

$35.2 million / 4 years is provided to fund the Australian Commission on Safety and Quality in Health Care. The Budget papers state that there will also be a funding contribution from the states and territories, although what this will be is not divulged. Current commonwealth funding provides for $11 million in 2009-10 and $5.5 million in 2010-11.

The Commission has an increasingly important role in ensuring the quality and safety of health care in Australia, helping to develop national guidelines and a national system of accreditation for care in hospitals, mental health and primary care. It is important that this work is properly and fully resourced.

The Commission, which has operated with DoHA, will be established as an independent agency.

Building the foundations for reform – information and awareness

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	9.9	18.3	1.1	0.2	-

$29.5 million / 4 years is provided for a national communications / advertising campaign around the government's health care reforms. Virtually all this money will be spent in 2009-10 and 2010-11. Some of this advertising has already started to be rolled out.

Aged care

Under the NHHN Agreement, the Commonwealth will take full policy and funding responsibility for aged care. The 2010-11 Budget has **$532.9 million / 5 years** in increased funding for aged care, as committed through the NHHN Agreement. The Budget also includes **$81.6 million / 4 years** to boost the currently inadequate aged care nursing workforce. The Government's media announcements call this a "$739 million investment in aged care to better support older Australians"[2], but this is only true if the spending includes the **$276.4 million / 3 years** that is money transferred from existing funds in the forward estimates for aged care places to provide continued funding for Long Stay Older Patients in public hospitals.

As part of the NHHN Agreement, the Australian Government will take full policy and funding responsibility for aged care. Financially the changes will comparatively small – the funds currently provided to the states under the Home and Community Care (HACC) Program for people aged 65 and over (50 and over for Indigenous Australians) will cease from July 2012.

Currently the Australian Government provides approximately 60% of the funding for this program. The state and territory governments provide the remaining funding. They are also responsible for program management, including the approval and funding of individual HACC services in their jurisdictions, and are the primary point of contact for HACC service providers and consumers. In 2008 – 2009, $1.788 billion was provided for the HACC Program nationally, an increase of over 8 per cent compared to funding in 2007 – 2008.

The Government claims that these changes "will allow the Government to build a nationally consistent aged care system allowing people to seamlessly move from basic help at home through to residential care as their care needs change, assisted through improvements to aged care information and assessment services."[3]

In April the Government announced that it was calling for yet another inquiry into the aged care system, this one to be undertaken by the Productivity Commission. The Government will also conduct a research study on staffing levels, skills mix and resident care needs in Australian residential aged care facilities.

Note that the Budget includes continued funding for aged care assessments. These funds are also provided to the states and territories through NP payments, but they are not included as part of the NHHN Agreement. It appears that the funding for aged care assessments has been cut substantially over that previously provided in the forward estimates.

[2] http://www.alp.org.au/more-support-older-australians-national-health-and-hospitals-network

[3] Ibid

Aged care – expanded access to multipurpose services

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	50.7	35.5	35.5	0.3

The 2010-11 Budget provides **$122 million / 4 years** (this includes funding of $27.4 million which is assigned to Western Australia) to establish up to 286 additional new sub-acute beds or bed equivalents and expand the capacity of existing multi-purpose services (MPS) facilities. This measure is described as supporting up to 5,400 people a year when fully implemented, and as freeing existing bed capacity in acute hospitals, to provide around 33,000 more acute services each year.

The money is assigned to the states and territories as follows: NSW $38.8 million / 3 years; Victoria $12.4 million / 3 years; Queensland $16.1 million / 3 years; South Australia $20.9 million / 3 years; Western Australia $27.4 million / 3 years; Tasmania $4.1 million / 3 years; Northern Territory $0.3 million / 3 years.

The MPS program began in 1993, and there are currently around 126 services in operation. It is not clear how many aged care places these services now provide – at June 2007 it was 2,492, so presumably now there are around 3,000 places. The Australian, state and territory governments jointly fund the MPSs to provide integrated and cost-effective health and aged care services for small rural communities which are unlikely to sustain separate services such as an acute hospital, residential care or community health and home care services. By bringing the services together, economies of scale are achieved to support the services. The catchment population for the MPS model varies, but is generally around 1,000 to 4,000.

In 2003-04 the Commonwealth was described as the minority funder of the program, providing around $45 million a year of the $188 million in operating costs for what was then 86 MPSs.[4] A page from the DoHA website dated 2008 states that the Australian Government provided $87.9 million in funding for MPSs in 2008-09.[5] It's not possible to deduce how far the current funding will go towards delivering on the goal outlined.

The 12 April media release from the Prime Minister[6] states that the Government will also make it easier to establish new MPSs by allowing them to be established in larger communities, creating an additional 300 beds. This additional aspect is not mentioned in the Budget Papers.

[4] http://www.anao.gov.au/uploads/documents/2003-04_Audit_Report_40.pdf

[5] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-aged-care-australia.htm~ageing-publicat-aged-care-australia-pt8~ageing-publicat-aged-care-australia-pt8-3

[6] http://www.pm.gov.au/node/6655

Aged care – expansion of zero-interest loans

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	72.1	72.1	0.4	0.4

The Australian Government will provide **$300 million** in zero interest loans to assist in expanding the availability of residential aged care beds. The additional funding is expected to provide an additional 2,500 places. This adds to the $300 million in zero interest loans provided in the 2008-09 Budget. Changes in the guidelines governing the Zero Real Interest Loan program will cost **$145 million / 4 years**.

Aged care – improving access to General Practice and primary health care

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	13.4	14.1	35.2	34.5
Medicare Australia	0.2	0.5	0.2	o.1	0.1
Total	**0.2**	**13.9**	**14.2**	**35.3**	**34.6**
Related capital Medicare Australia	-	0.3	0.1	-	-

$98.6 million /5 years is provided for the provision of financial incentives to GPs, nurses, geriatricians and allied health professionals to provide bulk billed services to residents of aged care facilities.

Aged care homes have increasingly reported difficulties obtaining GP and primary care services. This funding will provide a 50 per cent increase in the incentive payment to GPs providing at least 60 attendances a year to older people in aged care homes and more than double the incentive payment for GPs who provide at least 140 attendances a year. This Budget measure is expected to result in an additional 295,000 GP and primary health care services to older Australians over the next four years.

Currently the incentive payment is $43.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients the incentive is $3.10 per patient.

The government's media release[7] states that from 2012-13 this funding will also be used to set up a flexible funding pool, to be administered by Medicare Locals, to target gaps in primary health care services for aged care recipients. It seems that funding for this will be of the order of $20 million /year.

[7] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-je-je034.htm

This Budget measure is expected to result in an additional 295,000 GP and primary health care services to older Australians over the next four years.

Aged care – improving the viability of community care providers

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	2.3	2.5	2.6	2.7

$10.1 million / 4 years is provided to pay community care providers in regional, rural and remote Australia the same incentives that are paid to residential care providers. The increased payment will be made to eligible community care providers, multi-purpose services and ATSI flexible services.

The Budget Papers state that these incentives recognise the additional cost to providers of services in these regions compared to metropolitan areas – but then pays only the same rate, not an increased rate.

Aged care – increasing business efficiency

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	0.3	2.1	2.2	2.2
Related capital DoHA	-	0.3	-	-	-

$7.0 million / 4 years (including $0.3 million in capital) is provided to improve the business efficiency of aged care providers by establishing a new provider benchmarking system. This will allow aged care providers to compare their operational and service performance with other providers and identify areas for improvement.

Eligible aged care providers will also be provided with access to financial advisory services to help improve their operational efficiency.

Aged care – protecting savings

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	5.3	5.1	5.2	5.3
Related capital DoHA	-	1.0	-	-	-

$21.8 million / 4 years (including $1 million in capital funding) is provided to enhance the protection of accommodation bonds held by aged care providers by applying more stringent requirements on how these bonds can be invested. Reporting requirements on how bonds are used will also be strengthened.

Aged care – strengthening arrangements for complaints.

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	9.6	11.9	12.7	13.7
Aged Care Standards & Accreditation Agency	-	0.5	0.7	0.7	0.8
Total	**-**	**10.1**	**12.6**	**13.4**	**14.5**

$50.6 million / 4 years is provided to improve complaints handling processes for consumers of aged care services. This is in the form of additional funding for the Aged Care Complaints Investigation Scheme, including better access to mediation and conciliation services, and additional funding to the Aged Care Standards and Accreditation Agency to meet the likely rise in referrals from the expanded complaints scheme.

In August 2009 the Government engaged Associate Professor Merrilyn Walton to conduct a review of the operation of the Aged Care Complaints Investigation Scheme. This review coincided with the Government's review of the aged care accreditation process. The review was released in April 2010.[8]

Aged care – supporting long stay older patients

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	1.0	1.0	0.4	0.4

$276.4 million / 3 years is redirected from high care residential aged care places to the state and territory governments to provide similar levels of care for patients in public hospitals. However this does not account for **$37.5 million** in the forward estimates for 2011-12 for this activity.

$m

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2011-2012	36.8	26.9	18.1	8.9	11.2	2.7	1.0	0.3	105.9
2012-2013	32.1	23.4	15.8	7.8	9.8	2.3	0.9	0.3	92.3
2013-2014	27.2	19.8	13.4	6.6	8.3	2.0	0.7	0.3	78.2

The Budget Papers explain that this measure will fund up to 2000 places in 2011-12, up to 1700 places in 2012-13 and up to 1400 places in 2013-14, at a cost of about $55,000 / place. It is also stated that this initiative allows for the continuation of the

8 http://www.health.gov.au/internet/main/publishing.nsf/Content/6E29D85E65EF32FACA25770300036CB1/$File/ReviewCIS21009.pdf

existing LSOP initiative, currently funded at $37.5 million / year, for a further two years. However this means that the new funding provided in 2011-12 is actually only $68.4 million.

All of this funding is met from within the forward estimates. Unless there is unused money for high care residential aged care places (there is no evidence for this) this means that this hospital-based program is funded at the expense of places in residential care. At the same time money ($247.7 million / 4 years) is also being redirected from high level residential care to high level community care.

Aged care assessments – continued funding

(As previously noted, these are not part of the NHHN, but through 2011-12 the funds will be paid to the states and territories through NP payments.)

The funding provided is described as $18.6 million / 2 years for aged care assessments teams and $15.9 million / 2 years for the Aged Care Assessment Program. This is a total of **$34.5 million / 2 years**, which is well below the funding previously provided for aged care assessments; the 2008-09 Budget provided $78.7 million in 2010-11 and 82.2 million in 2011-12.

General practice and primary care

The 2010-11 Budget will deliver $1.2 billion / 5 years boost to GP and primary health care. This is made up of $449.2 million for better coordination of diabetes care, $355.2 million for infrastructure, including 23 additional GP Super Clinics

This is a large sum. However most of this does not start to roll out until 2012-13. The funding provided for infrastructure may well be used for election campaign announcements, as was the case with GP Super Clinics in 2007, so there is no guarantee that this will go where it is most needed or even where it can deliver most value. The **$126.3 million** provided for after hours care is in fact not new money but continued funding, at reduced levels for the National Health Call Centre Network, which was set up by COAG and the Howard Government in 2006.

There is the potential for real innovation in the way primary care health services are delivered and funded through Medicare Locals. However at this stage so few details have been provided that there is no certainty this will be the case.

Similarly, the proposal to change the way coordinated care is delivered for diabetes offers the possibilities of real improvements in patient outcomes, assuming the implementation is done well. However it's a shame that other chronic illnesses were excluded from this initiative, which anyway seems to expect only a fraction of people with diabetes to take advantage of this coordinated care. It's interesting that the provision does not outline any expected savings over the forward estimates – although perhaps, given the apparent underfunding of the program, these are included but hidden from public view.

To the extent that these provisions represent the government's adoption and implementation of the National Primary Health Care Strategy[9], most would agree there is much more to be done.

General practice and primary care – coordinated diabetes care

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	4.3	9.8	179.2	242.7
Medicare Australia	-	1.3	2.1	3.3	3.6
DVA	-	0.1	0.1	0.7	0.8
Total	**-**	**5.7**	**12.0**	**183.2**	**247.0**
Related capital Medicare Australia	-	-	1.3	-	-

[9] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/report-primaryhealth

This initiative provides **$449.2 million / 4 years** with the aim of improving the quality and coordination of primary care services for people with diabetes. Virtually all this money is spent in the two years 2012-13 and 2013-14 when the program is scheduled to be up and running.

Although details announced to date are sketchy, under the program patients wishing to take part would be required to register with a GP practice. The practice would be required to develop a personalised care plan and coordinated access to other health providers such as dieticians and physiotherapists.

Patients who enrolled with the scheme would no longer be entitled to Medicare benefits. Instead, their general practice would receive $950 a year for their care, out of a total $1200, to handle all the consultation costs for that patient – regardless of whether the treatment was related to their diabetes, or another problem. The remaining $250, to be spent on care by allied health workers such as physiotherapists and dieticians, would apparently be paid directly to them. GPs could keep the unspent portion of the $950 and the practice would also receive around $10,800 a year, to be "paid in part on the basis of performance in providing better care and improving health outcomes".

DoHA has stated that the current average cost of Medicare benefits for a diabetic patient was between $490 and $761 a year, and that if the $1200 ran out for some patients, GPs could apply to dip into a ''contingency fund'' included in the overall cost of the plan. The average cost of admitting a diabetic to hospital is $4300.

The Government expects 4300 general practices – 60 per cent of all GPs – would join the program by 2012-13 when it is scheduled to begin, and approximately 260,000 patients with diabetes will be voluntarily enrolled in the personalised care program by 2013-14.

However 260,000 patients represents only about one-quarter of the 1 million people those currently diagnosed with diabetes (a figure that is rising exponentially). Moreover, on the basis of funding of $247 million in 2013-14, this is only $950 / patient, so it is not clear where the additional funds of $10,800 / year (pre patient?) for practices would come from.

The proposal has been quite controversial, not least because it singles diabetes out as the only chronic illness to receive this coordinated care. However diabetes is a growing health problem, and currently only a minority of people with diabetes receive optimal care.

Doctors have been particularly critical, and it is likely that many details of this proposal will change in the lead up to implementation.

General practice and primary care – establishing Medicare Locals and improving access to after hours primary care

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	13.4	66.6	156.1	179.7
Medicare Australia	-	0.6	-	0.4	-
Total	**-**	**14.0**	**66.6**	**156.6**	**179.7**

A total of **$416.8 million / 4 years** is provided to establish a nation-wide network of Primary Health Care Organisations to be known as Medicare Locals and to improve access to after hours care.

The first priority of Medicare Locals will be to coordinate the expansion of access to after hours GP services, which will be linked to the National Health Call Centre Network. **$126.3 million** is for this purpose. The Commonwealth funding contribution to the National Health Call Centre Network ($110.9 million / 4 years; states and territories contribution was supposed to be around $65 million) was provided in the 2006-07 budget and funding lapsed in June 2010. In 2009-10 the commonwealth funding level was $34.4 million, so on this basis the network is receiving less funding than previously.

The development of Medicare Locals, which will be done where possible form existing Divisions of General Practice, is the Government's response to recommendations of the National Primary Health Care Strategy. Over time, it is proposed that Medicare Locals will also support community health promotion and prevention programs, and take a greater role in community-based mental health service provision. However it is not clear how Medicare Locals will integrate with Local Hospital Networks.

Once established, $180 million in contracted funding to Divisions will be redirected to Medicare Locals.

General practice and primary care – improved primary infrastructure

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	56.7	179.4	119.1	-

$355.2 million / 3 years is provided to improve access to primary care by establishing an additional 23 GP Super Clinics and providing approximately 425 grants to expand existing general practices and primary care, community health and Indigenous

medical services.[10]

On the basis of the 2008-09 funding commitment of $275.2 million to provide 31 GP Super Clinics, each clinics costs, on average, $8.9 million, so $205 million of these new funds will go to Super Clinics, leaving $150 million for the 425 grants promised (i.e. an average of $354,000 / grant). The Government has said that the grants will range from $100,000 to a maximum of $500,000 per practice, perhaps implying that it will be spending less on GP Super Clinics than previously. It is not clear if the funds provided will be sufficient to enable the grantees to deliver GP Super Clinic style services; the NHHRC recommended that such grants average $1 million.

The roll-out of the 2007 election commitment for GP Super Clinics has been painfully slow. So far only three are fully operational and eight are partially operational[11]

General practice and primary care – improving access to primary care

The Budget Papers commit to the continued funding (included in the forward estimates) of the $2006-07 Budget measure that allows emergency departments and outpatient clinics in public hospitals to provide MBS eligible services. To be eligible, hospitals must be in an area of workforce shortage with a population of less than 7,000.

In 2006-07 this provision was funded at $3.0 million / 5 years. There is no way to know how much this initiative actually costs or how often it is used, and whether it is used appropriately.

[10] This is how this provision is described in the Budget Papers. In contrast, Minister Roxon's media release on the Budget[10] states that "the Government will invest $355.2 million to build around 450 GP Super Clinic-type facilities. Around 23 new dedicated GP Super Clinics will be constructed and more than 400 general practices, primary care and community health services, and Aboriginal Medical Services will be given Government assistance to build expanded facilities."

[11] http://www.theaustralian.com.au/news/nation/super-clinics-scheme-comes-under-fire/story-e6frg6nf-1225865738545

Hospitals

Over the next five years the Government will spend **$3.6 billion** on public hospitals in addition to the increases in funding that will result as a consequence of the new governance and finance arrangements made under the NHHN Agreement. That represents 50% of the $7.3 billion total commitment to health care reform – a surprisingly large amount to provide to acute care when the drivers for health care reform have been about better prevention and how to provide better primary health services for the chronically ill to keep them out of hospitals.

Of the $3.6 billion, **$255.2 million** is for funding mechanisms, and a huge **$122.6 million** of this is for DoHA infrastructure. There is also **$402.1 million** for hospital infrastructure.

While significant funds **($1.6 billion / 4 years**) are provided for sub-acute services, there is nothing to support innovation in the way acute and post-acute care services could be bundled to better support patients leaving hospital and to address preventable readmittance.

Budget Paper 3 (pp32- 36) provides information on how these funds are distributed to the states and territories.

How the new governance and finance system will work

Under the NHHN Agreement, the Commonwealth will become the majority funder of public hospitals by funding 60% of the efficient price of public hospital services delivered to public patients and also funding 60% of capital, research and training in public hospitals.

The Commonwealth and all States, with the exception of Western Australia, have agreed that these reforms will be financed through a combination of:

- funding sourced from the National Healthcare Specific Purpose Payment;
- an agreed amount of State GST revenue, which would then be allocated on States' behalf to health and hospitals reform; and
- additional top-up funding to be paid by the Commonwealth, reflecting the Commonwealth's greater responsibility for financing growth in hospital costs.

Local Hospital Networks (LHNs) will be the operational managers, responsible for management and performance of a small number of public hospitals with a geographical or functional connection. The States will determine the number and location of LHN's.

Concern has been expressed that the LHNs will not be an efficient size and will not be able to address issues of equity.[12] For example, NSW, which in 2005 consolidated 17 area health services into eight, is expected to have 30 LHNs.

[12] http://www.mja.com.au/public/issues/192_09_030510/ROP/eag10259_fm.html

LHNs will be paid for the delivery of services through activity based funding, developed on the basis of a national efficient price for each public hospital service provided to public patients. Some small regional and rural public hospitals, and other agreed services, will be block funded consistent with Community Service Obligations, reflecting the higher costs associated with delivering services in these areas.

The states and territories will remain the systems managers for public hospitals. They will be responsible for overall hospital service policy and planning, purchasing services from LHNs through Service Agreements, major capital planning and management, and overseeing LHN performance.

A new independent hospital pricing authority will be established to set the efficient price for the Commonwealth's contribution to public hospital services and for determining the Commonwealth's payments for block funding, as well as being empowered to make binding determinations about cost shifting and cross border issues.

The Commonwealth contribution to activity based funding will be paid into a NHHN Fund which will then make payments to the state-based Funding Authorities responsible for overseeing the distribution of funds to LHNs. The Commonwealth will pay its portion of funding directly to the States for a range of services that are best managed on a State-wide basis, including:

- funding for research and training delivered in public hospitals;
- block funding for agreed functions and services, and community service obligations required to support small regional and rural public hospitals; and
- a funding stream for public hospital capital investment (other than minor capital which will be directly managed by Local Hospital Networks).

New clinical safety and quality standards developed by a permanent Australian Commission on Safety and Quality in Health Care.

A national Performance and Accountability Framework will be introduced with national standards, performance indicators, and reports on public and private hospitals, LHNs, and Primary Health Care Organisations. The reporting about the national, state and local performance of the health system will be the responsibility of a new National Performance Authority.

Independent hospital pricing authority

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	3.8	31.8	28.5	27.7

$91.8 million / 4 years is provided to establish an Independent Hospital Pricing Authority which will manage the development of national activity-based funding arrangements and set the efficient price for public hospital services. This will

determine the Commonwealth's contribution to public hospital services and for block funding. This authority will also make binding determinations about cost shifting and cross border issues.

To date, no information has been provided on how this new authority would be established and who would have responsibility for the appointments to the authority.

Hospitals – activity-based funding

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	1.6	2.2	19.1	17.4
Department of Finance	0.1	0.1	0.1	0.1	0.1
Total	**0.1**	**1.7**	**2.3**	**19.2**	**17.5**
Related capital DoHA	-	66.0	35.8	4.5	16.3

$163.4 million / 5 years is provided to develop the infrastructure and applications framework needed to implement activity-based funding. **$122.6 million** of this is for related capital costs – no explanation is provided for this.

Under activity- based funding (previously known as casemix funding), hospitals are funded on the basis of how many procedures are performed. Each procedure has a set value, weighted to local geographic variables and other factors. Those championing the model (which is already used in a modified form in Victoria) argue that it provides a genuine incentive for hospital administrators to look for efficiencies. However data from the Productivity Commission shows that Victoria's cost per treatment is not substantially different than that for other states.

Some concerns are that casemix funding does not work well for very sick patients with multiple problems, and that it could encourage hospitals to discharge patients early, or discharge them only to readmit them again.

Hospitals – improving access to emergency departments

(1) Four hour national access target – facilitation and reward funding

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Treasury	-	150.0	100.0	100.0	150.0
DoHA	-	0.5	0.5	0.4	0.4
Total	**-**	**150.5**	**100.5**	**100.4**	**150.4**

(2) Four hour national access target – capital funding
Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
Treasury	100.0	50.0	50.0	50.0	-
DoHA	-	0.4	0.4	0.3	0.2
Total	**100.0**	**50.4**	**50.4**	**50.3**	**0.2**

A total of **$753.3 million / 5 years** is provided to introduce a four-hour national access target for access to treatment in the emergency rooms of public hospitals and to expand the capacity of hospitals to provide emergency department treatment.

Of this, **$250 million** is provided over four years from 2010-11 to help states and territories move towards the four-hour target. This will be implemented progressively over time, with the four hour target applying in 2011 to those cases in the most urgent category of clinical need (category 1). By 1 January 2015, all triage category patients will be subject to the access target. Application of the four-hour target will be moderated in remote and other areas of Australia where there is a significant undersupply of GPs and significant impediments to accessing a GP. Application of the target in these circumstances will be agreed between the Commonwealth and individual jurisdictions, and be subject to periodic review. This initiative is expected to support the delivery of around 805,000 emergency department attendances in 2013-14.

A further **$250 million** will be available for reward payments to those states and territories who meet this target. There is no information about the consequences for those states and territories who do not meet the target. Will they be required to submit a plan outlining how the deficiencies will be addressed?

$251.4 million / 5 years is provided to expand capacity within the hospital system for emergency department treatment.

Recent AIHW data[13] show that the proportion of emergency department patients seen within the recommended time for their triage category has stayed constant over the years 2004-05 to 2008-09.

Hospitals – improving access to elective surgery

(1) Facilitation and reward funding
Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
Treasury	-	300.0	118.0	116.9	116.0
DoHA	-	0.6	0.6	0.5	0.5
Total	**-**	**300.6**	**118.6**	**116.5**	**116.5**

[13] http://www.aihw.gov.au/publications/hse/89/11647.pdf

(2) Capital funding
Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
Treasury	75.0	50.0	25.0	-	-
DoHA	-	0.4	0.4	-	-
Total	**75.0**	**50.4**	**25.4**	**-**	**-**

$803 million / 5 years is provided to improve access to elective surgery. However only $583 million of this is new funding, as $220 million in 2010-11 is from the previous election commitment of $600 million.

COAG, with the exception of Western Australia, agreed to implement access targets for elective surgery so that, by December 2014, 95 per cent of patients waiting for surgery in categories 1 and 2 will be treated within clinically recommended times, and by December 2015, 95 per cent of patients in category 3 would be treated within clinically recommended times. Implementation of these elective surgery access targets will be staged.

$650 million / 4 years is provided to implement this target. Of this, **$300 million** will be provided to the states and territories to reduce the backlog. This is expected to support an additional 22,000 elective surgery procedures each year by 2013-14.

A further **$350 million** is to be available in reward payments.

$150 million is provided for elective surgery capital to support the construction of facilities such as day surgery centres, elective surgery centres, and information technology to reform clinical and management systems. The Commonwealth will meet 60 per cent of the recurrent cost of these services from 2014-15.

Previously the Government expected that $100 million would cover the costs of 25,000 additional elective procedures; now $116 million will provide for 22,000 additional procedures plus the reward payments.

Recent AIHW data[14] show that in 2008-09, when the Rudd Government's election commitments were in place, 50% of elective surgery patients waited 34 days or less, an increase from 29 days in 2004-05.

Hospitals – new sub-acute hospital beds

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
Treasury	-	233.6	317.6	446.6	625.5
DoHA	-	0.7	0.6	0.5	0.4
Total	**-**	**234.3**	**318.2**	**447.1**	**625.9**

$1.624 billion / 4 years is provided for funding for at least 1,300 additional beds for sub-acute services. To receive this funding the states and territories will be required

[14] http://www.aihw.gov.au/publications/hse/89/11647.pdf

to submit plans for the provision of beds in public or private hospitals or in community settings. The funding will provide beds for palliative, rehabilitative and geriatric care as well as sub-acute mental health treatment. Given that only 1,300 new beds will be established, mental health services will derive small benefit from this initiative.

Interestingly the COAG communiqué[15] refers only to subacute beds in public hospitals. It also refers to the provision of 1,200 packages of sub-acute care over four years, which could be the LSOP initiative (see aged care section) but this is not clear.

Hospitals – flexible funding for emergency departments, elective surgery and sub-acute care

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
Treasury	125.0	25.0	25.0	25.0	-
DoHA	-	0.2	0.2	0.1	-
Total	**125.0**	**25.2**	**25.2**	**25.1**	**-**

$200.4 million / 4 years is provided to increase hospital capacity and improve services to patients through a flexible funding pool for improvements to emergency departments, elective surgery and sub-acute care.

Given the lack of detail around this provision, we can be fairly certain that this was funding provided by Rudd to buy off the Premiers and Chief Ministers on his proposed health reform deal.

[15] http://www.coag.gov.au/coag_meeting_outcomes/2010-04-19/docs/communique_20_April_2010.pdf

Workforce

One of the real successes for the Rudd Government has been the increased investment in the health care workforce. The 2010-11 Budget commits **$1.17 billion / 4 years** to workforce, including **$639 million** for more doctors, **$419 million** for more nurses, **$12 million** for more allied health professionals, and **$100 million** for more training for nurses and other carers in the aged care workforce and projects to test and evaluate models for the use of nurse practitioners in aged care.

Not all of this is new money, although to what extent this is the case is not easy to determine. The total expenditure of $1.17 billion does not include the **$211.1 million** which is acknowledged to be funds from the existing aged care workforce development programs.

This investment will result in an additional 5,000 GPs and 680 medical specialists over the next decade, and provide 5,400 pre-vocational general practice training places. The new funds will also pay for 5,400 junior doctors to take part in general practice placements before gaining their final qualifications.

However there is a down-side. When assessed against the government's own reports, the additional spending on training places, which amounts to just $63 million a year, producing an average annual increase of 500 GPs and 68 specialists, is not enough to overcome current shortages.

For example, the health department has estimated that an additional 3,000 GPs are needed by 2020 just to maintain current levels of GP and primary care. This does no even begin to address current workforce shortages, the greater needs of an ageing population and the increase in the number of doctors reaching retirement age over the next 10-15 years. By these estimates, the government's training plan, even if fully implemented, will provide less than half of the new GPs that are needed.

The increase in specialists will do little to address the needs in areas such as mental health, pathology, and obstetrics, and is a long way from meeting the shortfall of 1,280 estimated by AMWAC.

The funding provisions to support nursing and aged care staffing are welcome, but their impact is undermined by the likelihood that not all of the money in the package is new spending. It appears that the Budget Papers and accompanying media releases have been deliberately obtuse in this regard. It should also be noted that funding support for the initiative introduced in the 2008-09 Budget to attract nurses back into the workforce is withdrawn, for a savings of **$39.1 million**.

Workforce – more places on the General Practice Training Program

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
GPET Ltd	-	2.6	11.1	26.0	44.8
DoHA	-	0.6	19.2	76.3	158.5
DVA	-	-	0.2	0.7	1.4
Medicare Australia	-	-	0.2	1.0	2.1
Total	**-**	**3.3**	**30.8**	**104.0**	**206.9**

$344.9 million / 4 years is provided to increase the number of GP training places. This provision means that the number of GP training places will grow by up to 1,200 from 2014.

In 2007 the number of GP registrars starting training each year was capped at 600, so this commitment, on top of those already made, will double the number of places available each year by 2014. Over time, these investments will result in a total of 5,500 extra GPs practicing or in training by 2020.

Workforce – more general practice training rotations for junior doctors

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
GPET Ltd	-	19.1	24.9	32.3	32.8
DoHA	-	7.0	8.9	11.5	11.7
DVA	-	0.1	0.1	0.1	0.1
Medicare Australia	-	0.1	0.2	0.2	0.2
Total	**-**	**26.4**	**34.1**	**44.2**	**44.9**

$149.6 million / 4 years is provided to deliver, by 2012-13, approximately 575 additional places per year in the Prevocational General Practice Placement Program. This means that the total number of such places by 2012 will be 975. This is a considerable increase from the 400 places currently available in this program.

Workforce – training specialist doctors

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	14.0	28.8	43.4	58.4

$144.5 million / 4 years is provided to expand the Specialist Training Program. This currently provides approximately 360 places / year. The budget papers describe this as ‘sufficient to bring the total number of annual places up to 900 by 2014. However it seems that what this statement really means – and what this funding implies – is that

this is really 540 additional places by 2014, and 680 additional places by 2020. Apparently the new places will focus on areas such as general surgery, pathology, radiology, obstetrics and gynaecology, where serious shortages have been identified.

Workforce – nurse practitioners

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	2.1	6.8	6.3	3.4

$18.7 million / 4 years is provided for projects to develop, test and evaluate workforce models for the use of nurse practitioners in aged care. A previous pilot study has found that NPs can play a valuable role in aged care.[16] Given this finding – from a study that finished in April 2007, it's a shame that more is not being done. These proposed projects will obviously have a short time frame, and there is currently no mechanism for their continuation while they are being evaluated – a situation that ensures that time and expertise will be lost if and when the decision is made to scale up these projects.

Workforce – support for practice nurses

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	o.3	66.7	140.7	161.7
DVA	-	-	3.4	6.2	6.4
Medicare Australia	-	2.1	0.5	0.7	0.5
Total	-	2.5	70.7	147.7	168.2
Related capital					
Medicare Australia	-	1.4	-	-	-

$390.3 million / 4 years is provided for a new practice nurse grants initiative which will replace the existing incentives for GP practices to employ PNs. It is unclear how much of this is new funding as this replaces the current funding through the Practice Incentive Program practice nurse incentive and the Medicare Benefits Schedule practice nurse items.

In 2004-05 the PIP incentive was funded at $112.4 million / 4 years, and MBS currently provides reimbursement for wound care, immunizations, pap smears, certain CDM items and antenatal care. It is likely that there is little new money here, although there should be enough to allow for expansion of the program to urban areas.

The program provides $25,000 per full time GP for a Registered Nurse and $12,500 per full time GP for an Enrolled Nurse. It is capped at five incentives per practice. The new arrangements will also include:

[16] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-workforce-nurse-practitioner-eval-report.htm~ageing-workforce-nurse-practitioner-eval-report-2.htm

- Support for all accredited practices to employ an Aboriginal Health Worker instead of or in addition to a practice nurse (Registered Nurse or Enrolled Nurse).
- Support for practices in urban areas where there are workforce shortages and for AMSs and ACCHSs to employ an allied health professional instead of, or in addition to a practice nurse and/or Aboriginal Health Worker.
- A rural loading.
- A one-off $5,000 incentive to support eligible non-accredited practices to become accredited.

Workforce – expanding clinical placement scholarships for allied health students

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	1.6	1.6	1.6	1.6
2008-09 Budget	0.8	0.8	-	-	-

$6.5 million / 4 years is provided for clinical placement scholarships for allied health students who undertake clinical placements for up to 6 weeks in rural and remote communities. The Budget Papers state that this will provide 100 additional scholarships each year. However the previous funding for this provision, provided in the 2008-09 budget, was only for 3 years (funding in the last year (2010-11) is for **$0.8 million**) so this funding will be all that is available beyond that time.

Workforce – rural locum scheme for allied health professionals

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	1.4	1.3	1.3	1.3

$5.3 million / 4 years will establish a rural locum scheme for allied health professionals. The scheme will provide around 100 locum placements annually to allow allied health professionals to take leave and undertake professional opportunities. It's not clear what costs are covered by the scheme – these are not outlined as they are for the locum scheme for nurses (below).

Workforce – rural locum scheme for nurses

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DoHA	-	7.9	6.9	6.9	7.1

$28.8 million / 4 years will establish a rural locum scheme for nurses. The scheme will allow nurses in rural areas to take leave and undertake continuing professional development. The service swill provide around 750 locum nurses per year with living costs assistance, including accommodation and travel support (presumably for the

locums rather than those taking leave?) and a locum allowance to improve that attractiveness of locum posts.

Workforce – building nursing careers

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	1.6	4.8	7.0	7.6

$21.0 million / 4 years is provided for an additional 600 enrolled nursing training places and 300 undergraduate nursing scholarships, commencing in January 2011.

These training places and scholarships are specifically for people working in the aged care sector. Under this measure $18,000 will be provided to registered training organisations for each enrolled nursing training place provided. Scholarships of $30,000 will be provided to aged care workers who undertake an undergraduate course in nursing.

This measure was first authorised in the 2002-03 Budget when $26.3 million / 4 years was provided for no less than 1000 aged care nursing scholarships. Applicants form regional and rural areas were given preference. The provision was renewed in the 2006-07 Budget with $36 million / 4 years.

Although the language of this initiative indicates that this funding is for additional scholarships, it is unclear if this is in fact the case or whether this represents continued funding.

Workforce – research into aged care staffing levels

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	0.3	0.3	-	-

$0.5 million / 2 years is provided to conduct research into aged care staffing levels.

Workforce – training and education incentive payments

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	11.3	14.3	17.0	17.4

$59.9 million / 4 years is provided for incentive to encourage aged care workers to undertake further studies to enhance their career as a personal carer, enrolled nurse or registered nurse. Incentive payments, which depend on the qualification, will be made in two instalments: one for commencement of studies and the second on completion of the qualification. The Minister's media release announces that this builds on current workplace training programs in which the government has invested

"more than $135 million".[17] However it's not clear when the Rudd government made such an investment – assuming this refers to aged care and not to workplace training programs in general.

Workforce – supporting a professional aged care workforce

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-			-	-

$211.2 million / 4 years is used from existing funding to refocus the existing aged care workforce development programs. This will include the establishment of Teaching Nursing Homes to strengthen the links between the aged care sector, research and training institutions and Local Hospital Networks and up to 400 nursing graduate placements to provide graduates with support from experienced staff, mentoring, access to clinical support and additional training as they become fully functioning nursing staff. There will also be more postgraduate scholarships.

The main elements of the current program are (1) the Aged Care Nursing Scholarship Scheme which provides Registered/Division 1 nurses who are studying for their Masters with scholarships valued up to $15,000 a year. It also offers up to $10,000 a year to assist Registered/Division 1 and Enrolled nurses working in aged care facilities for further education and training; and (2) the Postgraduate Community Aged Care Nursing Scholarship Scheme provides up to $10,000 to eligible Registered/Division 1 nurses working in the community aged care sector for tertiary studies, TAFE programs, vocational education, training courses and attendance at conferences.

It is not easy to assess how much of this is new money. Some of these provisions were funded in the 2006-07 Budget, which provided $79.4 million / 4 years for aged care education and training.

Workforce – exploring regulation of the personal care workforce

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	1.1	1.5	0.8	-

$3.5 million / 3 years is provided to 'explore' a national scope of practice and competency framework for the approximately 121,000 personal care workers and assistants in nursing, including aged care. The language here is obtuse – and it is not clear if the final result is expected to be a competency framework or not.

Currently there are no national standards for regulating or setting minimum qualifications for these workers. The Budget Papers state that this provision will

[17] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-je-je038.htm

provide as basis for a proposal to consider registration of personal care workers as part of the National Registration and Accreditation Scheme.

It all sounds rather tentative!

Prevention

The preventive health provisions included as part of the National Health and Hospitals Network are analysed separately in this paper.

See page 42.

Mental health

The mental health provisions included as part of the National Health and Hospitals Network are analysed separately in this paper.

See page 44.

Prevention

The Commonwealth Government has committed to provide **$642.9 million / 6 years** for the NP on Preventive Health, which will address the issues such as smoking, nutrition, alcohol and physical activity outlined in the reports from the Preventative Health Task Force.[18]

However the Budget papers show that over the forward estimates only **$415.7 million** will be available, and with the exception of $11 million in 2010-11, this money does not start to flow until 2011-12.

It is assumed, that with a small variation in the funding level, this is the same NP as that outlined in last year's budget, which provided **$448.1 million / 4 years**.

Additional funding of **$61.7 million / 4 years** for community-based physical activity and healthy eating programs is provided in the NP for local government programs

The 2010-11 Budget does advance the ball significantly with tough action on smoking by increasing the tobacco excise by 25 percent, reducing the attraction of cigarettes through plain packaging and investing in campaigns to encourage people to quit smoking.

There are also efforts to tackle binge drinking, although not all of the $50 million / 4 years provided for the National Binge Drinking Strategy is new money. Closing the tax loophole on 'alcopops' has resulted in a reduction of spirits consumption of 3.45 million standard drinks per week.

The Government has released its response to the National Preventative Health Strategy[19] and has responded to about half of the 136 recommendations made. Progress is lacking in a concerted effort to tackle obesity.

COAG agreed in November 2008 to establish a National Preventative Health Agency, which was also a recommendation of the National Preventative Task Force. Legislation to do this is currently proceeding through the parliament.

Tobacco

Australia will now have some of the world's toughest measures against tobacco, which is responsible for the deaths of some 15,000 Australians a year.

Excise on tobacco products was increased by 25 per cent from 30 April. This is

[18] Most recently the Government cites this figure as $872.1 million, including $262.7 million in sport funding

[19] http://www.preventativehealth.org.au/

expected to lead to 87,000 Australians quitting smoking. The proceeds from all tobacco excise – approximately **$7.5 billion / year** – will be used to pay for the proposed health care reforms.

From July 1, 2012, all tobacco products will be sold in plain packaging. Internet advertising of tobacco will also be restricted in line with restrictions for other media.

The Government will also launch a **$27.8 million** social marketing campaign targeting high-risk and disadvantaged groups, including people with mental illness and prisoners.

Binge Drinking

The Government will provide **$50.0 million / 4 years** for the National Binge Drinking Campaign. This includes:

- **$25.0 million** to provide sponsorship to community organisations as an alternative to alcohol sponsorship;
- **$20.0 million** for community level initiatives to tackle binge drinking; and
- **$5.0 million** for enhanced telephone counselling and referrals for people with alcohol-related problems, and possible expansion of existing social marketing.

These additional investments in alcohol programs were agreed with the Australian Greens and Senator Xenophon in the context of the passage of the 'alcopops' legislation last year.

The 2006-07 Budget provided $25.2 million for a media campaign around the safe use of alcohol. This funding expired June 2010, so some of the above funding can be viewed as continued funding for this program. The 2008-09 Budget provided $53.5 million through to 2011-12 for the National Binge Drinking Strategy. This year's funding will add to that, but means that there will be reduced funds in 2012-13 and 2013-14.

Australian Health Survey

Together with the National Heart Foundation, the Australian Government has engaged the Australian Bureau of Statistics to undertake a **$54 million** comprehensive Australian Health Survey. Starting in 2011, 50,000 Australians will be asked to complete the survey, including information about health issues, medications, nutrition, exercise and optional pathology samples. The information generated by the survey will provide health researchers with crucial data on the risk factors for disease and changing patterns of disease in the Australian population.

Obesity

In the 2008-09 Budget the Government committed $62 million / 4 years for anti-obesity initiatives, including those in the sports portfolio. This funding is boosted by $262/7 million for sports and recreation in this Budget.

Mental health

Mental health was the big loser in the health care reform announcements and the 2010-2011 budget. Mental disorders account for 13% of Australia's total burden of disease and injury[20] and are estimated to cost $20 billion annually, including lost productivity and labour participation.[21] Almost 50% of Australians aged 16-85 years will experience a mental disorder in their lifetime, but only one-third of these people will receive treatment.[22]

Despite this burden to individuals, society and the economy, Australia spends only 6% of the health budget on mental health, placing us well below comparable nations. The 2006 Senate Select Committee on Mental Health report recommended that Australia set a target for mental health spending equal to 9-12% of the health budget by 2012.[23] But with the dramatic increase in health spending announced this year, the spending gap has widened.

This year's budget contains **$181.3 million / 4 years** for mental health programs, but only **$31.4 million** of this is new funding. There is **$84.3 million** in continued funding for current programs and **$65.4 million** in restored or repositioned funds.

The Prime Minister has called evidence-based policy making the key element in the government's agenda. So it is disappointing to note that even when there is very good evidence to support evidence-based models like Headspace (for mild to moderate mental ill-health) and the Early Psychosis Prevention and Intervention Centre (for psychosis), which provide early interventions for young people with, or at risk of mental illness – a key priority group - the funding is inexplicably meagre. Patrick McGorry has pointed out that the funding provided will help just 3% of the 750,000 young Australians currently locked out of the mental health care they and their families desperately need.

In last year's budget analysis I wrote this:

> 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.

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[20] Australian Institute of Health and Welfare, 2007. *The burden of disease and injury in Australia, 2003*, AIHW, Canberra
[21] Budget Paper No 2, 2010-11
[22] Australian Bureau of Statistics, 2008. *2007 National Survey of Mental Health and Wellbeing: summary of results*, ABS, Canberra
[23] Senate Select Committee on Mental Health, 2006. *A national approach to mental health – from crisis to community.*

> 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.

The situation has not improved, and the Government's claims that it is 'building the foundations for better mental health care' ring very hollow. Over the past three budgets the Government has cut a total of **$354.6 million** from mental health programs.

The Government budget numbers and the Minister's interpretation of them are frankly rubbery at best and a sleight of hand at worst. The Minister has publicly claimed that the Rudd Government has doubled funding for mental health programs on top of the Medicare and PBS spending on mental health. But this is only the case if what is compared is the funding for the years 2004-05 to 2007-08 (the years before and in the early implementation phases of the COAG mental health programs) with the years from 2008-09 to 2011-12 (when there is full implementation of the programs introduced by the Howard Government). Even this situation only holds true because of the blow out in the cost of the Better Access program, which the Minister apparently regards, strangely, as not being part of Medicare.

More youth friendly services

Expenses ($m)

	2009-10	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
DoHA	-	10.8m	19.9m	23.8m	24.3m

Funding of **$78.8 million / 4 years** is provided. This was originally announced in the COAG communiqué as $78.3 million / 4 years and in the Minister's April 12 media release as $78 million / 4 years

This funding is to provide up to 30 new Headspace sites, to provide additional funding to the existing 30 sites, and expand telephone and web-based mental health services for young people.

Headspace provides community-based support and assistance to young Australians aged 12-25 with, or at risk of, mental illness. Once the new sites are fully established they should provide support and early intervention services for an additional 20,000 young people each year.

However, as Australian of the Year Patrick McGorry has highlighted, the core funding for existing headspace sites is half of what is needed to sustain them and carry out community awareness work and attract providers into outer urban and rural/regional sites, so even 30 new sites with this new money is not a feasible proposition.

During the 2004 election, the Howard Government committed $50 million / 4 years to

2007-08 for youth mental health, but the roll-out of this initiative was considerably delayed. Headspace, the Youth Mental Health Foundation, was finally launched in July 2006, with funding of $54 million / 3 years. In December 2008 the Commonwealth Government announced $35.6 million / 3 years in funding to Headspace to enable it to continue its work.

An evaluation of Headspace was completed in 2009.[24] It found that only a third of Headspace sites were delivering across all core areas, that many sites now have waiting lists for their services, six sites were yet to recruit GPs, and the engagement of psychiatrists was limited.

More mental health nurses

Expenses ($m)

	2009-10	2010-2011	2011-2012	2012-2013	2013-2014
DoHA	-	5.3	7.7	-	-

Funding of **$13 million / 2 years** is provided to the Mental Health Nurse Incentive program for 136 mental health nurses who will provide an estimated 11,700 extra services. The program funds mental health nurses in general practices and private psychiatric practices to assist in providing coordinated clinical care for people with severe mental health disorders. This funding is only for two additional years.

When first introduced this program was funded at $191.6 million / 5years. This funding was cut by $188.0 million / 4 years in the 2008-09 budget, due to low uptake of the program. However the new funding level for this program was given at May 2008 Senate Estimates as $49.45 million / 5 years, and in the August 2008 and September 2008 progress reports it is given as $34.5 million / 5 years. The January 2009 progress report gives the funding level as $56.8 million / 5 years and February 2010 progress report states that this program was funded at $68.7 million over six years (2006-2011) with no explanation provided for the variation.

At the end of November 2009, there were 579 organisations registered in the program, with 358 currently participating. A total of 34,937 patients have been treated since the program's inception. This is considerably less than the 36,000 patients who would receive support that was originally envisioned.

Flexible care packages for patients with severe mental illness

Expenses ($m)

	2009-10	2010-2011	2011-2012	2012-2013	2013-2014
DoHA	-	-3.0	5.2	2.5	1.4
Medicare Australia	0.1	0.1	-	-0.1	-0.1
Total	0.1	-3.0	5.1	2.4	1.3

[24] Social Policy Research Centre, 2009. Headspace evaluation report. Available at http://www.sprc.unsw.edu.au/media/File/Report19_09_headspace_EvalReport.pdf

This funding of **$58.5 million / 5 years** is to provide personal multidisciplinary care packages for patients with severe mental illness by expanding the existing Access to Allied Psychological Services (ATAPS) program. This program allows GPs to refer patients to mental health nurses, psychologists, occupational therapists, social workers and social support services. The expectation is that 6,000 patients / year will receive these services

This was originally announced in the Minister's April 20 media release as $57 million funding to provide services for up to 25,000 people with severe mental illness.

In actual fact this measure provides only **$5.9 million / 5 years** in new funds. The remainder ($52.4 million) comes from a requirement, effective July 1, 2010, that occupational therapists and social workers can no longer bill Medicare for mental health services provided under the Better Access program.

What is happening here is disturbing because it changes the nature of both the Better Access program and the ATAPS program without any public acknowledgement that this is the case.

Better Access is arguably a problematic program that is currently under evaluation, in large part because the costs of this program have blown out dramatically (it is now expected to cost $1.4 billion / 4 years rather than the initially predicted $381 million). Only a relatively small number of services are provided by occupational therapists and social workers; the services are provided on a fee-for-service basis and so often require patients to pay an out-of-pocket cost. The occupational therapy services go primarily to young boys aged 0-14 (presumably children with behavioural problems), and the social work services go mainly to young women aged 15-44. We currently know nothing about the effectiveness of these services, but from July 1 they will no longer be available through this program.

The ATAPS initiative, under which GPs can refer patients with mental disorders for short-term psychology services, was established in 2003. The program currently receives $27 million per year from the federal budget. Since then it has delivered over 600,000 services to more than 100,000 patients, particularly those who are traditionally underserved: 68 percent are low-income, 45 percent live in rural areas, two percent are Indigenous. Seventy-five percent of these services are bulk billed, and where there are co-payments, these are small.

The need for ATAPS has grown, not diminished since the introduction of the Better Access program, which delivers the majority of its services in metropolitan areas and has co-payments for psychology that average $29 a session. Moreover we know that ATAPS is achieving positive outcomes of medium to large improvement in approximately 86 percent of cases while there is no data about the effectiveness of services provided under Better Access.

In response to the recently released review of the ATAPS program, the Minister was clear that there would be no new resources for ATAPS in the future. The Minister's letter to the Divisions of General Practice states that under new funding arrangements, Tier 1 (base) funding for the program will be based on the current distribution of ATAPS funding and preserved at or close to current levels. Tier 2 (special purpose)

funding will consist of current funds for services for women with perinatal depression, suicide prevention, bushfire victims and people at risk of homelessness. There is a commitment to a new planning process 'in future years' to prioritise the allocation of Tier 2 funding, but no commitment to increased funds.

Regrettably, there is also no increased focus on the needs of Indigenous people and children - despite the emphasis given to these in the report, nothing to address the challenges involved in recruiting, training and retaining the ATAPS workforce, and no processes for driving needed improvements in efficiency, effectiveness and quality.

Now it appears that the ATAPS program (at once the best source of care for those who live in medically-underserved areas and a program with many shortcomings) is to either morph into a program for people with serious mental illness or juggle the needs of several different patient groups, with only a minimal budget increase. It seems very likely that many people will miss out on needed services.

Expanding the Early Psychosis Prevention and Intervention Centre (EPPIC) model ($25.5 million / 4 years)

Expenses ($m)

	2009-10	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
DoHA	-	0.6	0.5	0.5	0.5
Treasury	-	5.9	5.9	5.9	5.9
Total	-	6.5	6.3	6.4	6.4

$25.5 million / 4 years is provided to established new centres based on the EPPIC model currently operating in Victoria, in partnership with the states and territories. This was originally announced in the COAG communiqué as $24.8 million / 4 years and in the Minister's April 12 media release as $25 million / 4 years.

EPPIC provides integrated and comprehensive psychiatric services to address the needs of young people aged 15-24 with emerging psychotic disorders. With state contributions these centres are estimated to provide services for up to 3,500 young people (presumably this is annually?).

Continuation of Mental Health Support for Drought-Affected Communities program

Expenses ($m)

	2009-10	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
DoHA	-	5.5	-	-	-

This provision, initially announced and funded in the 2007-08 budget, is funded at **$5.5 million** for a further year. Last year's budget provided $5.2 million for this program for 2009-10.

Removal of practice accreditation requirements for General Practice Focussed Psychological Strategies services

Expenses ($m)

	2009-10	2010-2011	2011-2012	2012-2013	2013-2014
DoHA	-	-0.3	-0.5	-0.5	-0.6

The government has changed the rules to allow GP FPS services to be provided in practices that are not accredited. However these doctors will need to be trained to provide these services.

This provision is described as providing savings of **$1.9 million / 4 years** as it will mean fewer prescription drugs are prescribed.

GP-provided FPS services have decreased somewhat over time since the demise of the Better Outcomes in Mental Health program (see Table 4).

Table 4: GP FPS services

Calendar year	Number of GP FPS services	Cost to Medicare of these services ($m)
2007	36,094	3.7
2008	36,477	3.9
2009	34,567	3.8

New sub-acute hospital beds

The Government claims that some of the additional 1,300 additional beds for sub-acute services could be used for sub-acute mental health services. However even half of these new beds went to mental health (an unlikely situation) this would provide only a fraction of the step down beds that are needed in this sector.

The Mental Health Council of Australia says since the mid-1990s there had been a marked decrease in the number of non-acute community-based mental health beds, with about half of the 4400 beds disappearing. MHCA claims that more than 40% of patients now in acute mental health beds would not be there if more suitable community-based beds were available.

What has happened to COAG mental health programs?

The 2006-07 budget delivered on the Howard Government's commitment of $1.9 billion for the COAG mental health package. Apart form the Better Access program and the provision of funding for mental health nurses, there were a number of other provisions which now need continued funding.

New early intervention services for parents, children and young people (KidsMatter) (initially funded at $17.2 million / 4 years).
In October , Minister Roxon pledged $12.2 million to expand KidsMatter to 400 schools over the next three years, and $6.5 million to develop a version for pre-schoolers. This funding was in MYEFO. Beyondblue, which has already contributed $8 million to the project, will put another $3 million towards the expansion of KidsMatter.

Improving the capacity of workers in Indigenous communities (initially funded at $16.9 million / 4 years)
In semester one 2010, Registered Training Organisations will commence delivering the two mental health training programs developed under this initiative to Aboriginal Health Workers, counsellors, substance use workers and other clinic staff.

New mental health worker positions have been established and filled in all ten Aboriginal Medical Services in South Australia, Queensland, Tasmania, Northern Territory and Western Australia.

It is not clear if there is further funding for this program or if it has been subsumed into other workforce programs.

Support for day-to-day living in the community (initially funded at $35.4 million / 4 years)
An additional $19 million has been provided for this initiative during 2009-2011. A preliminary evaluation of the program was undertaken in late 2008/early 2009, with the final report due in June 2010.

Funding for telephone counselling, self help and web-based support programs (initially funded at $44.1million / 4 years).
This measure is currently being evaluated to inform strategies to move from the development phase to wider implementation. It is not clear if there is funding for this financial year.

Improved services for people with drug and alcohol problems and mental illness (initially funded at $71.1 million / 4 years)
It appears that this program does not have funding beyond June 2011.

Mental health services in rural and remote areas (initially funded at $37.8 million
In the 2009-2010 Budget, additional funding of $6.7 million over four years was allocated to the initiative. The DOHA website says this takes the total funding to almost $91 million (over the years 2006-02013) but it not clear how this is the case, particularly as $15.5 million was taken out of this program in the 2008.09 budget.

The program is currently under review.

Expanding suicide prevention programs (initially funded at $47.2 million / 4 years)
This program is to be evaluated in 2010-11. It is not clear if there is funding for this financial year.

Additional education places, scholarships and clinical training in mental health (initially funded at $77.3 million / 4 years)
In the 2008-09 budget, $35.0 million / 4 years was provided to expand this provision that provides post-graduate funding for mental health nurses and psychologists. The original measure was to provide training support for a total of 1,400 additional mental health nurses and 700 additional clinical psychologists by the end of 2011. The 2008-09 budget stated that the additional $35.0 million would provide scholarships for 1070 mental health nurses (of which over 100 will be for nurses in rural and remotes areas) and 222 scholarships for psychologists in rural and remote areas. To date over 890 postgraduate scholarships in both mental health nursing and clinical psychology have been awarded – this seems considerably less than proposed.

The February 2010 progress report has this initiative (funding $102.5 million / 5 years) also supporting psychiatry training. In 2009, a total of 56 FTE psychiatry training positions were approved, and the number is expected to grow to 70 FTE training positions for the 2010 academic year.

What is the fate of the mental health programs operated by the Department of Families, Housing, Community Services and Indigenous Affairs?

FaHCSIA operated a several programs funded under the 2006 COAG mental health agreement that are an important part of the integrated services needed for people with mental illnesses and their families and carers. It is understood that DoHA was seeking to take over the operation of these programs.

The April 12 media release from Health Minister Roxon stated:

"$617.5 million currently being provided for successful community-based services for people with severe mental illness and their families such as Personal Helpers and Mentors services, Support for Day to Day Living, and Mental Health Respite and Community Based projects, will be linked and coordinated with the primary health care organisations [Medicare Locals] being established as part of the National Health and Hospitals Network."

FaHCSIA has commissioned a strategic evaluation of its three COAG community mental health programs; the final report due in March 2010. The FaHCSIA website has the following information about these programs:

Personal Helpers and Mentors Program (PHaMs) ($284.8m / 5 years)
The Personal Helpers and Mentors Program has assisted around 8,900 people (as at December 2009) whose lives are severely affected by mental illness.

More Respite Places to Help Families and Carers ($224.7m / 5 years)
In 2008-09 the Mental Health Respite Program assisted more than 23,500 carers. FaHCSIA has funded 134 service providers around Australia and provided an additional $4.2 million from existing program funding to 41 centres to meet the high demand for respite care.

Community Based Programs to help Families Cope with Mental Illness
($45.2m / 5 years)
In 2008-09 the Mental Health Community Based Program assisted around 7,300 families and carers.

Words not actions

It appears that Australians who are dissatisfied with what has been delivered on mental health will have to wait until 2011 for any changes.

The April 20 media release from the Health Minister said this:

"The Government has always acknowledged the need for mental health reform. These measures signal the beginning of a new national leadership role for the Australian Government in delivering much-needed service improvements for people with mental illness and their carers in this country.
They should be seen as the start of a much greater involvement in the delivery of mental health care and support by the Australian Government.
However, further changes to roles and responsibilities will be carefully considered to ensure they result in better outcomes for consumers and do not fragment services.
The Government will work further with states and territories, mental health consumers, carers, experts and leading advocates in the mental health sector, on the implementation of these reforms.
The Government will continue to review how existing government expenditure might be better targeted to improve community based mental health care.
Governments will report back to COAG in 2011 on:

- the potential for further reforms to governments' roles and responsibilities for mental health;
- better integrating local services for people with severe mental illness, including with Local Hospital Networks and primary health care organisations."

The Minister has been quoted as saying this about mental health reform: "It isn't possible for us to do everything at once and it's not possible for the system to absorb everything being done at once…You have to grow within your capacity... and there is a lot in mental health in money that we already spent that is not yet properly in order."

To some extent this statement is true, but as the huge growth in the Better Access program shows, this is already capacity in the system – if the right incentives are provided. But the really concerning issue behind the Minister's statement is that it somehow betrays her sense that mental health exists in a silo isolated from the rest of the health care system. To the extent that the Government's proposed policies are about prevention, early intervention, better primary care, coordinated care and chronic disease management (and to the extent they should also be about quality, equity and 'bending the curve' of burgeoning health costs) then they are inevitably about the expansion of better mental health services and the integration of these with the rest of the health care system.

Australians desperate to see improved and expanded mental health services in the near future could hope that the Prime Minister has a change of heart during the upcoming

election campaign, or that in the implementation of the new funding provisions for health workforce and primary care, more attention is given to the fact that the majority of mental health services are provided by GPs.

The other alternative, regrettably, is to accept that the Rudd Government has ignored their needs, and does not see mental health as a priority issue.

Pharmaceutical Benefits Scheme (PBS)

The 2010-11 Budget delivers total PBS savings **of $1.782 billion / 4 years** through the Fifth Community Pharmacy Agreement and pricing reforms. The expectation of further savings (unquantified from more cost-effective arrangements for funding biological disease-modifying anti-rheumatic drugs is also indicated. Spending on new PBS listings and community information about generic medicines amounts to **$145.0 million / 4 years.** There is an additional budget cost of **$87.9 million** attributable to the Government's failure to deliver on the proposal to reduce wastage in the dispensing of IV chemotherapy drugs as outlined in the 2008-09 Budget.

The Budget papers reveal that the PBS is expected to grow by an average of 5% over the forward estimates.

Table x: Estimates of PBS expenditure (Budget Paper No 1)

Expense ($m)

	Actual 2008-09	**Estimate 2009-10**	**Estimate 2010-11**	**Estimate 2011-12**	**Projected 2012-13**	**Projected 2013-14**
Pharmaceutical services and benefits	9,210	9,808	10,248	10,762	11,076	11,740
(% growth)		(6.5)	(4.5)	(5.0)	(2.9)	(6.0)

Fifth Community Pharmacy Agreement

The Fifth Pharmacy Agreement delivers savings of **$596.2 million** over the life of the Agreement (**$483.5 million / 4 years**) compared to the forward estimates. While undoubtedly these savings were strongly contested by the Pharmacy Guild, they represent a fraction of the total cost of the Agreement which is **$15.4 billion / 5 years**. This figure is the equivalent of 27% of the PBS costs over this time frame.

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
Medicare Australia	0.4	10.7	9.4	4.9	4.6
DVA	-	-7.3	-8.4	-7.7	-7.3
DoHA	-	-133.2	-113.7	-126.5	-117.5
Total	**0.4**	**-129.8**	**-112.8**	**-129.2**	**-120.3**
Related capital Medicare Australia	-	4.6	3.4	-	-

Gross savings of almost $1 billion are achieved by the following measures:

- Cessation of the 40% payment for prescriptions processed using PBS Online (-$417.7 million);
- Freezing the indexation of the dispensing fee in 2010-11 and 2011-12 (-$281.5 million);
- Cessation of a number of under-performing professional pharmacy programs (-$226.4 million);

- Reduction of private hospital pharmacy remuneration in line with public hospital pharmacy (-$35.5 million);
- Freezing the indexation of the Community Service Obligation funding pool for 2010-2011 (-$19.2 million);
- Cessation of the freight allowance paid to non-metropolitan pharmacists in Western Australia (-$5.3 million).

These savings are offset by new funding of $375.3 million for new initiatives:

- Several new patient-focused pharmacy programs, including patient medication monitoring ($285.5 million);
- 15% payment for every prescription processed electronically to NeHTA specifications ($82.6 million);
- Collection of data on pharmaceuticals priced below the PBS general co-payment, including patient, prescriber and dispenser demographic data ($7.2 million).

Total funds of $38 million go to Medicare Australia, for the management of this program.

PBS – community information on generic medicines

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	4.2	2.7	1.6	1.6

Funding of $10 million / 4 years goes to the National Prescribing Service to develop and implement a public awareness and education campaign about the safety and effectiveness of generic medicines. The NPS has run several previous campaigns on this issue, most recently the 2008–09 “Generic medicines are an equal choice” campaign.

PBS- further pricing reform

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DVA	-	-2.0	-10.9	-29.0	-29.2
DoHA	-	-28.7	-180.2	-499.4	-517.2
Total	**-**	**-30.7**	**-191.2**	**-528.4**	**-546.4**

The Government will make further changes to the formulary mechanism under which prices for certain classes of medicines are set, for total savings of **$1.329 billion / 4 years.**

These PBS savings are substantial, and will affect both brand name and generic pharmaceuticals. They are made in the context of a new and unprecedented Memorandum of Understanding between Medicines Australia and the Government that will cover government-industry relations over the next four years. Medicines Australia has moved to protect its members, who are the major players in both the on-patent and off-patent markets, from future unpredictability in Government PBS cost-

cutting. This MoU also encompasses a move to allow for parallel filings and consideration at both the TGA and the PBAC.

PBS – minor new listings

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DVA	0.3	0.9	1.4	1.8	2.1
DoHA	6.8	18.7	26.8	34.6	40.9
Medicare Australia	0.1	0.2	0.2	0.3	0.4
Total	**7.1**	**19.7**	**28.4**	**36.7**	**43.3**

A number of minor new listings and extensions of current listings have been added tot eh PBS since the MYEFO, at a cost of $135.1 million / 5 years. These new listings include Atripla for HIV/AIDS; Effient for acute coronary syndrome; Sutent for the treatment of certain tumours of the digestive tract; and Volibrisi for the treatment of pulmonary hypertension.

Revised arrangements for efficient funding of chemotherapy drugs

This provision, negotiated in the context of the Fifth Pharmacy Agreement, revises a provision in the 2008-09 Budget that achieved savings of **$105.4 million / 4 years**. The cost to the budget is now **$87.9 million / 5 years**, meaning that savings achieved are of the order of **$17 million** over the forward estimates. Given that cost to Medicare Australia for the operation of this provision is $5.2 million, with related capital costs of $2.8 million, these are very minimal savings.

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DVA	-	3.2	2.0	1.6	1.6
DoHA	-	37.0	20.6	6.3	7.9
Medicare Australia	0.1	1.9	1.7	0.8	0.5
Total	**0.1**	**42.1**	**24.3**	**8.7**	**10.0**
Related capital Medicare Australia	-	1.7	1.1	-	-

2008-09 Budget measure, with savings of $105.4 million / 4 years:

Expense ($m)

	2007-08	2008-09	2009-10	2010-11	2011-12
DVA	-	-	-3.3	-3.2	-3.4
DoHA	-	4.4	-31.9	-33.6	-35.8
Medicare Australia	-	0.6 +0.8	0.1	-	-
Total	**-**	**5.8**	**-35.1**	**-36.8**	**-39.2**

This 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 objected to this provision, claiming that the Government wanted pharmacists to dispense ‘left-over’ cancer drugs.

After a long stand-off, this issue has now been resolved - a new infusion fee of $68.75 will be provided to pharmacists for each infusion in addition to the standard dispensing fee, currently $6.42. Clearly the pharmacists were the victors here; if wasted cancer drugs really cost $150 million a year, then nothing has been saved.

Medicare Benefits Schedule (MBS)

The Budget has a mixed bag of changes to MBS items that achieve savings of **$31.6 million / 5 years** and spend **$16.9 million**. Some of these changes are in response to the 'slashing of red tape' and MBS simplification that was promised in 2008; others reflect the Government's compromise with ophthalmologists over the controversial cutting of reimbursement rates for cataract surgery in last year's budget.

MBS – restructure of items to provide better primary care services

This provision represents the response, issued in a media release from the Minister dated 14 December 2009[25], to the review of MBS red tape and simplification. The Government claims that this action " addresses doctor's concerns that the current MBS is overly complex, encourages 'six-minute medicine' and fails to encourage preventative care, particularly for those with chronic illnesses." Despite the long time frame required to bring these changes in, they are quite minimal. The changes are effective May 2010.

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DVA	-0.1	-1.7	-1.7	-1.7	-1.6
DoHA	1.5	-0.5	-0.3	-0.3	-0.4
Medicare Australia	-0.1	-2.0	-2.1	-2.2	-2.3
Total	**1.2**	**-4.3**	**-4.0**	**-4.2**	**-4.3**

The changes encompass 15 measures, and achieve savings of **$15.5 million / 5 years**. The changes include:

- A higher fee of $66.45 for longer consultations;
- Streamlining and merging similar items, with a reduction in item numbers in the relevant parts of the schedule from 85 to 33; and
- Simplification of after-hours and case-conferencing items.

MBS – new and revised listings

A series of new and revised listings to the MBS since the MYEFO provide savings of **$6.8 million / 5 years**.

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DVA	-	-0.1	-0.1	-0.1	-0.1
DoHA	-0.2	-1.3	-1.4	-1.6	-1.8
Total	**-0.2**	**-1.4**	**-1.5**	**-1.7**	**-1.9**

[25] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-nr-nr234.htm?OpenDocument&yr=2009&mth=12

MBS – rebates for cataract-related items - revision

This measure was initially included in the 2009-110 budget. At that time the Government indicated it would 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.

Media reports indicates that rebates for nine cataract procedures would be halved from November 2009 with the scheduled fee for the most commonly claimed item (42702) set to fall from $831.60 to $409.60. Total savings for the 2009-10 provision were given as **$153.6 million / 4 years**.

This measure modifies now reduces cataract rebates by 12% instead of 50%; reducing savings by **$70.4 million / 5 years**.

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DVA	0.8	1.1	1.0	0.9	0.9
DoHA	10.9	12.4	13.0	14.1	15.3
Total	**11.6**	**13.5**	**14.0**	**15.1**	**16.2**

The caps that are imposed on rebates under the Extended Medicare Safety Net mean that private ophthalmologists will face pressure not to increase the cost to patients to compensate for this loss of income.

MBS – revision of access for specialist consultation items

Three newly recognised medical specialities – Sexual Health Medicine, Addiction Medicine and Sports and Exercise Medicine – will have access to the MBS for specialist attendance services from 1 November 2010. The cost is given as **$16.9 million / 4 years**. This seems surprisingly small.

Expense ($m)

	2009-10	**2010-11**	**2011-12**	**2012-13**	**2013-14**
DVA	-	0.1	0.2	0.2	0.2
DoHA	-	2.1	3.7	4.4	5.2
Medicare Australia	-	0.3	0.2	0.2	0.3
Total	**-**	**2.5**	**4.0**	**4.8**	**5.6**

MBS – removal of practice accreditation requirements for the GP Focussed Psychological Strategies

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	-0.3	-0.5	-0.5	-0.6

This provision will provide savings of **$1.9 million / 4 years**. It is discussed in the section on mental health provisions.

Indigenous health

Despite the Government's commitment to 'close the gap' on Indigenous health, there is nothing in the 2010-11 Budget to advance this cause. Continued funding is provided for two current programs (albeit at reduced levels over previous commitments) and the NPs for Closing the Gap in the Northern Territory, health projects that are part of the East Kimberley development package, satellite dialysis facilities in remote NT communities, sexual assault counseling in remote NT areas, and reducing rheumatic fever and associated heart problems for Indigenous children continue to run. However together these NPs will provide just **$29.3 million in 2010-11** for these isolated communities, and **$46.6 million** over the forward estimates. (Only 26% of the Indigenous population live in remote or very remote areas; 31% of Indigenous Australians live in the country's biggest cities.) The only funds that will help Indigenous communities that are not in the NT or remote areas are provided through the NP on Indigenous early childhood development. This will provide **$20.3 million** to the states and territories in 2010-11 (**$93 million** over the forward estimates).

The National Health and Hospitals Reform Commission called for an Indigenous health investment strategy 'that is proportionate to health need, the cost of service delivery, and the achievement of desired outcomes', but there was nothing in the $7 billion committed to health care reform that was specifically targeted at closing the gap.

While it is arguably too soon to see real progress in improving health and wellbeing, the most recent reports on the FaCHSIA website about the impact of the NTER have data only up to June 2009.

Moreover, a health impact assessment[26] of the Northern Territory Emergency Response conducted by the Australian Indigenous Doctors Association (AIDA) in collaboration with the University of New South Wales' Centre for Health Equity Training, Research and Evaluation, raises serious concerns about the continued future wellbeing of Indigenous children and families under the NTER. The assessment found that the Intervention would potentially lead to 'profound' long-term damage, and that any potential benefits to physical health are largely outweighed by negative impacts to psychological health, social health and wellbeing as well as cultural integrity.

Clearly addressing the health disparities between Indigenous and non-Indigenous Australians is a commitment the Government has made only in words, which are not matched with dollars and action.

[26] http://www.aida.org.au/hia.aspx

Table 5: NPs for Indigenous health

$million

	2009-10	2010-11	2011-12	2012-13	2013-14
Closing the Gap -NT Health services	8.9	4.9	4.9	-	-
- rheumatic fever ATSI kids	*2.3*	*2.4*	*2.5*	*2.5*	*2.6*
- NT sexual assault counselling remote areas	*1.4*	*1.4*	*1.5*	-	-
- NT satellite renal dialysis	*1.0*	*0.3*	*0.1*	-	-
Other payments					
- E Kimberley development	*19.9*	*20.3*	*3.3*	-	-
Indigenous early childhood development	*13.9*	*20.3*	*23*	*24*	*25.7*
Total	**47.4**	**49.6**	**35.3**	**26.5**	**28.3**

Note that this Table does not include the COAG Indigenous Health NP , the status of which seems to be in limbo, presumably as a consequence of the health reform agenda.

Combating petrol sniffing – expanding the supply and uptake of Opal fuel

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	6.0	8.2	12.1	12.2

$30.5 million / 4 years is provided to reduce the community impacts of petrol sniffing by expanding the voluntary roll-out of Opal fuel. This measure is described as providing expanded storage and distribution capacity in Darwin and Northern Queensland, and to make Opal fuel available at an additional 39 sites around 11 communities in NT, Queensland and Western Australia. It also includes funding for a communications strategy.

However it appears that the government is expecting to do more with less in this important area. The 2006-7 Budget had previously provided **$55.2 million / 4 years** for this work, in addition to $12 million to support the roll-out of Opal fuel in Alice Springs. Thus, at $6 million, the 2010-11 funding for this initiative is only 37.5% of that in 2009-10.

Addressing domestic violence – continuing training for health workers in regional and remote areas.

Funding of **$1.8 million in 2010-11** is included in the forward estimates to continue to provide incentives and support payments for practice nurses and Aboriginal Health Workers in regional and rural areas to undertake training to help them recognise the signs of domestic violence and to make appropriate referrals to community resources.

While this provision is not specifically targeted to Indigenous communities, the rate of family violence victimisation for Indigenous women may be as high as 40 times the rate for non-Indigenous women.

Miscellaneous provisions

Spending

The 2010-11 Budget also has a raft of small spending provisions, costing **$53.3 million / 4 years**. However only **$27.6 million** of this is new funding; the remainder is found from within current funds.

Table 6: Miscellaneous spending provisions

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Addressing domestic violence	-	[1.8]	-	-	-	[1.8]
Bernie Banton Foundation	[0.1]	-	-	-	-	[0.1]
Blood products – new listings	-	1.2	0.9	0.5	0.5	3.1
Jigsaw Foundation	-	1.3	1.3	1.3	1.3	5.0
National Cord Blood Collection Network	-	5.7	4.0	4.1	4.2	18.1#
National Male Health Policy	-	-	-	-	-	[16.7]
PHI – lifetime cover	-	-	-	-	-	-
PSR investigations	-	2.0	-	-	-	2.0
Rural health – cataract surgery	-	1.0	1.1	1.3	1.6	5.0
WA Children's Health Telethon	[1.5]*	-	-	-	-	[1.5]
Total	**1.6**	**13.0**	**7.3**	**7.2**	**7.6**	**53.3**
Total new spending	**-**	**11.2**	**7.3**	**7.2**	**7.6**	**27.6**

* not all of this funding is from the DoHA budget
# $5.6 million was taken from this program in the 2008-09 budget

Addressing domestic violence

$1.8 million is provided in 20010-11 to continue the provision of incentives and support payments for practice nurses and Aboriginal Health Workers in regional and rural areas to help them undertake training to recognise the signs of domestic violence.

This provision is discussed in more detail in the Indigenous health section (see page 61).

Donation to the Bernie Banton Foundation

The Government will provide **$100,000** from current resources in 2009-10 to the Bernie Banton Foundation to assist asbestos disease sufferers and their families.

Assessing new listings of blood products

$3.1 million / 4 years is provided to assess proposals to list new blood products under the National Blood Agreement.

Jigsaw Foundation – support for craniofacial surgery

Funding of **$5.0 million** is provided, contingent on matching funding form the Victorian Government and other donors.

National Cord Blood Collection Network funding

$18.1 million / 4 years will increase the Commonwealth contribution to the National Cord Blood Collection Network. The states and territories also provide funding for the NCBCN. The NCBCN is managed through the Australian Bone Marrow Donor Registry. It was established in 2000 with funding of $9 million / 4years and it was re-funded at the same levels in 2004-05. However the 2008-09 Budget took $5.6 in savings from the budget in 2010-11 and 2011-12. So only **$12.5** million of these funds are new spending.

The Network, also known as AUSCORD, collects, banks and stores umbilical and placental cord blood which is available to patients requiring haemopoietic stem cell transplantation.

National Male Health Policy

$16.7 million / 4 years is provided from within existing resources. This measure will provide:

- $3.0 million for the Australian Men's Sheds Association.
- $6.0 million to promote the role of Indigenous men in their communities and particularly to encourage their participation during the antenatal and early childhood period.
- $6.9 million for a longitudinal study into the social, economic and behavioural determinants of health that affects men's lives.
- $0.4 million for regular bulletins on men's health to health professionals, policy developers and consumers.
- $0.4 million for health promotion materials.

- $50,000 to the Andrology Australia forum in June 2010.

The National Male Health Policy[27] has six priority areas:
1. Optimal health outcomes for males.
2. Health equity between population groups of males.
3. Improved health for males at different life stages.
4. A focus on preventive health for males.
5. Building a strong evidence base on male health.
6. Improved access to health care for males.

The current funding only begins to address some of these.

Private health insurance – supporting lifetime health cover

The Government will spend $2.4 million / 4 years to provide information about the lifetime health cover surcharge to people approaching their 31st birthday and new immigrants. The cost of the mailouts will be met from contributions from the PHI industry.

Professional Services Review – supporting more investigations of inappropriate practice

$2.0 million is provided in 2010-11 to expand the number of investigations as a consequence of the compliance audit program announced in the 2008-09 Budget.

Rural health – additional funding for cataract surgery

$5.0 million / 4 years is provided for additional cataract eye operations to patients in rural and remote areas. These services will be provided through the Medical Specialist Outreach Assistance Program. The MSOAP program, initially funded in 2000-10 at $48.4 million and refunded at the same level in 2004-05, received supplemental funding of $12.0 million in 2008-09.

Western Australia' Children's Health Telethon - donation

The Government will provide **$1.5 million** to the 2009 Annual appeal. The cost of this measure will be met from the existing budgets of DoHA, DEEWR, and FaHCSIA.

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27 http://www.health.gov.au/internet/main/publishing.nsf/content/0547F4712F6AB5D3CA257457001D4ECF/$File/MainDocument.pdf

Savings

The 2010-11 Budget has a mish-mash of small savings provisions. Total savings from these amount to **$236.8 million / 5 years**. Some of the logic behind these cuts is hard to see and it suggests that the primary goal was achieving a target rather than any strategic approach to health program operations and efficiencies.

Table 7: Miscellaneous savings provisions

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Radiation oncology services	-	-21.8	-22.2	-22.6	-23.0	-89.6
Aligning services in rural and remote areas	-	-2.1	-2.1	-2.1	-2.1	-8.4
Combatting illicit drug use – media campaign	-	-1.1	-1.2	-0.8	-0.9	-4.0
Community Care and Flexible Care Grants	-0.5	-1.1	-1.2	-1.4	-0.8	-5.0
DoHA grant programs	-	-13.3	-18.6	-25.4	-31.5	-88.8
Nurses back into the workforce	-	-8.0	-11.0	-12.3	-7.9	-39.2
Pt Augusta MRI	-	-1.2	-1.2	-1.2	-1.2	-4.8
Changes for cervical cancer PIP	-	0.4	-8.0	-7.9	-8.0	-23.5
Diabetes insulin pump program	-0.5	0.5	-	-0.3	-0.2	-0.5
Total	**-1.0**	**-47.7**	**-65.5**	**-74.0**	**-75.6**	**-236.8**

Better access to radiation oncology services – further efficiency

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	-21.8	-22.2	-22.6	-23.0

The Government will cease funding for the capital component of the Better Access to Radiation Oncology measure announced in the 2006-07 Budget. This measure was funded at $90.3 million in the 2006-07 Budget, and previously at $72.7 million in the 2002-03 Budget.

The rationale offered is that funding for health infrastructure will now come from the Health and Hospitals Fund. There is an ongoing need for radiation therapy services, especially outside of metropolitan areas.

COAG health services – aligning services in rural and remote areas – more efficient arrangements

Savings of **$8.4 million / 4 years** are achieved by cessation of this measure, which has funded a strategy to consolidate and streamline health services delivery to populations of less than 7,000. The Budget Papers state that this strategy will now be delivered through the establishment of Local Hospital Networks and Medicare Locals. There is little evidence that such a strategy has been in place up until now.

Combating illicit drug use – savings from media campaign

Savings of **$4.0 million / 4 years** are taken from the media campaign funds that are part of the National Drugs Campaign, leaving **$21.2 million / 4 years** for this effort.

The efforts to address illegal drugs, which received funding of **$68.2 million / 4 years** in 2006-07 and **$126.2 million / 4 years** in 2007-08 have eroded under the Rudd Government which has pulled **$38.4 million** from current funding and failed to continue funding for some initiatives.

Community Care Grants and Flexible Care Grants

Funding for the Community Care Grants program and the Flexible Care Grants program is reduced by **$5.2 million** by reducing the number of establishment grants available. The Budget Papers state that there has been a declining number of applications for these grants.

Port Augusta MRI – discontinued

Savings of **$4.8 million / 4 years** are made because the government was not able to identify a suitable operator for a viable Medicare -eligible MRI services in Port Augusta.

The funding for the MRI was first announced by the Howard Government in September 2007 and the Rudd Government supported that commitment. However data suggests that there would not be enough patients to justify the cost of an MRI. In 2009 only 626 MRI scans were performed on residents from key towns in the region, including those from Port Lincoln, Whyalla, Roxby Downs and Port Pirie. This is far short of the number typically seen by metropolitan MRI machines, with the Flinders Medical Centre machine conducting more than 7470 scans last year.

DoHA grant programs - reprioritisation

Savings of **$88.9 million / 4 years** are made in DoHA grants programs. The Budget Papers state that this is unallocated funding that will be redirected to support other Government priorities in the Health and Ageing portfolio (in which case it's not clear

why it's a savings). There is no indication as to where this funding comes from or where it will go.

Supporting nurses back into the workforce – redirection of funding

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	-1.3	-2.2	-2.5	-1.6
Treasury	-	-6.6	-8.8	-9.9	-6.3
Total	**-**	**-8.0**	**-11.0**	**-12.3**	**-7.9**

Savings of **$39.1 million / 4 years** are made in the program that was established to attract trained nurses back into the workforce. The Budget Papers state that this is unallocated funding that will be redirected to support other Government priorities (in which case it's not clear why it's a savings).

This measure was funded at $39.4 million / 5 years (to 2011-12) in the 2008-09 Budget and some funds have been spent, so it's not clear where all the savings come from, other then the 2012-13 funding (it is implied that this is provided for in the forward estimates).

PIP – changes to incentive payments for cervical cancer screening

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-	-	-8.0	-7.9	-8.0
Medicare Australia	-	0.3	-	-	-
Total	**-**	**0.3**	**-8.0**	**-7.9**	**-8.0**

Savings of **$23.5 million / 4 years** are made in the PIP for cervical cancer screening. The Government will increase the target that GP practices must reach to receive the incentive payment from 50% to 65% of female patients aged between 20 and 69 years.

The two-year participation rate for the National Cervical Screening Program was 61.5% of women in the target age group in 2006-2007 so there is clearly room for improvement here. It is disconcerting that the budget numbers indicate that DoHA does not believe GPs will be able to meet the new targets.

It is interesting to note that since the Rudd Government came to office **$251.3 million** has been cut from Practice Incentive Programs in the name of efficiency or restructure.

Changes to Type 1 diabetes insulin pump program

Expense ($m)

	2009-10	2010-11	2011-12	2012-13	2013-14
DoHA	-0.5	0.5	-	-0.3	-0.2

Savings of **$0.5 million / 5 years** are made in this program, which was initially funded at **$5.5 million / 4 years** in the 2008-09 Budget. The Budget papers state that the program cap remains at $5.5 million. However it does seem likely from the budget numbers that fewer pumps will be provided.

This program provides subsidies which are means tested and are between 80% and 10% of total pump purchase price depending on gross family income. The minimum subsidy paid is $500 and the maximum subsidy is $6,400 depending on the insulin pump chosen.