

Analysis of the Federal Health Budget and Related Provisions 2015-16

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About this budget analysis

This analysis looks at the health and related provisions in the Australian Government's 2015-16 Budget. This is done in the light of current and past strategies, policies, programs and funding, and is supported, where possible, by data drawn from Medicare, the Pharmaceutical Benefits Scheme, reports and published papers.

As was the case last year, this year's analysis has been delayed. The Budget Papers are even more impenetrable than those from 2014-15, provisions in the Budget have already changed as the Abbott Government struggles to sell its policies, and new announcements have been made in the weeks since the Budget was released. This delay does mean that new information about federal health expenditures and the impact of the proposed changes, along with such information as was obtained from Senate Budget Estimates held in early June,¹ can be included.

Indigenous affairs issues in the 2015-16 Budget have been previously analysed and this report is available at <http://ses.library.usyd.edu.au/handle/2123/13476>

Budget analyses from previous years are available at <http://ses.library.usyd.edu.au/browse?type=author&value=Russell%2C+Lesley>

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

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¹ http://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/claccte/estimates/index

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Introduction

The impacts of the 2015-16 Budget must be assessed in light of the previous Budget, which casts a long shadow.

Australians' health and wellbeing depends not just on their ability to access quality and affordable healthcare services when they need them, but on a range of other services, of which education, employment, social justice and welfare supports are the most important.

ACOSS estimates that, combined, the two budgets strip approximately **\$15 billion / 4 years** from basic services and supports that affect low and middle income households.² Analysis from NATSEM highlights that the Abbott Government's Budget changes are being made at the expense of the less well-off and that its second Budget has done little to reverse the unfair redistributions of its first budget.³

The over-arching aim appears to be to improve the federal budget deficit by shifting costs off the Commonwealth Government's balance sheet on to the States and Territories, service providers and consumers.

The Health Budget this year sees the Government using the same methods to take savings with the same objectives as last year, but what leaps out is the continuing failure to develop and implement strategies and policies to underpin these decisions. Budget decisions smack of policy on the run, or in some cases, no policy at all. There is no inkling of any reformist imagination.

In critical areas like mental health, e-health and primary care we see a common *modus operandi*: commission a report but delay acting on it; implement a few aspects of the report and ignore the remainder – or set up an advisory group to obtain yet more advice and further delay; rebadge anything named by the previous Labor Government; and finally - make sure there are no plans and no funding for anything beyond three years.

The Government continues to find savings by using price signals (or co-payments) to reduce demand. The controversial Medicare co-payment has been abandoned but changes to Medicare reimbursements will see patients' out of pocket costs grow – effectively implementing co-payments by stealth. And PBS co-payments remain on the table, at least until replacement savings are found. Other common methods for achieving savings include: tightening up eligibility and funding rules for patients' benefits and providers' incentives; cutting funds from health programs and agencies in the name of efficiency and rationalisation; and re-negotiating agreements with service providers, including states and territories, non-government providers and the private sector.

This Budget also reinforces the Government's intent to claw back **\$80 billion** over the next decade from the States' and Territories' budgets for health and education, with **\$57 million** of this to come from funding for public hospitals. This has service to reignite the 'blame game' which the previous Labor Government had worked hard to address (if imperfectly). At a time when cross jurisdictional and cross

² http://acoss.org.au/images/uploads/ACOSS_Budget_Analysis_2015-16.pdf

³ <http://www.natsem.canberra.edu.au/publications/?publication=interim-analysis-of-the-2015-16-federal-budget>

sector efforts and collaborations are needed to deliver integrated care and improve efficiencies, this is undermining the good will needed to achieve these reforms.

The one substantial Government commitment is to the Medical Research Future Fund, which has become the beneficiary, even the justification, for savings from many areas in the Health portfolio. It is ironic that these program cuts will quickly lead to impacts on the health of individuals and the population as a whole – the very things that the MRFF is lauded as addressing through the research it will support.

The biggest concern must be that these efforts of the Abbott Government to ensure that our grandchildren do not bear the burden of Government debt mean future generations will bear the economic and social burdens of increasing rates of illness and disability.

The key messages from a 2012 WHO report entitled *Health systems, health and wealth: Assessing the case for investing in health systems*⁴ are these:

- **Health is central to well-being and wealth.** Healthier people are more productive and better health reduces demands on health care now and in the future. Health and wealth reinforce each other and health systems are a catalyst for both
- **Health systems investment brings real benefits.** Appropriate investment in health systems is an effective way of improving health and wealth and societies can choose ‘how’ and ‘how much’ to invest in health systems despite all the competing demands for resources. Health systems help create societal wellbeing and promote equity.
- **Policy makers can make health systems and health system investment work better.** Explicit strategies for improvement are key and these work best if they reflect the burden of disease and risk factors, combining prevention and treatment accordingly.

These messages all apply to Australia’s formulation and funding of health policies and services, and never more so than in 2015.

⁴ http://www.euro.who.int/_data/assets/pdf_file/0009/83997/E93699.pdf

State / Territory and Commonwealth relations

The 2015-16 Budget highlights the Abbott Government’s renegotiation of contracts with the States and Territories in order to achieve savings and implement its fiscal and social ideologies. Policies and program cuts in the 2014-15 and 2015-16 Budgets have shifted costs from the Commonwealth to the States and Territories and also to consumers and to the medical profession.

Small wonder then that, despite talk about “co-operative federalism” and “ending the blame game”, Commonwealth-State relations remain fraught. In particular, tensions over the roles and responsibility for high-cost issues like health remain unresolved and are aggravated as the Commonwealth floats ideas and then quickly withdraws or disowns them in the face of public opposition.

Even as there is broad agreement about the need for better integration of healthcare services to manage the growing burden of chronic illnesses together with the need for a more efficient, effective and sustainable health system, Commonwealth-State collaborative across the systems are stifled.

In 2015-16 the Commonwealth will provide **\$17.2 billion** to support State and Territory health services (see Table 1). This is 4.8% more than in 2014-15.

Table 1. Payments to support state health services

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
National Health Reform funding	15,459.4	16,440.9	17,382.4	-	-
Public hospitals funding	-	-	-	18,103.3	18,873.1
National Partnership payments					
-Health infrastructure	736.3	318.3	96.5	29.5	-
-Health services	88.8	72.6	55.1	23.2	17.1
-Indigenous health	61.0	12.9	12.9	6.2	6.4
-Other health payments	458.6	339.1	143.3	146.3	148.1
Total	16,804.2	17,183.7	17,690.2	18,308.5	19,044.8

From 2015-16 Budget paper No 3 Table 2.4

Examination of how this funding has changed over the past three Budgets highlights the cuts that have been made. The 2015-16 funding in this Budget is **\$400 million** less than that proposed for 2015-16 in last year’s budget, and about **\$1.3 billion** less than proposed for 2015-16 in the 2013-14 Budget.

Tables 2 and 3 highlight how the Budget estimates have changed since 2013-14 for National Health Reform payments and for National Partnership (NP) agreements.

Table 2. Payments to States and Territories for public hospitals under National Health Reform

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
2015-16 Budget	-	15,459.4	16,440.9	17,382.4	18,103.3	18,873.1
2014-15 Budget	13,884.5 + 916.2*	15,115.5 + nfp*	16,551.3	18,094.9	18,872.1	-
2013-14 Budget	14,040.0 + 818.5*	15,531.1 + 99.5*	17,164.1 + 99.5*	18,956.1 +99.5*	-	-

*NHR reward funding

A direct comparison on NPs is not really possible and perhaps not even fair, given that some of these were for one-off initiatives and some funding once provided through NPs is now provided through different mechanisms. Nevertheless such comparisons do serve to highlight the loss of the NPs on mental health and prevention and the significant decline in funding for the NP on Indigenous health.

Table 3. Payments for States and Territories for health National Partnership Agreements

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
2015-16 Budget	-	1344.7	742.9	307.8	205.2	171.6
2014-15 Budget	1093.8	1304.1	949.1	668.9	660.0	-
2013-14 Budget	1218.5	1410.6	1208.5	974.6	-	-

Special assistance for Tasmania

This Budget provides Tasmania with the last of the funding from the Tasmanian Health Assistance Package - **\$22.9 million** in 2015-16, including **\$10.9 million** to reduce elective surgery waiting lists. This is in addition to the post-budget announcement of **\$143.7 million / 2 years** for the continued operation of the Mersey Hospital.

This funding is not included in the Tables above.

See section on Hospitals and Acute Care for further information.

National Health Reform Funding

The 2015-16 Budget confirms that the Abbott Government remains committed to its 2014-15 decision to cut **\$57 billion** over the next 10 years from Commonwealth funds to States and Territories for public hospitals. Semantic games are being played about savings taken over the forward estimates and those proposed over the next ten years and about whether changes in indexation constitute funding increases or budget cuts.⁵ (See Table 2 and Table 3 for National Health Reform / Public Hospital funding across the forward estimates.)

There are very real reasons for concern that the Government’s agenda involves doing considerably less in terms of supporting the States and Territories in funding public hospitals. A December 2014 issues paper on “Roles and Responsibilities in Health Care” prepared for the Reform of the Federation White Paper laid out some very sensible issues and questions for discussion.⁶ However a leaked proposal prepared by the Department of Prime Minister and Cabinet as part of the Federation reform process proposed handing over the full funding of public hospitals to the States.

This would mean that the loss of up to **\$18 billion / year** which would decimate State and Territory budgets. States would have to raise taxes, cut back on hospital admissions or perhaps even means test access to public hospitals. Meanwhile the main means of reducing hospital admissions and costs – by addressing shortfalls in primary care – would remain under Commonwealth control.

Currently the States and Territories provide the majority of public hospital funding (see Table 4). Moreover, as Figures 1 and 2 show, this contribution is declining over time.

Table 4. Funding of public hospitals under National Health Reform 2013-14⁷

Jurisdiction	State/Territory contribution (\$b)	State/Territory contribution (%)	Commonwealth contribution (\$b)	Commonwealth contribution (%)
New South Wales	6.4	60%	4.3	40%
Victoria	4.5	56%	3.5	44%
Queensland	5.4	66%	2.8	34%
South Australia	2.1	68%	1.0	32%
Western Australia	2.8	65%	1.5	35%
Tasmania	0.6	67%	0.3	33%
Northern Territory	0.7	87.5%	0.1	12.5%
Australian Capital Territory	0.6	67%	0.3	33%
Total	23.1	63%	13.8	37%

From Administrator National Health Funding Pool

⁵ <http://www.abc.net.au/news/2014-06-23/has-hospital-funding-been-cut-by-50-billion-fact-check/5486988>

⁶ https://federation.dpmc.gov.au/sites/default/files/issues-paper/Health_Issues_Paper.pdf

⁷ Includes activity-based, block and public health funding.
<http://www.publichospitalfunding.gov.au/publications/annual-reports/2013-14>

Figure 1. Funding for public hospitals⁸

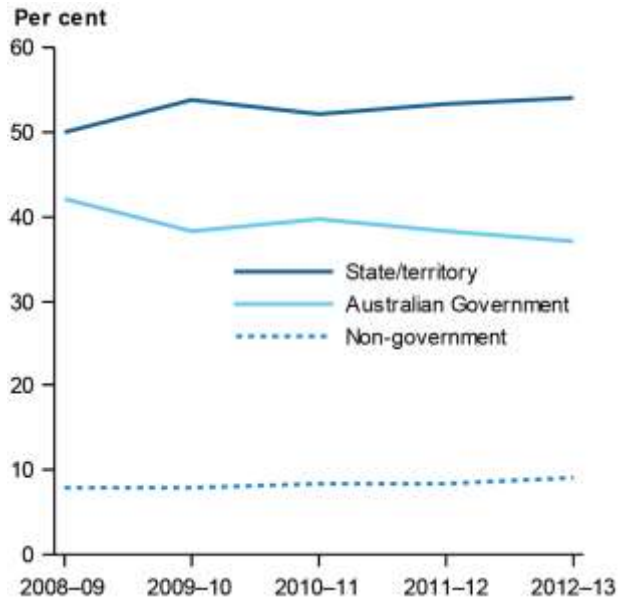
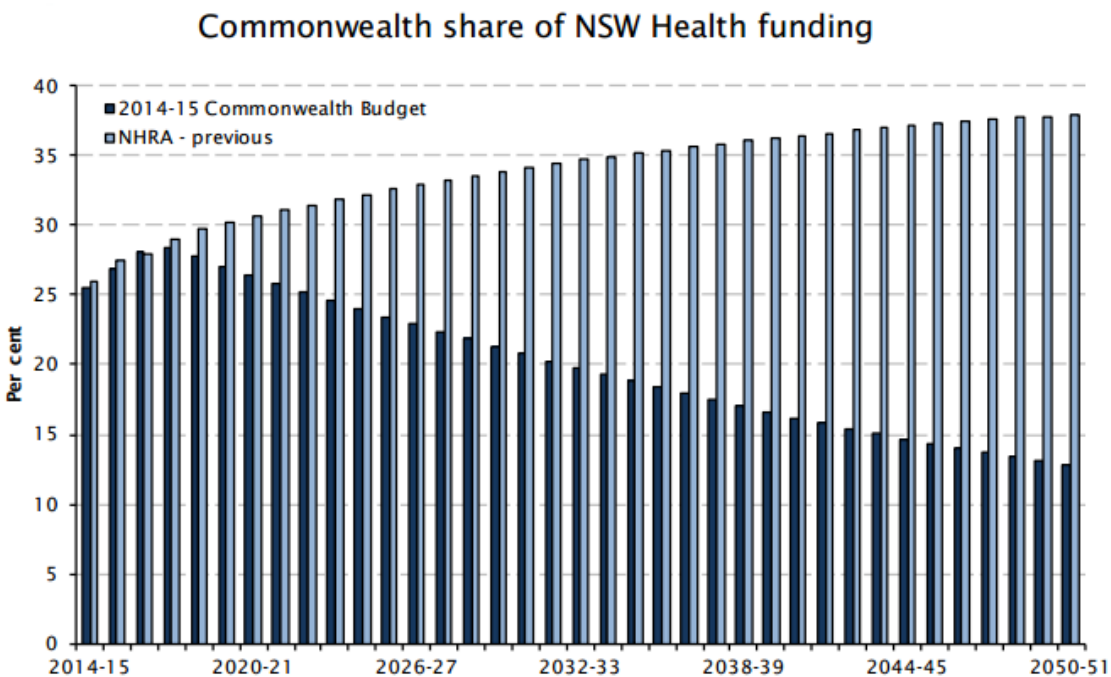


Figure 2. Commonwealth share of NSW health funding⁹



⁸ <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129551482>

⁹ <http://www.abc.net.au/news/2014-06-23/commonwealth-share-of-nsw-health-funding/5536804>

Until June 2017 the NHR funding is linked to the level of services delivered by public hospitals: each State and Territory entitlement is linked to growth in public hospital activity and the National Efficient Price. At Senate Estimates DoH explained the 2014-15 reduction in predicted spending as due to a decrease in activity. From 1 July 2017 the funding will be linked to the CPI and population growth.

The last payments made in 2014-15 under the NP in Improving Public Hospital Services, which used to be included here, in this Budget are shown under Other Health National Payments (as if to highlight that they are not part of hospital funding reform). In 2014-15 **\$14.5 million** was paid in reward funding for the National Elective Surgery Target (NEST), and **\$45.2 million** was paid in reward funding for the National Emergency Access Target (NEAT). This is considerable less than was anticipated in the 2013-14 Budget (**\$99.5 million**), presumably because not all States and Territories qualified for reward funding (see Table 5). The basis on which these payments were made is reported by the Administrator of the National Health Funding Pool.¹⁰

Table 5. Reward payments to States and Territories under NHR Agreements 2014-15

	NSW \$m	VIC \$m	QLD \$m	WA \$m	SA \$m	TAS \$m	ACT \$m	NT \$m
NEST	8.5	-	-	0.9	4.1	-	0.7	0.2
NEAT	28.6	-	16.7	-	-	-	-	-

Lost in the debate about hospital funding is the loss post 2013-14 of funding for sub-acute beds and long-stay older patients which is likely to have an impact on bed availability, Length of Stay data and health outcomes for frail older patients.

It is also not clear what has happened to the preventive health funds that used to make up a small part of this funding (given in the 2013-14 Budget as **\$251.9 million** for 2015-16). This represents the sum of amounts identified under the National Healthcare Reform agreements relating to public health, youth health services, and the delivery of essential vaccines.

¹⁰ <http://www.publichospitalfunding.gov.au/reports/national>

National Partnership payments

In 2015-16 **\$742.8 million** will be provided to the States and Territories under four National Partnership (NP) agreements.

NPs on Health Infrastructure

\$318.3 million is provided in 2015-16 through NPs on Health Infrastructure.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Health and Hospitals Fund	650.2	239.7	95.0	29.5	-
-Hospital infrastructure & other projects of national significance	66.4	0.6	-	-	-
-National cancer system	112.4	63.1	1.5	1.6	-
-Regional priority round	471.4	176.0	93.5	27.9	-
Albury-Wodonga cardiac catheterisation lab	-	3.5	1.5	-	-
Bright Hospital feasibility study	0.1	0.1	-	-	-
Cancer support clinic, Katherine	0.5	-	-	-	-
Construction of Palmerstone Hospital	20.0	20.0	-	-	-
Improving local access to care, Phillip Island	-	2.5	-	-	-
Oncology day treatment centre, Frankston Hospital	0.7	-	-	-	-
Redevelopment of Royal Vic Eye & Ear Hospital	50.0	50.0	-	-	-
Upgrade, Ballina Hospital	1.9	2.6	-	-	-
Upgrade, Casino & District Memorial Hospital	3.0	-	-	-	-
Warrnambool Integrated Cancer Care Centre	10.0	-	-	-	-
Total	736.3	318.3	96.5	29.5	-

From 2015-16 Budget Paper No 3

These NPs comprise the Health and Hospitals Fund (HHF) (which has ceased making new disbursements and the remaining **\$1 billion** will go to the MRFF) and a series of small grants which represent local election commitments. The funding to be provided over the forward estimates for the HHF regional priority round is **\$34.2 million** less than in the 2014-15 Budget.

NPs on Health Services

\$72.7 million will be provided in 2015-16 for NPs on Health Services.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Canberra Hospital – dedicated paediatric emergency care	5.0	-	-	-	-
Expansion of BreastScreen Australia	12.4	13.6	15.8	-	-
Health care grants for Torres Strait	4.5	4.6	4.7	-	-
Hummingbird House	15	0.8	0.8	0.8	0.8
Improving Health Services in Tasmania	27.6	14.8	-	-	-
<i>-Better access to community based palliative care services</i>	<i>1.7</i>	<i>1.7</i>	-	-	-
<i>-Cradle Coast Connected Care clinical repository</i>	<i>0.3</i>	<i>0.3</i>	-	-	-
<i>-Improving patient pathways through clinical and system redesign</i>	<i>5.3</i>	<i>9.0</i>	-	-	-
<i>-Innovative flexible funding for mental health</i>	<i>1.0</i>	<i>1.0</i>	-	-	-
<i>-Reducing elective surgery waiting lists</i>	<i>19.3</i>	<i>10.9</i>	-	-	-
National Bowel Cancer Screening Program – participant follow-up	1.9	2.4	4.7	6.4	-
National Perinatal Depression Initiative	8.3	nfp	nfp	nfp	nfp
OzFoodNet	1.7	1.7	1.7	nfp	nfp
Royal Darwin Hospital – equipped, prepared, ready	15.3	15.5	15.7	16.0	16.3
Torres St health protection strategy – mosquito control	1.0	1.0	1.0	-	-
Vaccine preventable diseases surveillance	0.8	0.8	0.8	-	-
Victorian cytology service	8.9	9.3	9.8	-	-
Total	88.8	72.6	55.1	23.2	17.1

From 2015-16 Budget paper No 3

The only new NP under Health Services is for the provision of **\$4.7 million / 5 years** for the construction and operation of a dedicated respite and hospice care facility for children in Queensland.

This Budget provides the last of the funding to Tasmania that was part of the Tasmanian Health Assistance Package (**\$14.8 million**). It is amusing to note that the only reference to this on the DoH website is a curt note that this was a provision established by the previous Government!¹¹

\$63.5 million / 4 years is provided through a new NP with the Northern Territory for the continued operation of the National Critical Care and Trauma Response Centre (NCCTRC) at Royal Darwin Hospital. The Budget Papers say this funding has already been provided by the Government – meaning it is continued funding in the forward estimates. Only about **\$32 million** of this is new funding as the current NP provides funding of **\$31.3 million** for 2015-16 and 2016-17. (This provision is discussed further in the Miscellaneous Section). It is not clear why the Government considers it necessary to sign a new 4 year NP when the current NP still has 2 years to run.

Considerable concern has been generated by the failure to provide future funding for the National Perinatal Depression Initiative (NPDI). To date no explanation has been forthcoming from the Government.¹²

The NDPI was created in 2008, when State and Territory Governments, together with the Federal Government, agreed to collaborate on the development of a five year national initiative to improve the prevention and early detection of antenatal and postnatal depression and to provide better care, support and treatment for expectant and new mothers

The Commonwealth committed **\$55 million / 5 years** towards the NPDI – **\$30 million** to the states and territories, **\$20 million** to the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care program, and **\$5 million** to *beyondblue*. The states and territories committed an additional **\$30 million / 5 years**, bringing the total funding to **\$85 million** nationally.

Although the funding for this program expired in June 2013, the 2014-15 Budget provided future funding (**\$8.2 million / year**) for the three years 2014-15 to 2016-17, so the money is in the forward estimates. The apparent loss of this program might be linked to the apparent loss of the ATAPS program and the huge delay in doing anything about mental health reform.

¹¹ <http://www.health.gov.au/tashealthassist>

¹² <http://www.abc.net.au/news/2015-06-19/government-pulls-funding-from-perinatal-depression-program/6560266>

NP on Indigenous Health

Funds for Indigenous health provided through NPs have declined precipitously in recent years. In 2015-16 only **\$12.9 million** will be provided and all of this is for programs in remote areas – mostly in the Northern Territory.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Accommodation, infrastructure for renal services in NT	10.0	-	-	-	-
Improving trachoma control	4.1	4.2	4.2	-	-
Early childhood development –antenatal and reproductive health	31.5	-	-	-	-
NT remote Aboriginal investment - health	-	5.6	5.9	6.2	6.4
Renal dialysis services in Central Australia	1.7	-	-	-	-
Rheumatic fever strategy	3.0	3.1	2.7	-	-
Stronger Futures in NT - health	10.3	-	-	-	-
Torres Strait health protection strategy – Sabais clinic	0.5	-	-	-	-
Total	61.0	12.9	12.9	6.2	6.4

From 2015-16 Budget paper No 3

Funding previously provided to the Northern Territory via the NP on Stronger Futures is replaced from 2015-16 by a new NP on Northern Territory remote Aboriginal investment. The only changes seem to be the name of the NP and a decrease in funding from around **\$10 million / year** to **\$5-6 million / year**.

It is not clear whether the Government’s strategy in future years is increasing to require Indigenous Australians to use mainstream services, or whether new NPs will be established once the ATSI Health Plan is implemented.

This provision is discussed in greater detail in my analysis of the impact of the 2015-16 Budget on Indigenous Affairs.¹³

¹³ <http://ses.library.usyd.edu.au/handle/2123/13476>

Other Health NPs

\$339.1 million is provided in 2015-16 for adult public dental services, essential vaccines and funding for mental health services.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Treating more public dental patients	135.8	-	-	-	-
Adult public dental health services	-	155.0	nfp	nfp	nfp
Essential vaccines	211.1	138.8	143.3	146.3	148.1
National Coronial Information System	0.4	-	-	-	-
Supporting National Mental Health Reform	51.6	45.3	-	-	-
Total	398.9	339.1	143.3	146.3	148.1

The Budget provides funding for the NP on Adult Public Dental Services, the commencement of which was deferred for 12 months in the 2014-15 Budget, but then cuts by nearly 25% the funds previously allocated for 2015-16 (from **\$200 million** to **\$155 million**). Moreover there is no certainty provided for future funding. Budget Paper 3 indicates that “Funding arrangements beyond 2015-16 are subject to negotiations with the states” – the usual modus operandi of the Abbott Government. The statement from the Minister for Health, Sussan Ley, released two days before the Budget, stated that “more than **\$200 million**” would be provided in the Budget for dental services in 2015-16.¹⁴ Her statement also referenced the Government’s White Paper on Reforming the Federation as providing an opportunity to greater co-ordination with less duplication. In this political environment that could well be read as the Abbott Government looking to divest itself of responsibilities for public dental services.

This provision is discussed further in the section in Dental Health.

The NP on Essential Vaccines provides funding to the States and Territories for the purchase of essential vaccines that are provided through the National Immunisation Program (NIP) and have not yet transitioned to centralized purchasing arrangements.

Under a COAG agreement, starting in 2009-10 the funding for the NIP changed from a Specific Purpose Payment (SPP) to a Commonwealth Own Purpose Expense (COPE) arrangement. The Commonwealth is responsible for the procurement and payment of NIP vaccines and the functions associated with implementation of the NIP remain the responsibility of the States and Territories. Funding for this is provided as part of the National Health Reform / Public Hospitals funding (see Table XX) but is no longer specifically stated. The 2013-14 Budget gave the total funding for the public health component of the NHR funding (this includes more than the vaccine service delivery function) as **\$365.3 million**.

¹⁴

[http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BD05EAE33B0B2F97CA257E410005BC65/\\$File/SL049.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BD05EAE33B0B2F97CA257E410005BC65/$File/SL049.pdf)

The Budget Paper state that over **\$400 million** in funding has been transferred to Commonwealth centralized purchasing arrangements since the 2014-15 MYEFO. It appears from this statement and a comparison of funding for this provision over the years since 2009-10 that little progress has been made to date in implementing the COAG agreement, which should enable significant price savings.

It is not clear what has happened since June 2015 to the NP for the National Coronial information System. This is paid to Victoria and has been in operation since at least 2008-09.

Like all the mental health programs, the NP on Supporting National Mental Health Reform and the programs and services it supports is without a known future. The Budget Papers make no comment on this.

The agreement documents for this NP highlight that the focus is to be on delivering improved health, social, economic and housing outcomes for people with severe and persistent mental illness by addressing gaps in services and preventing cycling through state mental health systems.¹⁵

¹⁵ http://archive.coag.gov.au/coag_meeting_outcomes/2012-04-13/docs/NPA_Supporting_NMHR.pdf

Hospitals and acute care

As previously noted (see section on State and Territory and Commonwealth relations), the Abbott Government is withdrawing from the Commonwealth commitment to sustainable public hospital funding, and to meeting an equal share of growth in public hospital costs.

While reports from the National Health Performance Authority¹⁶ highlight improvements in the targets set as part of the National Health Reform Agreements, this is still some considerable way to go before these targets are met by all hospitals in all jurisdictions, as the 2015 AMA Public Hospital Report card highlights.¹⁷ The likelihood of these targets being met is reduced by Commonwealth actions that reduce hospital funding and make access to primary care and specialist care and many PBS drugs more expensive.

It is ironic that the Independent Hospital Pricing Authority (IHPA) an independent government agency established by the Commonwealth as part of the *National Health Reform Act 2011*, to implement Activity Based Funding (ABF) for Australian public hospitals, has recently released a draft Pricing Framework 2016-17 for consultation.¹⁸ The expectation is that this will be implemented in 2016-17 as proposed by the previous Labor Government, only to be withdrawn in 2017-18 as proposed by the Abbott Government, which will also then abolish the IHPA.

Mersey Hospital - Tasmania

On 28 May 2015, a joint statement from the Federal Health Minister Sussan Ley and the Tasmanian Health Minister Michael Ferguson announced the Abbott Government would provide the Mersey hospital with operational funding of **\$148.5 million / 2 years**.¹⁹

Funding for the Mersey Hospital was due to run out on June 30. This statement leaves unresolved the issue of the future of this hospital, and whether it will return to state funding.

This is the only federally owned hospital in Australia, although it is operated by the Tasmanian Government. As the Howard government's health minister in 2007, Mr Abbott took over funding for the hospital from the Tasmanian Government. It followed public outrage at an announcement that the hospital would be downgraded to a day procedure centre, with only a limited overnight emergency facility.

¹⁶ <http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/Our-reports>

¹⁷ <https://ama.com.au/article/ama-public-hospital-report-card-2015>

¹⁸ <https://consultation.ihpa.gov.au/>

¹⁹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley064.htm>

The State Government has stated an intention to turn the Mersey into a state centre for elective day surgery but the local community wants to maintain a 24/7 emergency department and high dependency unit and maternity services.²⁰ While ever the future of the hospital remains firmly in the political cycle there will be doubts about its long-term future.

Royal Darwin Hospital

The 2015-16 Budget provides **\$63.5 million / 4 years** is provided through a new NP with the Northern Territory for the continued operation of the National Critical Care and Trauma Response Centre (NCCTRC) at Royal Darwin Hospital. The NCCTRC was announced after the 2002 Bali bombings and formally established in 2005. Its function is to ensure enhanced surge capacity for Royal Darwin Hospital to provide a rapid response in the event of a mass casualty incident in the region. To achieve this objective the NCCTRC has provided significant financial support (around **\$15 million / year**) to Royal Darwin Hospital to enhance the capability of the hospital's surgical and trauma divisions.

This provision is discussed in more detail in the Miscellaneous Section.

²⁰ <http://www.themercury.com.au/news/tasmania/federal-funds-to-flow-to-tasmanias-mersey-community-hospital-under-new-two-year-deal/story-fnj4f7k1-1227372244782>

Medicare

The Budget Papers show that Medicare expenditure is expected to exceed **\$21.1 billion** in 2015–16, an increase of 1.6% from 2014-15. Growth in Medicare expenditure to 2018–19 is expected to be 6.7% in real terms, which is below forecast growth in expenditure on the private health insurance rebate (7.0%), but higher than PBS growth (3.8%) over the same period

The Abbott Government’s policy on Medicare continues to be unknown and unknowable.

The 2014-15 Budget introduced co-payments for most GP visits and for out-of-hospital diagnostic imaging and pathology tests. This would for the first time remove bulk billing for these items. That this was a decision based on ideology rather than policy was indicated by the varying explanations provided for this action. It was variously sold as helping to address the budget emergency, ensuring the sustainability of Medicare, sending a price signal and reducing unnecessary health services.

In the 2014-15 MYEFO the Government moved to modify their proposal, with changes to rebates for Level A and B GP consultations and a \$5 reduction in rebates for GP consultations for non-concessional patients. This essentially placed the responsibility for a co-payment (or not) on doctors by diminishing their fees via the reduction in rebates and a freeze on rebate indexation and then allowing them to charge an optional patient co-payment. Not surprisingly, there was major opposition from doctors and patients alike.

Now, the Government has decided not to proceed with these measure (although the pause on indexation for doctors, allied health professionals and optometrists remains and is extended to 2018) – a decision that is expected to cost the Budget **\$2.9 billion** over the forward estimates, but will still achieve savings of **\$1.3 billion**.

A paper published in the Medical Journal of Australia in March²¹ found that the indexation freeze will cost GPs **\$384.32** per 100 consultations in 2017–18 dollars, requiring an **\$8.43** copayment per non-concessional patient consultation to maintain their current incomes. It predicted that even though the rebate reduction has been retracted, the freeze will have greater impact with time — nearly double the amount of the rebate reduction by 2017–18 – and the freeze may still force GPs who currently bulk bill to charge copayments as their practice costs rise. More recently, the second interim report from the Senate Select Committee on Health published similar findings and quoted the AMA as calling the indexation freeze ‘co-payments by stealth’.²²

There is some hope that Health Minister Sussan Ley’s recently announced review of all items on the Medicare Benefits Schedule (MBS) represents a new approach that will be more grounded in evidence and deliver some improved quality, safety and health outcomes. However there are also concerns about this review. It is required to review the 5,500 items currently on the MBS within a very short time frame, and while there is no savings target attached to the review, the Minister has indicated that any savings would go to the MRFF rather than to a restructure of MBS items (for example, to better reward

²¹ <https://www.mja.com.au/journal/2015/202/6/cost-freezing-general-practice>

²² http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Second_Interim_Report

coordinated care).²³ There needs to be an ongoing review of the MBS that considers items and their reimbursement in the light of new evidence and medical and technological progress. There is growing recognition through publications and the recently launched Choosing Wisely Australia program²⁴ that the MBS²⁵ and the PBS currently have many low-value items.

The AMA and others have spoken out about how current funding arrangements for general practice do not adequately encourage and reward team and community-based care and coordinated care and need to be overhauled. There is growing support for alternatives to the current fee-for-service model. Some GPs have acknowledged the tension between their professional aspirations to provide quality care, especially for patients with multi-morbidities and the demands of running a business.²⁶ Many of these issues could be addressed by applying savings achieved by disinvestment from low-value services to the proposals that will be developed by the Primary Health Care Advisory Group.

It remains to be seen if the Abbott Government is willing to embark on these initiatives which have the potential to deliver savings and needed reforms and make Medicare sustainable into the future.

Out of pocket costs

The issue of growing out-of-pocket (OOP) costs and their impact on the ability of Australians to access needed health care is undermining the universality of Medicare, widening health inequalities and arguably leading to increased hospital costs.

Currently, individual co-payments comprise around 17% of total health care expenditure in Australia – the largest non-government source of funding for health goods and services.²⁷ This includes where individuals meet the full cost of goods and services – for example, medications that are not subsidised by the PBS, health services not subject to a Medicare rebate – and where individuals share the cost of health goods and services with third party payers such as Medicare and private health insurance funds.

This contribution by individuals represents a higher proportion of health care funding than in most other

²³ <http://www.news.com.au/national/medical-research-future-fund-cure-for-cancer-delayed/story-fncynjr2-1227329143739>

²⁴ <http://www.choosingwisely.org.au/>

<http://link.springer.com/article/10.1007/s40273-015-0293-8>

²⁵ <https://www.mja.com.au/journal/2012/197/10/over-150-potentially-low-value-health-care-practices-australian-study>

²⁶ <https://ama.com.au/ausmed/providing-high-quality-care-doesn%E2%80%99t-pay>

²⁷

[http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~media/committees/clac_ctte/australian_healthcare/report.pdf](http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~/media/committees/clac_ctte/australian_healthcare/report.pdf)

OECD countries and equates to \$1,078 per capita. Moreover, in most OECD countries over the last decade the proportion of total expenditure coming from individual co-payments has been decreasing, while in Australia out-of-pocket expenditure on health per capita continues to grow at a faster rate than the broader economy, average incomes and overall household expenditure.²⁸

Measured in current prices, out-of pocket expenditure on health per capita has grown by 89.0% over the decade to 2011–12. In particular, total patient out-of-pocket expenses for primary and specialist care have significantly increased over the past 10 years, rising from \$9.7 billion in 2001–02 to \$17.1 billion in 2011–12, a 76% increase.²⁹ The average cost of a GP visit in 2013-14 was \$47 from Medicare plus \$5 from the patient. For a private specialist, the average visit cost \$82 from Medicare plus \$38 from the patient.³⁰

About one-third of individuals' out-of-pocket costs go for medicines, and although this includes nutritional supplements and 'complementary' and 'alternative' medicines, the out-of-pocket costs of essential over-the-counter and prescription medicines is also rising.³¹

While these figures give a general guide to medical OOP costs, it is important to understand that in health care there are few 'average' patients. That is because health care usage (and health care costs) are not evenly distributed across the population. Increasing numbers of Australians are incurring high OOP costs on a regular basis, due to factors such as their location, type of illness and the availability of public health care services.

People with chronic illnesses and disabilities use health care much more often than the rest of the population and the increase in out-of-pocket costs falls disproportionately on this group, which already has a lower average income, thus compounding their financial disadvantage. So begins a vicious cycle, where those with poor health and fewer financial resources must pay proportionately more out-of-pocket for their needed care, meaning they often go without.

The Abbott Government has pushed to introduce or increase co-payments, claiming variously that growth in health care costs is unsustainable, price signals are needed to reduce GP visits, budget deficits must be addressed and increased funding is needed for medical research. But targeting primary care for cost savings will quickly backfire. Research shows that while the number of GP visits has increased, these services are cost-effective; if the same services were performed in other areas of the health care system, they would cost considerably more.³²

²⁸ Ibid

²⁹ Ibid

³⁰ <http://johnmenadue.com/blog/?p=2922>

³¹

[http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~media/committees/clac_ctte/australian_healthcare/report.pdf](http://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/australian_healthcare/~/media/committees/clac_ctte/australian_healthcare/report.pdf)

³² http://ses.library.usyd.edu.au/bitstream/2123/11883/4/9781743324240_ONLINE.pdf

The World Health Organisation has highlighted some of the potential negative consequences of co-payments, including the fact that they are the least equitable form of health funding because they are regressive (the rich pay the same amount as the poor for any particular service).³³ There is now a raft of Australian reports highlighting the adverse impacts of co-payments.³⁴

It is clear that whether the policy focus is on economic, health or social equity outcomes, greater attention needs to be paid to tackling rising out-of-pocket costs. With our ageing population and rising rates of chronic conditions, we can expect that there will be increasing numbers of Australians requiring long-term health and medical care from a range of different providers and in both hospital and community settings. Our current health care financing systems and safety-net arrangements are inadequate in meeting the needs of this group to ensure they can manage their health care costs and afford the services they need.

This is a difficult topic – it involves a potent mix of evidence, ideology, consultation and leadership. There is no silver bullet and effective solutions are unlikely to be found through simple ‘add ons’ to our current health funding system, developed in an age where the majority of health care was for short-term, acute problems. They are more likely to involve a multi-faceted approach and require a re-thinking of the ways in which we generate and allocate our health care resources and ensure health care funding decisions reflect our society’s underlying values.

Work in this important area has barely begun, probably because in the absence of truly universal health care, it’s a wicked problem to solve, involving a potent mix of evidence, ideology, consultation and leadership. There is no silver bullet and effective solutions are unlikely to be found through simple ‘add ons’ to the current health funding system, developed in an age when the majority of health care was for short-term, acute problems. A multi-faceted approach is required, based on evidence and need and reflecting our society’s underlying values.

It is important that policies target those with the largest out-of-pocket costs and those who have problems affording their essential health care expenses. These are not necessarily people on the lowest incomes or people with concession cards. The increasingly high thresholds mean many people with complex medical needs can’t afford to reach the protections of the safety nets. Simply carving out exclusions on the basis of age or concessional status risks shifting costs to other vulnerable groups, thus widening inequalities and increasing preventable health problems.

In addition, tackling over-testing, inappropriate prescribing and unwarranted variation in health care services is needed, together with a concerted effort to identify low-value health care practices and incentives to encourage disinvestment in these. These efforts will not necessarily address patients’ out-of-pocket costs directly, but will ensure better value for the health care budgets of both individuals and governments.

If new policies are to be sound and publicly accepted, they must be underpinned by work to establish what the public wants and to better engage Australians in the current debate over health care costs, by establishing who bears the burden of unmanageable out-of-pocket costs, and by consultation with

³³ <http://apps.who.int/medicinedocs/en/d/Js4912e/3.4.html>

³⁴ The most recent of these are summarised at Russell L. Analysis of 2014-15 Health Budget: Unfair and unhealthy. <http://ses.library.usyd.edu.au/bitstream/2123/11981/1/2014-15healthbudget.pdf>

health care professionals at the coal face about how they see this issue from both a business and a health outcomes perspective.

It is ironic that the last time an Australian government moved to tackle out-of-pocket costs was when Tony Abbott was Minister for Health and introduced the Extended Medicare Safety Net to cover rising specialists' fees. However this approach was recognisably flawed from the beginning and quickly led to inappropriate fee increases by some specialists. Successive governments have been forced to tinker with the policy to limit cost blow-outs; none has been willing to address the fact that the majority of safety net benefits flow to the most well-off Australians. It was no surprise that this policy failed to deliver on the expected outcomes and had unintended negative consequences and it serves as a lesson for future policy-makers.

To kick-start the necessary analyses, debates and policy formulations, Jennifer Doggett and I have developed a discussion paper which lays out the issues, as we see them.³⁵

Solutions might be drawn from initiatives that make better, more cost-effective use of the various skills of the health care workforce, by a reconsideration of when the GP gatekeeper role is essential, by transparency around specialist fees, perhaps even shaming those whose fees are significant outliers, and through the establishment of community health centres with salaried staff in areas of need. For people who are recognised as having ongoing high health care costs, reduced co-payments and out-of-pocket costs could be linked to voluntary registration with a general practice and a pharmacy, thus also ensuring greater coordination and continuity of care.

We are well aware that these proposals for addressing out-of-pocket costs will be seen as controversial by some. The paper is admittedly short on solutions, but we are hopeful these will come. Our purpose is to galvanise thought, evidence and action to address this key issue of fairness and equity. There is no shortage of collated evidence and expert advice available to drive policy development – all that is needed is leadership.

Budget provisions

Medicare Benefits Schedule – reversal of changes to GP rebates

Savings of **\$2.99 billion / 5 years** are foregone by the Abbott Government's decision not to proceed with the changes to rebates proposed in December 2014 and costed in the 2014-15 MYEFO.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	182.7	657.8	699.0	726.5	762.8
DVA	3.5	6.4	6.0	5.7	5.4
DHS	-4.7	-18.3	-13.4	-13.9	-14.2
Total	181.4	645.9	691.6	718.3	754.1
<i>Related capital DHS</i>	<i>-0.3</i>	<i>-0.2</i>	<i>-</i>	<i>-</i>	<i>-</i>

³⁵ <http://ses.library.usyd.edu.au/handle/2123/12659>

However it appears that the Government is still achieving savings of some **\$1.3 billion** over the years 2014-15 to 2017-18. This may be explained by inclusion of the savings from the freeze on Medicare rebates – although these were costed separately in previous budgets.

As originally proposed in the 2014-15 Budget this policy – then touted as a patient copayment - was set to save **\$3.5 billion / 5 years**.

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-	1.4	-1,164.4	-1,181.6	-1,226.8
DHS	0.2	7.4	34.2	28.6	26.0
Total	0.2	8.8	-1,130.2	-1,153.0	-1,200.8
<i>Related capital DHS</i>	-	5.4	2.4	-	-

From 2014-5 Budget

In the face of major opposition to this proposal, in December 2014 the Prime Minister announced that the \$7 Medicare co-payment would not proceed.³⁶ Under the new proposal Medicare rebates for common GP consultations would be reduced by \$5 for non-concessional patients aged 16 and over from 1 July 2015. The Government stated that “Doctors may choose to recoup the \$5 rebate reduction through an optional co-payment or continue to bulk bill non-concessional patients over the age of 16”, describing this as an ‘optional copayment’.

At the same time, changes were made to the standard GP consultation items and Medicare fees for all services provided by GPs, medical specialists, allied health practitioners, optometrists and others will remain at their current level until July 2018.

It was stated that these changes would contribute more than **\$3 billion** to the Medical Research Future Fund.

MYEFO 2014-15 provided new costings for this policy over the forward estimates.

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-	-183.1	375.9	50.9	-248.7
DHS	-	2.1	-12.9	-12.7	-11.5
Total	-	-181.1	363.0	38.2	-260.2

From MYEFO 2014-15

It is assumed then that the total savings from this policy are derived by subtracting the MYEFO figures from the Budget figures. This would deliver savings of the order of **\$3.5 billion**.

³⁶ <https://www.pm.gov.au/media/2014-12-09/strong-and-sustainable-medicare-0>

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
Total	0.2	-172.3	-767.2	-1115.0	-1461.0

Derived by subtracting MYFO expenses from 2014-15 Budget expenses

Medicare Benefits Schedule – modification of health assessment items

Savings of **\$144.6 million / 4 years** are made by removing the current duplication between health assessments under MBS and health assessments provided by the States and Territories. The savings are directed to fund other health policy priorities or to the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DHS	-	0.1	-0.2	-0.2	-0.2
DoH	-	-20.0	-36.2	-41.3	-46.7
Total	-	-19.9	-36.3	-41.4	-46.9

Medicare currently funds the Healthy Kids check for children who have received, or are receiving their four-year-old immunisation. A number of States offer similar child health checks. For example, the Victorian Government funds free regular health and development checks at Maternal and Child Health centres for children up to the age of three and a half.

A child health check is required in order to qualify for the FTB Part A Supplement.³⁷ Both the Medicare Healthy Kids check and State and Territory child health checks meet this requirement.

Details of what the revisions to health assessments will be are not provided in the Budget, but some information was provided in Senate Estimates. The ability to bill for a Health Check for kids aged 0-4 under MBS items 701 (brief), 703 (standard), 705 (long), and 707 (prolonged) will be removed on the assumption that most services provided under these items for this age group are Healthy Kids checks. GPs who continue to provide these services must bill for a standard GP consult. The current reimbursement for item 703 (the most popular) is **\$137.90** and the reimbursement for a standard GP consult is **\$37.05**. This will likely mean additional costs for parents who cannot access State and Territory services.

Indigenous children will continue to be eligible for the Aboriginal and Torres Strait Islander health assessment every nine months under MBS item 715. It is not clear what happens to item 10986 (provision of a health check by a Practice Nurse or an Aboriginal Health Worker).

Senate Estimates was told that State and Territory child health checks provided a more comprehensive health assessment (this could not be verified) and that the Government only has payments data for the provision of these checks, and does not have any information about subsequent referrals. DoH gave the following data: in 2008-09 37,924 services were provided at a cost of **\$1.73 million**; in 2013-14 157,680

³⁷ <http://www.humanservices.gov.au/customer/enablers/centrelink/family-tax-benefit-part-a-part-b/healthy-start-for-school-health-check>

services were provided at a cost of **\$20.52 million**. The estimate was that 53% of the eligible population had received a Healthy Kids check (it is not clear if this applies to Medicare data or to FTB-A Supplement data, but presumably the former).

Medicare Australia data show that for children aged 0-4 years in 2013-14 137,004 services were provided at a cost of **\$17.65 million**. This includes services provided under item 10986. The differences between these data and DOH are not known. Also it is not clear why savings over the forward estimates makes the bold assumption that 100% of eligible kids would get this service over the next 4 years when uptake of this item has been relatively slow.

New and amended listings on the Medicare Benefit Schedule

The addition of new and amended items to the MBS and to Veterans' Benefits will cost **\$39.8 million / 4 years**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	8.4	11.3	9.9	8.4
DVA	-	0.3	0.4	0.3	0.3
DHS	-	0.2	0.1	0.1	0.1
Total	-	8.8	11.8	10.3	8.8

The new and amended listings include:

- Rebates for second expert opinions for diagnoses related to the testing of bone marrow specimens, tissue pathology and cytopathology/
- New items for the treatment of early stage breast cancer using targeted intraoperative radiotherapy.
- New items to enable routine monitoring of implanted cardiac devices to be provided remotely.
- Extended eligibility for the use of telehealth services to optometrists, to support patients use of video consultations with specialist ophthalmologists.

Revised listings include:

- Paediatric surgical services
- Computed tomography colonography

It is assumed that these revised listings generate savings.

The total cost of these items is more than offset by savings of **\$287.80 / 4 years** taken in MYEFO from new and amended MBS items.

Review and reform of the Medicare Benefits Schedule

\$34.3 million / 2 years is allocated for review of the MBS items and to continue the activities of the Medical Services Advisory Committee (MSAC).

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	17.0	17.3	-	-

The current funding levels for MSAC for MBS review work is of the order of **\$9.5 million / year**.

Currently, the MBS has more than 5,500 services listed, not all of which reflect contemporary best clinical practice. Health Minister, Sussan Ley, has announced an MBS Review Taskforce that will consider how MBS services can be aligned with contemporary clinical evidence and improve health outcomes for patients.³⁸ The Health Minister has said the Government's proposed reforms would be "an ongoing process" (although funding is only provided for two years) and that the taskforce is expected to report back "with key priority areas for action" in late 2015. Barely 3% of items on the MBS have been properly assessed against contemporary evidence for safety, effectiveness and cost effectiveness so this is a large task.

In the 2009-10 Budget, Labor initiated an independent systematic review of MBS items via an MBS Quality Framework and **\$9.3 million / 2 years** was provided for this work. In 2011 the decision was made to refer all applications for new MBS items, as well as significant amendments to existing items, to MSAC as the sole source of expert appraisal and advice to ensure consistency and administrative efficiency. The 2011-12 Budget provided funding of **\$11.4 million / 2 years** and further funding of **\$19.6 million / 2 years** was provided in 2013-14 to enable MSAC conduct rolling reviews of the quality, safety and fee levels of items listed on the MBS.

The work of experts under this Framework is complicated and protracted³⁹ but has resulted in changes to MBS item rebates. Some occurred with little notice such as changes to Vitamin D testing, while others attracted significant attention, as was the case with changes recommended to the rebate paid for cataract surgery.

Labor has supported this review, with Shadow Minister for Health, Catherine King saying; " This is good, and smart health reform, based on evidence, quality and safety in healthcare. It is not about rationing healthcare but ensuring informed decisions on the part of both doctors and patients about the best approaches."⁴⁰

³⁸ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley045.htm>

³⁹ <https://www.chf.org.au/pdfs/chf/Presentation-DoHA-MBS-Quality-Framework-workshop-25May2010.pdf>

⁴⁰ <http://www.theguardian.com/commentisfree/2015/apr/16/reviewing-medicare-benefits-should-be-an-act-of-reform-not-saving-for-savings-sake>

The linking of MBS item review and reform to a complimentary review of primary care and the development of clearer Medicare compliance rules and benchmarks⁴¹, combined with the independent work of Choosing Wisely Australia, offers exciting possibilities for meaningful reforms. *However there remain* concerns that the Abbott Government will use the review as a mechanism to cut Medicare funding rather than an opportunity for needed reform.

Medicare After Hours Practice Incentive Program

More than **\$410 million / 4 years**, including **\$98.8 million** in 2015-16 are provided for a new After Hours Practice Incentive Program (AH PIP). These funds are redirected from the After Hours GP Helpline which is cancelled and the Medicare Locals After Hours Program.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	-1.8	-0.2	-0.3	-0.3
DHS	1.5	0.2	0.2	0.3	0.3
Total	1.5	-1.5

It is not clear if this funding also covers the provision of After Hours care by PHNs where this is needed.

The new PIP is based on recommendations from the After Hours Primary Health Care Review.⁴² It provides five separate payment levels, with quarterly payments:⁴³

- **Tier 1** - \$1 per Standardised Whole Patient Equivalent (SWPE) for a formal arrangement to ensure that practice patients have access to care in the complete after-hours period (eg a phone arrangement with a locum service).
- **Tier 2** - \$4 per SWPE for participating in a cooperative arrangement with other practices cover the sociable after-hours period (6pm–11pm weeknights) and making formal arrangements for patients at other times.
- **Tier 3** - \$5.50 per SWPR for the provision of direct care of practice patients during the sociable after-hours period of 6pm–11pm weeknights, with formal arrangements for a substitute service in place for other times.
- **Tier 4** - \$5.50 per SWPE for practices that cooperate to provide after- hours care to practice patients for the complete after hours period (hours outside of 8am to 6pm weeknights; hours outside of 8am to 12pm Saturdays; and all day Sundays and public holidays).
- **Tier 5** - \$11 per SWPE for practices directly providing round-the-clock care.

The new after-hours regime allows more flexibility by including GP telephone advice and telehealth services, as well as home visits and in-practice consultations.

⁴¹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-lev045.htm>

⁴² <http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc-review>

⁴³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/primary-ahphc#pip>

The top payment under the new AH PIP for round-the-clock coverage that is more than five times the \$2 flat rate (per weighted average patient) offered under the previous PIP. It remains to be seen if this more generous incentive will encourage more GPs to provide full after hours services.

The DoH website says that PHNs will receive funding to work with key local stakeholders to plan, coordinate and support after- hours services and ensure these are targeted to the specific needs of different communities. It is not clear if this applies to all PHNs or to those where there are gaps in after-hours service provision.

The Jackson After-Hours Review found that the main factor driving the increase in after-hours MBS claims over the four-year period to 2013 was non-urgent consultations on practice premises on weeknights, mostly in urban areas in the country's east and southeast. Another conspicuous driver of growth was in services by medical deputising services, in many cases backed by Medicare Locals. There was considerable opposition to these services from the AMA.

The After Hours GP Helpline (AHGPH) will cease operations June 30, 2015. The Jackson review identified a number of issues with the AHGPH but acknowledged that a full cost-benefit analysis of the Helpline had not been conducted. Now all the efforts put into public awareness of this service will be lost, leaving some consumers bewildered.

Many PHNs are not yet functional, and uptake of the new PIP is likely to be slow initially: this could leave a gap period where many communities are without functioning after- hours services. The impending transition from MLs to PHNs may stifle opportunities for collaboration in the establishment or expansion of after-hours services, especially in the initial period of operation.

Other Medicare issues

Medicare indexation freeze

The Government is freezing the indexation of Medicare rebates for four years from 1 July 2014 until July 2018. GP and specialist fees have been frozen since 1 November 2012, except for the on-off indexation of GP consultations by 2% on 1 July 2014. Medicare rebates for pathology and diagnostic imaging services have not increased for more than 15 years.

As previously noted, this cut to health professionals' reimbursements will inevitably be passed on to patients and private health insurers, ensuring that increases in out-of-pocket costs and higher private insurance premiums. It will also act to reduce bulk billing rates.

Medicare compliance rules

The Minister for Health has indicated, as part of the announcement on MBS review and the Primary Health Care Advisory Group, the intention to develop clearer Medicare compliance rules and benchmarks.⁴⁴ These will be developed in consultation with representatives from the medical profession, clinical leaders and patient representatives.

⁴⁴ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-lev045.htm>

The aim is to ensure that medical practitioners are not providing inappropriate services. The Minister for Health has indicated that the government is determined to prevent over-testing, duplication in service provision and “unnecessary referrals, duplication, inefficiencies and systemic waste.”

Alternative funding models

The Royal Australian College of General Practitioners (RACGP) has put forward an alternative funding model to standard fee-for-service that would reward GPs for treating complex patients, providing comprehensive services, and co-ordinating care between different healthcare providers.⁴⁵

While fee-for-service would be retained for ‘every day’ care, a range of new payments that are patient-focussed not disease and process focussed would replace existing Practice Incentive Payments and Service Incentive Payments.

The aim is for an Australian version of a patient-centered medical home, with patient enrolment to formalise relationships between patients and their GP.

Practices would receive a payment for each patient enrolled with it, based on their patients’ age, socio-economic status, whether they were Indigenous, and the local community’s health profile. There would also be rewards for working in rural and remote areas. These payments would address complexity, coordination of care and help reduce health inequalities.

Those practices that delivered a wide range of services, such as after-hours services, home care, palliative care and aged care in the community would be eligible for a new “comprehensiveness payment”. GPs or practices could also receive payments to co-ordinate the care of their patients between different health providers, to employ nurses, teach students, conduct research, and upgrade or maintain IT and infrastructure.⁴⁶

The plan does not identify the cost of the changes.

⁴⁵ <http://www.racgp.org.au/download/Documents/advocacy/Consultation-paper-RACGP-Vision-for-a-sustainable-health-system-14-A.pdf>

⁴⁶ <http://www.racgp.org.au/download/Documents/advocacy/Executive-Summary-RACGP-Vision-for-a-sustainable-health-system-14-Ap.pdf>

Pharmaceutical Benefits Scheme

The Australian Government provides subsidised medicines through the Pharmaceutical Benefits Scheme (PBS). In 2015-16 the PBS is expected to cost **\$9.77 billion** and to dispense approximately 298 million scripts.

Budget paper 1 outlines the trends in major components of the PBS over the forward estimates (see Table 6). However this table does not include the costs of the 6th Community Pharmacy Agreement (6th CPA)⁴⁷ and the costs and savings of the PBS Access and Sustainability Package⁴⁸ which were announced shortly after the Budget.⁴⁹

Table 6: Spending on Pharmaceutical Benefits Scheme 2014-15 to 2018-19

	Estimates			Projections	
	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Pharmaceutical benefits (concessional)	5,657	5,735	5,957	6,137	6,315
Pharmaceutical benefits (HSD, other hospital drugs)	2,213	2,601	2,809	2,965	3,072
Pharmaceutical benefits (general)	1,414	1,434	1,489	1,534	1,580
Pharmaceutical benefits (targeted medicine prgms)	148	114	106	113	115
Immunisation	180	273	309	315	314
Pharmaceutical benefits (Veterans)	388	369	376	389	402
Payments for wholesalers and pharmacy prgms	342	344	347	350	354
Other	265	268	272	278	284
Total	10,607	11,138	11,667	12,081	12,439

From 2015-16 Budget Paper 1 Table 8.2

Comparison of this Table as presented with 2014-15 Budget data shows projected increases in spending (see Table 7). The main variations seem to be significant increases in the cost of drugs dispensed through hospitals and payments to wholesalers and pharmacists.

This latter issue bears some investigation. This covers funds initially provided as part of the 2007 PBS Reform package when both pharmacists and wholesalers were given significant compensation

⁴⁷ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-lev053.htm>

⁴⁸ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-lev063.htm>

⁴⁹ 2015-16 Portfolio Budget Statements, Health portfolio page 57

arrangements. Pharmacists receive a payment (initially \$1.53 and indexed annually) for dispensing of 'premium free' medicine. As pointed out in a brief from the Parliamentary Library, this payment essentially provides pharmacists additional income for a task which is already remunerated by the dispensing fee.⁵⁰ (Note: as described in the following section, savings have subsequently been taken from this payment by a measure in the proposed PBS Access and Sustainability Package). This funding likely also includes the wholesaler Community Service Obligation (CSO) pool.

There is a projected decrease in the cost of targeted medicine programs. This includes the Special Access Program for Herceptin and the Life Saving Drugs Program which is currently under review. This review is expected to be completed in late 2015.

Table 7: Spending on Pharmaceutical Benefits Scheme 2014-15 to 2018-19

	Estimates			Projections	
	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
Pharmaceutical benefits (concessional)	5,641	5,512	5,564	5,852	6,040
Pharmaceutical benefits (HSD, other hospital drugs)	2,208	2,358	2,452	2,595	2,715
Pharmaceutical benefits (general)	1,410	1,378	1,391	1,463	1,510
Pharmaceutical benefits (targeted medicine prgms)	138	148	154	158	163
Immunisation	156	154	159	160	164
Pharmaceutical benefits (Veterans)	406	390	368	376	390
Payments for wholesalers and pharmacy prgms	368	406	402	401	401
Other	192	201	204	204	206
Total	10,519	10,547	10,693	11,209	11,589

From 2014-15 Budget Paper 1 Table 8.2

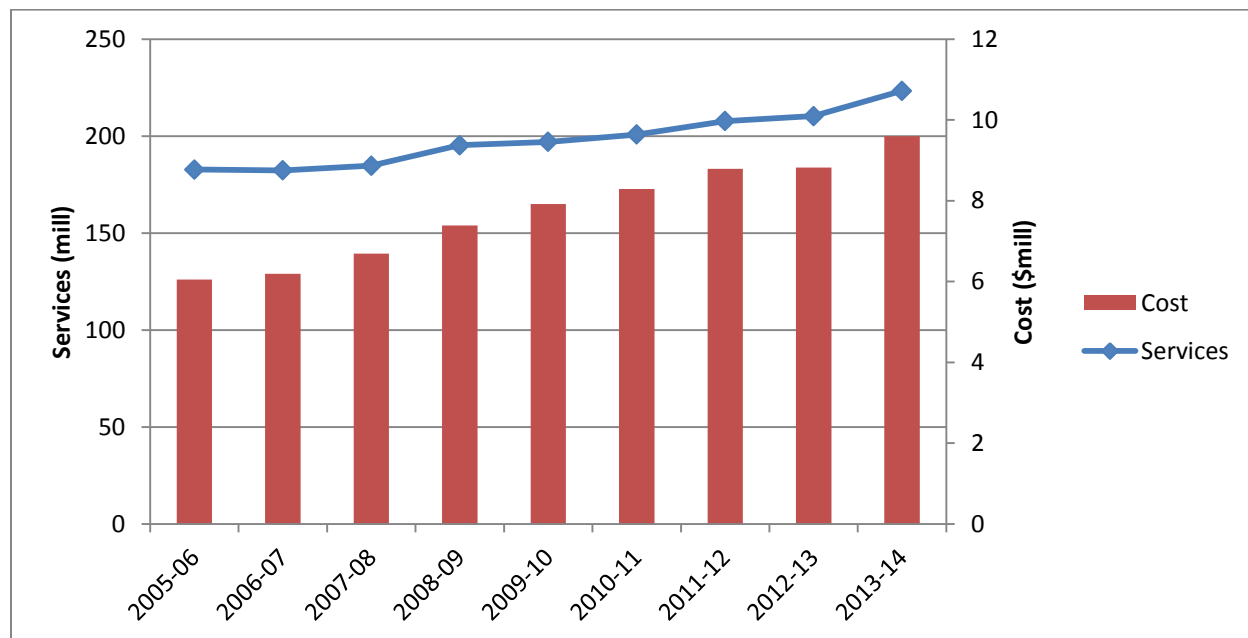
Since 2005, when PBS copayments were substantially increased, the average rate of growth of the PBS has slowed substantially (see Figure 3). Between 1994–95 and 2004–05, the cost of the PBS grew by nearly 13% each year but the average annual growth rate from 2005–06 to 2013–14 was 4.86% and

⁵⁰

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201011/HealthPharmaceuticals

future growth rates appear to be of this order or less. This slowing of growth in PBS expenditure has been attributed to the impact of various pricing policies introduced since 2005.⁵¹

Figure 3: PBS costs and services 2005-06 to 2013-14



Data from Medicare Australia

Every Budget the Government of the day makes much about the new medicines listed on the PBS and uses this as the rationale for continuing budget cuts and copayment increases in this area. Many of the new drugs listed are very expensive and often quite specialised medicines. The therapeutic category for anti-neoplastics and immuno-modulators (which includes cancer drugs) is the fastest growing category of the PBS. This is highlighted in Figure 4.

Since 2005-06 the cost of this category of drugs has increased by over 260% compared to 59% for the PBS as a whole. In this time frame the average cost of a prescription for these drugs has risen from \$478.30 to \$768.80.

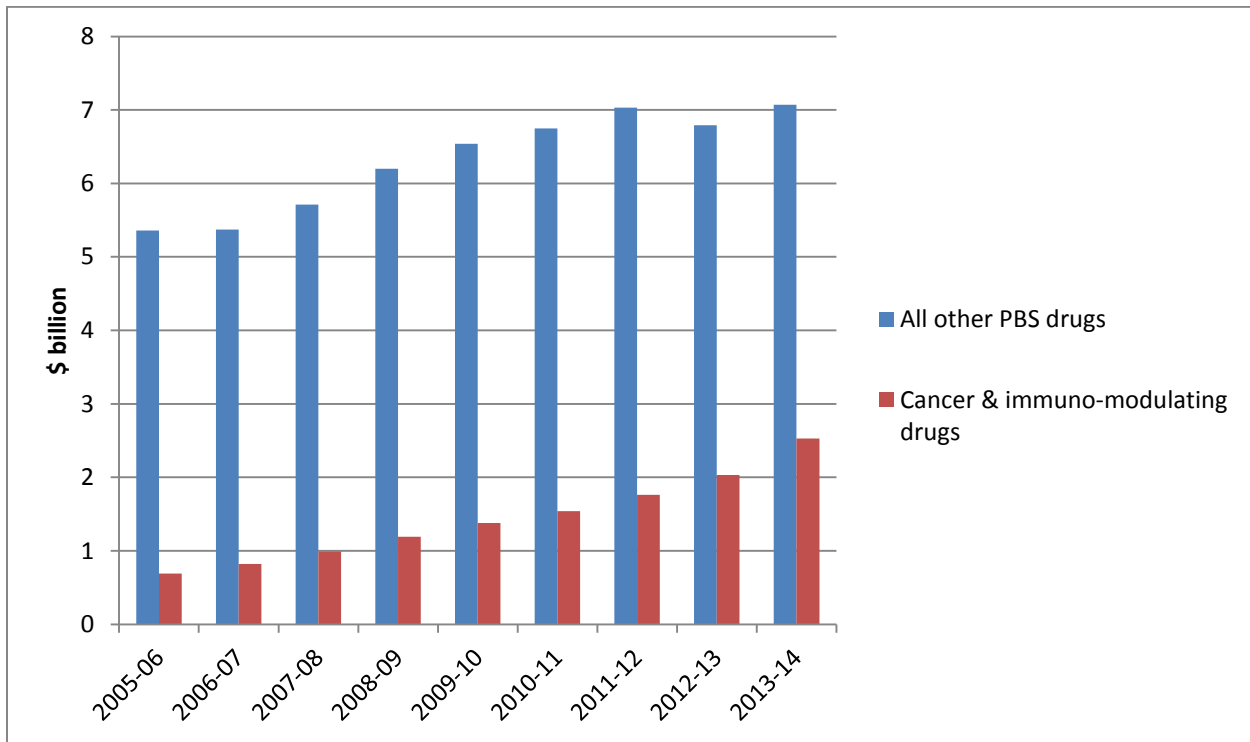
In December 2014, the Senate referred the matter of the availability of new, innovative and specialist cancer drugs to the Senate Community Affairs References Committee for inquiry and report.⁵² The report is due June 2015.

⁵¹

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1415/ExpendCostDrugs

⁵² http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Cancer_Drugs

Figure 4. Cost of cancer drugs to the PBS



Data from Medicare Australia

The Portfolio Budget Statements indicate that, beginning 1 July 2015, the Government will introduce a “balanced range of measures” that have been developed through consultation with PBS stakeholders to support the sustainability of the PBS. Media reports prior to the budget indicated that the Abbott Government would seek up to **\$5 billion** of savings over four to five years from reimbursements paid to pharmaceutical companies and pharmacies.⁵³

However these savings are not included in the Budget Papers. The major PBS savings in the Budget come from the retention of the provisions to increase PBS copayments and the threshold for the PBS safety net which were proposed in last year’s Budget. However within a few days of the Budget release, Health Minister Sussan Ley announced that she would not proceed with these changes, leaving a **\$1.3 billion** hole in the budget (and in funding for the MRFF).

The actual status of these savings as Government policy remains uncertain. At Senate Estimates Assistant Health Minister Fiona Nash said that these savings remained on the table until other, comparable savings could be found.

⁵³ Tingle L Abbott set for war with pharmacists. *Australian Financial Review*, 5 May 2015, p. 6.

The Pharmaceutical Benefits Access and Sustainability Package

On May 27 Health Minister Sussan Ley announced the promised Pharmaceutical Benefits Scheme (PBS) Access and Sustainability Package of reforms that the Government estimates to achieve **\$6.6 billion / 5 years** in PBS savings.⁵⁴

This Package encompasses:

- The **\$18.9 billion** 6th Community Pharmacy Agreement, which had been previously announced on 18 May 2015.
- **\$6.6 billion** in savings from what are described as “efficiencies throughout the PBS supply chain”.
- **\$2.8 billion** in additional funding support for the pharmacy sector
- A Strategic Agreement with the Generic Medicines Industry Association (GmiA)
- A Strategic Agreement with Medicines Australia was heralded ‘in principle’.

Key measures in the package include:

- Reduction by as much as 50% in prices of generic medicines made by removing the originator brand from pricing calculations (**\$2 billion** in savings).
- Allowing pharmacists to offer consumers a discount of up to \$1 per script on the price of the PBS co-payment (**\$360 million** in savings).⁵⁵
- Reworking the premium-free dispensing incentive so it only applies when there is a premium charged for another brand of the same medicine. This should support the better uptake of generic medicines. (**\$560 million** in savings).
- Price reductions on F1 formulary medicines (those protected by patents), with a 5% reduction in the price of on-patent medicines that have been listed for five years or more on the PBS (**\$1 billion** in savings).
- Extension of the existing safety net 20 day rule to a broader range of PBS medicines to discourage waste (**\$475 million** in savings).
- **\$20 million** awareness campaign to support the increased use of biosimilars (**\$880 million** in savings).
- Closing loopholes around the way combination drugs are subsidised under price disclosure reductions (**\$610 million** in savings).
- Removal of some comparatively low-cost over-the-counter medicines from the PBS, as recommended by the PBAC (**\$500 million** in savings).
- A new handling and infrastructure fee to pharmacists that will restore pharmacist remuneration to average levels provided under the previous 5th Community Pharmacy Agreement (**\$1.5 billion** in costs).⁵⁶

⁵⁴ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley063.htm>

⁵⁵ This was announced as part of the 6th CPA.

⁵⁶ This was announced as part of the 6th CPA.

- A doubling of investment in pharmacy-run primary care programs, which must be ‘scrutinised’ by MSAC to ensure they are evidence-based and cost-effective (up to **\$1.23 billion** in costs).⁵⁷
- An independent review of pharmacy remuneration and location rules to be undertaken during the first two years of the 6th CPA.⁵⁸

The hit to the pharmaceutical industry (**\$6.6 billion**) is in stark contrast to the funding going to pharmacy which now totals some **\$20 billion**.⁵⁹

The legislation to enact this package was enacted by the Australian Parliament on 23 June 2015.

Strategic Agreement with Medicines Australia

The Government’s proposed Strategic Agreement with Medicines Australia has collapsed. Medicines Australia put forward a proposed Strategic Agreement which met all aspects of the Letter of Intent signed by the Minister for Health on 27 May.⁶⁰ However on June 23 it was announced that, the Minister had closed down the negotiations and would not sign the proposed Agreement.⁶¹ An alternate view is that Medicines Australia rejected the Agreement.⁶² It is assumed that the disagreement is because the Minister needs to find additional savings over the \$6.6 billion agreed to, and that would mean a different approach to the prices of F1 drugs and the approval of biosimilars than that on the table.⁶³

6th Community Pharmacy Agreement

Since 1990 Commonwealth Governments have entered into and funded successive five year community pharmacy agreements, at a cost to date of over **\$45 billion**. These ensure a network of approximately 5460 retail pharmacies which are the primary means of dispensing PBS medicines to the public. These agreements are also used to fund professional programs and to provide a funding pool for the pharmaceutical wholesalers that supply PBS medicines to retail pharmacies.

On average Australia’s 5371 pharmacies each earn \$650,000 a year from dispensing medicines under the Pharmaceutical Benefits Scheme. This compares to the \$195,000 GPs earn on average from Medicare.

⁵⁷ This was announced as part of the 6th CPA. Only \$600 million of this is new funding.

⁵⁸ This was announced as part of the 6th CPA.

⁵⁹ Note: CHF says total is \$23 billion. See <https://www.chf.org.au/pdfs/chf/Media-Release---Pharmacy-agreement-offers-pills-with-a-sugar-coating.pdf>

⁶⁰ <https://medicinesaustralia.com.au/wp-content/uploads/sites/52/2015/03/20150527-SIGNED-FINAL-Letter-of-Intent-Medicines-Australia-260515.pdf>

⁶¹ http://www.aph.gov.au/Parliamentary_Business/Bills_LEGislation/Bills_Search_Results/Result?bld=r5462

⁶² <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-lev077.htm>

⁶³ <https://medicinesaustralia.com.au/media-release/health-minister-abandons-strategic-agreement-with-medicines-australia/>

The recently announced 6th Community Pharmacy Agreement (CPA) costs **\$18.9 billion / 5 years**, an increase of **\$3.5 billion** over the cost of the previous CPA. As shown in Table 8, all of this increase in funding goes to pharmacy for increases in dispensing and handling fees and new programs to deliver primary care services.

Table 8. Spending in Fifth and Sixth Community Pharmacy Agreements

Provision	5 th CPA	6 th CPA
Pharmacy remuneration	\$13.8 billion	\$16.7 billion
Professional programs	\$663 million	\$613 million
Pharmacy Trial program		\$50 million
Additional funding for primary care programs		Up to \$600 million
Wholesalers CSO	\$950 million	\$950 million
Total	\$15.4 billion	\$18.9 billion

Key provisions include:

Fees

- Introduction of an Administration, Handling and Infrastructure (AHI) fee to replace the existing pharmacy mark-up system. This delinks pharmacy remuneration from the variability in medicines prices brought about by price disclosure. (Cost \$1.5 billion).
The value of this fee from 1 July 2015 will be:
 - Where the approved price to pharmacist (wholesaler PBS list price) is up to \$180.00: \$3.49 per prescription
 - Where the approved price to pharmacist is between \$180.00 and \$2,089.71: \$3.49 plus 3.5% of the amount by which the price exceeds \$180
 - Where the approved price to pharmacist is \$2,089.71 or above: \$70.00
- The Premium-Free Dispensing Incentive (PFDI) will increase by 4 cents to \$1.72 but will apply to a smaller number of prescriptions than it does currently. The PFDI will no longer apply when there is not a brand premium on any substitutable brand of the item but the funding removed from the PFDI as a result of this change has been transferred into the new AHI Fee.
- The Dangerous Drug Fee will increase by 20 cents to \$2.91. This is the first increase in this fee since 2006.
- For prescriptions where the cost is under the co-payment (primarily for non-concessional patients), the AHI fee will apply. In addition, pharmacists may charge (at their discretion) the following allowable fees:
 - Safety Net Recording Fee: \$1.17 (up from \$1.15 currently)
 - Additional allowable fee: \$4.27
- Once systems are established, pharmacies will be required to transmit through PBS Online the price charged for under co-payment prescriptions.
- In addition to all fees that apply to ready-prepared items (including the new AHI Fee), an additional fee of \$2.04 will apply for extemporaneously prepared dispensing.
- All fees will be indexed annually by the official Consumer Price Index. Previously fees were indexed by the lower WCI9.

- DoH and the Pharmacy Guild will conduct an annual reconciliation of total actual versus estimated total community pharmacy and wholesaler remuneration, comparing actual PBS and RPBS prescription volumes with the estimates included in the 6th CPA document. If there is a material difference between actual volume and estimated volume, a risk sharing arrangement may be implemented to address the variance.

Option to discount consumer copayment

Pharmacies will have the option to discount the patient-co-payment by up to \$1. The intent is that this measure will deliver pharmacists greater flexibility to be able to compete on price and quality, while saving taxpayers a potential **\$360 million / 5 years**. It remains to be seen if these savings will result.

Chemotherapy

Changes will be made to the structure of remuneration for chemotherapy infusions. This is intended to include some payments being made direct to compounders, with a different fee applying depending on whether the compounder holds a TGA licence.

National Diabetes Services Scheme (NDSS)

The supply and delivery of NDSS products will be redirected through the established CSO distribution network to community pharmacies from June 2016. There will be a payment of \$1 (not indexed) to pharmacies for each product supplied. CSO wholesalers will also be entitled to receive \$1 for each unit they distribute.

Reviews

A Remuneration Review will be conducted to inform pharmacy and wholesaler remuneration arrangements for the 7th CPA (July 2020 onwards). The review will not be able to be used to change pharmacy remuneration during the 6th CPA. Remunerations have not been formally reviewed since 1989.

During the 6th CPA there will be a public review of the Location Rules and their role in supporting access to PBS medicines. The Location Rules cannot be changed during the 6th CPA based on the outcomes of this review except with the agreement of both the PGA and Government.

Wholesalers Community Service Obligation (CSO)

The current wholesaler mark-up arrangements will continue to apply under the 6th CPA and there will be no indexation of the CSO funding pool. Wholesalers will still be required to supply section 85 medicines under CSO arrangements at or below the official PBS price to pharmacists, and will not be permitted to impose new or additional fees where the supply is covered by the CSO requirements.

A role for pharmacy in primary care

\$1.2 billion / 5 years is provided to double the current investment in support programs for patients, with a focus on regional and rural areas. It appears this includes **\$50 million** for the Pharmacy Trial Program which expands the role of community pharmacists in the delivery of health care services to Indigenous Australians living in rural and remote areas (see Table 8).

This could include vaccinations, wound care and the management of chronic conditions such as arthritis. Pharmacists have previously proposed offering checks for weight, blood pressure, blood sugar and cholesterol. All such pharmacy programmes - new and existing – will be scrutinised and approved by MSAC to ensure they are evidence-based.

This increased investment has not been welcomed by organised medicine. It appears to be based on a discussion paper produced by the PSA.⁶⁴

ANAO report on Administration of Fifth Community Pharmacy Agreement

The ANAO report in the administration of the 5th CPA was released in March 2015.⁶⁵ It found that overall DoH's administration of the 5th CPA was mixed, and there is a limited basis for assessing the extent to which the 5CPA met its key objectives, including the achievement of **\$1 billion** in expected savings. There is no straightforward means for stakeholders to be informed of the expected or actual cost of key components. Specifically, the agreement does not document that some **\$2.2 billion** of pharmacy remuneration is sourced from patient co-payments and is not a cost to government.

The 5th CPA, costing **\$15.4 billion / 5 years**, was promoted as delivering **\$1 billion** in government savings. The major savings initiatives were:

- Cessation of the PBS Online incentive payment (**\$417.7 million**).
- Freezing the dispensing fee for two years (**\$281.5 million**).
- Cessation of under-performing professional programs (**\$226.4 million**).
- Reduction in private hospital pharmacy remuneration (**\$35.3 million**).
- Freezing the CSO Funding Pool for one year (**\$19.2 million**).

The 2010–11 Budget Papers clarified that the **\$1 billion** in savings was a gross figure, and after taking into account approved additional expenditure of **\$0.4 billion**, net savings were estimated to be **\$0.6 billion**. However, ANAO analysis indicates that the net savings estimated before the agreement was signed were closer to **\$0.4 billion**, due to shortcomings in DoH's 5CPA estimation methodology. The principal issues relate to: unexplained increases in the baseline cost of professional programs; the application of inappropriate indexation factors; and the treatment of patient co-payments.

The audit report found 941 pharmacy businesses received over **\$1 million** in remuneration under the community pharmacy agreements that enshrine their monopoly-like status. The audit also exposed how pharmacists can rort the system. For example, some pharmacists claim a \$1.50 per script government incentive for substituting cheaper generic medicines when sometimes no substitution is actually made. The cost of this Premium Free Dispensing Initiative, estimated at **\$620 million / 5 years**, blew out to **\$912 million**.

In addition to the shortfall in anticipated savings, a number of the Government's other strategic negotiating objectives were only partially realised. These included:

- The structure of pharmacy remuneration, based on defined mark-ups to the base price of pharmaceuticals with the addition of a variety of fees, remained essentially unchanged from the 4th CPA to the 5th CPA, despite the intention to restructure pharmacy remuneration arrangements by

⁶⁴ <http://www.psa.org.au/submissions/better-health-outcomes-through-improved-primary-care-6cpa-discussion-paper>

⁶⁵ <http://www.anao.gov.au/Publications/Audit-Reports/2014-2015/Administration-of-the-Fifth-Community-Pharmacy-Agreement>

shifting financial incentives from the volume driven sale of medicines to the delivery of value-adding professional services.

- A 'non-negotiable' aspect of the 5th CPA related to obtaining access from pharmacies to the full range of PBS data, including information relating to prescriptions that cost less than the general patient co-payment. This objective was only partially realised – prescription numbers but not cost information was obtained.
- Another key government negotiating objective for the 5CPA was to support information technology systems that are fully interoperable with broader e-health systems. However, the two Prescription Exchange Services (PESs) that were approved by Health for downloading electronic prescriptions by pharmacies did not have systems that were interoperable. Government funding for the Electronic Prescription Fee (EPF) was subsequently re-allocated to pay the PESs directly to make their systems interoperable.

Biosimilars

Biosimilars are biological products that are similar, but not identical, to an innovator product that is already marketed and whose patent has typically expired. Biologics are some of the most expensive drugs on the PBS; they have grown from about 4% of the PBS budget 10 years ago to about 25% currently. Biologics cost the Government about \$2.3 billion in 2013-14.⁶⁶

Biosimilars cannot be considered 'generic' equivalents of innovator products as they are not necessarily clinically interchangeable and in some cases may exhibit different therapeutic effects. The clinical performance and immunogenicity of biological drugs is highly dependent on the method of production and purification. Verifying similarity or comparability of a biosimilar with an innovator product therefore requires much more than demonstrating bioequivalence, which is sufficient for conventional generic drugs.

On 18 June 2015 the Pharmaceutical Benefits Advisory Committee (PBAC) issued a statement stating that if a biosimilar is approved by the Therapeutic Goods Administration (TGA) it will assess whether it should be listed on the PBS. Assessments will be done on a case-by-case basis and will potentially allow a pharmacist or clinician to substitute a biosimilar.⁶⁷ PBAC says the move was prompted by a number of biologic drugs coming off patent.

Aside from the concerns over the safety of biosimilars, this is an issue driven by the US pharmaceutical industry in the controversial Trans Pacific Partnership (TPP). The industry wants extended patent provisions and test data protection that will prolong monopolies over new medicines and delay competition from biosimilars. It has been estimated that if biosimilars had entered the market prior to July 2013 for each of the ten biologics accounting for the highest government expenditure, this would have resulted in over **\$205 million** in savings through public subsidies alone in the year 2013-14.⁶⁸ This

⁶⁶ <http://www.abc.net.au/news/2015-06-19/biosimilar-drugs-new-class-of-generic-biological-medicines/6557532>

⁶⁷ <http://www.pbs.gov.au/info/news/2015/06/statement-by-pbac-safety-of-biosimilar-medicines>

⁶⁸ <http://aftinet.org.au/cms/node/907>

figure illustrates the magnitude of the annual costs that would result for taxpayers from prolonging monopolies on biologic medicines.

Delisting medicines from the PBS

The Abbott Government will push ahead with efforts to delist from the PBS those items which are already available over the counter (OTC). There are currently 352 such items. Of these, the DoH, in consultation with the PBAC, is looking to delist 47. There will be a 5 month notification period of the intention to delist.

Impact of PBS and pharmacy changes on patients

The Abbott Government has touted recent PBS decisions and agreements as “landmark deals benefiting consumers”. However the extent to which these changes, if enacted as proposed, will help consumers is not clear and savings may be offset by increased charges and changes to the safety net thresholds.

Recent media reports⁶⁹ indicate that the decision to replace the 15% mark up component of a chemist’s fee with a flat \$3.49 “administration and handling fee” will drive up the price of low cost drugs by over 40%. This is a cost for both government and non-concession patients. General consumers will pay the extra out of their own pocket but when a pensioner buys the medicine the taxpayer will pick up the extra tab.

Consumers Health Forum has calculated that this will mean consumers will directly contribute an estimated **\$8.2 billion / 5 years** to pharmacy owners’ remuneration.⁷⁰ That amounts to 34% of the estimated **\$23.6 billion** in total payments for PBS medicines to pharmacies.

The delisting from the PBS of medicines such as pain medications will mean that pensioners and concession card holders will pay more for these over the counter.

The redirection of product supply and delivery funding from the National Diabetes Services Scheme run by Diabetes Australia to pharmacies and wholesalers is also an issue of significant concern. It is not clear how the patient support and education services currently provided by Diabetes Australia and other services which cannot be provided within pharmacy will be maintained under the new arrangements.

⁶⁹ See for example <http://www.news.com.au/lifestyle/health/the-price-of-hundreds-cheap-medicines-will-rise-by-40-per-cent-under-new-pharmacy-deal/story-fneuzlbd-1227371690867>

⁷⁰ <https://www.chf.org.au/pdfs/chf/Media-Release---Pharmacy-agreement-offers-pills-with-a-sugar-coating.pdf>

Budget provisions

Ceasing the Alternative Arrangement Transfer to Pharmaceutical Benefits Program

The Government will cease, effective 1 December 2015, the arrangement which allowed Cohealth Ltd to provide PBS medicines and pharmacy services to their clients.

Cohealth is an integrated pharmacy - a one-stop-shop where GP, pharmacy and other health services are located together under the one roof – located in Collingwood, Victoria. It is the only integrated service of its kind in Australia and has existed for several decades.⁷¹ Having the pharmacy next to doctors' offices improves health and reduces pharmaceutical-related hospital admissions. It serves an older, disadvantaged community where many people have complex health issues.

Cohealth's clients pay an annual prescription fee to fill their subscriptions rather than pay a PBS copayment each time they fill a prescription. The amount paid is equivalent to the PBS Safety Net. Cohealth's clients will now pay on a per prescription basis.

Increase in the Pharmaceutical Benefits Scheme safety net thresholds

Savings of an additional **\$5.1 million** are achieved by pushing back to 1 January the start date for the increase in safety net thresholds announced in the 2014–15 Budget. The savings taken by this measure will go to fund other Health priorities or to the MRFF.

	2014-15	2015-16	2016-17	2017-18	2018-19
DoH	-	-	-	-	-5.0
DVA	-	-	-	-	-0.1
Total	-	-	-	-	-5.1

The savings achieved under this provision were not specifically broken out in the 2014-15 Budget but were combined with those achieved through the increases in PBS payments. It is not clear if the figure in this year's budget is offset by the loss of savings in 2015 caused by the 12 month delay in implementation.

Table 9. Changes in PBS Safety Net thresholds over time

	2014	2015	2016	2017	2018
General (does not include CPI increase)	\$1,452.50	\$1,597.80	\$1,798.00	\$2,029.20	\$2,287.90
Concession	60 scripts	62 scripts	64 scripts	66 scripts	68 scripts

From June 2014 Senate Estimates

Legislation is needed to enact this provision.

⁷¹ <http://cohealth.org.au/>

New and amended listings on the Pharmaceutical Benefits Scheme

\$1.6 billion / 5 years is provided for new and amended listings on the PBS and RPBS based on decisions made since the 2014-15 MYEFO.

	2014-15	2015-16	2016-17	2017-18	2018-19
DoH	5.9	375.4	381.6	391.2	377.7
DVA	..	7.5	8.2	8.1	7.9
DHS	0.7	5.3	1.7	1.8	1.9
Total	6.7	388.2	391.4	401.1	387.5
<i>Related revenue DoH</i>	<i>nfp</i>	<i>nfp</i>	<i>nfp</i>	<i>nfp</i>	<i>nfp</i>

The drugs listed are, with one exception, biologics, mostly for the treatment of cancer. These drugs are very expensive and quite targeted in their effects. For such drugs it is usual for the Government to strike risk sharing agreements, so the full expenditure for these drugs will be less than that indicated over the forward estimates.

It should be noted that the listing of Herceptin for the treatment of metastatic breast cancer makes the Herceptin program unnecessary. The special program was established in 2001 after the PBAC has 3 times rejected the listing of Herceptin for late-stage breast cancer and following intense media attention.⁷²

It is interesting to note that Keytruda, for the treatment of melanoma, is not part of this list, even though it was approved by the PBAC in March 2015. Its listing on the PBS, effective 1 September 2015, was announced in June, after heavy lobbying and with much fanfare.⁷³

Pharmaceutical Benefits Scheme price changes

Savings of **\$252.2 million / 5 years** are taken for price amendments to certain medicines listed on the PBS. The savings are to be directed to fund other health priorities or the proposed Medical Research Future Fund

	2014-15	2015-16	2016-17	2017-18	2018-19
DoH	-13.3	-55.2	-55.6	-60.8	-66.9
DVA	-0.5	-1.8	-1.6	-1.7	-1.8
Treasury	0.1	0.4	0.5	0.5	0.5
Total	-13.7	-55.2	-50.6	-60.8	-66.9

These changes were made on the basis of PBAC recommendations. Several seems to relate to the cost of combination medicines. It appears that these changes were made possible by the expiry of the 2010 Memorandum of Understanding with Medicines Australia which dealt with such issues.⁷⁴

⁷² <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2408635/>

⁷³ <http://www.sbs.com.au/news/article/2015/06/28/govt-pay-revolutionary-melanoma-cancer-drug>

Proposal on the role of pharmacists in the general practice health care team.

The AMA has released a proposal to make non-dispensing pharmacists a key part of the future general practice health care team, supporting GPs to deliver high quality care for their patients.⁷⁵ This proposal is supported by the Pharmaceutical Society of Australia (PSA).

The proposal calls for the establishment of a new (Medicare funded?) program to support general practices to employ pharmacists - the Pharmacist in General Practice Incentive Program (PGPIP).

Under this plan, non-dispensing pharmacists would work in general practices to assist in areas such as:

- Medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a Residential Aged Care Facility (RACF).
- Patient medication advice to facilitate increased medication compliance and medication Optimization.
- Supporting GP prescribing.
- Liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital.
- Updating GPs on new drugs,
- Quality or medication safety audits.
- Developing and managing drug safety monitoring systems.

Supplementary activities, depending on the needs of individual practices, could include activities such as patient education sessions, mentoring new prescribers and teaching GP registrars on pharmacy issues.

The AMA backs up their proposal with data developed by Deloitte Access Economics that shows that the program (which, if taken up by 3,100 practices would cost **\$969.5 million / 4 years**) would deliver savings of \$1.56 in the health care system as a whole for every \$1 invested. Most of the expected savings would result from reduced hospitalisations as a consequence of Adverse Drug Events.

⁷⁴ <http://www.pbs.gov.au/info/industry/useful-resources/memorandum>

⁷⁵ <https://ama.com.au/article/general-practice-pharmacists-improving-patient-care>

Primary Care

Although the Abbott Government says all the right things about the centrality of primary care in Australia's health care system, it has done little to cement that centrality. The focus is on general practice rather than primary care and even that is not well served by changes to Medicare.

The implementation of Primary Health Networks offers some interesting possibilities, but this has been delayed and still lacks clear guidance.

The establishment of a Primary Health Care Advisory Group, alongside the review of MBS items, also offers possibilities to real reform – for the new models of service delivery and financing that are so needed.

Primary Health Care Advisory Group

The Minister for Health, Sussan Ley, has established a Primary Health Care Advisory Group to identify:

- Ways to provide better care for people with chronic and complex conditions.
- Innovative care and funding models and improved treatment options for mental health conditions.
- Ways to improve integration between the primary and acute care sectors.

Dr Steve Hambleton, former President of the Australian Medical Association (AMA), will chair this new group. The remit of the Advisory Group offers so much scope for real and needed reform so it will be very interesting to see if the Group's members accept this challenge and – if they do – what the Abbott Government's response will be.

The AG is required to report back with priorities by the end of the year.

Primary Health Networks

As of 1 July 2015 the DoH planned for the 61 Medicare Locals (MLs) to be replaced by 31 Primary Health Networks (PHNs). The Minister for Health announced the preferred providers for 28 PHNs in April and the remaining three in June.⁷⁶ At the time of Senate Estimates only 11 of these had signed contracts. There will clearly be an extended transition period in some areas: it is not known if MLs will be provided with continued funding for this.

The majority of the successful consortia involve MLs, some also include universities and hospitals. Four also involve private health insurance funds. These are:

- South-eastern NSW has partnered with Peoplecare, a national member-owned, not-for-profit health fund

⁷⁶ <http://www.health.gov.au/internet/main/publishing.nsf/Content/phn-prefapps>

- Grampians and Barwon south-west in Victoria partnered with GMHBA, a private health insurer
- Brisbane North partnered with HCF and Bupa
- Perth North/Perth South/country WA partnered with HCF and Bupa

The cost of these PHNs is of the order of **\$900 million**.⁷⁷ The transition from MLs will cost the Government **\$112 million**. The actual cost to the MLs is expected to be higher than this. The constant changes have created very large costs in staff redundancies, discontinuity and disruption in activity.

PHNs will have six priority areas for targeted work: mental health, Indigenous health, population health, health workforce, e-health and aged care. However there are currently no performance measures for these priority areas. However DoH guidance for PHNs can best be described as thin; the key objectives are improving effectiveness, efficiency and coordination.⁷⁸ They will function predominantly as facilitators and purchasers of care.

There is little Australian evidence to guide effective commissioning and ensure it is focused on outcomes rather than outputs. Key lessons Australian might learn from the UK National Health Service are that getting commissioning right is not easy and will require time and a number of iterations, and that achieving the desired objectives is made more complicated and more fraught by changes wrought simply as a consequence of changes in government and ideology.

At this early stage there are many questions about PHNs will commission and / or deliver programs such as those to provide services for Indigenous Australians, ATAPS and other mental health services such as Partners in Recovery. Some of these programs that might be best placed to deliver commissioned services to special population groups have been adversely impacted by the Government's funding cuts.

It remains to be seen whether these new organizations will deliver the efficiencies, innovation and improved health outcomes that was the intent of the new policy direction. This will be particularly important for rural and regional Australians who carry a higher burden of disease than their metropolitan counterparts.

A role for private health insurers in primary care

Private health insurers are confronted with the same problems as Medicare. About 35% of all Medibank's hospital and medical expenditure is generated by 2% of its members and about 70% of these patients suffer from chronic illnesses.

As the ageing population starts to jeopardise the sustainability for private health insurers, they have been looking for more efficient ways of delivering care and reducing the need for care. They have been encouraged in this approach by the Abbott Government, indirectly through the recommendations that have emerged from the National Commission of Audit and the Harper Competitiveness Review, and directly through the Coalition's ideological approach to means testing and healthcare financing.

⁷⁷ It is not clear in the Minister's statements if this is the annual operating costs from Government.

⁷⁸ http://www.health.gov.au/internet/main/publishing.nsf/content/primary_health_networks

In late 2013 Medibank Private began a trial called GP Access with medical centre manager IPN in which six of its ⁷⁹Brisbane medical centres provide Medibank members with enhanced GP services, including a guaranteed appointment within 24 hours and after hours home visits, for no out-of-pocket costs. In April 2014 the trial was expanded to 26 medical practices run by the firm in Brisbane, the Gold Coast, Ipswich and Cairns. Medibank got round the current restrictions on PHI role in out of hospital medical care by not paying IPN for the services directly but contributing to "administrative and management costs".

Other examples of this move into the primary care space include HCF providing an after-hours home GP service for their members and Bupa providing members with discounts in Healthscope's national network of medical centres, skin clinics and pathology services.

These programs raise concerns that people with private health insurance are likely getting services ahead of people without insurance but with greater need. These issues were discussed in detail in a series run by The Conversation.⁸⁰

However in June Medibank announced that an evaluation of the trial showed that the 13,000 members who used the service were pleased with it, but they didn't feel it added additional value to their private health insurance. Medibank will continue with separate trials to improve primary care for patients with chronic disease.

It appears the insurer was worried about public concerns and backlash.⁸¹ However Medibank Private's Medical Officer stated that the insurers was "of the view that there are better ways we can support primary care". This is likely through arrangements such as consortia to run PHNs.

These approaches signal the possibility of major changes to Australia's iconic Medicare system – and these should not happen by stealth. They require full analysis and debate about whether a more integrated public-private system is a feasible option that fits with Australian values and can improve efficiency in health care financing.⁸²

GP SuperClinics

The Abbott Government is no fan of GP SuperClinics. The 2014-15 Budget made the decision not to proceed on three SuperClinics – in Darwin, Rockingham and Wynnum – at a savings of **\$16.5 million**.

⁷⁹

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2015/February/private_health_insurance_and_primary_care

⁸⁰ <https://theconversation.com/the-debate-were-yet-to-have-about-private-health-insurance-39249>

⁸¹ <http://www.smh.com.au/federal-politics/political-news/medibank-dumps-gp-access-trial-20150525-gh8uai.html>

⁸² <https://theconversation.com/the-debate-were-yet-to-have-about-private-health-insurance-39249>

At that time the then Minister for Health, Peter Dutton, said the program had been a complete failure. He indicated that the Government was looking to retrieve money from SuperClinics where contracts had been signed on a case-by-case basis.⁸³ That approach appears to have foundered, likely on legal advice and / or the fact that many of these were located in marginal electorates.

Senate Estimates was told that of the originally planned 64 GP SuperClinics, 55 are now operational and 6 are still under construction, and 3 will not proceed. Interestingly the DoH page listing the location and operationability of the GP SuperClinics has not been updated since 2012.⁸⁴

Around **\$650 million** has been committed to build more than 60 GP SuperClinics around Australia and for Primary Care Infrastructure Grants to upgrade and extend around 425 existing general practices, primary care and community health services, and Aboriginal Medical Services.

The primary, and in many cases, sole use of the program funding is for capital infrastructure that provides an environment where the operators of the GP SuperClinics are then required to provide services to meet the ten objectives of the programme for a 20 year period. The GP SuperClinics Program does not fund the ongoing service provision and the Australian Government does not own or operate the clinics.

There has been no evaluation of the GP Superclinics program since that undertaken in 2011 when many Superclinics were still barely operational.⁸⁵

Diabetes

The Diabetes Care Project

The genesis of the Diabetes Care Project was much grander than the final result: the 2010-11 Budget provided **\$449.2 million / 4 years** to improve the quality and coordination of primary care services for people with diabetes. At the same time the COAG Diabetes Grants, set up in 2007-08,⁸⁶ were abolished – with no information about their effectiveness. Under the new proposed 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

⁸³ <http://www.abc.net.au/news/2014-04-08/government-moves-to-dismantle-labor-super-clinics-scheme/5375074>

⁸⁴ <http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-locations>

⁸⁵ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/GPSuperClinicsEvaluation-toc>

⁸⁶ <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2007-hfact31.htm>

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 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 expected 4300 general practices – 60 per cent of all GPs – would join the program by 2012-13 when it was scheduled to begin, and approximately 260,000 patients with diabetes (about 25% of those diagnosed at that time) will be voluntarily enrolled in the personalised care program by 2013-14.

The proposal was controversial because it singled out diabetes out as the only chronic illness to receive this coordinated care but mostly because of opposition from the AMA who saw it as fee capitation. In the face of their opposition, then Minister for Health, Nicola Roxon, backed down. The 2011-12 Budget provided **\$30.2 million / 4 years** for a pilot program with the design to be established by the Diabetes Advisory Group which now included the AMA as a member.

The pilot was a cluster randomised controlled trial with two Intervention Groups and a Control Group, where current models of care were tested alongside new care components comprised of:

- An integrated information platform (cdmNET) for GPs, allied health professionals and patients.
- Continuous quality improvement processes with data feedback.
- Flexible funding model based on patient risk stratification.
- Quality improvement support payments linked with a range of patient population outcomes.
- Dedicated Care Facilitators to work with the care team to provide patient support.

The project had three arms:

- A control group that received s usual care.
- Group 1, which tested improvements through the use of the cdmNet shared care planning tool and continuous quality improvement processes.
- Group 2, which tested all those components along with the new funding options.

The primary clinical endpoint was the difference in the change in HbA1c levels between treatment groups at the end of the project. Secondary outcomes included changes in other biochemical and clinical metrics, incidence of diabetes-related complications, health-related quality of life, clinical depression, success of tailored care and and economic sustainability.

The pilot study involved 184 practices (the DoH website says 150) and 7781 patients from urban, rural and regional areas of South Australia, Queensland and Victoria (Vic). It was delivered by a consortium of healthcare organisations and experts led by consulting firm McKinsey.⁸⁷

The study protocol was published in 2013.⁸⁸ The actual project ran for just 18 months – arguably insufficient time to see downstream impacts such as reduced hospitalisations.

Very little information was provided by DoH as this study proceeded.

⁸⁷ <http://www.health.gov.au/internet/main/publishing.nsf/Content/eval-rep-dcp>

⁸⁸ <http://www.ncbi.nlm.nih.gov/pubmed/24359432>

Evaluation of the Diabetes Care Project

The evaluation report, written by McKinsey, was not released until May 2015.⁸⁹

The evaluation of the trial found:

- Group 1 participants did not experience a significant improvement in HbA1c levels or other clinical metrics, aside from a small improvement in renal function.
- Group 2 participants had a statistically significant improvement in HbA1c levels compared to the control group and clinically modest secondary outcomes.
- At baseline, the average total healthcare cost across all groups was **\$8,647 / person / year**, of which hospital costs (**\$3,814**) were the largest contributor. Costs for both Group 1 and Group 2 participants were higher than the control group – **\$718 and \$203 / person / year** respectively. These are described as not statistically significant, with hospital costs contributing to the large variation.
- Even when reduced hospital admissions and other acute care savings were taken into account, the new funding arrangement was not cost-effective. This may be because the main benefits lie outside of 18-month trial period).

The evaluation committee made three recommendations arising from the DCP:

- Change the current chronic disease care funding model to incorporate flexible funding for:
 - Registration with a medical home (ie GP practice, AMS).
 - Payment for quality
 - Funding for (targeted) care facilitation.
- Continue to develop both eHealth and continuous quality improvement processes
- Better integration of primary and secondary care to reduce avoidable hospital costs.

The realistic assessment is that:

- This was not a well-designed project and it was not allowed to run for a sufficient length of time.
- The findings are predictable and the recommendations could have been made on the basis of current knowledge in 2011.
- The data on costs is useful and highlights both the need to do more and do it better in this area and where efforts should be targeted for maximum returns on the investments.

The DoH website says that the findings of the report will be used to support primary care research, assist the Primary Health Networks to develop their own innovative healthcare approaches, and inform the work of the Primary Health Care Advisory Group. The report has also been provided to the National Diabetes Strategy Advisory Group, to be considered in the development of the National Diabetes Strategy.

National Diabetes Strategy

In response to the release of the evaluation report the Health Minister will extend the consultation period for the promised National Diabetes Strategy (to the end of June?) to allow the public and AIHW to review the report.

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[http://www.health.gov.au/internet/main/publishing.nsf/Content/302DF0372F537A43CA257E35000138E8/\\$File/DCP%20Evaluation%20Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/302DF0372F537A43CA257E35000138E8/$File/DCP%20Evaluation%20Report.pdf)

An Advisory Group to develop a National Strategy for Diabetes was established in December 2013. A consultation paper was released in April 2015. This has a draft Framework for Action.⁹⁰ Not surprisingly, this paper has a strong emphasis on primary prevention and obesity – sure sticking points for this Government.

Primary Health Care Research, Evaluation and Development program

The third five-year phase of the Primary Health Care Research, Evaluation and Development (PHCRED) program has now ended with no decision about its future. The program has been positively evaluated and apparently DoH and / or the Minister for Health is considering options for investment in future primary health care research as part of a Departmental wide approach to the support of research.⁹¹

This failure to reach a timely decision in an important area like primary health care research and capacity building leaves the fate of the Australian Primary Health Care Research Institute (APHCRI) and the Primary Health Care Research Information Service (PHCRIS) and their work in the lurch.

APHCRI has funds only to December 2015. Although the APHCRI contract ends this year a number of commissioned research projects (including Centres of Research Excellence) will not be complete until 2016/2017, and one will conclude in July 2018.

At a time when research and implementation studies around primary health care priorities are keenly needed, it would be a waste of the substantial investment to date for this program to cease. This type of research does not fit well within the remit of the NHMRC and it seems extremely unlikely that the proposed MRFF will address this type of research.

The PHCRED program was established in 2000 to improve Australia's capacity to produce high quality primary care research involving all stakeholders. This followed the recommendations of the Review of the General Practice Strategy in 1998. The first two phases of this program received total funding of the order of **\$135 million**⁹² but funding levels for Phase 3 have never been made public,

As described in the strategic plan the goals of this Strategy are:

- An expanded pool of primary health care researchers;
- More research relevant to practice and policy; and
- In collaboration with other relevant organisations, well informed primary health care practice and policy.

⁹⁰ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ndsag>

⁹¹ <http://aphcri.anu.edu.au/whats-on/all-news/communiq%C3%A9-%E2%80%93-message-chair-rab>

⁹² [https://www.health.gov.au/internet/main/publishing.nsf/Content/4D9AB3396D926315CA2577CB0005D65D/\\$File/PHCRED%20Strategy%20Oct%202010%20PRINT.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/4D9AB3396D926315CA2577CB0005D65D/$File/PHCRED%20Strategy%20Oct%202010%20PRINT.pdf)

The major Strategy components are:

- The Australian Primary Health Care Research Institute (APHCRI) which is tasked with providing leadership in primary health care and embedding a research culture in general practice. APHCRI was established at the Australian National University in 2003.
- The Research Capacity Building Initiative (RCBI), established in 2000, which funds university Departments of General Practice and Rural Health to provide training and support in primary health care research, particularly among GPs.
- Primary health care research grants and awards administered through the NHMRC. These programs provide research training and experience for early, mid and senior level researchers and include the funding of both investigator and priority driven research relevant to both policy and practice.
- The Primary Health Care Research and Information Service (PHCRIS) established in the Department of General Practice at Flinders University to provide support in the area of dissemination and knowledge-exchange. PHCRIS was first established in 1995 as the National Information Service (NIS) and changed its name in 2001.

APHCRI on behalf of the network and other stakeholders has developed and submitted a paper outlining views on the future of dedicated primary health care research funding.⁹³

The key messages are;

- Primary health care is a vital part of an integrated and sustainable health system
- Targeted priority driven primary health care research, firmly embedded with the key stakeholders groups, i.e. policymakers, consumers and service providers, is too important to leave to the lottery of mainstream academic research funding
- The model for delivering this targeted research and impact focused program should be based on inclusive governance and partnership arrangements between academics and the key stakeholder groups

⁹³ <http://aphcri.anu.edu.au/files/Future%20of%20primary%20health%20care%20research%20in%20Australia.pdf>

Mental Health

Despite the enormous need and the very specific guidance for reform offered by the National Mental Health Commission (NHMC) National Review of Mental Health Programs and Services, *Contributing lives, thriving communities*,⁹⁴ there is nothing in the Health portfolio for mental health, and as far as can be determined, there is only one provision in the whole budget: a two-year extension of the access to social and mental health services for people in drought -affected communities.

For five months the Abbott Government stubbornly refused to release the NHMC report from the review it commissioned, as an election commitment, to assess the efficiency and effectiveness of Australia's mental health services.

The Abbott Government's concern for efficiency in the way federal programs are funded and operated apparently does not extend to mental health care. The Commonwealth currently spends **\$9.6 billion** annually on mental health, but the NHMC report found that "by far the biggest inefficiencies in the system come from doing the wrong things — from providing acute and crisis response services when prevention and early intervention services would have reduced the need for those expensive services, maintained people in the community with their families and enabled more people to participate in employment and education."

The report speaks with urgency about why a reordering of priorities for mental health funding is imperative, for both social and economic reasons. The key point is that mental health funds are not spent well. The outcomes are bad for patients and their families and bad for the budget bottom line.

Almost all (87.5%) of the **\$9.6 billion** of Commonwealth funding is spent on acute care and income support programs that are indicators of system failure. An increased focus on prevention and early intervention and a strengthening of the primary healthcare sector would increase access to care, reduce current pressures on hospital services, and help more people stay functional in their communities.

We understand that hospital admission and disability can be prevented for physical illnesses by screening, early intervention and affordable and timely access to community-based medical and support services. The idea of late intervention for cancer, heart disease and diabetes is unacceptable, but with mental illness this is almost the norm. Why has this been allowed to happen? The average cost of a hospital admission for a mental health disorder is **\$10,000**, a sum that could fund community support for a year.

More must be done to close the gaps that mean that people miss out on needed services because of where they live, their income, and their ability to navigate a complex and fragmented array of services. Mental health problems are dealt with in isolation, leading to poorer physical and mental health outcomes.

The current delivery system is driven more by what providers want than by what patients and their families want and need. The review struggled to assess the efficiency and effectiveness of the array of services and programs because the data are not there. The data that are collected measure activity but not outcomes and ignore patient satisfaction.

⁹⁴ <http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx>

Tackling suicide must be a national priority. In 2012, more than 2,500 Australians (almost seven people ever day) died by suicide and more than 25 times that number attempted to take their own lives. It's the leading cause of death for Australians aged between 15 and 44. The report proposes a target to reduce both suicides and suicide attempts by 50% over the next decade with sustainable, comprehensive, whole-of-community approaches.

The situation for Indigenous Australians is far worse; the report describes it as 'dire'. It's a dominant over-arching theme throughout, and there is a recommendation to make Indigenous mental health a national priority and agree an additional COAG Closing the Gap target for mental health.

What emerges from this review is that despite a raft of reports, plans, strategies and commitments, Australia lacks a clear destination in mental health and suicide prevention. There is no 'mental health system' but a collection of services and programs with little evidence of value and with no clarity of roles and responsibilities. The voices of the people with lived experience of mental illness – patients, families, carers and healthcare professionals – have consistently been ignored, misheard and undervalued.

The new system architecture that the report proposes – to 'redesign, redirect, rebalance, repackage' offers an immediate starting point for reform, as was promised by the Prime Minister and presents these reform opportunities in a context that is suitable for the budgetary times.

The first response from the Health Minister Sussan Ley was telling: she picked one key recommendation (to shift priorities from crisis care to prevention, early intervention and community support), take it out of context (present it as cutting hospital services) and announce emphatically that this will not be done.

Her second response indicated an unwillingness to act in a timely way on the report's recommendations: she announced the establishment of a new COAG working party to work with the states and territories, and a new expert reference group to focus on four key areas (suicide prevention; prevention of and early intervention in mental illness; primary care; and national leadership, including regional service integration). No clear timeline for specific action on the recommendations of the NMHC report has been announced.

In March, amid concern from the sector, the Minister announced a 12-month funding extension, worth **\$300 million**, for some 150 contracts for the delivery of mental health services. The Minister said the 12-month extension would allow services to continue to be delivered while work continued on the current Mental Health Review. The focus is supposedly on frontline services but it is not known which services have received funding and what their funding levels are. For the time being, in the absence of action on mental health reforms, these community organisations must operate on short-term funding.

Among the other mental health issues that remain up in the air is the way in which the new Primary Health Networks (PHNs) will commission mental health services, the funds that they will have for this, and how this will be done in those areas where mental health services and professionals are in short supply.

Issues in mental health

Government response to the review of mental health services

The main media release from the Minister for Health, Susan Ley, in response to the Review of Mental Health Programs and Services from the NMHC admitted that it “ paints a complex, fragmented, and in parts, disturbing picture of Australia’s mental health system.” And continued “ I acknowledge there are clear failures within both the mental health sector and governments and we must all share the burden of responsibility and work together to rectify the situation.”⁹⁵ It was also helpful to see her acknowledgement of the discontent among mental health stakeholders with the Fourth National Mental Health Plan and the National Road Map for Mental Health Reform 2012-2022.

The plans to address this report include:

- Establishment of an Expert Reference Group to inform the reform process, including the development of short, medium and long-term strategies in four key areas”
 - Suicide prevention.
 - Promotion, prevention and early intervention of mental health and illness.
 - The role of primary care in treatment of mental health, including better targeting of services.
 - National leadership, including regional service integration.
- Efforts to establish a dedicated COAG Working Group on Mental Health Reform to coordinate the reform process.

The ERG will be supported by:

- Stakeholder workshops
- An NDIS Mental Health working group.
- An Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.
- An inter-governmental approach to ensure Commonwealth agencies respond to the Report’s concerns about fragmentation of payments and services.

There has been a mixed reaction to the membership of the ERG which was announced in June.⁹⁶ There are 6 psychiatrists and only one consumer: inevitably many groups – Indigenous, CALD, carers, mental health nurses – feel they missed out and that their voices may not be heard

The Terms of Reference indicate that the scope of the ERG “will be weighted towards policy and programme changes which are within the role of the Commonwealth to directly implement through its current national programmes. It will also consider the broader system leadership role that the Commonwealth plays within the National Mental Health Strategy.”⁹⁷ The Minister has said that advice from the Expert Reference Group would help inform discussions she will have with State and Territory governments about developing a new National Mental Health Plan with much-improved co-ordination between federal, state and local bureaucracies and services.

⁹⁵

https://www.nesa.com.au/media/76667/150416_ley_govt%20plans%20national%20approach%20on%20mental%20health.pdf

⁹⁶ <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-policy>

⁹⁷ <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-tor>

The ERG has been given just four months to report back. It is not clear if this will be a detailed implementation plan, a set of points for the COAG Working Group (yet to be established) or something else. The ToR make it clear that the ERG is not a decision-making body.

There is no indication as to when a 5th National Mental Health Plan will be produced.

Headspace

The Government has given *Headspace* funding for 2015-16, but this funding has not been indexed, so centres that are already turning away youth in need of treatment must do more with less. Inevitably young people will miss out on crucial mental health services.

The Abbott Government has committed to expand to a total of 100 *Headspace* services by next year, and more than **\$400 million** has been committed to *Headspace* over the five years from 2013-14. Senate Estimates was told that there are currently 82 operational sites and each site gets an average of **\$840,000 / year** in addition to Medicare reimbursements.

There are problems with the *Headspace* program that must be addressed, even ahead of the Government's response to the NMHC review. To date there is little evidence that after 8 years of operation, the program has increased access to treatment for young people, particularly those from disadvantaged backgrounds or rural and regional areas.

The review called the current *Headspace* system a "collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice" and found that it has become too "overly centralised", with "rigid management requirements imposed on local services". It raised the concern that a "one-size-fits-all, shopfront-oriented approach" does not meet the needs of some communities or people from diverse groups, including those with "more complex or ongoing difficulties".

Others have been even harsher in their criticism: John Mendoza, former chief executive of the Mental Health Council of Australia and a previous chair of a *Headspace* centre in Queensland, said the original intent of the service had been "perverted" and the national head office had become "obsessed with brand and marketing". He spoke about "stifling levels of micro-management" that has left centre operators feeling like "fast food franchisees" with no capacity to respond to the unique needs of their local areas.⁹⁸

In my analysis of the mental health provisions in the 2014-15 Budget, I pointed out that the *Headspace* program appears to be under-funded if it is to be faithful to the model developed by Professor Pat McGorry.⁹⁹

The NMHC recommended that the PHNs be given the authority and money to manage contracts for non-government organisations like *Headspace* at a local and regional level. While theoretically possible, PHNs as currently established would find it difficult to manage the non-clinical aspects of such programs.

⁹⁸ <http://www.smh.com.au/national/headspace-mcdonaldisation-of-youth-mental-healthcare-a-ticking-time-bomb-20150425-1mszey.html>

⁹⁹ <http://ses.library.usyd.edu.au/bitstream/2123/10611/1/2014-15BudgetMentalHealthprovisions.pdf>

In March the DoH called for tenders for an independent governance review of the Headspace program.¹⁰⁰ This is apparently due before the end of the year.

Mental health and the National Disability Insurance Scheme

The access requirements for the NDIS include people with a psychiatric condition who have significant and permanent functional impairment. The Scheme will fund supports that assist a person to undertake activities of daily living including:

- Assistance with planning and decision making and household tasks..
- Assistance to build capacity to live independently and achieve their goals.
- Supports to engage in community activities such as recreation, education, training and employment.¹⁰¹

Since the NDIS was enacted there has been what has been described as a “clash in philosophies” when it comes to mental health. The ‘permanent impairment’ requirement is problematic for someone with mental illness – most people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly.¹⁰²

The ability to solve this problem in a satisfactory way depends upon the alignment of disability, mental health and physical health services – something that is just not possible when the mental health system is in disarray, the universal access and affordability of the healthcare system is under attack, and the NDIS is still being rolled out.

One example of problems is those Partners in Recovery programs which have had Medicare Locals as part of their operational consortium. As MLs have disappeared, the PiR consortia have been asked to identify new lead agencies. But this new situation will only apply until the PiR program is rolled into the NDIS. All these changes are happening contrary to the recommendations of the NMHC review, which sees the transfer of PiR to NDIS as eroding the existing benefits to individuals in receipt of quality services.

The National Disability Insurance Agency (NDIA) has a Mental Health Sector Reference Group, although it appears from the website this has only met once, in December 2014.¹⁰³ NDIA has commissioned two papers around the integration of mental health into the NDIS.¹⁰⁴

Medicare Better Access Program

The Better Access to Mental Health Care initiative (Better Access) with a range of MBS items to improve access to mental health services from GPs, psychiatrists, psychologists and allied health professionals

¹⁰⁰ <https://www.tenders.gov.au/?event=public.cn.view&CNUUID=A848BC21-C868-1238-D751433B4822DB6D>

¹⁰¹ http://www.ndis.gov.au/sites/default/files/documents/supports_ndis_fund_mental_health2_0.pdf

¹⁰² <http://www.everyaustraliancounts.com.au/opinion/every-australian-counts-exploring-psychosocial-disability-and-the-ndis/>

¹⁰³ <http://www.ndis.gov.au/document/1436>

¹⁰⁴ <http://www.ndis.gov.au/release-mental-health-papers>

was introduced in 2008. Since then the program has undergone many iterations, with changes and budget cuts made without any obvious evidence base.

The success of the program has been contentious. While there has been a significant uptake in services, it appears that this has not improved access to mental health care for those most in need and there is no evidence to show that those who do get services have improved mental health outcomes.

A recent paper published in the Medical Journal of Australia confirmed these findings.¹⁰⁵ The authors found there was considerable inequity in services in more disadvantaged and more rural areas.

The NMHC review found that Better Access has improved access to psychological treatment in the community and recommended its continuation. However it recommended that work be done to ensure the program is targeted to those most in need and that it is rolled up into regional models to address community needs in an integrated way (ie a role for PHNs). It noted that concerns have been raised about the efficacy of the GP Mental Health Care Plan and the number of sessions available to patients.

Mental Health Nurse Incentive Program

There were concerns about the fate of this program prior to the Budget. It was not mentioned in the Budget but it has received funding of **\$41.7 million** for the next year. Since its introduction in July 2007 this MHN Incentive Program has had funding changes in nearly every Budget. The funding provision for 2015-16 appears quite generous, considering the 2014-15 funding was **\$23.4 million**. This program has been capped at existing service levels for the past 4 years.

Primary Health Networks

Among the other mental health issues that remain up in the air is the way in which the new Primary Health Networks (PHNs) will commission mental health services, the funds that they will have for this, and how this will be done in those areas where mental health services and professionals are in short supply.

Access to Allied Psychological Services

There are rumours, which were not laid to rest during Senate Estimates, that the ATAPS program will not continue. Even in inner city areas such as Inner West Sydney this program has been so over-subscribed that there are long waiting times for referral. The SouthWest WA Medical Local recently reported that there is a 6 week waiting list for general referrals and the suicide prevention program has not been accepting new referrals since February 2015.

Partners in Recovery

35 Medicare Locals have been involved in the delivery of the PiR program. The existing PiR consortia have been asked to identify new lead agencies in their regions. There are currently 48 PiRs which have funding until June 2016 when they will be rolled into the NDIS.

¹⁰⁵ <https://www.mja.com.au/journal/2015/202/4/better-access-mental-health-care-and-failure-medicare-principle-universality>

At Senate Estimates DoH said that there are 13 PHN regions without a PiR program. There is no intention to establish PiR programs in these regions.

No Contributing Life report card from NMHC in 2014

The fact that the NHMC was consumed with the review of mental health services and programs meant that there was no report card produced in 2014. The NMHC has received funding of \$6.5 million for 2015-16 so it is hoped that the report card will be produced in 2015. It will likely tell a sad story as programs and services languish awaiting Government action on reform.

Dental health

It is painfully clear that the Abbott Government does not see public dental health care as necessary, despite all the arguments to support this. Over the past two Budgets the Government has cut more than **\$550 million** from public dental services.

A recent report from AIHW highlights that Australians' dental health has not improved in recent years. There has been a rise in the average number of children's baby teeth affected by decay and an increase in the number of adults reporting adverse oral impacts. Nearly half of all children aged 12 years had decay in their permanent teeth, over one-third of adults had untreated decay, over 50% of people aged 65 years and over had gum disease and over 20% of this age group had complete tooth loss.¹⁰⁶

Dental care constitutes around 6.4% of national health spending — to which individuals contributed 58% in 2010–11. The federal government, via direct outlays and premium rebates, contributed **\$1.437 billion**.

In what the CHF and the AHHA described as 'bittersweet news'¹⁰⁷ this Budget provides funding for the NP on Adult Public Dental Services, the commencement of which was deferred for 12 months in the 2014-15 Budget, but then cuts by nearly 25% the funds previously allocated for 2015-16 (from **\$200 million** to **\$155 million**). Moreover there is no certainty provided for future funding. Budget Paper 3 indicates that "Funding arrangements beyond 2015-16 are subject to negotiations with the states" – the usual modus operandi of the Abbott Government. Yet in opposition the Coalition was critical of the gap between the end of the Chronic Disease Dental Scheme and the start of the NP.

The announcement from the Minister for Health, Sussan Ley, headed "Abbott Government sinks teeth into dental reform", dated two days before the Budget was released, stated that "more than **\$200 million**" would be provided in the Budget for dental services in 2015-16.¹⁰⁸ Her statement also referenced the Government's White Paper on Reforming the Federation as providing an opportunity to greater co-ordination with less duplication. In this political environment that could well be read as the Abbott Government looking to divest itself of responsibilities for public dental services.

There is also concern about the pause in indexation for dental services provided under the Child Dental Benefit Scheme and for veterans, as well as reduced support for the dental workforce. Dentists who cross-subsidise the cost of providing dental care through these programs will find it harder to maintain bulk billing under the indexation pause.

It's hard to find recent data about the cost of dental services and who pays. A 2014 report from AIHW, using data from 2011-12 when the Chronic Disease Dental Scheme was in effect (thus blowing out the Commonwealth Government contribution over where it is today), found that the Government's

¹⁰⁶ <http://www.aihw.gov.au/publication-detail/?id=60129548265>

¹⁰⁷ <https://ahha.asn.au/news/dental-health-funding-clawback-previous-commitments>

¹⁰⁸ [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BD05EAE33B0B2F97CA257E410005BC65/\\$File/SL049.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BD05EAE33B0B2F97CA257E410005BC65/$File/SL049.pdf)

contribution to dental services through the Private Health Insurance then was **\$528 million**, about 50% of its direct funding (**\$1.06 billion**)¹⁰⁹ (see Table 10). This direct funding includes hospital services, PBS drugs and veterans' care.

Table 10. Funding for dental services 2011-12

Funding source	\$million	%
Commonwealth Government	1060	12.7
State, Territory and local governments	718	8.6
Government payments for PHIR	528	6.3
Health insurers	1261	15.1
Individuals	4736	56.8
Other	34	0.4
Total	8336	100

Data from AIHW 2014

Budget provisions

National Partnership Agreement in Adult Public Dental Services

\$155 million is provided in 2015-16 for a one-year agreement; This is **\$200 million** less than initially provided in 2014-15.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	-	-	-	-
Treasury	-	-	-	-	-

As is increasingly the case, the Budget Papers are cryptic on the funding of this provision. It was originally funded at **\$1.3 billion / 4 years** and these funds are in the forward estimates, although not shown. Funding for future years is dependent on negotiations with the States and Territories. Budget Paper 2 refers to this one-year agreement replacing the existing NP on Adults Public Health Services – does this indicate that the Abbott Government is pulling back from an agreement already reached, or is the intention to state that this new NP replaces the NP on Treating More Public Dental Patients, which expired in June 2015?

In the 2014-15 Budget savings of **\$390.0 million / 4 years** were taken by deferring the commencement of the National Partnership Agreement for Adult Public Dental Services from 2014-15 to 2015-16 (see Table 11). The savings from this measure were invested in the Medical Research Future Fund.

¹⁰⁹ <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548452>

Table 11. Deferred implementation of NP on Adult Public Health Services 2014-15 Budget

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DoH	-	-0.5	-0.2	-0.1	-0.1
Treasury	-	-200.0	-95.0	-95.0	-
Total	-	-200.5	-95.2	-95.1	-0.1

(See also the section on State / Territory and Commonwealth relations)

Child Dental Benefits Schedule - indexation

Savings of **\$125.6 million / 4 years** are taken by aligning the indexation arrangements for both benefits payable and the benefits cap with indexation arrangements for other health care programs. The savings will go to fund other health priorities or will be invested in the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	-14.9	-25.3	-37.6	-47.7

The CDBS began operating 1 January 2014. It is a means-tested dental benefit for children aged 2 to 17 funded through Medicare. Benefits are capped at \$1,000 over two years, indexed annually.

Pausing indexation of these services brings the CDBS indexation arrangements in line with the paused indexation for other Medicare Benefits Schedule items included in the 2014-15 Budget.

Senate Estimates gave the estimated expenditure for the CDBS over the forward estimates as \$1.91 billion / 4 years. (see Table 12)

Table 12 : Estimated expenditure for the Child Dental Benefits Scheme

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	605	616	630	656

Senate Estimates was told that 5.6 million services to 1,047, 192 children have been delivered since the Scheme started in January 201 and that 95% of these services incurred no out-of-pocket costs. The estimated pool of eligible children is 3,062,309. It appears that about 50% of eligible children have accessed the scheme and that each child who does receives 5-6 services. The estimates expenditure does not appear to indicate any substantial increase in the percentage of eligible children accessing the scheme in the next 4 years. This may be due to anticipated increases in out-of-pocket costs as a result of the freeze on indexation of reimbursements and a decrease in the number of families who qualify as a result of changes in family payments.

Continuation of indexation pause for DVA dental and allied health provider fees

The 2014-15 Budget imposed an indexation pause on DVA dental and allied health provider payments to 1 July 2016. This aligned indexation of payments to these providers with those for medical services and delivered savings of **\$35.7 million / 4 years**. The 2015-16 Budget takes further savings of **\$69.6 million / 4 years** which are achieved by extending the pause on indexation of DVA dental and allied health provider payments until 1 July 2018.

This is discussed further in the section on Provisions in Other Portfolios.

Changes to relocation incentives for dentists

In Senate Estimates it was elucidated that **\$30 million** will be cut from DRISS through the application of the MMM and targeting smaller rural towns.

This is discussed further in the section in rural health.

Closing the dental divide

This is a summary of an article I published in the Medical Journal of Australia.¹¹⁰

A recent report from the Australian Institute of Health and Welfare highlights that Australians' dental health has not improved in recent years. There has been a rise in the average number of children's baby teeth affected by decay and an increase in the number of adults reporting adverse oral impacts. Nearly half of all children aged 12 years had decay in their permanent teeth, over one-third of adults had untreated decay, over 50% of people aged 65 years and over had gum disease and over 20% of this age group had complete tooth loss.

There are consequences for the people involved, the health care system and the economy as a whole. The costs are substantial: \$7.857 billion was spent on dental treatment in 2010–11 and additional care costs exceeded \$1 billion. Dental care constitutes around 6.4% of national health spending — to which individuals contributed 58% in 2010–11. The federal government, via direct outlays and premium rebates, contributed \$1.437 billion.

In the absence of regular dental checks, and when access to dental services is limited by geography, affordability and long waiting times for public services, dental problems quickly become medical problems. Many patients seek pain relief from general practitioners and emergency departments. In the 2011–12 financial year there were 63 327 potentially preventable hospitalisations for dental conditions and 128 712 separations for dental procedures requiring a general anaesthetic.

For too many Australians a visit to the dentist — for any reason — is an unaffordable luxury. People who have private health insurance are more likely to access dental care, but insurance cover is clearly

¹¹⁰ <https://www.mja.com.au/journal/2014/201/11/closing-dental-divide>

inadequate, with 78.7% of people with ancillary cover reporting that they paid some of the cost of care, and 9.4% of people reporting they paid all of their expenses.

If we are serious about a focus on effective and efficient health care expenditure, equitable access and closing the gaps in health disparities, then it is time to end the dental–medical divide.

The following initiatives are put forward for consideration in the current political and economic environment in which integrating dental care into Medicare is seen as a step too far. Implementing my proposals will require concerted action from all stakeholders, but depends more on changes in cultures and focus than increased resources.

1. Make dental and medical professionals partners in delivering health care services and to include the mouth as part of the body.
2. Health promotion activities related to eating well, smoking and substance misuse, breastfeeding and better management of chronic conditions and polypharmacy need to include oral health information.
3. Oral hygiene is a critical aspect of care for the frail aged, people with mental illness, people with disabilities and those on certain medication regimens.
4. If private health insurance funds are keen to play a role in primary care to ensure that their customers are less likely to need acute care services, then it is time for them to consider their role in providing better dental care with reduced costs.
5. In the absence of universal dental care, the best-value investments for governments are in three broad areas: fluoridation, preventive services for children, and preventive and treatment services for the poor and those with special needs.
6. Investment in a “Dental Health Service Corps” made up of dentists and dental staff, doctors, nurses, community and Aboriginal health workers and public health professionals to take oral health services and education where they are needed.

Prevention

The 2014-15 Budget eviscerated preventive health funding, with over **\$377 million** ripped from the major federal programs that were addressing alcohol, tobacco and obesity. This came on top of the **\$27.0 million** savings made in the 2013-14 MYEFO by scrapping the Healthier Communities – Priority Infrastructure Program.

The 2015-16 Budget makes further cuts in key prevention programs; the exact amount is hidden and difficult to estimate. There are likely a number of prevention programs affected by the cuts to Flexible Funds. The only major new funding is **\$188.2 million / 5 years** for immunisation programs, the provision of new vaccines and improving coverage rates.

The Abbott Government's focus is solely on secondary prevention – issues such as cancer screening and immunisation – and, with the exception of tobacco harms, primary prevention is ignored. Even in the space where they are willing to work there are problems: a recent paper calls for new approaches to diabetes prevention by tackling dietary risk factors.¹¹¹

Some of the new spending on immunisation is directed at efforts to improve coverage rates, and to track these by expansion of the National Immunisation Program (NIP) register. When combined with the No Jab No Pay policy, these efforts provide a 'carrot and stick' approach to encouraging vaccination. It is interesting to note that the costings for the No Jab No Pay policy, with savings continuing to grow across the forward estimates, seem to assume that these efforts to improve immunisation rates will not be effective.

One of the few new programs to be developed in this area is on the harms of crystal methamphetamine (ice). However experts in the area have cautioned against a kneejerk response to this problem, highlighting that tackling ice use in individuals and communities presents serious challenges for treatment and rehabilitation services and also for police and courts that will require both short term and long term responses. To develop the most considered and robust response will take time, community consultation and professional consultation.¹¹² The Government's real commitment to this issue must be questioned as they spend **\$20 million** on a public awareness campaign while cutting **\$8 million** from treatment programs.

The Government seems determined to ignore the harms and costs due to alcohol which causes greater harm than ice. Every day 430 Australians are hospitalised as a consequences of alcohol abuse, there are 5500 alcohol-related Australian deaths each year,¹¹³ and alcohol is a key contributor to family and community violence.

In April 2008 the Australian Government introduced the 'alcopops' tax on ready-to-drink (RTD) beverages. The aim of the tax was to reduce harm from binge drinking among young people, as a group

¹¹¹ <https://www.mja.com.au/journal/2015/202/11/government-action-diabetes-prevention-time-try-something-new>

¹¹² <http://www.governmentnews.com.au/2015/04/abbott-goes-cold-on-ice-menace/>

¹¹³ <http://www.abc.net.au/news/2014-07-31/15-australians-die-each-day-from-alcohol-related-illness-study/5637050>

which are the primary target market (young females in particular) for RTD beverages. Although there has been opposition to the tax from the industry (and initially from the Abbott Government) and mixed early reports about its impact, a recent study into the impact of the GST and 'alcopops' tax on the incidence of alcohol harms found:

- The GST (whose introduction led to reduce prices for RTDs) was associated with a statistically significant increase in Emergency Department (ED) presentations for acute alcohol problems among 18-24 year old females.
- The 'alcopops' tax (whose introduction increased the price of RTDs) was associated with a statistically significant decrease in ED presentations among 15-50 year old males, and 15-65 year old females, particularly 18-24 year old females.
- The alcopops tax was also associated with declining ED presentations in underage drinkers.¹¹⁴

One of the few areas where the Abbott Government has not acted to undermine Labor initiatives is tobacco control. Despite Coalition ties to Big Tobacco and Abbott's criticism of the previous Labor Government's increase in tobacco excise tax, the Government has kept the strong anti-tobacco provisions. The Government will continue to act to protect plain packaging and is using the budget deficit as an excuse to keep the increased excise tax.¹¹⁵

Together these and other anti-smoking efforts have had a real impact on Australian smoking rates which continue to decline. In the two years since the plain packaging laws came into effect in December 2012, tobacco consumption fell 12.8%.¹¹⁶ The National Drug Strategy's Household Survey shows that the daily smoking rate fell 15% 2010 and December 1 2013, to 12.5%.¹¹⁷

However there are concerns that provisions in the Trans Pacific Partnership, which is currently being negotiated, will undermine Australia's strong anti-tobacco laws.¹¹⁸

A serious area of concern is that nothing is being done to tackle the growing and costly epidemic of obesity in Australia. The opportunities that might arise to boost physical activity as a result of the inclusion of Sport in the Health Portfolio have to date delivered nothing.

We cannot afford to drop the ball so dramatically on preventive health and we will pay the price down the road.

¹¹⁴ <http://www.fare.org.au/wp-content/uploads/2015/06/FARE-submission-on-the-Rethink-tax-discussion-paper-1-June-2015.pdf>

¹¹⁵ <http://www.theguardian.com/world/australia-news-blog/2013/aug/15/tony-abbott-tobacco-tax-rise>

¹¹⁶ <http://www.theguardian.com/society/2015/mar/12/plain-packaging-to-thank-for-australias-decline-in-smoking-says-labor>

¹¹⁷ <http://www.ft.com/cms/s/0/c4016952-0d4a-11e4-bcb2-00144feabdc0.html#axzz3cAHpn1V7>

¹¹⁸ http://works.bepress.com/matthew_rimmer/129/

Budget provisions

New and amended listings to National Immunisation Program

\$161.8 million / 5 years is provided for new and amended listings to the National Immunisation Program (NIP).

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	0.1	6.2	42.8	43.8	37.9
DHS	-	2.3	8.2	5.9	5.4
Treasury	-	0.1	0.7	1.6	1.6
Total	0.1	8.5	51.6	51.3	44.8
<i>DHS Capital Expense</i>	-	2.4	2.8	0.4	-

These include:

- An additional dose of Diphtheria, Tetanus and Acellular Pertussis (DTPa) vaccine for children aged 18 months for extra protection against whooping cough (from 1 Jan 2016).
- Zostavax vaccine to prevent shingles for 70 year olds, with a catch up program for 71–79 year olds (from 1 November 2016).

In addition, this provision in the Budget states that a vaccination register will be established to record all adult vaccines provided under the NIP from 1 September 2016.

Health professionals have called for the introduction of a whole-of-life register to include adult vaccinations. However, as pointed out by the Parliamentary Library,¹¹⁹ the exact nature of the Government's response on this issue is not clear. A media release from the Minister has the Government 'exploring options to capture adult immunisation records.'

In 2006 the Government announced **\$1.2 million** for a scoping study to examine 'the feasibility of establishing a whole-of-life immunisation register', but it appears that study was never done.

Improving immunisation coverage rates

\$26.4 million / 4 years is provided to improve immunisation coverage rates.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	8.4	4.6	3.1	3.7
Treasury	-	-	1.8	1.9	1.9
Total	-	8.4	6.4	6.0	5.6

¹¹⁹

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201516/Vaccination

This initiative includes:

- An incentive payment to doctors and other immunisation providers when they identify a child who is overdue for vaccination and call them in for a catch up.
- Funds for an awareness campaign to promote the NIP and address parents' concerns regarding immunisation.
- Expansion of the existing National Human Papillomavirus Vaccination Program Register to the Australian School Vaccination Register, to include all adolescent vaccinations delivered in schools under the NIP.

Tobacco plain packaging legislation

The Government will provide funding and continue to defend international legal challenges to the *Tobacco Plain Packaging Act 2011*, which is the subject of dispute proceedings in the World Trade Organisation. This funding goes to DoH, the Attorney General's Department, DFAT and the Australian Government Solicitor General; it is not for publication.

Recent news is that Ukraine will drop its case against Australia which was instigated at the request of the American Chamber of Commerce.¹²⁰ Other cases have been filed by Honduras, Dominican Republic, Cuba and Indonesia.

A leaked chapter of the Trans Pacific Partnership (TPP) contains information about the TPP's proposed investor-state dispute settlement (ISDS) clause. Such clauses give investors direct access to international arbitration, where they can bring claims against a government over regulatory measures they think may damage their bottom line. This could enable Big Tobacco to contest Australia's plain packaging laws. The leaked chapter has a footnote saying Australia is exempt from ISDS, but that may change 'subject to certain conditions'. The draft doesn't indicate the exact nature of these conditions, and the footnote remains in brackets, indicating the issue has not yet been settled.¹²¹

Reforms to National Cervical Screening Program

The National Cervical Screening Program (NCSP) will be reformed to reflect recommendations from MSAC at a net cost of **\$13,000 / 4 years**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	2.2	2.0	-0.1	-0.6
DHS	-	-	-0.3	-1.6	-1.6
Total	-	2.2	1.7	-1.7	-2.2

From 1 May 2017, the current two-yearly Pap test will be replaced by a 5 year HPV test for women aged 25-74 years.

¹²⁰ <http://www.smh.com.au/world/ukraine-likely-to-drop-plain-packaging-challenge-against-australia-20150605-ghevfi.html>

<http://theconversation.com/leaked-tpp-investment-chapter-shows-risks-to-australias-health-39799>

¹²¹

An HPV test every five years is considered more effective at protecting against cervical cancer and just as safe as, screening with a Pap test every two years.¹²² HPV vaccinated women will still require cervical screening as the HPV vaccine does not protect against all the types of HPV that cause cervical cancer.

Renewal of National Drugs Campaign

\$20 million / 2 years is provided to renew the National Drugs Campaign. This will be used for a national media campaign focused on awareness of the harms caused by methamphetamine (ice).

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	10.0	10.0	-	-

In the 2010-11 Budget, cuts were made to the National Drugs Campaign, but **\$21.2 million / 4 years** was provided to continue a national media campaign to promote the avoidance and cessation of illicit drug use. The campaigns were to focus on ecstasy, methamphetamine and cannabis use by young people. No further funding was provided in 2014-15.

In the 2014-15 MYEFO the Abbott Government abolished the Drug and Alcohol Prevention and Treatment Advisory Committee. Since then, the Government has chosen to focus solely on the problems associated with ice use. This is happening even as **\$8 million** is cut from drug and alcohol programs funded through the Flexible Funds.

In April 2015 the Prime Minister announced a task force to tackle the current ice problems in the community and in criminal gangs.¹²³ The taskforce will coordinate local, state and federal efforts against the use, sale, manufacture and importation of the drug and develop a national ice action strategy. An interim report is due by the middle of the year.

In May 2015 the Government launched what was described as a **\$9 million**, six-week blitz campaign.¹²⁴ (Note that elsewhere the campaign has been described as costing **\$11 million**.) This involved an ad almost identical to one first aired in 2007. The recycling of this ad may explain how funding was available for this in 2014-15.

In 2013 advice was provided to DoH that shock and awe advertising campaigns about drugs are a turn off for young people.¹²⁵ Despite this, the Abbott government's advertising blitz on ice has adopted a hard-hitting approach by depicting an ice user violently lashing out in a hospital.

The National Drug Strategy 2010-2015 expires this year.

¹²² <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/MSAC-recommendations>

¹²³ <https://www.pm.gov.au/media/2015-04-08/national-ice-taskforce-0>

¹²⁴ <http://www.abc.net.au/news/2015-05-10/federal-government-launches-graphic-ice-ad-campaign/6457810>

¹²⁵ <http://www.theage.com.au/victoria/shock-and-awe-ice-campaigns-a-turn-off-research-20150522-gh7as2.html>

Indigenous Health

There were no specific Indigenous issues included in the Health budget, and there are questions about the future of some programs.

Aboriginal Community Controlled Health Organisations

The Abbott Government has provided **\$1.4 billion / 3 years (\$448 million / per year)** for Aboriginal Community Controlled Health Organisations (ACCHOs). This will include a 1.5% CPI increase over the 3 year period. This appears to be a reduction from current funding levels.¹²⁶ NACCHO and Affiliate funding of **\$18 million** is provided for 18 months and in that time DoH will commence a review of NACCHO's role and function.¹²⁷

In addition, NACCHO has secured confirmation of an extension of the exemption from Section 19.2 of the *Health Insurance Act 1973* which expires on 30 June 2015, which enables ACCHOs to receive financial benefit from Medicare rebates in addition to Government funding. This extension will be granted until June 2018.

The freeze on MBS rebate indexation will have a significant financial impact on ACCHOs as will any increase in Medicare and PBS co-payments.

Flexible Funds

In combination the 2014-15 and 2015-16 Budgets will cut **\$500 million / 4 years** from 14 of the 16 DoH flexible funds. There is still no clarity in relation to how these savings are to be achieved, although the Aboriginal and Torres Strait Islander Chronic Disease Fund will not be cut. However cuts to other funds such as those that support the provision of essential services in rural, regional and remote Australia, that manage responses to communicable diseases and that deliver delivering substance abuse treatment services will affect Indigenous Australians.

Aboriginal and Torres Strait Islander Chronic Disease Fund

Within the Health portfolio, the Aboriginal and Torres Strait Islander Chronic Disease Fund supports activities to improve the prevention, detection, and management of chronic disease in Indigenous Australians and to contribute to the target of closing the gap in life expectancy. The Fund consolidates 16 existing programs, including the majority of initiatives under the Indigenous Chronic Disease Package, into a single flexible fund. The three priority areas targeted are:

- Tackling chronic disease risk factors
- Primary health care services that can deliver
- Fixing the gaps and improving the patient journey.

¹²⁶ Dr Katrina Alford advises there has been a reduction in ACHHO funding of \$1.112 billion

¹²⁷ http://www.naccho.org.au/download/naccho_health_futures/NACCHO%20Aboriginal%20Health%20%20-%20Post%202015%20Budget%20Analysis.pdf

The Fund was established in the 2011 Budget and came into operation on 1 July 2011. The funding is **\$833.27 million / 4 years** (from 1 July 2011 to 30 June 2015). The majority of funding has been directly allocated to organisations to support activities under the Fund's Indigenous Chronic Disease Package programs.¹²⁸

At June 2015 Senate Estimates it was confirmed that most, but not all, of the activities under this fund were continuing. Local community campaigns and the chronic disease self-management program were named as two programs that were not continued.

Tackling Indigenous Smoking Program

The 2014-15 Budget cut **\$130 million / 5 years** from the Tackling Indigenous Smoking Program, despite the fact that 44% of Indigenous people smoke.¹²⁹ The program was reviewed in 2014 and the DoH website says that this review will "provide the Government with options to ensure the program is being implemented efficiently and in line with the best available evidence. The outcome of the review will inform new funding arrangements from 1 July 2015."¹³⁰ However there were no announcements in the Budget.

The redesigned program was announced on 29 May 2015, but with no increase in funding.¹³¹ It is not clear when or if the review of this program, conducted by the University of Canberra, will be released.

Funding in 2014-15 was **\$46.4 million**; this is reduced to **\$35.3 million** in 2015-16. Staffing levels have also fallen significantly, from 284 FTEs in May 2014 to 194 FTEs in May 2015. There will be further disruption to this important program as current contracts cease at the end of June 2015 and the 49 organisations that deliver the program must go through the IAS Invitation to Apply Process for further funding. Transitional funding will be available for the next 6 months.

Australian Nurse Family Partnership Program and New Directions: Mothers and Babies Services

In the 2014-15 Budget there was additional funding for a Better Start to Life will improve early childhood outcomes :

- **\$54 million** expansion, from 2015-16, of New Directions from 85 to 137 sites (52 additional sites overall) to ensure more Indigenous children are able to access effective child and maternal health programs.

¹²⁸ http://www.checkup.org.au/icms_docs/162956_GUIDELINES_MOICDP_Funding_Guidelines.pdf

¹²⁹ <https://theconversation.com/indigenous-smoking-program-cuts-risk-widening-the-gap-29051>

¹³⁰ http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/tackling_indigenous_smoking

¹³¹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-nash025.htm>

- **\$40 million** expansion, from 2015-16, of the Australian Nurse Family Partnership Program from 3 to 13 sites (10 additional sites overall) to provide targeted support to high needs Indigenous families in areas of identified need.

In 2015 the Australian Nurse Family Partnership Program will grow from three to five sites and New Directions: Mothers and Babies Services will reach an additional 25 services, bringing the total to 110 services, with an enhanced capacity to identify and manage Fetal Alcohol Spectrum Disorder in affected communities.¹³²

Prevention – Shingles vaccine

The Budget provides for the listing of Zostavax vaccine for the prevention of shingles to be listed on the National Immunisation Program for 70 year olds from 1 November 2016. This measure includes a 5-years program to provide a catch-up program for people aged 71-79.

There is concern that the 70-79 year old age cohort largely excludes Indigenous people because of their lower life expectancy.

Pharmaceutical Benefits Scheme

Close the Gap PBS Co-payment

This is an ongoing measure and although it was not mentioned in the Budget, it was stated in Senate Estimates that this would continue as currently.

QUMAX Program

The QUMAX program is a quality use of medicines initiative that aims to improve health outcomes for Indigenous people through a range of services provided by participating ACCHO and community pharmacies in rural and urban Australia. It commenced in 2008 as a two year pilot. It was later approved for a transition year outside the 4th Community Pharmacy Agreement and for a further four years under the 5th Community Pharmacy Agreement.¹³³

NACCHO and the Pharmacy Guild of Australia have been negotiating 1 year transition funding of QUMAX to enable development of an Implementation Plan under the 6th Community Pharmacy Agreement. NACCHO will seek to expand QUMAX from 76 services to 134 services.¹³⁴

¹³² http://www.naccho.org.au/download/naccho_health_futures/NACCHO%20Aboriginal%20Health%20%20-%20Post%202015%20Budget%20Analysis.pdf

¹³³ <http://www.naccho.org.au/promote-health/qumax/>

¹³⁴ http://www.naccho.org.au/download/naccho_health_futures/NACCHO%20Aboriginal%20Health%20%20-%20Post%202015%20Budget%20Analysis.pdf

Medicare provisions

MBS Practice Incentive Program (PIP) Indigenous Health Incentive

This is an ongoing program (although it may be subject to an indexation freeze). It is expected to be considered as part of the new MBS Review.

Healthy Kids Check

The Budget cut Medicare funding for the Healthy Kids Check, a consultation with a nurse or GP to assess a child's health and development before they start school, on the basis that this measure is a duplication with existing State and Territory based programs. NACCHO states that this change will not impact ACCHOs or Indigenous children as ACCHOs can continue to bill health assessments through a separate item (MBS item 715).

Primary care - PHN Funding

The current transition of Medicare Locals (MLs) to Primary Health Networks (PHNs) is proceeding slowly and many details relating to specific programs remain unknown, perhaps even undecided.

To date, 21 of 61 MLs outsource the provision of services for Indigenous Australians directly to ACCHOs. The provision of these services will now move to a competitive commissioning process, leading to concerns about issues such as cultural safety and sensitivity.

The Minister for Health, Sussan Ley, has advised NACCHO that funding for Complementary Care and Supplementary Services will transition to the PHNs.¹³⁵

Mental Health

The Budget has nothing that responds to the National Mental Health Commission's review of programs and services. The report describes Indigenous mental health as 'dire'. It's a dominant over-arching theme throughout, and there is a recommendation to make Indigenous mental health a national priority and agree an additional COAG Closing the Gap target for mental health.¹³⁶

There is a particular need to address the link between incarceration and mental illness. Among Indigenous people in prison, the rates of mental illness such as anxiety, depression, substance misuse

¹³⁵ http://www.naccho.org.au/download/naccho_health_futures/NACCHO%20Aboriginal%20Health%20%20-%20Post%202015%20Budget%20Analysis.pdf

¹³⁶ <http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx>

and psychosis, are very high: 73% overall for Indigenous men and 86% for women according to a 2008 estimate from Queensland.¹³⁷

Despite this, the Government has delayed any action and has established an Expert Reference Group to develop implementation strategies. There is no Indigenous representation on the Reference Group.

Substance and alcohol abuse

Alcohol abuse

Alcohol abuse has been identified as a major public health concern among Indigenous people, with serious physical and social consequences. Indigenous Australians between the ages of 35 and 54 are up to eight times more likely to die than their peers, with alcohol abuse the main culprit and alcohol is associated with 40% of male and 30% of female Indigenous suicides.¹³⁸

Fewer Indigenous people drink alcohol than in the wider community, but those who do drink do so at levels harmful to their health. Culturally appropriate intervention approaches are needed and 'dry zones' are only seen as stop gap measures.

Cuts made in Flexible Funds will affect Indigenous drug and alcohol programs.

Ice campaign

This Budget commits **\$20 million / 2 years** for a new stage of the National Drugs Campaign primarily aimed at the use of ice. No consultation has been undertaken in the lead up to the announcement of this health promotion campaign.

It almost certainly will not achieve tangible outcomes for Aboriginal people, despite concerns about a growing ice epidemic in remote Indigenous communities.¹³⁹

Opal fuel

There are 123 petrol stations selling Opal fuel in remote parts of Australia but some retailers in the roll-out zones don't and there are pockets of sniffing near state borders. In December 2014 it was announced that a bulk storage tank for low-aromatic unleaded fuel (LAF or Opal) is to be installed in northern Australia as part of the roll-out of OPAL in the fight to curb the problem of petrol sniffing.¹⁴⁰

¹³⁷ <https://www.mja.com.au/journal/2012/197/1/prevalence-mental-illness-among-aboriginal-and-torres-strait-islander-people>

¹³⁸ <http://www.theguardian.com/australia-news/2015/feb/20/alcohol-abuse-behind-high-rates-of-early-death-among-indigenous-study-finds>

¹³⁹ <http://nacchocommunique.com/2015/04/10/naccho-aboriginal-health-news-there-is-no-escape-from-the-ice-epidemic-in-aboriginal-communities/>

¹⁴⁰ <http://www.theguardian.com/australia-news/2014/dec/08/new-storage-tank-for-low-aromatic-fuel-aims-to-combat-nt-petrol-sniffing>

Rural health

The 2015-16 Budget offered little for rural and remote health. The single major provision that directly benefits rural and remote areas is the retargeting of financial incentives to encourage doctors to work in small rural towns, but this comes at the expense of larger rural and regional centres and outer metropolitan areas, many of which also have serious workforce shortages.

Rural and remote areas have generally older populations, higher levels of health risks, and higher rates of chronic disease. In addition there are the pressures of the problems affecting the social, economic and environmental sustainability of their communities. Despite greater levels of need, rural people have less access to health services, with substantial shortages of nearly all health professions and of health-related infrastructure.¹⁴¹

Certain population groups suffer more than others. Around 70% of Indigenous Australians live in regional and rural areas and their health and wellbeing is tragically deficient. Men in rural regions face distinct health issues: they are more likely than their urban counterparts to experience chronic health conditions, have higher mortality rates from injury, cardiovascular disease and diabetes, and report risk factors such as daily smoking and risky drinking behaviour and poor health literacy.¹⁴²

There is less access to specialised mental health care in rural areas where suicide rates are highest. 'Rural stoicism', resilient attitudes and lower educational levels also influence help-seeking behaviour, readiness to engage with mental health services, and adherence to preventive advice. The NHMC report on mental health services recommended that the development of Primary Health Networks provides an ideal opportunity to harness the existing infrastructure and better target mental health resources to meet population needs on a regional basis.¹⁴³ The big winners from this approach would be those living in rural and regional Australia who suffer most from the current lack of effective community and professional services in their own local areas.

Some cuts to rural health programs have been made by stealth and remain unknown. Assistant Minister for Health, Fiona Nash, has refused to provide details of funding cuts to the Rural Health Outreach Fund and which rural services will be affected.¹⁴⁴

Workforce numbers remain an issue for rural and remote areas. It's not clear if proposed changes to rural relocation incentives for doctors and dentists will work better than the existing arrangements (there has apparently been no modelling done) and the new arrangements have not built in mechanisms to address Indigenous needs.

¹⁴¹ <http://ruralhealth.org.au/sites/default/files/publications//nrha-factsheet-way-forward.pdf>

¹⁴² <http://www.aihw.gov.au/publication-detail/?id=6442468343>

¹⁴³ <http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx>

¹⁴⁴ http://www.stephenjones.org.au/abbott_government_cuts_and_runs_on_rural_health

The new geographical classification scheme to be introduced is based on the work done by Professor John Humphreys at Monash University.¹⁴⁵ This is the second geographical classification system to be introduced in the past 6 years. In July 2009 the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA), developed by the Australian Bureau of Statistics, was introduced. The new scheme seems to be well accepted but there will always be anomalies and so flexibility is needed in implementation.

The Budget Papers this year highlight the Abbott Government’s Partnership for Regional Growth and the White Paper on Developing Northern Australia. The Budget Papers list the following new initiatives as particularly relevant to regional Australia:

- Streamlining health workforce scholarships : a rural return of service obligation will now be associated with most scholarships (see Workforce section).
- Better targeted rural financial incentives for doctors.
- Consolidated and streamlined dental workforce programs: the Modified Monash Model will be applied. (no further information about this initiative is provided).
- New MBS items for targeted intraoperative radiotherapy for early-stage invasive breast cancer: this will mean that women in rural and remote areas will not need to travel for radiotherapy after surgery (see Medicare section).
- New MBS listing for remote monitoring of patients with implanted cardiac devices (see Medicare section).
- MBS rebates for optometrist to assist patients during telehealth consultations with ophthalmologists (see Medicare section).
- Positioning the north as a global leader in tropical health.

Budget provisions

Better targeted rural financial incentives for doctors

Existing medical training programs will be reprioritized to better target rural areas. Exact funding levels cannot be ascertained from the Budget Papers. It is not clear what the funding in the table below means.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	0.6	2.6	..	-0.1	-0.1
DHS	-0.6	-2.6	..	0.1	0.1
Total	-	-	-	-	-

Funding from the More Doctors for Outer Metropolitan Areas Relocation Incentive Grant and the HECS Reimbursement Scheme will be redirected to the GP Rural Incentives Program (GPRIP). The expanded GPRIP will be redesigned to a seven step scheme to increase incentives for GPs in smaller rural

¹⁴⁵ https://consultations.health.gov.au/hwd-access-incentives-branch/independent-expert-panel-public-submissions/supporting_documents/Discussion%20Paper%20Modified%20Monash%20Model.pdf

communities, based on the Modified Monash Model of rural classification. Incentive payments will be adjusted, based on where doctors choose to practise and their years of service. In media release this is described as a **\$113 million** (over 4 years?) program.

The GPRIP was introduced by Labor in 2010. The program then was formed by consolidation of the Rural Retention Program (RRP) and the Registrars Rural Incentive Payments Scheme. It was funded at \$64.3 million / 4 years. According to the Minister’s media release at the time, a GP relocating from a major city to a regional centre would receive a \$15,000 grant, and doctors who practice in the most remote locations would potentially have their maximum retention incentives increased from \$25,000 per year to \$47,000 per year.

Indicative modelling by DoH of this new program shows a doctor who stays in a very remote area for five years could earn up to \$60,000 as an incentive payment, whereas a doctor choosing a less remote region and only staying for two years could receive about \$4,000 in incentive payments. Research has found doctors would only consider relocating to a rural location of 5,000 people or less for an additional 64% of their current salary, well above the current government incentive payments.

On 1 December 2014, Minister Nash announced that an Independent Expert Panel would consider the application of the Modified Monash Model (MMM) to GPRIP, and also consider pathways for junior doctors to rural practice.¹⁴⁶

Not all of the recommendations of the Expert Panel report have been implemented; in particular, the recommendation that rural GPs often deliver complex care within their communities and that GPRIP payments is not the most efficient mechanism to reward this higher level of community service. The Panel strongly recommended that some funds from the existing GPRIP should be redirected to existing programs which recognise this more complex work, such as the Practice Incentives Program (PIP) Procedural General Practitioner Payments.

The retargeted money does not include a target for bolstering health services in Indigenous communities.

Changes to relocation incentives for dentists

In Senate Estimates it was elucidated that **\$30 million** will be cut from DRISS through the application of the MMM and targeting smaller rural towns.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	29.2	18.95	19.2	19.4

Figures provided in Senate Estimates

It is a signal either that dental care doesn’t rate with this Government or that there is embarrassment about cutting a program to deliver more dental care to rural areas, but the application of similar principles to those above to the Dental Relocation Incentive Support Scheme (DRISS) is hidden away in the Budget under the provisions for the ‘rationalisation and streamlining Health programs’.

¹⁴⁶ http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Independent_Expert_Panel

The DRISS has not been evaluated and the DoH has admitted that Impact of reduced funding and MMM on DRISS and actual relocations is not clear. What is known is that 4 rounds of DRISS resulted in 128 successful allocations for dentist relocation to regional/rural areas.

Supporting the Royal Flying Doctor Service

Additional funding of **\$20 million / 2 years** is provided to support the Royal Flying Doctor Service (RFDS).

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	9.9	10.1	-	-

This additional funding will provide **\$68 million** for each of the next two years. The Prime Minister has also (separately) announced **\$33.7 million / 4 years** for a Remote Airstrip Upgrade Program.¹⁴⁷

The RFDS has always been funded from budget cycle to budget cycle, with occasional 'top ups'. The 2007-08 budget provided additional funding of **\$156.6 million / 5 years** from 2006-07 to 2010-11 and this was described as bringing total funding for this period to **\$274 million**.¹⁴⁸ The RFDS received several funding grants from the Health and Hospitals Fund in the 2012-13 Budget for a new Base building and accommodation in Charleville, a hangar and patient transfer facility in Roma, and a new dental health project.

The extent to which the RFDS relies upon federal funding is unknown; it also receives funding from state governments and private sources.

Wimmera Health Care Group – Redevelopment of oncology, dialysis and community palliative care centre

\$1 million is provided in 2014-5 to the Wimmera Health Care Group for the redevelopment of the Oncology, Dialysis and Community Palliative Care Centre in Horsham, Victoria.

This funding is to supplement the **\$2 million** of privately raised funds that will be needed for the new centre. The Budget Papers state that the cost of this measure will be met from the existing resources of the Department of Infrastructure and Regional Development. This is not reflected in the way the budget provision is written.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Dept Infrastructure and Regional Development	-	-	-	-	-
DoH	1.0	-	-	-	-
Total	1.0	-	-	-	-

¹⁴⁷ <http://www.flyingdoctor.org.au/News.html?NewSite=1&ItemID=896>

¹⁴⁸ <http://www.budget.gov.au/2007-08/ministerial/html/dotars-18.htm>

This provision was announced by the Prime Minister in March 2015. This funding is clearly to boost support for the local member Andrew Broad. In local media statements this is described only as an oncology centre. Building is apparently not due to start until 2017.

Developing Northern Australia – positioning the north as a leader in tropical health

\$15.3 million / 4 years is provided to invest in research into exotic disease threats. This includes **\$6.8 million** to the NHMRC and **\$8.5 million** to establish an Australian Tropical Medicine Commercialisation Grants program.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Aust Trade Commission	-	1.4	2.2	2.7	2.3
NHMRC	-	0.9	2.2	2.2	1.5
Total	-	2.3	4.4	4.9	3.8

The Northern Australian Tropical Disease Collaboration Program, funded through the NHMRC, is described as supporting innovative research into tropical diseases, building strong collaborations and capacity in the health and medical workforce, and promoting effective translation of research into health policy and practice. Research will focus in tropical diseases with a high impact on human health including: dengue, malaria, melioidosis, Lyssa Hendra and Nipah viruses, chikungunya and Murray Valley encephalitis and multi-drug resistant TB. .

The Australian Tropical Medicines Commercialisation Grants program will be an Austrade initiative delivered by the Department of Industry and Science. It is described as looking to take advantage of business opportunities by establishing targeted funding to translate and commercialise research in new therapeutics and diagnostics in tropical medicine.

It is not clear if these initiatives are targeted specifically at the Australian Institute of Tropical Health and Medicine (AITHM) at James Cook University.

Cuts to Rural Health Outreach Flexible Fund

At Senate Estimates there was information that there would be cuts to this fund but no indication as to the extent of those cuts. By extrapolation from the information given, it appears that this fund will be cut by **\$10.7 million**. Given that the total expenditure for this fund is around **\$31 million / year**, this could mean a significant impact on the programs run under this Flexible Fund.

These programs include:

- Medical Specialist Outreach Assistance Program (MSOAP)
- MSOAP ophthalmology
- MSOAP multi-disciplinary maternity services
- Rural Women’s GP Service Program

- Kimberley Paediatric Outreach Program

These are all valuable programs for people in rural and remote communities, especially women. Budget cuts at any level will have major consequences.

Other issues

Prevocational training

The expert panel that provided advice to the Government on the redesign of the GPRIP also recommended that the Government re-introduce the Prevocational General Practice Placements Program (PGPPP) which provides junior doctors with a rural general practice experience as part of their prevocational training. The report recommended “that the Government consider a range of options to introduce a program that provides a high quality community medicine and general practice training in rural and remote areas through extended placements for junior doctors”.

The PGPPP was discontinued in the 2014-15 Budget.

Workforce

The 2014-15 Budget abolished Health Workforce Australia (HWA) and saw its responsibilities subsumed into the DoH even as the Department was hit with required efficiency dividends, staff cutbacks and multiple restructures. We will almost certainly pay the price for the loss of a national, coordinated approach to health workforce reform.

One of the last reports published by HWA summed it up succinctly: “The medical workforce is a national resource; a resource that is valuable to the community both in terms of the cost of training, which is substantially borne by the taxpayer, and in terms of the benefit derived by the community from a well trained health workforce. Uncoordinated decision making in the past in the absence of an active workforce planning mechanism has seen a “boom and bust” cycle in medical training and resulting doctor numbers. This has a cost to the community and a cost to the taxpayer.”¹⁴⁹

Review of Rural Practice Incentives.

A number of changes have been made to rural practice incentives on the basis of a review by an expert panel. The review, to consider the application of the Modified Monash Model (MMM) to the General Practice Rural Incentive Program (GPRIP) and also consider pathways for junior doctors to rural practice was commissioned on 1 December 2014 by Assistant Health Minister, Fiona Nash.¹⁵⁰

The expert panel reached the following conclusions:

- There is a reduced need to incentives to attract doctors to larger regional centres and incentives should be applied to smaller rural and more remote areas where they are more likely to compensate for the negative factors affecting recruitment, retention and support for comprehensive practice.
- Increased numbers alone are not the solution. The solution needs to be based on community health needs and appropriate service delivery models. Small rural communities require access to comprehensive primary care, emergency services, hospital care and maternity and procedural services. This in turn implies broadly skilled practitioners and teams operating within a training, referral and visiting service network as a 'system of care'
- Doctors in these smaller rural and remote areas are required to possess an advanced skillset including procedural and emergency medicine and to have greater workload flexibility to meet the needs of the community. Currently many doctors in these areas are either in-training or completing return-of-service obligations and may not have acquired the necessary skills to meet the needs of their communities.

¹⁴⁹

[https://www.health.gov.au/internet/main/publishing.nsf/Content/F3F2910B39DF55FDCA257D94007862F9/\\$File/AFHW%20-%20Doctors%20report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/F3F2910B39DF55FDCA257D94007862F9/$File/AFHW%20-%20Doctors%20report.pdf)

¹⁵⁰ http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/Independent_Expert_Panel

- Implicit in a viable practice model is sustainable delivery of services in rural and remote communities that are comprehensive and continuing across primary care / general practice into extended settings. Inherent in the model must be scope for adequate succession planning and system solutions that go beyond individual commitment, skills and personalities.
- GPRIP incentives should form part of a range of incentives that recognise the skills and work of rural and remote doctors. As a retention incentive, the GPRIP should be made available during critical points in a rural doctor's career path (after 2-3 years of service).
- Rural doctors require greater access to leave provisions to allow for upskilling, recreational leave, etc. both during and after their training.
- It is important that essential that junior doctors continue to have access to early and ongoing pathways to rural practice that will provide high quality general practice training through extended placements in rural locations. This education and training should not be limited only to those doctors who seek to practice in rural or remote areas but be available to doctors who may seek other career paths.
- The development of new training pathways will require key input and support from state jurisdictions and educators to ensure a fully integrated and coordinated medical education and training pipeline.

Unfortunately the full recommendations of this comprehensive and far-sighted report were ignored by Government which chose simply to revamp the GPRIP and similar incentives for dentists. These incentives now carry sufficient economic value that they will likely work in the short-term; but given that financial incentives are just one aspect of what attracts and retains well-qualified doctors (and dentists) to rural and remote areas, it remains to be seen if the new incentives programs will work long-term.

The recommendations about skill levels, team work, new practice models and locum relief remain to be addressed.

Prevocational training

The review also recommended that the Government re-introduce the Prevocational General Practice Placements Program (PGPPP) which provides junior doctors with a rural general practice experience as part of their prevocational training as part of a range of options for programs to *provide* "high quality community medicine and general practice training in rural and remote areas through extended placements for junior doctors".

The PGPPP was discontinued in the 2014-15 Budget. The Government's decision to cease the PGPPP from January 2015 came as a shock to the medical profession.

A recent study¹⁵¹ which compared general practice rotations with hospital rotations in relation to teaching and support, acquisition of skills and knowledge, and role autonomy found that the PGPPP rated better than all hospital rotations in 15 out of 20 areas.

GP Training

DoH has finally reached agreement with professional bodies on terms of reference for a profession-led GP Training Advisory Committee (GPTAC).¹⁵² The new body, which will have representation from the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, General Practice Registrars Australia, General Practice Supervisors Australian and independent member, will have a policy advisory function.

But until the body is established later this year, GP training governance remains in limbo and the tender period for applicants to run 11 new regional registrar training organisations (RTOs) ends next week.

In September, a new cohort of 1500 successful applicants for 2016 will add to the 8000-odd already in training.

Under the 2014 federal budget, the functions of GP Education and Training were to be transferred to DoH. But negotiations about roles in education and training for the RTO, colleges and DoH have yet to conclude.

Budget Provisions

Better targeted rural financial incentives for doctors

Existing medical training programs will be reprioritized to better target rural areas. Exact funding levels cannot be ascertained from the Budget Papers. It is not clear what the funding in the table below means.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	0.6	2.6	..	-0.1	-0.1
DHS	-0.6	-2.6	..	0.1	0.1
Total	-	-	-	-	-

Funding from the More Doctors for Outer Metropolitan Areas Relocation Incentive Grant and the HECS Reimbursement Scheme will be redirected to the GP Rural Incentives Program (GPRIP). The expanded

¹⁵¹ <http://onlinelibrary.wiley.com/doi/10.1111/tct.12224/abstract>

¹⁵² <http://www.medicalobserver.com.au/news/concern-as-gp-training-regime-still-in-limbo>

GPRIP will be redesigned to a seven step scheme to increase incentives for GPs in smaller rural communities, based on the Modified Monash Model of rural classification. Incentive payments will be adjusted, based on where doctors choose to practise and their years of service. In media release this is described as a **\$113 million** (over 4 years?) program.

For further details see section in Rural Health.

Changes to relocation incentives for dentists

In Senate Estimates it was elucidated that **\$30 million** will be cut from DRISS through the application of the MMM and targeting smaller rural towns.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	29.2	18.95	19.2	19.4

Figures provided in Senate Estimates

For further details see section in Rural Health.

Interagency transfer from Department of Veterans' Affairs of Junior Medical Officer Program

Responsibility for the Junior Medical Officer Program is transferred from the DVA to DoH.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	10.0	.010,	10.0	10.0
DVA	-	-10.0	-10.0	-10.0	-10.0
Total	-	-	-	-	-

This program provides training for junior doctors at the Greenslopes Private Hospital in Queensland and the Hollywood Private Hospital in Western Australia.

Streamlining health workforce scholarships

Savings of **\$72.5 million / 4 years** are taken by streamlining 9 health workforce scholarships into a single Health Workforce Scholarship Program. It is not clear how the savings are achieved, but savings of this order are unlikely to result simply from streamlining.

These savings are directed to fund other health policy priorities or to the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DOH	-	-14.2	-17.8	-19.0	-21.7

A return of service obligation will apply and will require recipients to work in rural or regional areas for one year. The Health Portfolio Budget Statement states that this measure, which applies to the current range of medical, nursing and allied health scholarships within the Health portfolio, is aimed at producing a more effective program and encourage more students to work in regional and rural areas. This measure will not affect the Puggy Hunter scholarships for Indigenous Australians.

In addition, the 100 places for medical students under the Medical Rural Bonded Scholarships Scheme (MRBS Scheme) will be transferred to the Bonded Medical Places Scheme (BMP Scheme). Currently, under the MRBS Scheme, medical students must work for six continuous years in rural or remote areas after completing their specialist training. Students on the BMP Scheme have greater geographical choice in fulfilling their return of service obligation – they must work in a district of workforce shortage area for a period of time equal to the length of their medical degree.

This change will mean that about 28.5% of medical students will be bonded.

The Mason Review of health workforce programs¹⁵³ found that there was limited evidence to show whether the desired workforce outcomes are actually achieved through scholarship programs. There is insufficient Australian academic literature or research on the issue of whether scholarships affect an individual's choice to enter and/or to remain in the health workforce. However there is some evidence to suggest that students from rural areas are more likely to practice in rural locations on completion of their training and so scholarships targeted to students of rural origin could therefore play an important distributional role.

However the Mason review found that rural bonding is seen as stigmatising rural practice. Many who have taken up these scholarships seek release from their obligations. The Mason review, conducted in 2013, found that in the decade since its introduction, fewer than 50 MRBS Scheme recipients had commenced their return of service period. On the other hand, Rural Australia Medical Undergraduate Scholarships (RAMUS) scheme is popular and oversubscribed.

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[http://www.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/\\$File/Review%20of%20Health%20Workforce%20programs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf)

e-Health

It appears that the Abbott Government about to begin a whole new strategy for e-health but without a roadmap to guide them.

The 2015-16 Budget presents the Government's response to the Royle Review of the Personally Controlled Electronic Health Record.¹⁵⁴ This review was commissioned in November 2013 and then Minister for Health, Peter Dutton, received the report in December 2013. However it was not released until May 2014 and the response has only come a year later.

The delay has proved expensive in terms of lost opportunities to improve the operation of the PCEHR, build public interest and increase use by healthcare providers and the public, and the money that has been spent.

The PCEHR project was initially funded in the 2010-11 Budget, with the provision of **\$466.7 million / 2 years** to establish the key components of the PCEHR system. Access to the online system was promise by 2012-13. Progress was slow, perhaps because the project was linked to the introduction of individual health care identifiers – always controversial – but also because National e-Health Transition Authority (NeHTA) has a costly history of a slow roll-out of overly complicated projects.

Now the PCEHR will be renamed to My Health Record and NeHTA will be closed and responsibility for e-health records will now be the joint responsibility of the DoH and the new, yet-to-be established Australian Commission for e-Health.

What is happening and not happening in e-health exemplifies the *modus operandi* of this Government, as outlined in the Introduction: everything on hold for a report that is then not released for 500 days and worse, this time is not used to develop a strategy to address the issues highlighted; a pretence that new money is provided when really savings are being taken from funds already in the forward estimates; and a small scale pilot program that may not go anywhere because there is no funding for anything beyond three years.

There is no disagreement from any quarter about the need for and the value of e-health records (although there is a debate about whether this should be personally controlled) – indeed it's a national priority. Currently, the electronic transfer of healthcare records is fragmented because data stored within disparate clinical information systems cannot be easily exchanged and because there are often restrictions as to who has access.

The current version of the PCEHR allows for sharing of clinical documents via a point-to-share environment but this can only happen if the patient and their healthcare providers are registered with and using the PCEHR service. There is no guarantee that all the health professionals involved in the care of a patient will participate and supply information or that the information supplied will be complete, especially as the patient has the ability to hide aspects of their record.

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[https://www.health.gov.au/internet/main/publishing.nsf/Content/17BF043A41D470A9CA257E13000C9322/\\$File/FINAL-Review-of-PCEHR-December-2013.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/17BF043A41D470A9CA257E13000C9322/$File/FINAL-Review-of-PCEHR-December-2013.pdf)

There is a debate about whether, even with proposed improvements, the PCEHR / My Health Record is what is really needed, given the previously noted factors that contribute to its incompleteness. Doctors cannot rely on the record and indeed the AMA's guidelines state that it should only be used as a 'memory prompt' not as a clinical history.¹⁵⁵ A submission to the PCEHR review detailed the significant clinical risks inherent in a patient-controlled record.¹⁵⁶

Still despite these problems and misgivings, the evidence suggests that a revamped PCEHR / My Health Record can contribute to improved healthcare and help patients be engaged in their healthcare management.

The major outstanding issues to address the current inadequacies and to support efficient healthcare delivery and continuity of care are:

- The development of an agreed set of standards for the clinical content.
- Technical requirements to support the cost-effective and safe (appropriate privacy protections) point-to-point transfer of patient records.
- Standards to ensure meaningful and safe clinical use.

However it seems that there will be no rapid changes. The Portfolio Budget Statement for Outcome 7.1 (e-Health) indicates that an Implementation Taskforce will be established to oversee and manage the transition of governance arrangements and operations from NeHTA to DoH and the Australian Commission for eHealth. The Commission will assume responsibility for the governance, operation and ongoing delivery of e-Health activities from 1 July 2016. It is not clear if the role of DoH is simply to oversee the work of the new Commission or whether it will also be involved in the implementation of e-Health activities. The recommendation was that the Commission report to COAG.

The proposed opt-out trials for the My Health Records will begin in 2016, but will not have much to show in the way of results for several years – and currently funding for this project effectively ceases in June 2018.

In her media statement the Minister for Health, Sussan Ley, said that, "In addition to improving patient health outcomes, it's also been identified that a fully-functioning national e-health system could save taxpayers **\$2.5 billion** per year within a decade by reducing inefficiencies, with an additional **\$1.6 billion** in annual savings also delivered to the states."¹⁵⁷ This is a very different figure to the 2010 estimate of Booz and Co that annual savings would be **\$7.6 billion**, although this was for a fully implemented system with 100% participation.¹⁵⁸

Up-to-date data on PCEHR enrolments are hard to find. The Minister's media release stated that less than 10% of Australians have an e-health record. The 2013-14 PCEHR Report states that on 30 June

¹⁵⁵

https://ama.com.au/sites/default/files/documents/AMA_Guide_to_using_the_PCEHR_Final_June_2012_Formatte_d_300812.pdf

¹⁵⁶ <http://coiera.com/2013/11/29/submission-to-the-pcehr-review-committee-2013/>

¹⁵⁷ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley050.htm>

¹⁵⁸ <http://www.strategyand.pwc.com/anzsea/home/press/press-releases/displays/48757598>

2014 the number of people with a PCEHR was 1,729,846 and the number of healthcare provider organisations registered to participate in the PCEHR system was 7,233.

A NeHTA report card with data to July 2013¹⁵⁹ showed enrolments from:

- 72 Aboriginal Medical Services
- 7 aged care facilities
- 47 allied health
- 70 community health centre
- 271 community pharmacy
- 3723 general practice (53% of total general practices in Australia)
- 50 Medicare Local/State/Territory or Area Health Service
- 3 private hospitals
- 8 public hospitals
- 73 specialists
- 175 other or unknown.

Although this information is now out of date (one report has almost 200 hospitals now with the capability to upload PCEHR data¹⁶⁰), clearly there is much more work to be done to increase enrolments of both patients and providers, especially hospitals.

In 2015-16 the Practice Incentives Program (PIP) e-Health Incentive (e-PIP) will be reviewed in order to attract more GP practices to the use of My Health Record. It is not clear if this review will be done by DoH, a contractor, the new Commission on e-Health or the Primary Health Care Advisory Group.

Royle Review of the Personally Controlled Electronic Health Record.

The PCEHR review was undertaken in a very short period of time in late 2013 by a team consisting of Executive Director of the Uniting Care Health Group, Mr Richard Royle, AMA President Dr Steve Hambleton and Australia Post CIO, Andrew Walduck.

This report was not released until after the Budget (May 19, 2014).¹⁶¹ It makes 38 recommendations to address shortcomings of the system and make it more effective for doctors and patients, but also found strong support for the PCEHR.

Key concerns identified in the report include challenges associated with the registration process linked to the opt-in nature of the PCEHR system, the limited amount of clinically usable information, inadequate governance arrangements and the usability of the system.

¹⁵⁹ http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=1582:nehta-reveals-pcehr-and-ehealth-uptake-data&catid=16:australian-ehealth&Itemid=328

¹⁶⁰ http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=1734:public-hospitals-uploading-discharges-summaries-to-pcehr&catid=16:australian-ehealth&Itemid=327

¹⁶¹ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-dutton038.htm>

Recommendations in the report include:

- Re-naming the PCEHR project to the My Health Record (MyHR) project.
- Commissioning an external review of the Department of Health's eHealth functions.
- Centralising the system operating of the PCEHR platform to the Department of Human Services (which is well-regarded from an IT project perspective).
- Transitioning the project to an 'opt out' model for all Australians from 1 January 2015, to maximise usage.
- That the National e-Health Transition Authority be 'dissolved' due to governance issues and replaced with an Australian Commission for Electronic Health (ACeH), reporting directly to the COAG Standing Council on Health.

Budget Provisions

My Health Record

\$485.1 million / 4 years is provided to continue operation of the eHealth system, make key improvements and implement trials of opt-out arrangements. The savings from this measure will be redirected to fund other health policy priorities or will be reinvested in the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Finance	-	-0.1	-0.1	..	-
DVA	-	-0.1	-0.1	-	-
DHS	-	-12.5	-15.9	-8.6	0.2
DoH	-	-39.6	-82.2	-41.0	5.1
Total	-	-52.2	-98.3	-49.6	5.3
<i>Related capital DHS</i>	-	-0.7	-2.1	-0.4	-
<i>Related capital DoH</i>	-	-9.5	-6.7	-	-
<i>Total - capital</i>	-	-10.1	-8.8	-0.4	-

Funding of **\$699.2 million / 4 years** for the redevelopment of the PCEHR was provisioned for in the contingency reserve at the 2014-15 Budget, so this represents a funding cut of **\$214.1 million**. \$426m / 3 years has been allocated to operating and enhancing the system and educational activities, \$50m is for the opt-out trials as well as changes to the governance arrangements underpinning the PCEHR.

Almost all of the funds provided will be spent over the first 3 years, so the average funding for each year is around **\$160 million**. This compares to **\$140.6 million** to the project for 2014-14. Given the nature of this program, it is not clear why more long-term funding is not provided. One possibility is the expectation that the opt-out trials will have produced sufficient information by that time to inform future policy and budget decisions.

DoH has ambitious plans for the trials, looking to include up to a million people at 2-5 sites. The trials are set to commence in July 2016 with a recommendation on what model works best made to government in 2017. A discussion paper of the necessary changes to legislation to implement the trial has been released.¹⁶²

In order to be successful the trial will need to be matched with the planned review of GP ePIP. To comply with the e-health Practice Incentive Payments (e-PIP), general practices must meet five requirements, including, as of May 2013, the ability to participate in the PCEHR system. The e-PIP provides quarterly incentive payments (capped at **\$12,500** per practice per quarter) for joining and using the national system. Currently practices are paid the ePIP if they install PCEHR-compliant software and other eHealth tools but GPs are not required to use them.

At Senate Estimates DoH indicated that it planned to have revamped incentives in place in early 2016 and it would also look at the PCEHR Teview's recommendations that funding for chronic disease planning be tied to use of the PCEHR. However these incentives apply only to GPs and not to specialists and other health professionals.

¹⁶² <https://consultations.health.gov.au/ehealth/ehr-and-hi-legislation-discussion-paper-1>

Miscellaneous

Accelerating growth in organ and tissue donation for transplantation

\$10.2 million / 2 years to improve organ and tissue donation and transplantation rates.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Aust Organ and Tissue Donation and Transplantation Authority	-	5.9	2.2	-	-
DoH	-	0.6	0.7	-	-
DHS	-	1.3	-0.4	-	-
Total	=	7.8	2.4	-	-

This money is described as:

- Delivering clinical education to hospitals
- Developing a new Australian Organ Matching System
- Enhancing the Australian Organ Donor Register to enable online registration and legal consent.

There is apparently an assumption that the new matching and / or registration systems will deliver small savings to DHS in 2016-17 (and beyond?).

The Supporting Leave for Living Organ Donors Program, which provides minimum wage for up to 9 weeks to employers of people who have taken leave to donate, will continue.

The Australian Organ and Tissue Donation Authority (variously abbreviated at AOTDTA and OTA) is a statutory authority established by the *Australian Organ and Tissue Donation and Transplantation Authority Act 2008*. Since its inception, the OTA has been funded at around **\$48 million/ year**. It works with the states and territories to deliver the national reform program on organ and tissue donation and leads the DonateLife Network, comprising 8 DonateLife organ and tissue donation agencies and hospital based staff in 72 hospitals.

In 2006, the Howard Government established the National Clinical Taskforce on Organ and Tissue Donation. This Taskforce was charged with providing evidence-based advice to government on how the system might be changed to improve the rate of safe, effective and ethical donation for transplantation in Australia. The Taskforce submitted its final report in January 2008.

Some of this report's recommendations were reflected in the Rudd Government's national reform package, announced on 2 July 2008. This package (variously reported as costing **\$151 million** and **\$136.4 million**) was endorsed by COAG and had a number of elements: '

- **\$67 million** to fund dedicated organ donation specialist doctors and other staff in public and private hospitals
- **\$46 million** to establish a new independent national authority to coordinate national organ donation initiatives, to be up and running by 1 January, 2009

- **\$17 million** in new funding for hospitals to meet additional staffing, bed and infrastructure costs associated with organ donation.
- **\$13.4 million** to continue national public awareness and education
- **\$1.9 million** for counselling for potential donor families
- Other significant measures including enhanced professional education programs, consistent clinical protocols, 'clinical trigger' checklists and data collection for organ transplants in hospitals.

In the 2014-15 Budget, the Government announced the merger of OTA and the National Blood Authority (NBA) to create a new independent body by 1 July 2015. This was a recommendation of the National Commission of Audit on the basis that the creation of a single entity would reduce running costs and streamline and consolidate service delivery. However although it may seem that organs, tissue and blood can, as bodily parts and fluids, be treated in similar ways, in fact their clinical and administrative management is very different.

A Parliamentary Committee report found that the potential savings would be negligible and the effort and disruption required to achieve them unwarranted.¹⁶³ The Committee reported that merging the OTA and NBA has the potential to be damaging to the achievement of the aims of the OTA's National Reform Program. There does not appear to be any savings in operational costs over the forward estimates.

Prior to the establishment of the OTA in 2009, organ donation levels in Australia were at a record low. Since 2009, there has been a substantial increase in the number of organ donors in Australia (378 in 2014 compared to 247 in 2009) and the number of transplant recipients (1,117 in 2014 compared to 808 in 2009).¹⁶⁴

The Australian donation rate was 16.1 donors per million people – although there are substantial variations by state and territory. The reasons for this are not known.

Specific state donation rates per million population (dpmp)¹⁶⁵

New South Wales:	12.6 dpmp
Victoria:	20.0 dpmp
Queensland:	15.0 dpmp
South Australia:	21.4 dpmp
Western Australia:	13.6 dpmp
Tasmania:	17.5 dpmp
Northern Territory:	28.6 dpmp
Australian Capital Territory:	18.1 dpmp

¹⁶³

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First%20Interim%20Report/c

¹⁶⁴ <http://www.donatelife.gov.au/discover/facts-and-statistics#sthash.wzOUrnS0.dpuf>

¹⁶⁵ <http://www.donatelife.gov.au/discover/facts-and-statistics#sthash.wzOUrnS0.dpuf>

On May 26, following the Government's recent budget allocation of \$20 million towards improving organ donation rates in Australia, Assistant Minister for Health Fiona Nash announced a review of the current organ and tissue donation and transplantation program, with a specific focus on the role of the Organ and Tissue Authority. The review follows what was described as a 'short study' by DoH and will be undertaken by Ernst and Young.¹⁶⁶ There is no mention of this in the Portfolio Budget Statements and at Senare Estimates it emerged that the Assistant Minister had not met with OTA prior to announcing this review.

The rationale given is that organ transplant rates have not increased as quickly as intended. However there are other possible reasons, including a drive to an opt-out system of donation, a push to blame (state-run) hospitals, and a move to replace DonateLife with a private body.

Following the announcement, television personality David Koch quit the OTA advisory board in protest at "yet another expensive inquiry" into the organ donation system, and accused the Assistant Health Minister of bowing to pressure from the community lobby group ShareLife, which is committed to increasing donation rates above the current ranking of 19th in the world.

An ANAO review released in April 2015 found that overall OTA had made reasonable progress in implementing most measures of the national reform program, including the introduction of a Professional Education Package and National Donor Family Support Service (NDFSS). However, OTA was found to not be achieving the targets set for the program's quantitative performance indicators: donor family request rate and donor family consent rate. OTA advised the Senate Community Affairs Legislation Committee in February 2015 that this was partly attributable to the variability of donation outcomes between states and territories and also to a lack of consistency between states and territories in applying the Family Donation Conversation training, which OTA considered had adversely affected the family consent rate.¹⁶⁷

This it seems that the problems lie more with the states and territories than with OTA. Also currently while 76% of Australians are registered as tissue and organ donors, their wishes are overturned by families 37% of the time.

Consolidation of Bone Marrow Transplant and International Searches Programs

The Bone Marrow Transplant and the International Searches programs will be consolidated into a new Haematopoietic Progenitor Cells Program. The cost of this measure (not specified) will be met from existing DoH resources.

This consolidation is described as streamlining the application and funding process and providing a single set of eligibility criteria, which will reduce the administrative burden for patients, hospital staff and the Australian Bone Marrow Donor Registry (ABMDR).

The Bone Marrow Transplant Program (BMTP), provides financial assistance to eligible individuals requiring life saving Haematopoietic stem cells (HSCs) from overseas donors. The assistance can cover either the cost of bringing the donor or their HSCs to Australia for transplantation and is intended to

¹⁶⁶ <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-nash024.htm>

¹⁶⁷ <http://www.anao.gov.au/Publications/Audit-Reports/2014-2015/Organ-and-Tissue-Donation-Community-Awareness-Professional-Education-and-Family-Support/Audit-summary>

cover costs outside of the Medicare arrangements. HSCs can be sourced through either bone marrow, cord blood or peripheral blood stem cells. Patients requiring this treatment must first find a suitable donor. The Australian Bone Marrow Donor Registry coordinates the searches to match donors with recipients. If a matched donor is unable to be located within Australia the treating hospital, on behalf of the patient, can submit an application for financial assistance under the Bone Marrow Transplant Program.

The ABMDR is funded by the Commonwealth, State and Territory governments through a variety of contracts. It is the only organisation responsible for the recruitment of volunteer bone marrow/blood stem cell donors and the administrative management of the National Cord Blood Collection Network of public cord blood banks in Australia.

Currently 175,400 Australians are registered on the ABMDR and the internationally-linked registry provides access to a database of more than 10 million potential donors worldwide. One in four Australians needing a transplant will be unable to find a donor match within their family and will need to access this registry.

Continuation of National Critical Care and Trauma Response Centre

\$63.5 million / 4 years is provided through a new NP with the Northern Territory for the continued operation of the National Critical Care and Trauma Response Centre (NCCTRC) at Royal Darwin Hospital. The Budget Papers say this funding has already been provided by the Government – meaning it is continued funding in the forward estimates. Only about **\$32 million** of this is new funding as the current NP provides funding of **\$31.3 million** for 2015-16 and 2016-17.

The NCCTRC was announced after the 2002 Bali bombings and formally established in 2005. Its function is to ensure enhanced surge capacity for Royal Darwin Hospital to provide a rapid response in the event of a mass casualty incident in the region. To achieve this objective the NCCTRC has provided significant financial support (around \$15 million / year) to Royal Darwin Hospital to enhance the capability of the hospital’s surgical and trauma divisions.

It is not clear why the Government considers it necessary to sign a new 4 year NP when the current NP still has 2 years to run.

Amendments to the National Joint Replacement Levy

An additional **\$0.6 million / 4 years** is provided to support the increased activity of the National Joint Replacement Registry (NJRR).

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	0.1	0.1	0.2	0.2
<i>Revenue DoH</i>	-	0.1	0.1	0.2	0.2

However, as indicated, this funding is not provided by the Government but comes from changes in calculating the levy imposed on industry (so it is proportional to market share) from 1 July 2015.

The Government has funded the NJRR since 1998. The 2007-08 Budget provided for the expansion of the data collected by the National Joint Replacement Registry. At that time its base funding was **\$5.3 million / 4 years** and in 2007-08 an extra **\$0.8 million / 4 years** was added.

In 2009 the Government announced that that Registry would be funded on a cost recovery basis. These costs are recovered from the suppliers of orthopaedic devices which currently have joint replacement prostheses listed on the Private Health Insurance (Prostheses) Rules (the Prostheses List).

Reducing the burden of the Industrial Chemicals Regulatory Framework to industry

\$4.2 million / 4 years is provided to amend the *Industrial Chemicals (Notification and Assessment) Act 1989* to focus regulatory assessment on industrial chemicals that pose the greatest risk, develop streamlined processes for new and existing chemicals, and using existing international approvals where appropriate.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	2.5	2.5	-	0.4
Revenue DoH	-	2.5	2.5	1.4	1.8
Related capital DoH	-	3.5	3.5	-	-

The Budget states that cost of this measure will be met by industry through increased levies between 2015-16 to 2021-22. It is not clear why this provision is not budget neutral over the forward estimates.

The regulation of industrial chemicals is the responsibility of the National Industrial Chemicals Notification and Assessment Scheme (NICNAS).

The proposed changes have been welcomed by industry but interestingly, there have been calls for more detail on the implementation and costs – a sign that industry was not consulted about the changes.

A discussion paper - Review of the National Industrial Chemicals Notification and Assessment Scheme - was released in June 2012 with calls for submissions and the promise of consultation.¹⁶⁸ A draft Regulation Impact Statement (RIS) was issued in June 2013.¹⁶⁹ This assessed the impact of four options for reform and made recommendations regarding a preferred option – which was Option 3: Graduated, risk based approach with pre and post-market emphasis based on risk profile of chemicals. Presumably the Government has based this provision on this RIS recommendation.

¹⁶⁸ <http://www.health.gov.au/internet/publications/publishing.nsf/Content/ohp-nicnas-discussion-paper-june-2012-l>

¹⁶⁹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-nicnas-draft-regulation-impact-statement.htm>

New and amended listings to Stoma Appliance Scheme

Savings of **\$7.6 million / 4 years** are taken from the Stoma Appliance Scheme (SAS). These will go to other health policy priorities or the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DoH	-	-1.6	-1.8	-2.0	-2.0

The budget paper state that this is due to the listing of 2 new items, amending the price of 21 items, deleting 1 item on scheme as recommended by Stoma Product Assessment Panel. These items are unspecified.

Patients pay a small annual administration fee to access the SAS. Approved stoma products are distributed at no cost through 22 independently operated stoma associations. Stoma associations submit a claim to Medicare Australia for products supplied and Medicare Australian pays these claims. In addition to the costs of the product, the stoma associations are paid a handling fee on products.

In recent budgets the SAS taken some substantial cuts:

- The 2014-15 Budget took savings of **\$0.2 million / 4 years** are achieved through the listing of three new items and amendments to the prices of three current items (all unspecified).
- The 2012-13 Budget took savings of **\$14.4 million / 4 years** from this program by removing the removal of automatic indexation for subsidised products.
- As part of the 2009-10 Federal Budget, the Government announced that the SAS would be reviewed with the view to establishing a new program framework that supported the Scheme's future sustainability.¹⁷⁰

The total cost of the SAS in 2013-14 was **\$83.2 million**.

Elsewhere in the Budget unspecified savings are expected to be achieved by piloting competitive tendering for a subset of products on the SAS (see section on Smaller Government).

¹⁷⁰ [http://www.health.gov.au/internet/main/publishing.nsf/Content/7488BFBC744183CCA257BF0001C9667/\\$File/Therapeutic%20Review%20of%20the%20Stoma%20Appliance%20Scheme%20-%20Dec%202010.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/7488BFBC744183CCA257BF0001C9667/$File/Therapeutic%20Review%20of%20the%20Stoma%20Appliance%20Scheme%20-%20Dec%202010.pdf)

Smaller government and across-the-board funding cuts

The Abbott Government is now delivering the fourth phase of its Smaller Government Reform agenda. The stated aim is “to ensure the public sector is as streamlined, effective and transparent as possible”. Nothing could be further from the truth: in the majority of cases it is not clear what programs are being cut and by how much, in other cases there is no evidence that abolishing and amalgamating government bodies will achieve either saving or efficiencies.

In the 2015-16 Budget these savings, which in Health total at least **\$1.2 billion / 5 years** are achieved though further reductions in the number of Government bodies, across-the-board efficiencies, staff reductions, indexation pauses and program ‘rationalising and streamlining’.

These come on top of savings of **\$3.59 billion / 4 years** taken last year under the same imprimatur of improving efficiency and reducing waste.

The adverse impacts are already being felt. In both Health and Indigenous Affairs many organisations and programs have waited until the last minute to hear of they have funding for the next financial year. This erodes morale and leads to staff leaving – a situation that is not improved when all that is forthcoming is a 12-month extension of funding at 2014-15 levels.

Indexation pauses across Medicare and related services threaten to lower bulk billing rates and will be an increased impost on patients as out-of-pocket costs increase.

Other changes implemented by this Government have costs that are not provided – in particular, substantial costs must accrue as programs, agencies, divisions and even whole departments change names and focus.

The loss of DoH and agency staff and expertise shows in large delays in important decision making processes, the failure to respond to reports and reviews in appropriate timeframes and the lack of needed detail in policy and program changes that hinder their implementation.

A fifth phase of the Smaller Government Reform agenda will be included in MYEFO 2015-16

Table 13. Smaller Government Reforms 2014-15 and 2015-16

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2017-18 \$m
Indexation Pauses						
Administered Program Indexation Pause* 2014-15	-	-15.1	-34.1	-54.9	-60.9	
Administered Program Indexation Pause* 2015-16	-	-	-	-	-8.4	-21.9
Health Flexible Funds – pausing indexation, achieving efficiencies 2014-15	-	-	-46.4	-69.7	-81.0	
Health Flexible Funds funding cuts 2015-16	-	-	-58.0	-117.0	-181.0	-240.0
Pausing indexation of some MBS fees, Medicare Levy Surcharge, PHI rebate thresholds 2014-15	-	-131.5	-378.5	-480.1	-597.3	
Consistent indexation measures 2015-16	-	-	-14.9	-25.3	-37.6	-41.7
Smaller Government						
Health Portfolio	-	-3.2	-14.6	-29.3	-32.8	-33.0
Rationalisation & streamling						
Health programs (does not include cuts to Flexible Funds)	-	-12.0	-63.5	-98.7	-92.3	-97.2
Total 2015-16 (direct Health impact only)	-	-15.2	-151.0	-270.3	-343.7	-411.9

From 2014-15 Budget Paper No 2 and 2015-16 Budget Paper No 2 *indicates wider impact than DoH

Budget provisions

Rationalising and streamlining Department of Health programs

Savings of **\$962.8 million / 5 years** are achieved across a range of Health programs. These savings go to fund other health priorities or to the MRFF.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DHS	-	..	-	--	
DoH	-12.0	-121.5	-215.7	-276.3	-337.2
Total	-12.0	-121.5	-215.7	-276.3	-337.2

The areas where these cuts are made are outlined in only general terms in the Budget Papers:

- Flexible Funds
- Dental workforce programs
- Preventive health research
- GP SuperClinics that have not yet commenced construction
- Cessation of Inborn Errors of Metabolism Program
- Piloting competitive tendering for a subset of products on the Stoma Appliance Scheme.

Flexible Funds

In 2014-15 there were 16 Health Flexible Funds. These fund non-government organisations to deliver a range of health and community services in a range of areas.

The 2014-15 Budget cut **\$197 million** from these. At Senate Estimates in June 2014, the DoH said that it had not yet been determined which of the Flexible Funds would be cut, but did say that some that had taken cuts in other ways (such as the Health Workforce Fund and the Indigenous Chronic Disease Fund) would be protected from further savings. There is very little information available about these cuts and their impact.

2015 Senate Estimates revealed cuts of **\$596 million / 4 years**. Thus it appears that the Flexible Funds have sustained total cuts of **\$793 million / 5 years**.

The impact of this year's cuts over the forward estimates was elicited in Senate Estimates.¹⁷¹

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
Flexible funds	?	-58	-117	-181	-240

¹⁷¹ Senate Estimates information courtesy of AHHA

The Indigenous Health and Medical Indemnity funds are exempt from cuts. 11 Flexible Funds will experience cuts in 2015-16 (see Table 14) Senate Estimates was told that decisions had yet to be made on the specific program cuts that will be necessary to meet these overall cuts. Over 2000 grants are included in the Flexible Funds. The organisations that are funded to deliver these programs have currently received current funding for either 6 months or 12 months (which organisations received which period was an arbitrary decision) as an interim decision. It seems very disorganize within DoH and that means severe consequences for the organisations and programs relying on this funding.

Table 14 Budget cuts to Flexible Funds

Fund	Scope	Budget cuts 2015-16	Total funding	What is known about cuts
Chronic Disease Prevention and Service Improvement	-Prevention -Early detection & appropriate treatment -Integration & continuity of prevention & care -Self management	\$7.1m	\$252.81m / 4 yrs to June 2015	Likely affects primarily prevention activities
Communicable Disease Prevention and Service Improvement Grants	-Preventing blood borne viruses and STDs -Promoting approp treatment & management	\$3.0m	\$43.1m / 4 yrs to June 2015	
Substance Misuse Prevention and Service Improvement Grants	Activities under National Drug Strategy	\$7.0m	\$86.03m / 4 yrs to June 2015	31 March 2015, Minister Nash announced continuation of funding under NGOTGP at 2014-15 level for 12 months, pending review of drug and alcohol treatment services.
Substance Misuse Service Delivery Grants Fund	Substance misuse service, incl programs that target Indigenous Australians	\$1.2m	Not found	
Health Social Surveys	-Australian Health Survey -National Health Survey -Australian Longitudinal Study of Women's Health - Australian Longitudinal Study on Male Health	\$0.5m	\$31.83m / 4 yrs to June 2015	Little room for cuts to these programs.
Single Point of Contact for Health Information, Advice and Counselling	-After Hours GP Helpline - video consultation Pregnancy, Birth and Baby Helpline -National Health Services Directory - <i>healthdirect Australia</i> (nurse triage services)	\$11.0m	\$200m / 4 yrs from 2014-2015	Not clear if video consults on AH GP Helpline remain

Table 14 continued

Fund	Scope	Budget cuts 2015-16	Total funding	What is known about cuts
Practice Incentives for General Practices	GP PIPS & payments for: -Asthma -Aged Care Access -Cervical Screening -Diabetes -eHealth -Indigenous Health -Quality Prescribing -Teaching -Procedural GP Payment -Rural loading	\$10.0m	\$1.055b / 4 yrs to June 2015	Changes may result from recommendations of Primary Health Care Advisory Group
Health System Capacity Development	Activities which: -Build primary care evidence base -Support health improvements for key population groups -Provide assistance to health support organisations	\$6.0m	\$117 m / 4 yrs to June 2015	When applications were called was heavily over-subscribed.
Health Surveillance	Supports a wide range of public health monitoring and data collection, surveillance and reporting activities (mostly ongoing)	\$0.8m	\$78.2 m / 4 yrs to June 2015	Not clear how contestible many of these activities are.
Health Protection	Activities to prepare for and respond to changing health protection priorities : -National health emergencies -Communicable disease outbreaks -Natural disasters -Terrorist attacks	\$0.7m	Not found	Most of these activities are likely to be supported in the current political environment. Includes National Medicines Stockpile. Investment in preventive health / environmental health likely most at risk.
Rural Health Outreach	Supports delivery specialist and primary care services in rural and remote areas. Includes: -MSOAP programs (specialist eye, maternity services) -Services by female GPs.	\$10.7m	\$31 m / yr from 2013-14	This is a large cut to an important program so will do real damage. Women particularly affected.

Dental Workforce Programs

Although little detail was provided in the Budget Paper, at Senate Estimates it was revealed that some **\$30 million** will be cut from the Dental Relocation and Infrastructure Support Scheme (DRISS).

(see section on Workforce).

Preventive Health Research

There are no specifications provided about what will be cut in preventive health research. This could refer to cuts in Flexible Funds. It seems that there is an inherent opposition most prevention activities, despite their ability to contribute to reduced health costs and improved health outcomes.

GP SuperClinics

It is not clear where and how savings will be taken from GP Superclinics. The 2014-15 Budget made the decision not to proceed on three SuperClinics – in Darwin, Rockingham and Wynnum – at a savings of **\$16.5 million**.

At that time the then Minister for Health, Peter Dutton, said the program had been a complete failure. He indicated that the Government was looking to retrieve money from SuperClinics where contracts had been signed on a case-by-case basis.¹⁷² That approach appears to have foundered, likely on legal advice and / or the fact that many of these were located in marginal electorates.

(see section on Primary Care)

Inborn Errors of Metabolism Program

The Budget Papers state this this program will cease as key medicines are now listed on the PBS and low protein foods are available at much lower cost than when the program was initiated.

The Inborn Error of Metabolism (IEM) Program provides monthly financial assistance to approved grantees with protein metabolic disorders to assist with the purchasing of low protein foods needed for strict diets.¹⁷³ Interestingly, given the reference to medicines in the PBS in the Budget Papers, the IEM website states that non-food items, such as medications and supplements, cannot be purchased with money provided under the program.

These Budget cuts will affect many families whose children need expensive special foods, and there have been media complaints about the impact.¹⁷⁴ The Metabolic Dietary Disorders Association says 904

¹⁷² <http://www.abc.net.au/news/2014-04-08/government-moves-to-dismantle-labor-super-clinics-scheme/5375074>

¹⁷³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/Inborn+Error+of+Metabolism+Programme>

¹⁷⁴ See for example <http://www.canberratimes.com.au/act-news/heartless-cuts-to-special-diet-kids-20150525-gh8x9g.html>

sufferers access the grant, which means the cut, which is effective from the end of this year, will save between **\$15 - \$17 million / 5 years.**¹⁷⁵

Competitive Tendering for Products on the Stoma Appliance Scheme

As part of the 2009-10 Federal Budget, the Government announced that the SAS would be reviewed with the view to establishing a new program framework that supported the Scheme's future sustainability.¹⁷⁶

In recent budgets the SAS taken some substantial cuts:

- The 2015-16 Budget has savings of **\$7.6 million / 4 years.**
- The 2014-15 Budget took savings of **\$0.2 million / 4 years** are achieved through the listing of three new items and amendments to the prices of three current items (all unspecified).
- The 2012-13 Budget took savings of **\$14.4 million / 4 years** from this program by removing the removal of automatic indexation for subsidised products.

The total cost of the SAS in 2013-14 was **\$83.2 million.**

(See also the Miscellaneous Section)

Smaller government in the Health portfolio

Savings of **\$113.1 million / 5 years** are taken from a variety of activities, programs and agencies. The Budget Papers say these are based on a Functional and Efficiency Review of DoH in what is described as 'sharpening the scope and focus of government'.

	2014-15	2015-16	2016-17	2017-18	2018-19
	\$m	\$m	\$m	\$m	\$m
DoH	-3.2	-14.8	-29.3	-32.8	-33.0

The National Lead Clinicians Group is abolished with residual functions to be conducted by the DoH, saving **\$17.1 million / 5 years** from 2014-15.

Savings of **\$106 million / 4 years** will be made by;

- Consolidating the corporate and legal services of the Therapeutic Goods Administration into the Department of Health.
- Removing duplication between the activities of the Department and several agencies. Departmental activities in areas covered by IHPA, AOTDTA, NBA, NHPA, ACSQHC, NHMRC and AIHW will cease.
- Rationalising the structure of the Department to better align to Government priorities.
- Rationalising business support functions, property costs and contractor expenses.

¹⁷⁵ <http://www.canberratimes.com.au/act-news/heartless-cuts-to-special-diet-kids-20150525-gh8x9g.html>

¹⁷⁶ [http://www.health.gov.au/internet/main/publishing.nsf/Content/7488BFCC744183CCA257BF0001C9667/\\$File/Te%20Review%20of%20the%20Stoma%20Appliance%20Scheme%20-%20Dec%202010.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/7488BFCC744183CCA257BF0001C9667/$File/Te%20Review%20of%20the%20Stoma%20Appliance%20Scheme%20-%20Dec%202010.pdf)

\$10 million of the saving will be reinvested to develop the in-house analytical, economic and research capacity of DoH. This is a welcome move if it results in better analysis of data and improved program evaluations. It is not clear if this \$10 million comes from the \$113.1 million saved or is in addition to that.

In the 2014-15 Budget there was a proposal to combine 6 major agencies into a Health Productivity and Performance Commission. Senate Estimates was told that there had been no progress on this, that it was 'under Ministerial consideration'.

Further consultation on future ownership options for Australian Hearing

There has been a number of Government scoping studies to assess the optimal arrangements for delivery and ownership options of a number of Government businesses and assets.

Media releases from the Finance Minister in May 2015¹⁷⁷ stated that the Government will consult further with hearing impaired Australians, their families and other key stakeholders about the findings of the scoping study before making a decision on ownership options for Australian Hearing. The consultations will also focus on the implications of the full introduction of the National Disability Insurance Scheme for government-funded hearing services.

It is proposed that the NDIS will open the delivery of Community Service Obligation hearing services to competition, to give clients greater choice of providers and the hearing devices, services and support on offer.

A report is due in the second half of the 2015 calendar year.

Two-year extension of the Administered Program Indexation Pause

Unknown savings are taken from a number of Health programs by a 2-year extension of the indexation pause initiated in the 2014-15 Budget.

In the 2014-14 Budget, 32 programs in the Health portfolio (including one in sport) were among the 112 listed for indexation pauses commencing in either July 2015 or July 2015.¹⁷⁸ Information provided in Senate Estimates for the Finance Portfolio in 2014-14 revealed these cuts will amount to **\$29.425 million / 4 years** (see Table 15)¹⁷⁹. In this year's Budget there is a cross-portfolio provision to extend this pause for an additional 2 years but only to 78 programs.

¹⁷⁷ <http://www.financeminister.gov.au/media/2015/0508-further.html>

¹⁷⁸ <http://www.finance.gov.au/news/administered-programme-indexation-pause/>

¹⁷⁹ The exact programs referred to in this table not always clear.

Table 15 Savings in Administered Programs made in 2014-15 Budget

Program	Savings 2014-15 to 2017-18 \$m	When indexation pause commences
National Depression Initiative	1.020	1 July 2015
National Immunisation Strategy	1.594	1 July 2015
IPH Drug Strategy	0.276	1 July 2015
Better Access to Psychiatrists and GPs	0.873	1 July 2015
Hospital Accountability and Performance Program	0.382	1 July 2015
COAG Mental health – additional places	0.913	1 July 2015
COAG Mental Health – support for children	1.261	1 July 2015
COAG Mental Health – support for day-to-day living	1.544	1 July 2015
COAG Mental Health – telephone counselling	1.730	1 July 2015
Leadership in Mental Health Reform	1.259	1 July 2015
Mental Health More Option Better Outcomes	9.810	1 July 2015
National Mental Health Program	0.954	1 July 2015
NBN Telehealth Pilots	0.000	1 July 2015
Maternity Peer Support	0.183	1 July 2015
NIDS – NGO Drug Treatment Services	4.486	1 July 2015
Front of Pack Labelling	0.000	1 July 2015
Health Services Provisions Grants	0.214	1 July 2015
Strengthening the Management of the National Medical Stockpile	0.000	1 July 2015
Biosecurity Surveillance System	0.133	1 July 2015
Maintaining Seasonal and Pandemic Influenza Surveillance	0.099	1 July 2015
Post Market	0.124	1 July 2015
Strengthening Industry Codes of Conduct	0.022	1 July 2015
National Nutrition Policy	0.000	1 July 2015
Tas Assistance Package – TML elements	0.360	1 July 2015
COAG Mental Health – services in rural and remote areas	1.836	1 July 2015
Management and IM Capability	0.000	1 July 2015
COAG Biological Regulation Activity	0.037	1 July 2015
Health Connect (National Health Information Network)	0.000	1 July 2015
MBS Evaluations	0.059	1 July 2015
Pathology Reform Implementation	0.246	1 July 2015
Telehealth Incentive	0.000	1 July 2015
Total	29.415	

Medicare indexation

This year's budget takes savings of **\$119.5 million / 4 years** in the name of "consistent indexation" of Medicare reimbursements. This comes on top of savings of **\$1.587 billion / 4 years** in the 2014-15 Budget from freezing indexation of some MBS fees, Medicare Levy Surcharge and PHI rebate thresholds.

Provisions in other Portfolios

There are a number of health-related provisions in other jurisdictions.

Treasury – Revenue Measures

Increasing the Medicare levy low-income thresholds

The Medicare levy low-income thresholds have been increased to take account of movements in the CPI. This measure will have an estimated cost to revenue of **\$231.0 million / 4 years**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
ATO	-	-81.0	-50.0	-50.0	-50.0

Increasing these income thresholds is meant to ensure that those on low-incomes remain exempt from paying the Medicare Levy. Legislation will be needed to raise these income thresholds.

Relaxing criteria for release of superannuation for terminal medical conditions

Terminally ill patients will have early access to their superannuation. This will have a cost to revenue of **\$0.3 million / 4 years**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
ATO	-	-0.3

Currently patients must have two medical practitioners certify that they are likely to die within 1 year to gain unrestricted, tax- free access to their superannuation. From July 1 2015 the likely time to death is changed to 2 years.

Agriculture

National Food Plan – saving

Savings of **\$30.9 million / 4 years** have already been taken from uncommitted funding from the Gillard Government's National Food Plan initiatives. These savings will go to fund initiatives associated with the Agricultural Competitiveness White Paper.

The National Food Plan was Australia's first 'whole of government' food plan, intended to bring together all aspects of the federal government's food-related policy. Its development was announced in 2010 by the Gillard Government and the National Food Plan White Paper was released in May 2013.¹⁸⁰ The Paper has minimal focus on what Australians eat, or food processing in Australia; it is more an export plan, particularly for Australian producers.

The Paper made 16 recommendations for food policy in Australia, some achievable, other more visionary. At the time of the Paper's release, almost **\$40.0 million** in initiatives were announced. These included:

- **\$28.5 million** for the establishment of the Asian Food Markets Research Fund.
- An additional **\$5.6 million** to build relationships with trading partners in key and emerging markets.
- A review by the Productivity Commission of the impact of regulatory burdens across the food chain.
- Support for the skills and workforce needs of the food industry.
- **\$2.0 million** to develop a brand identity for Australian food and related technology.

With the election of the Abbott Government nothing further was done with this. It has effectively been replaced by the Agricultural Competitiveness White Paper.

Immediate assistance for drought affected communities

\$20 million is provided in 2015-16 to extend the access to social and mental health services for people in drought affected communities provided in the 2014-15 Budget. This previous measure was funded at **\$10.7 million / 2 years** (from 2013-14).

This assistance is delivered through the Family Support and Targeted Community Care (Mental Health) programs within the Social Services portfolio.¹⁸¹

¹⁸⁰ http://www.agriculture.gov.au/ag-farm-food/food/publications/national_food_plan/white-paper

¹⁸¹ <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/targeted-community-care-mental-health-program>

Human Services

Efficiencies

Savings of **\$55.1 million / 4 years** are taken by implementing efficiencies within the Department of Human Services. Some of these savings are achieved by phasing out the option for customers to receive Medicare and PBS payments via cheque or credit EFTPOS from July 2016 in favour of payments by Electronic Funds Transfer.

Social Services

No Job No Pay

Savings of **\$508.3 million / 5 years** will be achieved by requiring that children's immunisation requirements are fully met before families an access subsidised child care payments or the Family Tax Benefit Part A end-of-year supplement.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DHS	0.3	18.7	7.8	3.0	2.9
Finance	-	0.1	-	-	-
DSS	-	-90.8	-156.3	-149.9	-144.1
Total	0.3	-72.1	-148.5	-146.9	-141.2

From 1 January 2016, the Government will close off some exemptions from the immunisation requirements for eligibility for the FTB-A end-of-year supplement, Child Care Benefit (CCB) and Child Care Rebate (CCR) payments and require that all children meet the immunisation schedules if their families are to receive these payments.

A requirement for children to meet immunisation schedules has been attached to childcare payments since 1998 and for the FTB-A supplement from 2012. However exemptions for medical reasons and for conscientious objection to immunisation have been included in the relevant legislation.

Media reports suggest around 10,000 families will lose eligibility for payments in 2016–17 as a result of the measure. It is interesting to note that there does not appear to be any allowance in the budget estimates for parents to act to improve the immunisation status of their children on the basis of a significant financial incentive.

Some health professionals and researchers have questioned whether imposing financial penalties is an effective way of lifting immunisation rates and engaging with parents who are hesitant about vaccinations.¹⁸²

Redirection of funding from Wound Management Scoping Study

The Government will not proceed with the Wound Management Scoping Study which was announced in the 2013-14 Budget. This will achieve savings of **\$0.3 million**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DSS	-0.3	-	-	-	-

This scoping study was part of the former Government's Supporting Senior Australians package. There are two reasons why these savings are illusory: firstly, this provision was within the jurisdiction of DoH (then the Department of Health and Ageing) when it was introduced, and secondly, the funds for this measure were to be met from within the existing resources of DoHA.

Veterans' Affairs

Continuation of indexation pause for dental and allied health provider fees

Savings of **\$69.6 million / 4 years** are achieved by extending the pause on indexation of DVA dental and allied health provider payments until 1 July 2018. These savings will be redirected to fund other Veterans; policy priorities.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DVA	-	-0.9	-18.6	-27.4	-22.7

The 2014-15 Budget imposed an indexation pause on DVA dental and allied health provider payments to 1 July 2016. This aligned indexation of payments to these providers with those for medical services and delivered savings of **\$35.7 million / 4 years** (See Table 16). These savings were directed to the MRFF.

Table 16 Deferred indexation of dental and allied health provider fees 2014-15

	2013-14 \$m	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m
DVA	-	-4.4	-9.4	-9.0	-12.8

¹⁸² <http://www.abc.net.au/news/2015-04-13/no-benefits-for-anti-vaccination-parents/6387914>

The Australian Dental Association (ADA) has made the case that dentists' customary fees have increased over the last seven years at a rate below the Health Index but DVA scales have not kept pace. The result is the current discrepancy between the two has reached on average nearly 20%, in some cases the discrepancy is as high as 60%. The ADA states that a freeze on indexation will mean that dentists will find it increasingly difficult to service DVA patients.¹⁸³

Extension of trial for in-home telehealth for veterans

\$3.7 million / 2 years is provided to extend the duration of the current trial of in-home telehealth for veterans for a further 18 months to support an effective evaluation of the trial.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DVA	-	2.3	1.4	-	-

This trial, called the In-Home Telemonitoring for Veterans Trial and is aimed at enhancing services provided under the Coordinated Veterans' Care (CVC) Program, which provides ongoing, planned and coordinated care, led by a GP with a nurse coordinator. The trial aims to test if in-home telemonitoring is a safe, effective and efficient complement to face-to-face GP consultations, whether telemonitoring can improve CVC participants' quality of life and their ability to live in their own home for longer, and reduce unplanned hospital admissions.

The trial commenced in June 2013 at the first site in the New England region, NSW, and was due to finish in June 2015. Other trial sites include the North Coast, NSW, the Darling Downs in Queensland, and Bayside, Victoria. The 18 month extension (until December 2016) provided in the 2015-16 Budget involves no further recruitment to the trial. There is some information available on the internet about an evaluation of this program¹⁸⁴ that is described as running for 3 years from 2012.

In 2012 the Labor Government announced a **\$20.6 million** trial programs to enable older Australians, people living with cancer, and people requiring palliative care, especially those in rural and remote Australia, to obtain medical advice and care via videoconferencing, often in their own home. Seven organisations received funding.¹⁸⁵ Evaluations for these projects have been announced¹⁸⁶ but don't seem to be publicly available.

While some Australian trials have been evaluated, apparently these later ones have not.

¹⁸³ http://www.ada.org.au/App_CmsLib/Media/Lib/1406/M784264_v1_635394781080553038.pdf

¹⁸⁴ http://www.slideshare.net/sharon_Campbell/telehealth-for-dva-veterans-evaluation

¹⁸⁵ <http://health.gov.au/ehealth-nbntelehealth>

¹⁸⁶ http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=1421:csiro-to-demonstrate-evidence-for-telehealth-under-nbn-project&catid=16:australian-ehealth&Itemid=327

Increased number of case co-ordinators

\$10.0 million / 4 years is provided to fund additional case co-ordinators for veterans and their families.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DVA	-	2.5	2.5	2.5	2.5

Case co-ordinators provide support to clients and their families with complex medical, physical and social needs.

No further information on the number and role of case co-ordinators at DVA could be elucidated.

New listings and price amendments for Repatriation Pharmaceutical Benefits Scheme

The Budget Papers say that **\$0.2million / 5 years** is provided for new listings and price amendments on the RPBS. However the accompanying table clearly shows that cost to be **\$0.4 million / 5 years**.

	2014-15 \$m	2015-16 \$m	2016-17 \$m	2017-18 \$m	2018-19 \$m
DVA	..	0.1	0.1	0.1	0.

The new listings and price amendments are not provided. It is assumed that these are for items not available on the PBS.

Mental health and substance abuse services

The Budget media release from the Minister for Veterans' Affairs, Michael Ronaldson, stated that "The DVA Budget for mental health will remain uncapped and be driven by demand from clients. Over the past 12 months, the Government has expanded access to the Veterans and Veterans Families Counselling Service (VVCS). We have also made it easier for veterans dealing with depression, post-traumatic stress disorder and anxiety, plus substance and alcohol use disorders, to access free and immediate treatment for their conditions regardless of whether they are related to service."¹⁸⁷

¹⁸⁷ http://minister.dva.gov.au/media_releases/2015/may/va043.htm

