2013-14 BUDGET: Analysis of Health and Ageing Provisions

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NOTE

This paper presents the author's analysis of the Health and Ageing provisions in the Australian Government's 2013-14 Budget in the context of current and past strategies, policies, programs and funding support.

This work has been done using only materials and data that are publicly available.

A separate analysis (available at http://ses.library.usyd.edu.au/handle/2123/9115)looks at the Indigenous provisions in the Budget and the implementation and impact of the Commonwealth's Indigenous Chronic Disease Package.

The opinions expressed are solely those of the author who takes responsibility for them and for any inadvertent errors. This work does not represent the official views of the Menzies Centre for Health Policy, the Australian Primary Health Care Research Institute (APHCRI) or the Commonwealth Department of Health and Ageing which funds APHCRI.

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Introduction

In a tough political and budget year with several major initiatives to be funded - most notably the Gonski education reforms and the National Disability Insurance Scheme, now known as DisabilityCare Australia - the health and ageing section of the 2013-14 Budget has fared reasonably well. Overall the Budget contained $43 billion in savings over the forward estimates, much of which will be funneled into these new 'critical investments.' Of this, $1.22 billion over five years was taken from current health programs, with the majority of this ($902 million) from Medicare.

In 2013-14 the Australian Government expects to spend $64.64 billion on health, amounting to 16.2% of all Government expenses. Health spending is forecast to grow at 8.6% over the forward estimates – this is a faster rate in real terms than education (7% of spending) and social security and welfare (35% of spending).

Australia gets good value for this spend. The fourth COAG Reform Council Report on the National Healthcare Agreement shows that the overall health of Australians and the quality of our healthcare system continues to improve.[1] Life expectancy is increasing and the number of low birthweight babies and rates of infant mortality are dropping.

Still, Australia's health system faces some serious challenges. We have an increasing chronic disease burden, a growing and ageing population, rising costs of health services and technologies, and a gap that stubbornly yawns between the health of Indigenous and non-Indigenous Australians. In particular, there has been a lack of progress in prevention.

Levels of overweight and obesity continue to rise; in the years between 2007–08 and 2011–12 there was no significant change in the proportion of adults or children at a healthy body weight. The cost of obesity to Australia's collective wellbeing has now reached $120 billion a year - the equivalent of about 8% of the economy's annual output.[2] It is estimated that each one percentage point rise in the obesity rate costs about $4 billion a year in national wellbeing, yet levels of investment in programs to tackle obesity and overweight remain tiny.

At the same time, despite a flurry of small efforts around the better management of chronic disease, co-ordinated care and multi-disciplinary teams, there is little evidence of real improvements in patient outcomes. Despite the rhetoric around putting prevention and primary care at the heart of the health care system, the major focus of reform and expenditure continues to be around increasingly expensive and specialised acute care in major metropolitan centres. The recent Mason Review of the health workforce summed this up succinctly, and called for measures to redirect resources to the provision of high quality primary care, population health initiatives and preventative care.[3] It found that the focus of health care reforms must move

[1] http://www.coagreformcouncil.gov.au/sites/default/files/files/Health%202011-12%20-%20Chapter%204.pdf

[2] http://www.smh.com.au/national/health/obesity-costs-drag-down-national-good-20130308-2fr0b.html

[3] http://www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programs

beyond specialist medicine and acute care beds to appropriate generalist skills, team based community care and the training and development of the nursing and allied health workforce.

While the Gillard Government has been bold in introducing large-scale new initiatives such as those in mental health, aged care and dental health, these programs are in the early stages of implementation and a substantial amount of work remains to be done if these are to reach full capabilities and reach. There was little in the 2013-14 Budget to ensure that these programs move forward expeditiously. Indeed we have already seen some tinkering at the margins with budgets.

The looming federal election in September may bring a change of Government and this will undoubtedly impact on the health and ageing portfolio, in particular on new initiatives such as Medicare Locals, dental health reforms and restrictions to the private health insurance rebate.

For example, in July 2010 the Leader of the Opposition, Tony Abbott, announced that in Government he would scrap the Gillard Government's plans to boost after-hours doctors' services, build GP super clinics, the planned authorities to monitor costs and performance, and the development of e-health services as part of a $1.5 billion plan to improve mental health services.[4]

The Federal Coalition has several times confirmed its policy to scrap Medicare Locals and dismiss the 3,000 people who worked at Medicare Locals.[5] However more recently the Shadow Minister for Health, Peter Dutton, has moderated his language and stated that a Coalition government would review Medicare Locals.[6] While Mr Dutton has declined to say how an Abbott government would reform and restructure primary care, it appears that an Abbott Government would look to align new primary care structures with regional health boards.

The challenge for any new government post September is that too many Australians are missing out on the care they need or are not receiving the best possible care for their condition. That will require more attention to issues like equity, out-of-pocket costs and quality. We must also become more sophisticated about measurement and evaluation to ensure that we are achieving meaningful health outcomes and value for taxpayers' dollars.

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[4] http://www.smh.com.au/national/abbott-to-spend-15b-on-mental-health-plan-20100630-zmvn.html

[5] http://www.theaustralian.com.au/national-affairs/treasury/coalition-will-abolish-all-medicare-locals/story-fnhi8fqc-1226596742854

[6] http://www.peterdutton.com.au/Home/LatestNews/tabid/94/articleType/ArticleView/articleId/388/Coalition-to-review-Medicare-Locals.aspx

Expenditure on health

In 2013-14 the Australian Government expects to spend **$64.64 billion** on health – this amounts to 16.2% of all Government expenses. This figure is expected to rise to **$75.49 billion** by 2016-17 (16.6% of spending). (See Table 1)

Table 1. Total spending on health

	Estimates			Projections	
	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
Total Government expenses	381,439	398,301	415,663	431,015	454,747
Health	62,249	64,636	68,081	71,597	75,493

From 2013-14 Budget Paper No 1

Health spending is forecast to grow at 8.6% over the forward estimates – a faster rate in real terms than education (7% of spending) and social security and welfare (35% of spending).

Funding for aged care services is included in the Budget as a sub-function of social security and welfare and it's not easy to single out provisions that relate specifically to those functions controlled by the Department of Health and Ageing (DoHA). My estimate of spending on aged care services in 2013-14 is of the order of **$12.6 billion**. (See Table 2) A media release from the Minster for Health says that the Government is investing **$79.2 billion** in health and aged care services in 2013-14. However it's never clear when these statements include the funding provided to the States and Territories, so making them align is an impossible task.

Table 2. Estimated federal spending on aged care

	Estimates			Projections	
	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
Residential and flexible care	8,311	8,811	9,325	9,979	10,573
Home support	1,386	1,485	1,603	1,720	1,863
Home care	1,144	1,205	1,294	1,410	1,736
NP – assistance to the aged	801	843	304	316	329
Workforce and quality	152	175	176	203	219
Other- e.g. ageing and service improvement; information	?	?	?	?	?
Total (incomplete)	**11,784**	**12,519**	**12,702**	**13,628**	**14,720**

From 2013-14 Budget Paper No 1

The breakdown of spending over the various health sub-functions is outlined in Table 3. Some of these sub-functions are cryptically named and what is included has changed over time, so it is difficult to elucidate where the funding for some significant programs and activities (e.g. medical indemnity, e-health, rural health) now resides. Also it seems that some National Partnership payments are included here and others are not.

Table 3. Spending on health sub-functions

	Estimates			Projections	
	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
Medical services and benefits	25,307	25,552	27,430	28,918	30,548
Medicare services	*18,549*	*19,092*	*20,843*	*22,161*	*23,662*
Private health insurance	*5,564*	*5,399*	*5,578*	*5,748*	*5,912*
General medical consultations and services	*928*	*916*	*912*	*904*	*908*
Primary care practice incentives	*281*	*208*	*223*	*229*	*234*
Other[7]	*-15*	*-63*	*-126*	*-124*	*-168*
Hospital services[8]	2,694	2,762	2,038	1,900	1,905
National Health Reform Payment[9]	13,252	13,941	15,432	17,060	18,849
Pharmaceutical benefits and services	10,689	11,139	11,664	12,087	12,562
Concessional benefits	*5,642*	*5,801*	*6,042*	*6,218*	*6,399*
General benefits	*1,530*	*1,613*	*1,721*	*1,817*	*1,922*
HSD and hospital drugs	*2,264*	*2,435*	*2,581*	*2,747*	*2,933*
Veterans' benefits	*449*	*415*	*395*	*371*	*370*
Wholesalers and pharmacy programs	*209*	*212*	*216*	*219*	*219*
Other	*595*	*663*	*709*	*715*	*719*
ATSI health	752	851	826	854	890
Health services	6,362	7,053	7,418	7,481	7,413
Health infrastructure	*1,345*	*1,522*	*1,828*	*1,559*	*999*
National blood agreement management	*1,077*	*1,127*	*1,203*	*1,281*	*1,370*
Blood and organ donation services	*728*	*772*	*823*	*872*	*931*
Mental health	*381*	*502*	*546*	*598*	*606*
Other	*2,831*	*3,130*	*3,018*	*3,171*	*3,507*
General administration	3,192	3,337	3,273	3,296	3,327
Total	**62,249**	**64,636**	**68,081**	**71,597**	**75,493**

[7] It is not clear where these savings are made in the health budget.

[8] This includes payments made to the States and Territories for specific hospital improvements in addition to the hospital funding provided under the National Health Reform sub-function.

[9] Note that this funding is not the same as that outlined for this sub-function in 2013-14 Budget Paper No 3

Commonwealth – State funding agreements

In 2013-14 the Commonwealth will provide the States with **$44.1 billion** in payments for specific purposes. The majority of this ($31.3 billion) is paid as National Specific Purpose Payments (SPPs), National Health Reform and National Education Reform funding; the remaining payments ($12.8 billion) are distributed through National Partnership (NP) payments. This does not include **$1.0 billion** for the Health and Hospitals Fund Regional Priority Round and funding to assist the States with their contribution to DisabilityCare Australia.

Of the SPPs, **$16.1 billion** (36.5%) is for health, of which **$14.04** billion is for National Health Reform funding and **$2.04 billion** is for National Partnership payments.

National Health Reform (NHR) funding

In 2013-14, the Commonwealth will provide the States and Territories with **$14.04 billion**, comprising **$13.7 billion** for hospital services and **$326 million** for public health.

Comparison with last year's Budget figures show that how the decisions made in the 2012-13 MYEFO have cut NHR funding across the forward estimates. (See Tables 4, 5 and 6) These cuts were done on the basis of downward revisions to the weighted population used to calculate hospital utilisation following the 2011 Census and the Australian Institute of Health and Welfare health price index. The health price index has declined due to the high Australian dollar exerting downward pressure (as much as 20 percent) on the cost of imported medical goods. In 2013-14 the funding cut is **$343 million**.

However while there is some logic to adjusting the funding provided for hospital services, it is distressing to see that cuts are also made to public health funding included in the NHR funds. These funds are described in the 2012-13 Budget papers as providing for national public health, youth health services and the service delivery of essential vaccines. With public health funding always such a negligible proportion of healthcare funding - in this case just 2.3% of total federal NHR funds - every dollar counts.

These funds, together with State and Territory contributions, are paid into the accounts for each state and territory set up within the National Health Funding Pool. The public health outcomes and how they will be developed and measured are not included in the National Health Reform Agreement document. It is unclear if this federal funding cut will also result in less funds coming from the States and Territories for public health, although this is assumed to be the case.

The one consolation here is that there is a limit to such cuts: the NHR Agreements commits the Commonwealth to providing at least **$16.4 billion** of additional funding under NHR over the period 2014-15 to 2019-20.

In February 2013 Prime Minister Julia Gillard agreed to return the **$107 million** cut from Victoria's 2012-13 funding.[10] It is not clear if this funding is included here. It is included elsewhere in Budget Paper No 2 as a payment made directly to the Victorian Local Hospital Networks.

The new funding arrangements under NHR will be in their final transition year in 2013-14; from 2014-15, hospital funding will be provided on the basis of where patients are receiving their hospital treatment and the national efficient price of hospital services.

Table 4. National Health Reform Funding (2012-13 Budget Papers)

	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**
National Health Reform funding	13,518	14,383	15,944	17,639
Hospital services	*13,204*	*14,049*	*15,588*	*17,261*
Public health	*314*	*334*	*356*	*379*

From 2012-13 Budget Paper No 3

Table 5. National Health Reform Funding (2012-13 MYEFO)

	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**
National Health Reform funding	13,264	14,014	15,537	17,192
Hospital services	*12,956*	*13,688*	*15,193*	*16,828*
Public health	*308*	*325*	*344*	*363*

From 2012-13 MYEFO

Table 6. National Health Reform Funding (2013-14 Budget Papers)

	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
National Health Reform funding	13,280	14,040	15,531	17,164	18,956
Hospital services	*12,972*	*13,714*	*15,186*	*16,799*	*18,570*
Public health	*308*	*326*	*345*	*365*	*386*

From 2013-14 Budget Paper No 3

[10] http://www.heraldsun.com.au/news/victoria/prime-minister-julia-gillard-reverses-labors-victorian-hospital-funding-cuts/story-e6frf7kx-1226582182228

National Partnerships (NPs)

It is estimated that there are 155 NPs, IPs and Project Agreements in existence. Many of these are in health. The evolution and use of NPs has presented challenges to State and Territory governments. These have been enunciated by Victoria as:

- A growing number of agreements are placing a large administrative burden on the state and distracting attention from reforms of national significance;
- Some small agreements impose disproportionately high reporting requirements relative to the level of funding provided;
- Output rather than outcome focussed agreements reduce the scope to innovate and lead in driving service delivery efficiencies;
- Prescriptive funding conditions represent an encroachment by the Commonwealth Government into areas of State responsibility, undermining the principle of subsidiarity that underpins Australian federalism and reducing opportunities for policy and service innovation; and
- A lack of certainty surrounding the expiry of agreements presents financial and policy risks to Victoria, especially where service level expectations have been raised.[11]

In 2013-14 the Commonwealth will provide the States and Territories with **$2.04 billion** in NPs to address specific health issues. Comparing this to last year's figures is interesting. (See Tables 7 and 8) It reveals readjustments in funding over the forward estimates for most NPs and arguably in several cases this is how funding for 2016-17 has been achieved. The most egregious example of this is where **$130.4 million** has been cut from the funds provided to the NP for Preventive Health for 2013-14 to 2014-14; the remaining funding is now **$302.1 million / 4 years** with **$130.4 million** of that provided in 2016-17. These cuts were taken in the 2012-13 MYEFO.

The Government has agreed to bring forward **$148.7 million** in payments from 2013-14 to 2012013 to reflect agreements reached with Western Australia, Queensland and the ACT. The NPs affected are Essential Vaccines, Preventive Health, Financial Assistance for Long Stay Patients, and Certain Concessions for Pension Concessions Card and Seniors Card Holders.

11 http://www.dtf.vic.gov.au/CA25713E0002EF43/WebObj/CommonwealthPaymentsSubmission/$File/CommonwealthPaymentsSubmission.pdf

Table 7. Funding for NPs 2013-14 Budget

Payment Type	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
National Health Reform funding	**13,280**	**14,040**	**15,531**	**17,164**	**18,956**
Hospital services	12,971.8	13,714.0	15,185.9	16,798.9	18,569.9
Public health	308.6	326.0	345.2	365.3	386.2
National Partnerships	**1,727**	**2,037**	**1,510**	**1,308**	**1,074**
National Health Reform	663.9	818.5	99.5	99.5	99.5
Health infrastructure	465.5	509.1	562.1	393.4	38.2
Health services	62.4	74.5	275.1	367.1	448.6
Indigenous health	51.1	54.0	25.1	17.1	17.6
Mental health	71.5	100.8	121.8	125.5	80.2
Preventive health	68.7	64.6	53.5	53.5	130.4
Other health payments	343.0	415.5	373.0	251.9	259.6
Total	**15,007**	**16,077**	**17,041**	**18,472**	**20,030**

From 2013-14 Budget Paper No 3.

Table 8. Funding for NPs 2012-13 Budget

Payment type	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m
National Healthcare SPP	**12,698**	**-**	**-**	**-**	**-**
National Health Reform funding	**-**	**13,518**	**14,383**	**15,944**	**17,639**
Hospital Services	-	13,204.0	14,048.7	15,587.9	17,260.8
Public Health	-	314.2	334.3	355.7	378.5
National Partnerships	**2,705**	**1,941**	**2,086**	**1,341**	**1,090**
National Health Reform	880.6	663.9	803.2	99.5	99.5
Health Infrastructure	970.2	566.3	434.7	395.6	504.1
Health Services	101.7	44.9	50.2	48.4	49.9
Indigenous Health	46.5	59.7	31.2	10.8	2.7
Mental Health	9.0	71.5	100.8	121.8	125.5
Preventive Health	100.3	151.2	196.6	235.9	-
Other Health Payments	597.1	383.3	469.2	429.0	308.7
Total	**15,403**	**15,460**	**16,469**	**17,285**	**18,730m**

From 2012-13 Budget Paper No 3

NPs supporting National Health Reform

The NP on Improving Public Hospital Services (NPA-IPHS) was signed in February 2011. It provides for up to **$1.55 billion** to assist meeting elective surgery and emergency department targets, **$1.6 billion** for new sub-acute beds and a **$200 million** flexible funding pool for capital and recurrent projects across elective surgery, emergency department and sub-acute care. An Expert Panel was established to examine safety and quality issues and practical impediments to the timing and phasing of the elective surgery and emergency department targets.

The aim is to:

- Increase the proportion of emergency department patients to physically leave the emergency department (for admission to hospital, referral to another hospital, or discharge) in 4 hours or less - the National Emergency Access Target (NEAT).
- Increase the proportion of elective surgery patients seen within clinically recommended times and reducing the number of patients waiting beyond the clinically recommended time - the National Elective Surgery Target (NEST).

Budget Paper No 3 provides limited information on the payments made through these two NPs. Most of this funding expires in June 2014, leaving only facilitation and reward funding in the forward estimates. There is no indication as to how much has been paid out to date as facilitation and reward and which States and Territories (if any) have received this funding. There is some indication from the 2012-13 Budget Papers that these funds will not flow until the current financial year.

Reports from the COAG Reform Council show varied performances by States and Territories in achieving the established targets, and the Council has said that these reports demonstrate that "Australia's health system still faces big challenges to meet the community's high expectations". Only the ACT fully achieved nine targets in the agreement for treating elective surgery patients within the clinically recommended time, reducing the time waited by those overdue for elective surgery, and reducing the proportion of people who have waited the longest. In emergency departments, only Western Australia fully achieved its target for the proportion of people treated, discharged or referred on within four hours.[12] [13]

[12] http://www.coagreformcouncil.gov.au/reports/healthcare/healthcare-2011-12-comparing-performance-across-australia

[13] http://bit.ly/11LGkyf

Table 9. NPs on National Health Reform

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
NP on National Health Reform					
Flexible funding pool for EDs, elective surgery, sub-acute care	25.0	1.1	-	-	-
National elective surgery target					
Capital funding	-	*1.2*	-	-	-
Facilitation and reward funding	-	*51.7*	*49.5*	*49.5*	*49.5*
National emergency access target					
Capital funding	*50.0*	*1.9*	-	-	-
Facilitation and reward funding	*50.0*	*51.7*	*50.0*	*50.0*	*50.0*
New sub-acute beds guarantee funding	446.5	632.5	-	-	-
NP on Financial assistance for long stay older patients	92.4	78.2	-	-	-
Total	**663.9**	**818.5**	**99.5**	**99.5**	**99.5**

From 2013-14 Budget Paper No 3

More information can be gathered from other reports to COAG.

A June 2011 report from the Expert Panel Review of Elective Surgery and Emergency Access put forward 15 recommendations for implementing this NPA, including some changes in how targets were set and measured.[14] COAG agreed to all the recommendations and they were incorporated into the revised NPA-IPHS signed by COAG in July 2011. The Australian Institute of Health and Welfare (AIHW) was asked to work with the Royal Australasian College of Surgeons to develop national definitions for elective surgery categories, including 'not ready for care' by December 2012.[15] It is not clear if these definitions have been finalised.

The AIHW is also required to produce an annual report on these hospital statistics. The 2012 report was released in February 2013.[16]

It found that:

- With respect to NEAT, five States and Territories (Qld, WA, SA, Tas, ACT) achieved higher proportions than the baseline (based on 2009-10 data), but only WA met the 2012 target.

[14] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Expert-Panel-Report

[15] http://www.aihw.gov.au/national-definitions-for-elective-surgery-urgency-categories/

[16] http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129542732

Overall, 65.5% of patients presenting to a public hospital emergency department had their visit to the emergency department completed in 4 hours or less

- With respect to NEST, comparisons are more difficult as clinical urgency categories are not currently comparable across States and Territories. Six States and Territories achieved proportions seen on time greater than or equal to the baseline for two or three urgency categories and six States and Territories had average overdue waits shorter than the baseline for two or three urgency categories. Victoria and WA came close to achieving most 2012 targets; some states like Queensland did very poorly. Median waiting times ranged from 27 days in Queensland to 55 days in the ACT.

The COAG Reform Council's Healthcare 2011 -12 Report[17] on looked at the delivery of new sub-acute beds under the NPA-IPHS which requires the States and Territories to deliver and operate an additional 1316 new subacute beds over the years 2010– 11 to 2013–14. It found that by 30 June 2012, an additional 713 new subacute beds had been delivered, above the 2011–12 target. Victoria, Queensland and Tasmania delivered more beds than targeted. Western Australia, South Australia, the ACT and Northern Territory delivered fewer beds than targeted. NSW delivered more beds than its renegotiated target. However no information was provided on the allocation of the beds across the required sectors of palliative care, geriatric care, mental health and respite care.

NP on Health Infrastructure

The National Partnership Agreement on Health Infrastructure was agreed by COAG at its meeting on 7 December 2009. Most of the funding in the NP comes from the Health and Hospitals Fund. There has been a significant shuffling of funds across the forward estimates in this NP.

[17] http://www.coagreformcouncil.gov.au/sites/default/files/files/Health%202011-12%20-%20Chapter%204.pdf

Table 10: NP on Health Infrastructure

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Health and Hospitals Fund					
Hospital Infrastructure and projects of national significance	166.2	99.2	65.0	0.6	-
National cancer system	188.3	148.8	101.1	50.5	1.6
Regional priority round	108.6	261.1	396.1	342.3	36.6
Other Health Infrastructure payments					
Grafton Hospital	2.0	-	-	-	-
Radiation oncology services in Tasmania	0.4	-	-	-	-
Total	**465.5**	**509.1**	**562.1**	**393.4**	**38.2**

From 2013-14 Budget Paper No 3

It is also interesting to note which of the States and Territories receive these funds. (See Table 11) Some of this is explained because the next Regional Priority funding round will focus on rural and remote areas. Most of the cancer funding ($233 million of $490 million) will go to Victoria and only Queensland and Victoria get funding for hospital infrastructure (aside from $1 million in 2013-14 to Tasmania).

Table 11: NP on Health Infrastructure – spending by State and Territory

State / Territory	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
NSW	92.2	82.8	**195.9**	**195.3**	**27.0**
VIC	75.1	138.6	141.5	87.0	**0**
QLD	204.1	121.1	76.2	50.3	0
WA	15.9	89.5	75.3	35.0	1.6
SA	149.9	25.5	11.4	33.7	0
TAS	14.2	7.6	6.8	50.0	0
ACT	6.4	4.9	0.1	0.1	0
NT	7.5	39.0	60.0	91.7	9.7

From 2013-14 Budget Paper No 3

NP on Health Services

Funding for a variety of health services is made under this NP. Some of these payments are quite small. Where the policy proposal or payment is considered relatively low value and / or low risk, a simpler form of National Partnership called a Project Agreement may be used.[18] Project Agreements are slowly replacing Implementation Plans developed under this omnibus NP.

The significant increase in funding through the NP on Health Services, commencing in 2014-15, is due to the Adult Public Dental Services – part of the dental health package announced in August 2012.[19] A total of **$1.3 billion** is provided for services for adults on low incomes, including pensioners and concession card holders, and those with special needs. A further **$68.6 million / 4 years** is for a package of services for Tasmania. This is part of a **$325 million** Assistance Package for Tasmania's health system announced in June 2012.[20] (This is discussed in more detail in my analysis of the 2012-13 MYEFO[21])

Last year this NP included funding for human quarantine services **($0.5 million / year**). It is has never been clear how decisions are made about where some funding belongs. For example:

- Why isn't the funding for perinatal depression in the NP on Mental Health.
- Why isn't the funding for vaccine –preventable diseases surveillance linked with the NP on Essential Vaccines?
- Why is funding for Adult Public Dental Services separate from funding for treating more public dental patients?

[18] http://www.federalfinancialrelations.gov.au/content/circulars/circular_2011_02.pdf

[19] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BEB596CE56CBCF33CA257A690006E268/$File/TP074.pdf

[20] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-tp-tp053.htm?OpenDocument&yr=2012&mth=06

[21] http://aphcri.anu.edu.au/sites/aphcri.jagws03.anu.edu.au/files/panel/416/l.russell.myefo2012.pdf

Table 12: NP on Health Services

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Early intervention pilot program	0.2	-	-	-	-
National antimicrobial utilisation surveillance program	0.2	0.2	-	-	-
NT medical school contribution	2.2	2.3	2.3	2.3	2.4
Adult Public Dental Services	-	-	200.0	295.0	390.0
BreastScreen Australia radiography workforce initiatives	0.2	-	-	-	-
Canberra Hospital –dedicated paediatric emergency care	-	-	5.0	-	-
Expansion of BreastScreen Australia program	-	9.8	10.4	12.0	14.2
Health care grants for Torres Strait	5.3	4.4	4.5	4.6	4.7
Improving health services in Tasmania	20.7	18.4	15.2	14.3	-
National Bowel Cancer Screening Program – participant follow-up function	1.4	1.8	1.9	2.2	-
National perinatal depression initiative	6.1	10.8	8.2	8.2	8.2
OzFoodNet	1.6	1.7	1.7	1.7	1.8
Royal Darwin Hospital	14.8	14.9	15.2	15.5	15.8
Torres Strait health protection strategy – mosquito control	0.9	0.9	1.0	1.0	1.0
Vaccine preventable disease surveillance	0.8	0.8	0.8	0.8	0.8
Victorian cytology service	8.1	8.5	8.9	9.4	9.8
Total	**62.4**	**74.5**	**275.1**	**367.1**	**448.6**

From 2013-14 Budget Paper No 3

Previously funding was provided under this NP to Queensland health facilities to offset some of the costs associated with the treatment of Papua New Guinea (PNG) nationals, in particular those with tuberculosis (TB). Who pays for the treatment of these patients and where this treatment is given has been the subject of disagreement between the Australian federal and Queensland state governments.[22] Some Torres Strait Island clinics have closed and it seems that the redeveloped Saibai Island clinic will no longer receive PNG patients. The current funding **($3.7 million / 4**

[22] http://www.radioaustralia.net.au/international/radio/program/asia-pacific/serious-tb-situation-in-pngs-remote-western-province/949866

years to Queensland) is to provide additional staff for the treatment of communicable diseases at the clinic on Sabai Island and the development and implementation of a culturally appropriate sexual health education campaign for people in the Torres Strait.

The importance of managing these issues well is highlighted by the fact that recently a PNG national with extensively drug resistant TB (XDR-TB) died after spending almost a year in an isolation ward at Cairns Base Hospital.[23], she died on 8 March 2013. The woman came from Daru Island, located just north of the Torres Strait and Cape York Peninsula, where there is a known epidemic of TB. Her treatment cost Queensland Health about $500,000 and would have cost $1 million had she lived to complete it. Since then another PNG national has been diagnosed with XDR-TB in Australia.

NP on Mental Health

This NP includes funding of **$309 million / 5 years** to the States and Territories for the establishment of up to 16 new early psychosis services across Australia. The new services will be based on the model established by the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne. EPPIC provides an integrated and comprehensive mental health service aimed at addressing the needs of people aged 15-24 with a first episode of psychosis. It is encouraging to note that this provision, initially **$222 million / 5 years**, has been provided with **$80.2 million** in 2016-17 which will presumably cover operational expenses. To date very little of this funding has been spent.

Also included in this NP is the NP to support National Mental Health Reform. This provides **$201 million / 5 years** in federal funds and was agreed by COAG at its meeting on 13 April 2012. These funds, augmented by the State and Territories, will go to projects focussed on improving outcomes for people with severe and persistent mental illness through better access to supported housing, support to limit Emergency Department presentations and the need for inpatient admission, and services to enhance recovery.

Table 13: NP on Mental Health

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Early Psychosis Youth Centres	28.2	50.2	70.2	80.2	80.2
Supporting National Mental Health Reform	43.3	50.6	51.6	45.3	-
Total	**71.5**	**100.8**	**121.8**	**125.5**	**80.2**

From 2013-14 Budget Paper No 3

[23] https://www.mja.com.au/journal/2013/198/7/extensively-drug-resistant-tuberculosis-hovers-threateningly-australia-s-door

NP on Indigenous Health

In 2013-14 the Australian Government will pay **$54 million** to the States and Territories through National Partnership payments (NPs) for work in 12 areas of Indigenous health. (See Table 14)

Of the **$113.8 million** provided of the four years to 2016-17, over 50% **($68.8 million**) is allocated to the Northern Territory. However expenditure drops considerably over the forward estimates.

Table 14. NP on Indigenous Health

NPs	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Sexual assault counseling in remote NT	1.3	-	-	-	-
Accommodation related to renal services in NT	-	10.0	-	-	-
CTG in the NT	0.4	-	-	-	-
Improving ear services for Indigenous children	6.5	0.7	-	-	-
Improving trachoma control services	3.9	4.4	4.1	4.2	4.2
Indigenous early childhood development – antenatal and reproductive health	24.3	24.4	6.0	-	-
Reducing rheumatic fever in Indigenous children	2.5	2.6	2.6	2.7	2.7
Renal dialysis services in Central Australia	1.6	1.7	1.7	-	-
Stronger Futures in the NT	9.0	9.8	10.3	10.2	10.8
Torres Strait health protection strategy – mosquito control	1.5	0.5	0.5	-	-
Total	**51.1**	**54.0**	**25.1**	**17.1**	**17.6**

From 2013-14 Budget Paper No 3

In 2011 new funding of **$13 million** to assist Indigenous families affected by renal diseases in the Northern Territory towns of Alice Springs and Tennant Creek. This funding was announced as the "first step" towards addressing some of the issues raised in the Central Australian Renal Study.[24] However this funding was handed back - $3 million by the former NT Labor

[24] http://www.health.gov.au/internet/main/publishing.nsf/Content/A7B443D6D3F55E67CA2578B100831F9A/$File/Final%20Report%20Central%20Australia%20Renal%20Study.pdf

Government and $10 million in March 2013 by the current NT government.[25] This **$10 million** still appears here. In April 2013, Minister for Indigenous Health, Warren Snowdon, announced an extra **$2.4 million** in funding to Aboriginal Health Organisations to expand kidney treatment and tackle the causes in hopes to eliminate renal disease in remote communities across the Northern Territory.

NP on Preventive Health

The Government has chosen not to highlight the significant funding changes that have been made to the NP for Preventive Health since the 2012-13 Budget. In the 2012-13 MYEFO, **$187 million** was cut from this NP. (See Tables 15 and 16) Now that funding has been restored in 2015-16 and 2016-17, with the majority of this **($130.4 million**) not available until 2016-17. (See Table 17) That still means there is less money to spend at a time when no significant progress has been made on reducing obesity rates. The total federal funds spent on public health and prevention is around 3% of the total healthcare budget – a percentage that has barely changed despite the development of the National Preventative Health Strategy.

Table 15. NP on Preventive Health (2012-13)

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m
Enabling infrastructure	2.5	-	-	-
Healthy children	64.9	97.4	130.8	-
Healthy communities	15.2	11.1	-	-
Healthy workers	62.8	88.2	105.2	-
Social marketing	6.0	-	-	-
Total	**151.2**	**196.6**	**235.9**	**-**

From 2012-13 Budget Paper No 3

Table 16. NP on Preventive Health (2012-13 MYEFO)

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m
Enabling infrastructure	2.5	-	-	-
Healthy children	23.85	28.86	28.86	-
Healthy communities	15.2	11.1	-	-
Healthy workers	21.15	24.65	24.65	-
Social marketing	6.0	-	-	-
Total	**68.73**	**64.61**	**53.25**	**-**

From 2012-13 MYEFO

[25] http://www.theaustralian.com.au/national-affairs/health/nt-rejects-funds-for-dialysis-centres/story-fn59nokw-1226599375065

Table 17. NP on Preventive Health (2013-14)

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Enabling infrastructure	2.5	-	-	-	-
Healthy children	23.9	28.9	28.9	28.9	105.8
Healthy communities	15.2	11.1	-	-	-
Healthy workers	21.2	24.7	24.7	24.7	24.7
Social marketing	6.0	-	-	-	-
Total	**68.7**	**64.6**	**53.5**	**53.5**	**130.4**

From 2013 -14 Budget Paper No 3

Other health NPs

A significant amount of the funds here is for the delivery of immunisation programs under the National Immunisation Program. The funding here is less than that provided – no explanation is given but it is assumed that this is because the purchasing arrangements for some vaccines have been centralised. Progress towards this goal could not be established but it appears to be slow.

Commonwealth and the States and Territories have been implementing a 2008 COAG commitment to move to a more nationally consistent approach to activity based funding for public hospitals. The Commonwealth has committed **$153.58 million** for this initiative, of which **$133.41 million** is to be paid to the States and Territories in three separate tranches. The 2012-13 funding is the last tranche. This funding was originally given as **$55.52 million**.[26]

Table 18. Other Health NPs

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
East Kimberley Development Package – health related projects	2.8	-	-	-	-
Essential vaccines	227.6	259.9	253.0	251.9	259.6
Hospital and health workforce reform – activity- based funding	43.0	-	-	-	-
National Coronial Information System	0.4	0.4	0.4	-	-
Treating more public dental patients	69.2	155.2	119.6	-	-
Total	**343.0**	**415.5**	**373.0**	**251.9**	**259.6**

From 2013 -14 Budget Paper No 3

[26] http://www.federalfinancialrelations.gov.au/content/npa/health_payments/workforce-reform/activity_based_funding/national_partnership.pdf

Improving the sustainability of the health budget / budget cuts

Total health expenditure has grown in nominal terms by over 40% from 2007-08 to an estimated **$64.6 billion** in 2013-14.

Measures claimed by the Government as putting health expenditure on a more sustainable footing include:

- The agreement between the government and the pharmaceutical industry that has saved **$1.9 billion** since 2010 and will save an estimated further **$2 billion** over the forward estimates. The Memorandum of Understanding between Medicines Australia and the Commonwealth of Australia in relation to the PBS will expire on 30 June 2014.
- Means testing of the private health insurance rebate, which commenced on 1 July 2012 and capping growth in the rebate which is expected to commence on 1 April 2014.
- Aligning the indexation of MBS fees to the financial year in line with many other Government programs meaning MBS fees will be indexed on 1 July rather than 1 November each year. The next indexation will occur on 1 July 2014. This will provide savings of **$664.4 million / 4years.**
- Increasing the upper threshold for the Extended Medicare Safety Net from $1,221.90 to $2,000, from 1 January 2015, saving **$105.6 million / 4 years**.

The 2013-14 Budget cuts a total **$1.22 billion / 5 years** from current programs. (see Table 19) The majority of this **($902 million**) is taken from Medicare. Another **$178.5 million** is taken from health agencies.

Table 19. Savings taken in the 2013-13 Budget

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Medicare					
- Increasing threshold for EMSN	-	0.1	-7.8	-48.5	-49.4
- New listings	-0.1	-0.4	-0.4	-0.3	-0.3
- Realignment of indexation	-	-159.9	-153.3	-173.6	-177.6
- Removal of out-of-hospital rebate*	[-2.1]	[-2.1]	[-2.1]	[-2.1]	[-2.1]
- Remove double billing	-	0.2	-25.4	-44.6	-49.8
Infrastructure					
- Health and Hospitals Fund	-3.4	-5.9	-1.5	-	-
- NRRHIP prioritisation	-	-5.0	-5.0	-5.0	-5.0
- Woomera Hospital	-	-	-1.4	-1.4	-1.4
Agencies					
- NBA (incl revenue loss)	-	-0.4	-14.3	-28.6	-39.7
- IHPA	-	-0.6	-0.6	-0.6	-0.6
- ACSQHC	-	-4.1	-5.0	-4.0	-
- HWA	-	-20.0	-20.0	-20.0	-20.0
Promotional funding					
- Health Kids Check	-2.0	-2.0	-2.0	-2.0	-2.1
Aged Care					
- Workforce supplement	-	-2.7	-10.9	-20.2	-27.8
- Staying at Home	0.1	1.0	-0.4	-0.8	..
e-Health					
- NHIN	-	-	-	-5.9	-25.4
Appliances					
- Stoma Appliance Scheme	-0.1	-0.4	-0.4	-0.4	-0.4
- Continence Aids Payment Scheme*	-	[-0.15]	[-0.15]	[-0.15]	[-0.15]
Total	**-6.8**	**-202.35**	**-250.65**	**-358.15**	**-401.75**

**distribution over forward estimates not provided*

2013-14 Budget measures

Cancer care

In this Budget, the Government is providing **$226.4 million / 5 years** for cancer care initiatives. With the exception of **$18.5 million** for a new Prostate Cancer Research Centre, these funds are for the continuation and / or expansion of current programs, most of which were originally funded in the 2008-09 or 2009-10 Budgets.

Additional Funding for BreastScreen Australia

New funding of **$55.7 million / 4 years** in provided to expand the range of women invited to participate in the BreastScreen Australia program from 50-69 to 50-74 years of age. When fully implemented in 206-17 more than 145,000 additional women, aged 70-74, are expected to access mammography services over a two year period. Some of these funds will go to targeted communications to women and health professionals about the expanded age range and to support services, jurisdictional registries and data reporting.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Treasury	-	9.8	10.4	12.0	14.2
DoHA	-	2.8	3.1	1.7	1.7
Total	-	12.6	13.5	13.7	15.9

BreastScreen Australia was established in 1991 and is a joint initiative between the Commonwealth (which provides overall coordination of policy formulation, national data collection, quality control, monitoring and evaluation) and the States and Territories (which have primary responsibility for the implementation of the program at the local level. Services have been targeted specifically at well women without symptoms aged 50-69, although women aged 40-49 and 70 years and older have been able to attend for screening. The program's aim is to achieve a participation rate of 70% among women aged 50-69 years; however screening rates are currently only 54.9% for women in this age group, and around 36% for Indigenous women.[27] Some women in this age group are already being screened (an estimated 100,000 in 2009-10[28]) so it is likely the expected 145,000 participants are additional to this.

[27] The Australian Institute of Health and Welfare (AIHW) produces annual reports on BreastScreen Australia. The latest report, for 2009-10 was released in October 2012. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737423102

[28] http://bit.ly/1458zLn

A report on the evaluation of BreastScreen Australia was released in 2009.[29] This report recommended extending the target age range to provide biennial screening for women aged 70–74 years. There are an estimated 365,400 women in this age group, so the expected participation rates are low. The incidence of breast cancer in women in the 70-74 age group (314/100,000) is slightly less than that for women aged 65-69 (337/100,000).[30]

$120 million was provided in the 2009-10 Budget to upgrade BreastScreen Australia services to digital mammographic technology by June 2013. It is not clear how this roll-out has progressed. A response to a Senate Estimates questions shows that as at 13 June 2011, **$47.7 million** had been expended.[31]

Additional funding for McGrath Foundation Breast Care Nurse initiative

$19.5 million / 4 years is provided to continue and expand the Breast Care Nurse initiative run by the McGrath Foundation. This funding is stated to provide approximately 13 new positions to be located in new Regional Cancer Centres and outer metropolitan areas.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	4.8	4.9	5.0	5.1

This provision was originally announced in January 2013 as **$18.5 million** to continue funding 44 existing Government-funded McGrath Breast Care Nurses and provide an additional 10 full-time equivalent McGrath Breast Care Nurse positions.[32] In the 2008-09 Budget, the McGrath Foundation received **$12.0 million / 4 years** to recruit, train and employ 30 new breast cancer nurses[33]for rural and remote areas or areas where there was no breast cancer nurse.

Australian Prostate Cancer Research Centres

$18.5 million / 4 years is provided to fund the a new prostate cancer research centre at the Kinghorn Centre (NSW) and to provide continued funding to existing centres at the Epworth Hospital (Vic), Queensland University of Technology / Princess Alexandra Hospital (Qld)

[29] http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/br-evaluation-lp

[30] http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/39E9A7D358239DF4CA25762A0006B283/$File/full.pdf

[31] parlinfo.aph.gov.au/.../display.w3p;...Id%3A%22committees%2Festimate%..

[32] http://www.pm.gov.au/press-office/more-funding-mcgrath-foundation-breast-care-nurses

[33] Sometimes this is reported as 44 nurses: the difference may lie in number of nurses employed vs FTEs.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	4.0	4.7	-	4.9

During the 2007 election the Rudd Government committed to provide **$15 million / 5 years** for the establishment of two dedicated Prostate Cancer Research Centres. This funding was provided in the 2008-09 Budget. In November 2008 the Epworth Hospital received **$7.5 million** to establish a Prostate Cancer Research Centre,[34] and in January 2009 a similar grant was provided for a Prostate Cancer Research Centre at the Princess Alexandra Hospital, to be hosted by the Queensland University of Technology.[35]

Bone Marrow Transplant Program

Additional funding of **$23.8 million / 4 years** is provided to meet increases in demands and program costs for the Bone Marrow Transplant Program.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	3.8	5.1	6.6	8.4

Bone marrow transplantation (BMT) (this refers to haemopoietic stem cell transplantation using blood, marrow or cord blood derived stem cells) is an uncommon therapy. The most recent data available show that a total of 1,379 transplants were performed in 2010 in Australia, of which 454 were higher risk allogeneic transplants. The most recent publicly available analysis of costs of BMT in Australia was performed in NSW in 2010.[36] However it gives no indication of the costs involved.

In 2011 the Australian Government signed a **$7.4 million/ 3 year** funding agreement with the Australian Bone Marrow Donor Registry (ABMDR).[37] This was announced as among the first agreements under DoHA's National Alignment (DNA), which aims to increase the use of multi-year funding agreements. It is assumed that the additional funding in this budget is a supplement and extension of this funding agreement rather than a provision to the States and Territories, but this is not clear.

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34 http://ministers.treasury.gov.au/wmsDisplayDocs.aspx?doc=speeches/2008/044.htm&pageID=003&min=wms&Year=2008&DocType=1

35 http://ministers.treasury.gov.au/DisplayDocs.aspx?doc=pressreleases/2009/002.htm&pageID=003&min=wms&Year=2009&doctype=0

36 http://www.health.nsw.gov.au/pubs/2010/bloodmarrowtra.html

37 http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ck-ck034.htm

Cancer data to improve cancer survival

$2.4 million / 4 years is provided to Cancer Australia to collect, collate and report national cancer data relating to the stage of cancer at diagnosis, treatment, and frequency of recurrence after treatment.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Cancer Australia	-	0.6	0.6	0.6	0.6

In the 2009-10 Budget, Cancer Australia and AIHW received funding of **$4.2 million / 4 years** to improve the range of cancer data and related evidence available at a population level in Australia.

Chemotherapy services

$29.6 million / 2 years is provided to increase dispensing fees for chemotherapy medicines listed on the PBS and to conduct a comprehensive review of the current arrangements for chemotherapy services.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	0.1	29.5	-	-	-

Dispensing fees will be increased by $60 per infusion, from $76.37 to $137.37 for six months from 1 July 2013. The review will cost **$1.2 million** and will report to the Minister for Health by October 2013.

This issue is discussed in more detail in the PBS section.

Improving lung cancer outcomes

$5.9 million / 4 years is provided to Cancer Australia to continue to develop improved care for the 10,000 people diagnosed with lung cancer each year. This work included training and education program for primary care providers, best practice in the delivery of lung cancer treatment and end-of-life care, national research and monitoring of lung cancer data.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Cancer Australia	-	1.5	1.5	1.5	1.5

The 2009-10 Budget previously provided **$6.8 million / 4 years** for this work.

National Bowel Cancer Screening Program

$16.1 million / 4 years is provided to enhance the Program Register for the National Bowel Cancer Screening Program (NBCSP) to support electronic reporting by health professionals and meet increased costs resulting from expansion of age groups for testing.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	3.7	3.8	4.4	4.1
DVA	-	..	..	..	..
DHS	-	..	..	..	..
Total	-	3.7	3.8	4.4	4.2

The 2012-13 Budget provided **$49.7 million / 4 years** to expand the NBCSP to increase the frequency of bowel cancer screening available to Australians aged between 50 and 74 years. This was in addition to the **$138.7 million / 4 years** provided in the 201-12 Budget.

A recent study shows that more than three-quarters of eligible Australians are not being screened for bowel cancer despite it being offered for free. Just 25% of eligible men and 20% of women were screened for bowel cancer during the period studied.[38] The quantitative performance indicator for bowel cancer screening (Program 1.1) is 41% for each of the years 2012-13 to 2016-17. There appears to be little effort to (1) reach this target and (2) extend the target to improve participation and detection rates.

Victorian Cytology Service

$36.5 million / 4 years is provided in continued funding to the Victorian Cytology Service for their work on cervical cancer. This funding is provided under the NP on Health Services and was due to expire on June 30, 2013.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	8.5	8.9	9.4	9.8

Youth Cancer Networks

$18.2 million / 4 years is provided to CanTeen to support the Youth Cancer Networks program.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	4.5	4.5	4.5	4.7

[38] http://www.guardian.co.uk/world/2013/jun/19/australia-bowel-cancer-screening

The 2008-09 Budget previously provided **$15.0 million / 3 years** to CanTeen to establish Youth Cancer Networks in Australia to improve coordination of services, support and care for teenagers and young adults with cancer, and their families, including the establishment of six new adolescent and young adult cancer centres. While progress in this regard could not be accurately assessed, the CanTeen website states that this $15 million was the basis for a planned $30 million Youth Cancer Fund. It also states that the States and Territories have made commitments to fund ongoing service delivery, totaling in excess of **$20 million** in the first five years of the new services.[39]

[39] https://canteen.org.au/default.asp?articleid=831&menuid=57&isFlash=1

Prevention

The lack of focus on and investment in prevention is worrying at a time when overweight and obesity rates continue to rise and there is a substantial toll from the misuse of alcohol and drugs – and these are two of the three key issues that the government has prioritised for action through the National Preventive Health Agency.[40] The good news is that smoking rates have continued to decline (except among Indigenous people), and there is a goal to reduce the adult daily smoking rates in Australia to 10% by 2018 (and halving the smoking rate among Indigenous people in the same period). However this success with tobacco needs continued resources if it is to be continued, and a substantial and sustained effort is needed to tackle the other issues, especially obesity.

Instead this Budget and the funding cuts made in MYEFO have reduced public health funding to the States and Territories provided through the NHR Agreements. The Australian National Preventive Health Agency (ANPHA) has also had significant funding cuts in the critical first years of its operation.[41]

Aside from unspecified funds for compliance, enforcement and litigation activities associated with the tobacco plain packaging legislation, the only prevention funding provided in the 2013-14 budget is for secondary preventive activities such as cancer screening (**$73.8 million / 4 years**) and vaccination surveillance **($3.3 million / 4 years**).

The 2013-14 Portfolio Budget Statement for Program 1.6 Public Health, under 'Promote healthy lifestyle choices', lists the following activities for 2013-14*:*

- The development of a national nutrition policy, to be completed in 2014.
- Oversight and implement of elements of the NP on Preventive Health.
- Provision of national population and clinical guidelines to guide policy and programs promoting healthy eating, physical activity and healthy weight.
- Working closely with ANPHA which has responsibility for developing national awards for excellence in workplace health programs to support the Healthy Workers initiative and the National Tobacco social marketing campaigns.

Vaccine Preventable Disease Surveillance Program

$3.3 million / 4 years is provided for the continuation of the Vaccine Preventable Diseases Surveillance program. This currently covers 14 nationally notifiable diseases. This money is provided to the States and Territories under the NP on Health Services.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.8	0.8	0.8	0.8

[40] http://anpha.gov.au/internet/anpha/publishing.nsf

[41] http://aphcri.anu.edu.au/sites/aphcri.jagws03.anu.edu.au/files/panel/416/l.russell.myefo2012.pdf

Rural health

In 2013-14 it is estimated that the Department of Health and Ageing will spend $15 billion specifically in regional areas.[42] This amounts to 28% of the total budget, and the amount is expected to remain constant over the forward estimates.

Table 20: Regional and non-regional expenditure

Program	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Pharmaceuticals and Benefits				
regional	3,283	3,447	3,581	3,726
non-regional + non-specific	7,307	7,673	7,972	8,293
Medical Services and Benefits				
regional	5,537	6,047	6,430	6,868
non-regional + non-specific	13,556	14,804	15,743	16,814
Residential and Flexible Care				
regional	2,853	2,996	3,200	3,383
non-regional	6,060	6,367	6,800	7,190
Private Health Insurance				
regional	1,377	1,422	1,466	1,508
non-regional + non-specific	4,022	4,156	4,282	4,405
Targeted rural expenditure				
regional	2,223	2,038	2,106	1,538
non-regional + non-specific	-	-	-	-
Various other programs				
regional				
non-specific	7,842	8,203	8,752	9,675
Total				
regional	15,271	15,951	16,784	17,022
non-regional + non-specific	38,788	41,202	43,550	46,376

From 2013-14 Budget Paper Regional Australia: Strengthening Communities

Table 20 indicates regional expenditures:

- 31% of Pharmaceuticals and Benefits;
- 29% of Medical Services and Benefits;
- 32% of Residential aged Care (supplemented by expenditures on multi-purpose facilities which is included under Targeted Expenditures); and
- 25% of Private Health Insurance.

The levels of Targeted Rural Expenditure decline over the forward estimates. This is disturbing given the levels of rural disadvantage and poorer health outcomes.

The allocation of funding to regional infrastructure is discussed under Infrastructure (page 49).

[42] 2013-14 Budget Paper Regional Australia: Strengthening Communities

The Rural Health Workforce Strategy that was funded in 2009-10 had the following elements:

- A new geographical classification system (Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA)), to be phased in from July 2009.
- The GP Rural Incentives Program (**$64.3 million / 4 years**)
- Changes in service obligations (**$47.5 million / 4 years**)
- Increase in locum relief (**$22.6 million / 4 years**)

The Minister for Health, as part of the response to the Mason health workforce review, has committed to providing a more advanced system for classifying rural locations and areas of workforce need.[43] This will build on and update the ASGC-RA system.

General Practice Rural Incentives Program

The only specific rural health provision in the 2013-14 Budget is **$33.8 million** to fund the General Practice Rural Incentives Program (GPRIP) for an additional year. This funding is met by redirecting **$20 million** from savings taken in the budget of Health Workforce Australia and an additional **$13.8 million** from other workforce programs administered by DoHA (which seems a little like robbing Peter to pay Paul).

GPRIP was initially funded in the 2009-10 Budget at **$64.3 million / 4 years**. Additional funding of **$34.9 million** was provided in 2012-13, again through reallocation of funds from HWA and other workforce programs. It is not clear why this program is being funded on a yearly basis. There is some evidence that demand has exceeded expectations.

It is unclear if continued funding is provided for the other components of the Rural Health Workforce Strategy.

National Rural and Remote Infrastructure Program – prioritising remote areas and Indigenous communities

Future grant rounds of the National Rural and Remote Health Infrastructure Program (NRRHIP) will focus on targeting remote and very remote areas or Indigenous communities. **$20 million / 4 years** will be clawed back from this program.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-5.0	-5.0	-5.0	-5.0

NRRHIP provides funding to rural and remote communities for essential health infrastructure and equipment.

[43] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-tp-tp049.htm

Health workforce

A review of Australian Government health workforce programs, announced as part of the 2012-13 Budget, has been undertaken and the Mason Review was publicly released in May 2013.[44] This report relied heavily on HWA's modelling and Health Workforce 2025 report.[45]

The review found that 'root and branch' reform of the major drivers of the Australian health workforce cannot be achieved by the levers available to DoHA alone. Two other review processes are therefore important. The first is the scheduled analysis of the ongoing role and function of Health Workforce Australia (HWA), as part of the National Partnership Agreement on Hospital and Health Workforce Reform, which expired at the end of 2012-13. The second is a fresh analysis of the health workforce by the Productivity Commission, which has been foreshadowed to take place in the medium term.

Key findings of the Mason Review:

- Despite reforms, Australia's health care system continues to be focused heavily around increasingly expensive and specialised acute care in major metropolitan centres rather than on measures to redirect resources to the provision of high quality primary care, population health initiatives and preventative care.
- The focus must move beyond specialist medicine and acute care beds to appropriate generalist skills, team based community care and the training and development of the nursing and allied health workforce.
- The most significant health workforce issue is not one of total supply but one of distribution.

Key Recommendations:

- The creation of a coherent pathway for rural and regional education and training – in the short term and as a matter of urgency for generalist medical training – but which over time produces more appropriate resource allocation to nursing, allied health and dentistry.

The Mason Review found that these recommendations have the potential not only to achieve better health workforce outcomes in rural and regional areas, but to foster an emphasis on generalist medicine and integrated primary care. Implementation of these recommendations will require cooperation and collaboration from education sectors, including medical schools, State and Territory Governments, and professional bodies. To date the Australian Government has chosen to act only on making changes to the rural classification system.

[44] http://www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programs

[45] http://www.hwa.gov.au/health-workforce-2025

Health Workforce Australia

In the name of 'rationalisation' **$80 million / 4 years** will be cut from the budget of HWA. Some of this money goes to the General Practice Rural Incentives Program.

It is sad to see budget cuts being made to a critical agency for health care reform. HWA was established in 2010 to deliver a more effective, nationally coordinated approach to a sustainable health workforce for Australia. It works across both the health and education sectors. Its budget in 2012-13 was **$373.05 million**.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
HWA – efficiencies	-	-20.0	-20.0	-20.0	-20.0

These cuts come on top of **$33 million** taken in the 2012-13 Budget.

Health Workforce Redesign Program

$6.0 million is provided in 2013-14 to continue to implement and evaluate health workforce reforms and workforce redesign activities.

This funding is a remnant of the NP on Hospital and Health Workforce Reform. Under this NP HWA developed the National Health Workforce Innovation and Reform Strategic Framework for Action. In November 2011 Health Ministers approved an implementation plan for the framework to drive reform and innovation activity by HWA, jurisdictions and other stakeholders. HWA provides an annual report to Health Ministers on the implementation of the framework.[46]

General Practice Rural Incentive Program

$33.8 million is provided to fund the General Practice Rural Incentives Program (GPRIP) for an additional year. This funding is met by redirecting **$20 million** from savings taken in the budget of Health Workforce Australia and an additional **$13.8 million** from other workforce programs administered by DoHA. This is discussed further in the section on Rural Health.

International Health Professionals Program

$15.0 million is provided in 2013-14 to continue funding the International Health Professionals Program which provides a coordinated national approach to the recruitment of international health professionals.

[46] http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform/strategic-framework-for-action

It appears that this is also a remnant of the NP on on Hospital and Health Workforce Reform. This NP allocated **$45 million / 4 years** to the international recruitment of health professionals.

The 2012 Lost in the Labyrinth Report from the House of Representatives Standing Committee on Health and Ageing[47] confirmed concerns about the difficulties facing overseas-trained doctors in Australia and highlighted the need for a national, coordinated approach to the attraction, registration and support of international health professionals. Much of this work is being done by HWA.

47

http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=haa/overseasdoctors/report.htm%20

Medicare

Spending through the Medicare Benefits Schedule (MBS) is expected to reach **$19 billion** in 2013-14. In 2013-14, an estimated 353 million medical and associated services, or an average of 14.9 services per capita, will be funded through Medicare.

The Medicare levy will be increased by half a percentage point from 1 July 2014 to provide strong and stable funding for DisabilityCare Australia. This is expected to increase tax receipts by **$11.4 billion** over the forward estimates period. All of the monies raised by the additional levy will go directly to the DisabilityCare Australia Fund.

As a consequence of measures in this Budget nearly **$900 million / 4 years** will be cut from Medicare through a freeze on the indexation of MBS rebates, an increase in the Extended Medicare Safety Net (EMSN) threshold, and prevention of double billing. Patient and doctors' groups have warned these will result in a drop in bulk-billing and higher costs for patients; these claims have been dismissed by the Government.

Increasing the general threshold for the Extended Medicare Safety Net

Savings of **$105.6 million / 4 years** are achieved by increasing the general threshold of the EMNS to $2000 from 1 January, 2015.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.1	-8.4	-48.5	-49.4
DHS	-	-	0.6	-	-
Total	-	0.1	-7.8	-48.5	-49.4

The EMNS provides an additional rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible out-of-hospital services. Once the relevant annual threshold of out-of-pocket costs has been met, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, there is an upper limit on the amount of benefit that can be paid under the EMSN for a number of Medicare services.

There are two thresholds for the EMSN. These thresholds are indexed by the Consumer Price Index (CPI) on 1 January each year. The 2013 annual EMSN thresholds are:

- **$610.70** for Commonwealth concession cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card, and people who receive Family Tax Benefit (Part A); and
- **$1,221.90** for all other singles and families.

However, there is an upper limit on the amount of benefit that can be paid under the EMSN for a number of Medicare services.

Since its introduction in 2004, the EMSN has been changed a number of time as costs have blown out. Moreover it was found that, for some services, 78 cents in every additional dollar in safety net costs had been going to higher doctors' fees, not to benefit patients.

Following an announcement in the 2009-2010 Budget, on 1 January 2010 some Medicare items were capped after they were identified as areas of concern in the Extended Medicare Safety Net Review Report 2009.[48] A follow-up report released in July 2011 found that these changes had helped to make the EMSN more sustainable. Safety net expenditure in 2010 returned to about **$310 million / year**, similar to the cost in 2007 before costs blew out to **$538.6 million** in 2009, with almost 1 million people receiving benefits in 2010. However, the report also found that the safety net is not well targeted at Australians most in need, with people in the wealthiest areas are receiving more than half (53%) of safety net benefits, while only 3.7% of benefits are going to the most disadvantaged areas. People in rural areas are only receiving about one third the benefits per person compared to people in capital cities. In addition, the review shows that there are still some doctors who are charging excessive fees and providing complex procedures out of hospital in order to access safety net benefits.

Realigning indexation of the Medicare Benefits Schedule with the financial year

Indexation of fees for items listed in the MBS will shift from November to July, with the next indexation date being delayed until July 2014. This is expected to generate savings of **$664.4 million / 4 years**.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-152.2	-146.4	-162.7	-163.3
DVA	-	-7.7	-6.9	-10.8	-14.3
DHS	-	..	..	-	-
Total	-	-159.9	-153.3	-173.6	-177.7

Historically, fees for MBS services have been indexed in November each year. Indexation of MBS fees were delayed once before: in the 1996–97 Budget, the Howard Government effectively froze fees at 1995 levels for an additional 12 months.[49]

48 http://www.health.gov.au/internet/main/publishing.nsf/Content/Review_%20Extended_Medicare_Safety_Net/$File/ExtendedMedicareSafetyNetReview.pdf

49 http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201314/Medicare

The Government has said that with the current high rates of bulk billing (around 82%), it does not expect most patients to be affected, However while this may be true for GPs, out-of-pocket costs to see specialists are high and this will only make them higher.

New listings on the Medicare Benefits Schedule

Savings of **$1.5 million / 5 years** are achieved by amending the MBS (and Veterans' Benefits) for new listings since MYEFO.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-0.1	-0.4	-0.4	-0.3	-0.3

Details are not provided (other than a reference to the use of colonic stents as a better and safer alternative to open surgical techniques in the treatment of some cancers) so we do not know how many items are covered and which items are new expenditures and which are savings.

Removal of out-of-hospital Medicare rebate for selected items

Savings of **$10.7 million / 5 years** are taken by the removal of the out-of-hospital rebate for selected MBS items (including certain anaesthetic services, cosmetic services) based on safety and quality concerns about their use outside of hospitals. These decisions (not itemised) were effective 1 March 2013 and the savings were include as a 'decision taken but not yet announced' in the 2012-13 Budget. Presumably, although it is not noted in the Budget Papers, these decisions would also impact on the EMSN.

Removal of double billing under Medicare Benefits Schedule

Savings of **$119.6 million / 4 years** are achieved by preventing the duplication in GPs claiming a Medicare rebate for both a GP standard consultation item and a GP Chronic Disease Management item for the same patient on the same day. This provision is effective 1 November 2014. No explanation is provided for the delayed implementation date.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.2	-24.2	-42.3	-47.2
DHS	-	-	-0.4	-0.8	-0.9
DVA	-	-	-0.8	-1.5	-1.6
Total	-	0.2	-25.4	-44.6	-49.6

Complaints from GPs about these changes have centred around the fact that a chronically ill patient may present needing to be seen for both an acute and a chronic condition.

Comprehensive management framework for the Medicare Benefits Schedule

$19.6 million / 2 years is provided for the Medical Services Advisory Committee (MSAC) to review the quality, safety and cost-effectiveness of existing items on the MBS and to examine the evidence for proposed new medical technologies and procedures.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	9.8	9.8	-	-

The 2009-10 Budget included funding of **$9.3 million / 2 years** for a MBS Quality Framework, to establish new listing, pricing and review mechanisms for items listed on the MBS. In the 2011-12 Budget, **$11.4 million / 2 years** was provided to expand the role of MSAC and to conduct rolling reviews of the quality, safety and fee level of items on the MBS. No specified funding for these activities was provided in the 2012-13 Budget.

Since January 2011, when MSAC's terms of references were expanded to give it a role in changes to the MBS, MSAC has provided advice to the Minister in relation to 13 applications.

Medicare communications campaign

$10.0 million / 2 years is provided for a national communications campaign about the benefits of Medicare and health-related services and to inform Australians about access to Medicare services and rebates.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	6.5	3.5	-	-	-

Senate Estimates revealed a rush to spend the **$6.5 million** allocated for 2012-13 ahed of the end of the financial year and the election campaign.[50]

[50] http://www.heraldsun.com.au/news/national/government8217s-65m-medicare-ad-campaign-remains-a-mystery/story-fni0xqrb-1226657645526

Access to prescription drugs, medical devices and appliances

Pharmaceutical Benefits Scheme

In 2012-13, the PBS is expected to cost **$9.9 billion** in 2013-14, up from **$9.5 billion** in 2012-13. Treasury's PBS forward estimates have been downgraded by $4 billion over two budgets –the result of Treasury underestimating the impact of savings from the Expanded and Accelerated Price Disclosure Reforms and overestimating the demand for medicines.[51] Currently, the real rate of growth in pharmaceutical benefits expenditure is 2% a year, despite Australia's ageing population, and an estimated 6% annual growth in PBS volumes. Expenditure on pharmaceuticals as a percentage of GDP is now expected to decline every year between 2012-13 and 2016-17.[52]

There is some disagreement between Government figures on PBS growth and those of other stakeholders.[53] For example, the Pharmacy Guild claims that PBS and Repatriation PBS expenditure growth for the 12 months to 30 November 2012 decreased by 0.5%.[54] The most recent report from DoHA – Medicines Australia on Trends and Drivers of Pharmaceutical Benefits Scheme expenditure was release in May, 2013.[55]

Through until April 2013 reductions in the price of PBS medicines as a result of Price Disclosure have applied to 130 drugs. A further 39 price reductions will apply on 1 August 2013. In the period since the major round of price disclosure reductions on 1 April 2012, the Guild says that government expenditure decreased by 3.1% compared with the same period in 2011.[56]

The Government claims that since 2007 it has provided new PBS listings worth **$5 billion**. The 2013-14 Budget shows that since the 2012-13 MYEFO the Government has invested **$690.5 million / 5 years** in new listings and amendments to listings on the PBS.

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[51] http://medicinespartnership.com.au/category/pbs-scorecards/

[52] http://www.guild.org.au/iwov-resources/documents/The_Guild/tab-News_and_events/Guild_News_Centre/2013/MR_MPA_Budget_16May13.pdf

[53] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/EAEA13860C5CA270CA257B7800020652/$File/TP051.pdf

[54] http://www.guild.org.au/iwov-resources/documents/The_Guild/tab-News_and_events/Guild_News_Centre/2013/MR_PBS_data_22March13.pdf

[55] http://www.pbs.gov.au/publication/reports/trends-in-and-drivers-of-pbs-expenditure.pdf

[56] http://www.guild.org.au/iwov-resources/documents/The_Guild/tab-News_and_events/Guild_News_Centre/2013/MR_PBS_data_22March13.pdf

A recent report from the Grattan Institute claims that Australia is paying too much for prescription drugs, with the cost of this overpayment amounting to at least **$1.3 billion / year**, or 14% of the PBS budget. This report proposed reforms to pharmaceutical pricing in three areas:

- Independent, expert pricing within a defined budget;
- Slashing the price of generic drugs; and
- Encouraging people to use the most cost-effective medicine.

With the MoU between the Government and Medicines Australia due to expire in June 2014 and the Fifth Pharmacy Agreement due to expire in June 2015, it will be interesting to see if any of these proposals are considered as these are renegotiated.

In the past year there has been an issue over the cost for private hospitals and community pharmacists to dispense injectable and infusible chemotherapy drugs. The Revised Arrangements for the Efficient Funding of Chemotherapy Drugs came into effect for private hospitals and community pharmacies on 1 December 2011 and for public hospital pharmacies on 1 April 2012.[57] The arrangements were designed to achieve greater efficiency in the use of injectable and infusible chemotherapy medicines used in the treatment of cancer by only paying suppliers and pharmacies for the combination of vials that most cost efficiently makes up the required patient dose. The cuts were intended to save the federal budget $40m a year. Private hospitals and community pharmacists say tightening of the system has made it increasingly difficult for them to cover the costs of delivering the chemotherapy drugs. About 60% this type of chemotherapy is done in private hospitals and there were concerns that these changes could push up the cost of treatment for each patient by up to $100 for every dose.

Faced with a public backlash, the Minister for Health announced that the government will provide **$29.7 million** in the 2013-14 Budget to pay providers an additional $60 (above the current fee of $76.37) for each chemotherapy infusion on an interim basis from July 1 to December 31, 2014. (It is not clear where this provision is accounted for in the Budget.) In addition there will be a major review of funding arrangements for chemotherapy services, with recommendations for a longer-term sustainable approach to funding chemotherapy services, to be completed by October 2013.[58]

This is not the first time the Government has run into problems with pharmacy over the dispensing payments for chemotherapy drugs. In the 2008-09 Budget there was a measure designed to save $104 million / 4 years by changing the basis on which the pharmacists was reimbursed for the preparation and dispensing of chemotherapy drugs from a per vial basis to the amount of active ingredient. This was delayed and then never implemented due to pharmacists' opposition.

[57] http://www.pbs.gov.au/info/publication/factsheets/shared/revised-arrangements-for-chemotherapy

[58] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-tp-tp035.htm

Chemotherapy services

$29.6 million / 2 years is provided to increase dispensing fees for chemotherapy medicines listed on the PBS and to conduct a comprehensive review of the current arrangements for chemotherapy services.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	0.1	29.5	-	-	-

Dispensing fees will be increased by $60 per infusion, from $76.37 to $137.37 for six months from 1 July 2013. The review will cost **$1.2 million** and will report to the Minister for Health by October 2013.

This provision is included in the Budget Papers under the provisions relating to 'World Leading Cancer Care'.

PBS new and amended listings

New and amended listings on the PBS and the RPBS will cost **$686.7 million / 5 years**.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	34.5	143.8	155.2	170.9	187.3
DHA	0.2	0.3	0.3	0.3	0.4
DVA[59]	-0.5	-1.5	-1.5	-1.5	-1.5
Total	34.2	142.6	154.0	169.7	186.1
Related Revenue DoHA	*nfp*	*nfp*	*nfp*	*nfp*	*nfp*

As indicated by possible revenue associated with this provision, pricing arrangements have been negotiated to reduce the cost to the PBS of some of these medicines, presumably on the basis of efficacy.

PBS price increases

Price changes for a range of medicines on the PBS / RPBS will cost **$3.8 million / 5 years**.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	0.1	0.9	0.8	0.9	0.9
DVA	..	0.1	..	..	..
Total	0.1	0.9	0.9	0.9	0.9

[59] No information is provided about these savings and how they are achieved.

Additional funding for further pricing reform

Additional Funding of **$4.5 million** (including capital costs of **$1.4 million**) is provided in 2012-14 to the Department of Human Services for activities associated with the introduction of the Expanded and Accelerated Price Disclosure reforms.

Management and mitigation of legal challenges

An undisclosed level of funding is provided over the next four years for DoHA to respond to legal challenges in relation to the PBS. To my knowledge this is the first time such a contingency has been included in the Budget and it means that DoHA expects some legal challenges. These may well revolve around biosimilars.

Review of Alzheimers Disease medications

The Government has negotiated a 40% reduction in price for a number anti-dementia drugs, including donepezil, rivastigmine, galantamine and memantine. In 2012 these drugs cost $60 million.[60] The level of savings is not indicated in the Budget Papers.

This decision was taken on the basis of PBAC advice after consideration of the findings of the Post-Market Review of anti-dementia drugs to treat Alzheimers Disease in December 2012, including that these medicines are being used in a much broader population and for longer periods of time than originally agreed as cost-effective.[61] Additionally, the research on the effectiveness of these medicines indicates significant uncertainty in the benefits for patients, particularly beyond six months.

To account for the use of these medicines in a broader population, the PBAC recommended a price reduction and also agreed to simplify the continuing restriction to better align with current clinical use. The restriction changes are intended to make access to these medicines easier for prescribers and patients who respond to treatment

This review is one of the first of the new, "post-market reviews" that involve expert advice and consumer consultations prior to PBAC consideration

Medical Devices

Recent events, including those concerning Poly Implant Protheses (PIP) breast implants, have shown that locating patients with a high risk implantable device that may represent a health risk, can be difficult. A review of health technology in Australia done in 2009[62] recommended that

[60] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-mb-mb032.htm

[61] http://www.pbs.gov.au/info/news/2013/04/pbac-recommendations-alzheimers

[62] http://www.health.gov.au/internet/main/publishing.nsf/Content/htadiscussionpaper.htm

registries for high-risk implantable devices or procedures be established to assist with post-marketing surveillance of safety and efficacy. There was also an investigation by the Australian Commission on Safety and Quality in Health Care (ACSQHC) of the case for a register of high-risk implantable medical devices in 2008.[63] The ACSQHC Operating Principles for Australian Clinical Quality Registries was endorsed by Health Ministers in November 2010 and covers issues of data collection, security and custodianship, and ethics and privacy.

There is currently an Australian Breast Implant Register, but this has an 'opt-in' system and captures less than 4% of the PIP implants sold in Australia. The ACSQHC recommendation is that opt-out consent be a standard approach taken upon the establishment of new registers. The ACSQHC Operating Principles for Australian Clinical Quality Registries, endorsed by Health Ministers in November 2010, cover issues of data collection, security and custodianship, and ethics and privacy.

Establishment of National Patient Register and Clinical Quality Registers

$12.1 million / 4 years is provided to establish a national patient contact register for implantable medical devices and two clinical quality registers for breast implants and cardiac devices. From July 2014 the operating costs of the patient contact arrangements will be recovered from the medical device industry and from July 2015 the operating costs of the two clinical registers will also be recovered.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	3.6	3.0	2.9	2.7
Related revenue DoHA	-	-	*1.4*	*2.9*	*2.7*

Access to medical appliances

The Stoma Appliance Scheme (SAS) provides stoma-related products free of charge to members of stoma associations. There are approximately 40,000 members nationally who receive products under the SAS. The Scheme has a schedule that lists products that have been approved by DoHA to be issues to eligible members. The schedule determines the maximum quantities, the price of the product, and whether there are any restrictions. It is updated quarterly. The choice of products which a member uses is guided by a Stomal Therapy Nurse who is specifically trained to advise on the use of stomal products following colostomy or ileostomy surgery.

[63] http://www.crepatientsafety.org.au/registries/operating_principals_technical_standards_nov08.pdf

In 2008-09 the SAS cost **$68 million / year** with costs rising at a level that was considered unsustainable. In the 2009-10 Budget the Government indicated it would review the Stoma Appliance Scheme (SAS) and establish a revised program framework that would reduce the cost of the scheme by **$13.3 million / 4 years**. A report was completed in December 2010.[64] Pricing changes were to be implemented by July 2011.

The Continence Aids Payment Scheme (CAPS) helps people aged 5 years or more who have permanent and severe bladder or bowel incontinence and who do not reside in a high-care Australian Government funded aged care home to meet some of the costs of incontinence products. In the 2009-10 Budget the Government announced that from 1 July 2010 it would replace the Continence Aids Assistance Scheme with the continence support payment. Under CAPS eligible people will instead receive a payment as a contribution towards the cost of products. This change delivered a savings measure of **$10.7 million**.

Pricing arrangements for products listed on the Stoma Appliance Scheme

Changes to pricing arrangements for a number of products on the Stoma Appliance Scheme (SAS) will result in savings of **$1.7 million / 5 years**.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-0.1	-0.4	-0.4	-0.4	-0.4

Administrative costs of Continence Aids Payment Scheme

Savings of **$0.6 million / 4 years** are achieved by reducing the administrative costs of the Continence Aids Payment Scheme.

[64] http://bit.ly/17ivCHB

Infrastructure

The majority of infrastructure initiatives are provided through the Health and Hospitals Fund (HHF). To date there have been four funding rounds and a total of **$5 billion** has been disbursed. Regional areas have been the primary beneficiaries of this funding

Table 21: Health and Hospitals Fund – funding over the forward estimates

Program	Category	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Round 1					
	regional	65	-	-	-
	non-regional	173	118	51	-
Round 2					
	regional cancer initiative	69	5	-	-
Round 3					
	regional	142	191	391	215
	non-regional	-	-	-	-
Round 4					
	regional	131	156	92	43
	non-regional	-	-	-	-
Total					
	regional	407	352	483	258
	non-regional	173	118	51	-

From 2013-14 Budget Paper Regional Australia: Strengthening Communities

The National Rural and Remote Health Infrastructure Program also provides infrastructure funding. Six rounds have been conducted to date, with 267 projects funded at a value of **$52.6 million.**

In 2010 and 2011, the Australian Government invested $117 million in Primary Care Infrastructure Grants (PCIG) to upgrade around 425 general practices, primary care and community health services, and Aboriginal Medical Services to provide expanded accommodation for general practitioners and other health professionals; to improve access to integrated GP and primary health care services; and to offer extended hours of opening and clinical training facilities. The Primary Care Infrastructure Grants were provided through two rounds in 2010 and 2011.[65]

An audit of the program was conducted by ANAO in 2012.[66] It found that, the selection criteria were heavily weighted towards one of the key program objectives, the delivery of physical infrastructure,

[65] http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-pcigg2010

[66] http://www.anao.gov.au/Publications/Audit-Reports/2011-2012/Administration-of-the-Primary-Care-Infrastructure-Grants-Program

as compared to the other key program objective, improved access to new primary care services. ANAO also recommended an evaluation of the program.

Dedicated paediatric emergency care for Canberra Hospital

$5.0 million is provided to the ACT in 2014-15 towards the development of a dedicated service for children within the Emergency Department of Canberra Hospital. This is expected to provide services to around 15,000 children per year.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
Treasury	-	-	5.0	-	-

A paediatric emergency department was a Labor commitment made during the 2012 ACT election campaign.[67]

National Rural and Remote Infrastructure Program – prioritising remote areas and Indigenous communities

Future grant rounds of the National Rural and Remote Health Infrastructure Program (NRRHIP) will focus on targeting remote and very remote areas or Indigenous communities. **$20 million / 4 years** will be clawed back from this program.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-5.0	-5.0	-5.0	-5.0

NRRHIP provides funding to rural and remote communities for essential health infrastructure and equipment.

Primary Care Infrastructure Grants Program – Ashford Community Health Centre

The Government will contribute **$0.3 million** for the conversion of an existing community hall into a new medical centre in Ashford NSW.

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[67] http://www.actlabor.org.au/policy/policy-announcements/418-act-labor-commits-to-paediatric-emergency-department

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.3	-	-	-

It is notable that Ashford is in the electorate of federal independent member Tony Windsor.

Woomera Hospital

The Government will continue its funding agreement with the South Australian Government to provide funding of **$1.3 million** in 2013-14 to help with the winding down of services at Woomera Hospital, due to be completed by 1 July 2014.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-	-1.4	-1.4	-1.4

Although the hospital was due to close in July 2013, funding for the transition period was apparently included in the forward estimates so this decision results in savings of **$4.2 million**.

There has been a decline in the number of patients admitted to this hospital in recent years as the Roxby Downs Hospital has assumed the role of a regional health centre. Woomera Hospital is leased to the SA Government by the Commonwealth.

e-Health

There is only one e-health provision in the 2013-14 Budget- the cessation of funding for the National Health Information Network. However in May 2013 the Gillard Government announced it was providing **$20.3 million** to nine telehealth projects that will use the National Broadband Network to pilot new methods of health care delivery.[68] The projects will reach around 2500 patients in 50 NBN communities.

The penetration of e-medical records (in some form) in Australia was estimated at 66.1% in 2012 for the combined hospital and ambulatory segments of the health care system.[69] However there is a lot more work to be done before Australia can reap the benefits of e-health records and efficient and accurate patient data access. The planned introduction of a Personally Controlled Electronic Health Record (PCEHR) for all Australians is suffering from challenges around interoperability and the lack of technical skills among medical professionals, and Australians have been slower than predicted to sign up. Many have complained that the online registration is not easy to negotiate.

The 2010–11 Budget provided funding of **$466.7 million / 2 years** to establish the key components of a PCEHR system. Concern was expressed that this investment was insufficient, and the 2012–13 Budget a further **$233.7 million / 3 years** was provided. This funding was more than offset by savings taken from other e-health programs. Despite a last-minute media campaign, it appears the Government will likely struggle to meet its target of 500,000 registrants for the PCEHR by the end of June 2013 after it was revealed only 109,000 Australians had registered in the nine months from July 2012.[70]

It is also worthwhile noting that the new MoU between the Commonwealth and the States and Territories for the operation of the NeHTA has been agreed but not signed. In the meantime, NeHTA has received federal funding of $47.2 million to keep it operating for another year.[71]

Closure of National Health Information Network

Savings of **$31.2 million / 2 years** are taken by ceasing the National Health Information Network (NHIN) from 1 July 2015. The NHIN was established in 2004 as Health Connect. Functions of the NHIN are now being managed through the National e-Health Program and the PCEHR.

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[68] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-mb-mb028.htm

[69] http://idm.net.au/article/009541-budget-threat-aussie-ehealth-revolution

[70] http://www.itnews.com.au/News/340259,govt-unlikely-to-meet-e-health-sign-up-target.aspx

[71] http://www.theaustralian.com.au/australian-it/government/nehta-wins-a-472m-injection/story-fn4htb9o-1226665211001

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-	-	-5.9	-25.4

In the 2012-13 Budget **$73.6 million / 4 years** was taken from this program to fund the National e-Health program. In last year's budget analysis I queried where this funding – described as continuing the 2009-10 Budget measure which took **$34.8 million / 3 years** in savings – comes from, as HealthConnect was to have been wound up on 30 June 2009.

	2011-12 $m	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m
DoHA	-	-18.1	-18.1	-18.3	-19.1

From 2012-13 Budget Paper No 2

Health Agencies and Non-Government Organisations

There are now 18 health agencies and keeping track of their resourcing and reporting is difficult. The resourcing for these agencies in 2013-14 totals **$240 million**, or 22.8% of the total health resources. In this budget some of these agencies have had their budgets cut – by a total of **$178.5 million / 4 years.**

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
ANZTPA – continued funding	-	nfp	nfp	nfp	nfp
AIHW – development and implementation of KPIs	-	(1.5)*	(1.5)*	-	-
ARPANZA – enhanced capacity	-	3.9	1.3	1.3	1.3
ARPANZA – revenue from licence fees	-	*1.3*	*1.3*	*1.3*	*1.3*
HWA - efficiencies	-	-20.0	-20.0	-20.0	-20.0
OGTR - introduction of cost-recovery services	-	0.4	-	-	-
NBA (includes related revenue losses)	-	-0.4	-14.3	-28.6	-39.7
IHPA	-	-0.6	-0.6	-0.6	-0.6
ACSQHC	-	-4.1	-5.0	-4.0	-
Australian Red Cross – additional funding	-	(5.0)*	-	-	-
Grants for education and awareness of FMG	0.5	-	-	-	-

**assumed allocation of funds*

Continued Funding to the Australian New Zealand Therapeutic Products Agency

Unspecified funding is provided for the continued staged implementation of the ANZTPA. This agency will take over responsibility for regulating medicines, medical devices and other therapeutic goods in both Australia and New Zealand. Funding for this effort was previously provided in the 2012-13 Budget and the 2011-12 MYEFO.

Agreement for a single Trans-Tasman regulatory agency was reach in 2011. It is due for implementation within 5 years.[72] In April 2013 a new streamlined process for assessing medicines sold over the counter took effect.[73]

[72] http://www.tga.gov.au/about/international-anztpa-factsheet.htm

[73] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-sn-sn002.htm

This is not the first time efforts to develop a Trans-Tasman agency for therapeutic products has been undertaken, but previous efforts in 2006 foundered.[74]

Australian Institute of Health and Welfare – development and measurement of updated key performance indicators

$3.0 million / 2 years is provided to the Australian Institute of Health and Welfare (AIHW) to develop, revise and measure KPIs specified in the COAG reviews of the NHR Agreement and the NP on Homelessness. Funding for this measure is to be provided from within existing AIHW resources.

The AIHW budget for 2013-14 is **$52.24 million**, up from **$51.82 million** in 2012-13.

Australian Radiation Protection and Nuclear Safety Agency – improving capacity

$7.8 million / 4 years (including capital funding of **$2.5 million** in 2013-14) is provided to enhance Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) capacity to issue new licences and undertake compliance activities and to upgrade its facilities in Yallambie (Vic). This is in response to issues identified in the 2012 review of the *Australian Radiation Protection and Nuclear Safety Act 1998*.[75] Costs of **$5.1 million / 4 years** will be recovered from revised licensing fees for facility and process testing.

The ARPANSA budget for 2013-14 is **$27.87 million**, up from **$24.05 million** in 2012-13.

Health Workforce Australia – rationalisation

In the name of 'rationalisation' **$80 million / 4 years** will be cut from the budget of HWA. Some of this money goes to the General Practice Rural Incentives Program.

It is sad to see budget cuts being made to a critical agency for health care reform. HWA was established in 2010 to deliver a more effective, nationally coordinated approach to a sustainable health workforce for Australia. It works across both the health and education sectors. Its budget in 2012-13 was **$373.05 million**.

A review of Australian Government health workforce programs, announced as part of the 2012-13 Budget, has been undertaken and the Mason Review was publicly released in May 2013.[76] This report relied heavily on HWA's modelling and Health Workforce 2025 report.[77]

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[74] See for example: http://www.thenhf.com/article.php?id=2102

[75] http://www.health.gov.au/internet/main/publishing.nsf/Content/RRF+-+Radiation+Protection+and+Nuclear+Safety#review

[76] http://www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programs

HWA's budget in 2013-14 is **$209.87 million**, down from **$219.51 million** in 2012-13.

Office of the Gene Technology Regulator – introduction of cost recovery services

$0.4 million is provided in 2013-14 to investigate and develop an appropriate cost recovery model for the OGTR. Such cost recovery is provided for under the *Gene Technology Act 2001*. A draft Cost Recovery Impact Statement is expected by October 2013, the final model is to be considered by Government in 2014-15, at which time a decision will be made as to whether and how cost recovery is to be implemented.[78]

In 2004 a similar report was commissioned by OGTR.[79] It found that gene technology was an emerging technology and that the major burden of cost recovery would be borne by organisations undertaking research activities. A 2002 report found stakeholders opposed to cost recovery.[80] It is unclear if the biotechnology sector is now mature enough to sustain cost recovery and how this will be structured to address the impact on universities and other research institutions.

National Blood Authority

Under the heading 'Health Program Funding' – better targeting' **$47.2 million / 4 years** is cut from the budget of the National Blood Authority (NBA). This is to be done through more efficient and effective use of blood products, addressing antimicrobial resistance, and reducing variations in clinical practice.

The NBA's Budget in 2013-14 is **$1.2 billion**, up from **$1.1 billion** in 2012-13.

Independent Hospital Pricing Authority

$2.5 million / 4 years in savings is achieved by reducing consultancy services for the Independent Hospital Pricing Authority (IHPA).

The IHPA's budget in 2013-14 is **$25.7 million**, down from **$29.3 million** in 2012-13.

Australian Commission on Safety and Quality in Health Care

$13.1 million / 3 years is cut from the Budget of the Australian Commission on Safety and Quality in Health Care.

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[77] http://www.hwa.gov.au/health-workforce-2025

[78] http://www.ogtr.gov.au/internet/ogtr/publishing.nsf/Content/cost-recovery-htm

[79] www.**ogtr**.gov.au/internet/**ogtr**/publishing.nsf/Content/...3/.../acumen04.pdf

[80] www.**ogtr**.gov.au/internet/**ogtr**/publishing.nsf/Content/other.../acumen.pdf

Additional funding for Australian Red Cross

$5.0 million is provided to the Australian Red Cross from within existing resources for its humanitarian work. Previous budgets have supplied similar amounts - **$5.0 million** in 2012-13; **$5.1 million** in 2011-12; **$10.0 million / 2 years** in 2009-10.

Female genital mutilation – education and awareness

$0.5 million will be provided in grants in 2012-13 to organisations to undertake education and awareness activities regarding female genital mutilation (FGM). The cost of this will be met from within existing DoHA resources.

On 11 December 2012, the Prime Minister announced that the Minister for Health would coordinate efforts across government to address FGM in Australia.[81] As part of this, the Attorney-General conducted a review of Australia's legislative framework to consider whether existing legislative provisions are effective in comprehensively criminalising female genital mutilation. This report was publicly released in May 2013.[82]

[81] http://www.pm.gov.au/press-office/gillard-government-act-female-genital-mutilation-australia

[82] http://www.ag.gov.au/Publications/Pages/ReviewofAustraliasFemaleGenitalMutilationlegalframework-FinalReportPublicationandforms.aspx

Indigenous Health

Total government expenditure on Indigenous health has risen significantly since the commencement of the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes in 2009-10 and now represents about 5.1% of total government health expenditure.[83] This amounted to $4.7 billion in 2010-11; of this, the Commonwealth provided about one-third ($1.6 billion).[84]

However while there is a significant effort underway to close the gap in Indigenous disadvantage and life expectancy, in most areas this effort has yet to show real returns on the investments. The disadvantages that have built up over more than 200 years will not disappear overnight, and sustained and concerted efforts are needed to redress them. Chronic diseases, which account for a major part of the life expectancy gap, take time to develop, and equally, it will take time to halt their progress and even longer to prevent their advent in the first place. Programs will need to be sustained over decades if they are to have an impact on improving health outcomes.

On this basis, it is worrying to see that continued funding for the NP on Closing the Gap in Indigenous Health Outcomes, as announced in April, will be less over each of the next three years than in 2012-13. At the same time, the Budget Papers show that expenses in the Aboriginal and Torres Strait Islander health sub-function will decline by 2.7% in real terms. This comes as states such as Queensland and New South Wales have made damaging cuts to health services and Closing the Gap programs.

There are several critical developments in 2013 that together will likely determine whether the goal of Indigenous health equality is achieved by 2030. These include the scheduled completion and implementation of a National Aboriginal and Torres Strait Islander Health Plan,[85] the renewal - with adequate funding from all governments - of the NPA on Closing the Gap in Indigenous Health Outcomes,[86] and the federal election that is scheduled for 14 September 2013.

NPA on Closing the Gap in Indigenous Health Outcomes

In November 2008, the Council of Australian Governments (COAG) agreed to a **$1.6 billion / 4 years** National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health to address the first Closing the Gap target (to reduce close the life expectancy gap within a generation).
Within the NPA five priority areas were established:

- Tackling smoking;
- Primary health care services that can deliver;

[83] Indigenous Australians make up 2.6% of the population.

[84] http://www.pc.gov.au/gsp/ier/indigenous-expenditure-2012

[85] http://www.health.gov.au/natsihp

[86] The Commonwealth has announced funding of $777 million / 3 years ahead of the expiry of the NPA on June 30. It is not clear how many of the States and Territories have renewed their funding commitments.

- Fixing the gaps and improving the patient journey;
- Providing a healthy transition to adulthood; and
- Making Indigenous health everyone's business.

The Commonwealth's contribution to this NPA is the Indigenous Chronic Disease Package (ICDP) which provided **$805.5 million / 4 years**, beginning in 2009-10. This contributes to the first three priority areas of the NPA; state and territory efforts contribute to all five priority areas. Each jurisdiction has developed implementation plans detailing the activities that will achieve the objectives of the NPA (although some of these from the States and Territories have proved difficult to find).

On 18 April 2013 the Commonwealth announced continuing funding of **$777 million / 3 years** for the NPA which is due to expire 30 June.[87] This was described as "an increase over previous per annum expenditure." That is true, but this statement ignores the fact that funding over the last four years was ramped up and in 2012-13 it was **$317.9 million**. So the reality is that funds for each of the next three years will be less than in 2012-13.

The Government's media release says "While this work is encouraging we know there is more to be done. We need sustained investment and effort to continue the momentum and ensure continued progress." And COAG said the "improving opportunities for Indigenous Australians requires intensive and sustained effort from all levels of government."[88] The (important) recognition that these efforts will require sustained investment and effort is not backed by the actions of Australian governments. It is not clear how many of the States and Territories have renewed their contributions to the NPA.

We await news of how these new federal funds will be allocated over the forward estimates (and which programs will be cut and where). The 2013-14 Budget provides no further information on this. The scheduled completion and implementation of a National Aboriginal and Torres Strait Islander Health Plan may provide the incentives for further Australian Government and COAG action.

The 2009-10 Budget Papers provided some insights into Commonwealth expenses in this NPA, but this information has not been provided in the following years. At that time it was interesting to note that administrative expenses were high (estimated at **$112 million** in 2012-13) and they averaged 36% of expenditure over the forward estimates.

[87] http://www.pm.gov.au/press-office/777-million-renewed-effort-close-gap-indigenous-health

[88] http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage

National Partnership Payments for Indigenous Health

In 2013-14 the Australian Government will pay **$54 million** to the States and Territories through National Partnership payments (NPs) for work in 12 areas of Indigenous health. (See Table 2)

Of the **$113.8 million** provided of the four years to 2016-17, over 50% **($68.8 million**) is allocated to the Northern Territory. However expenditure drops considerably over the forward estimates.

Table 2.

NPs	**2012-13 $m**	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
Sexual assault counseling in remote NT	1.3	-	-	-	-
Accommodation related to renal services in NT	-	10.0	-	-	-
CTG in the NT	0.4	-	-	-	-
Improving ear services for Indigenous children	6.5	0.7	-	-	-
Improving trachoma control services	3.9	4.4	4.1	4.2	4.2
Indigenous early childhood development – antenatal and reproductive health	24.3	24.4	6.0	-	-
Reducing rheumatic fever in Indigenous children	2.5	2.6	2.6	2.7	2.7
Renal dialysis services in Central Australia	1.6	1.7	1.7	-	-
Stronger Futures in the NT	9.0	9.8	10.3	10.2	10.8
Torres Strait health protection strategy	1.5	0.5	0.5	-	-
Total	**51.1**	**54.0**	**25.1**	**17.1**	**17.6**

From 2013-14 Budget Paper No 3

Budget Initiatives

The 2013-14 Budget predicts that expenses in the Aboriginal and Torres Strait Islander sub-function will increase in 2013-14 but fall by 2.7% in real terms from 2013-14 to 2016-17. (See Table 4)

Table 4.

	Estimates			Projections	
	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
Aboriginal and Torres Strait Islander health	752	851	826	854	890
Total health	62,249	64,636	68,081	71,597	75,493

From 2013-14 Budget Paper No 1

In 2013-14 spending on Indigenous health initiatives includes:

- $380.8 million to improve the health and wellbeing of Indigenous people under the Stronger Futures in the Northern Territory package.
- $4.5 million in grants through the Indigenous Suicide Prevention program and an estimated $2 million from the Taking Action to Tackle Suicide package.[89]
- $10 million (estimated) through Bringing Them Home and Link Up Services.
- $65 million from the Substance Misuse Service Delivery Grants Fund will go to provide services in Indigenous communities.

Acute rheumatic fever vaccine

$1.4 million / 2 years is provided for early research into the development of a vaccine to prevent acute rheumatic fever. The New Zealand Government will also provide $1.4 million towards this effort. This was originally announced by the Prime Ministers of both countries as a $3million effort.[90]

	2012-13 $m	**2013-14 $m**	**2014-15 $m**	**2015-16 $m**	**2016-17 $m**
NHMRC	-	0.6	0.8	-	-

Acute rheumatic fever is particularly prevalent among Aboriginal, Torres Strait Islander, Maori and Pacific Islander peoples. A recent AIHW report shows that almost all cases of acute rheumatic fever recorded in the Northern Territory between 2005 and 2010 were for Indigenous

[89] On 23 May 2013 the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released, together with additional funding of $17.8 million / 4 years.
http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-mb-mb036.htm

[90] http://www.pm.gov.au/press-office/joint-statement-prime-ministers-key-and-gillard-february-2013

people (98%), with 58% of cases occurring in 5-14 year olds. These rates are among the highest in the world.[91]

Improving trachoma control for Indigenous Australians

$16.4 million / 4 years is provided to continue trachoma control activities. This funding is expected to improve eye health for 20,000 Indigenous Australians in up to 160 remote communities. Allocation over the forward estimates is not provided. This is renewed funding for provisions originally provided in the 2009-10 Budget. At that time **$58.3 million / 4 years** was provided for improved hearing and eye services. Of this, **$5.3 million / 3 years** went to four states (Queensland, NSW, Northern Territory and South Australia) under project agreements on improving trachoma control.

The National Trachoma Surveillance and Reporting Unit was established in 2010 to improve the quality of trachoma data collection and reporting in Australia. The most recent report is for 2010 (released in September 2012).[92]

The 2012 annual update on the implementation of The Roadmap to Close the Gap for Vision estimates that **$70 million** is needed to eliminate vision loss, which is 11% of the Indigenous health gap.[93]

Mosquito control and cross border liaison in the Torres Strait

$3.9 million / 4 years is provided to continue mosquito detection, control and elimination activities in the Torres Strait region. This funding goes to Queensland through a National Partnership on Health Services.

[91] http://www.aihw.gov.au/media-release-detail/?id=60129542802

[92] http://mbsonline.gov.au/internet/main/publishing.nsf/Content/cda-cdi3603b.htm

[93] http://iehu.unimelb.edu.au/__data/assets/pdf_file/0009/661869/2012_annual_update_roadmap.pdf

Mental health

Budget Paper No 1 states that from 2012-13 to 2013-14 expenses on mental health are expected to increase by 28.9% in real terms, and by 12.3% in real terms from 2013-14 to 2016-17. While this may reflect continued growth in the Better Access program, it also highlights how little of the mental health reform funding as actually been spent to date; significant expenditure on items such as the national rollout of EPPIC and the establishment of the Partners in Recovery Program has not yet started. This Budget has spending of **$96.2 million / 4 years** on mental health, not all of it in the health jurisdiction.

The 2012 Report Card on Mental Health and Suicide Prevention from the National Mental Health Commission was released in November 2012.[94] It has a single clear message – despite numerous reports, strategies and policies on mental health and considerable spending, Australia still has a failing grade.

The report card was considered in tone, but reading between the lines, the frustration with the status quo is palpable. It makes the case that mental health is literally a life-and-death issue that is everyone's responsibility. Too many Australians with mental health needs do not get treatment and only about 50% of those who do, get the services they need.

Mental health is at the root of the majority of suicides and suicide attempts, and people with serious mental illness die up to 32 years earlier than those who are not mentally ill. The huge burden mental illness imposes on patients, their families and carers, healthcare and social welfare systems, and society as a whole makes it shameful that we have not done more sooner and imperative that we do more now.

Despite a growing volume of evidence about mental health needs in Australia and how to address them effectively, there is still a lot we don't know and much of what we do know is not being utilised. For people with mental illness, the spectrum, capacity and quality of services available depends on where they live and their income.

We must move beyond counting hospital beds, Medicare services and prescriptions to improving health outcomes by ensuring that mental healthcare is well-targeted, effective, accessible and affordable, that it includes the full range of services for patients and their carers such as case management, housing, employment and disability assistance, and that it is delivered in a co-ordinated fashion. Certainly no one should be discharged from care into homelessness, and families and carers should not be left alone to cope with situations that vary from dangerous to soul destroying.

The report card makes plain what most stakeholders think about the fourth National Mental Health Plan by stating: "Australia has no nationally agreed picture of what a good mental health framework should look like and how it should be properly resourced."

[94] http://www.mentalhealthcommission.gov.au/our-report-card.aspx

It challenges government to be brave enough to set goals and targets and be publicly assessed against these. The report also issues a veiled threat that if governments don't deliver an honest picture of how Australia is performing and if the current Ten Year Roadmap for National Mental Health Reform doesn't deliver, then "we [the National Mental Health Commission] will work with others".

But the reality is that there is no one else to work with. Mental health reform in Australia is totally reliant on leadership and sustained investment from the highest levels of the Commonwealth, state and territory governments.

There are many in the mental health sector who find fault with this report. To some extent they are justified: it says much the same thing that the Richmond report said back in 1983; there is too little focus on prevention and early intervention, especially for children and youth, and the huge burden of depression and anxiety in the chronically ill and elderly; and the strong links between mental health problems and substance abuse are not being effectively addressed.

The real question is: what happens now? What is the agenda for the next 10 or 20 years and, given the ephemeral nature of governments, how do we get long-term commitments and sustained funding so that each annual report card from the commission will show the needed progress on the agreed-upon priorities and directions? Can all this start to happen now without resorting to yet another round of consultations and strategy development?

From the beginning of the 20th century, Australia has averaged a report or inquiry into mental health every 2½ years. Despite these reports and inquiries and dozens of plans and policies, Australia is not succeeding at matching mental health services to need. Since 2006 Australian governments have committed to spend **$8 billion** of new money on mental health, but spending between jurisdictions continues to be unco-ordinated and lacking accountability.

For the National Mental Health Commission's Report Card to become the game changer that everyone so desperately hopes for, what is needed is a culture change that sees mental health and wellbeing as a key indicator of the nation's commitment its citizens. There should be no conversation or policy about healthcare reform, closing the gap on Indigenous disadvantage, tackling homelessness, addressing social inclusion, improving education, and productivity without ensuring that mental health is also on the table.[95]

Mental Health Nurse Incentive Program

$23.8 million is provided in 2013-14 to maintain existing service levels for the Mental Health Nurse Incentive Program. This funding, which appears to be an increase over previous levels, is expected to enable the provision of services to approximately 60,000 patients. No further funding has been allocated beyond 2013-14.

[95] http://www.canberratimes.com.au/opinion/mental-health-breaks-down-20121129-2aiix.html

Since its inception this program has been endlessly tinkered with. Now it is not clear if it has a future. The Mental Health Nurse Incentive Program was first introduced in 2007 with funding of **$191.6 million / 5 years.** This funding was cut by **$188.0 million / 4 years** in the 2008-09 Budget due to low uptake of the program. The 2010-11 Budget saw **$13.0 million / 2 years** provided for an additional 136 mental health nurses. In the 2012-13 Budget additional funding of **$17.6 million / 2 years** was provided for 2011-12 and 2012-13, but the program was capped at existing service levels.

National Perinatal Depression Initiative

$37.4 million / 4 years is provided to continue the National Perinatal Depression Initiative. Of this, **$35.4 million** will go to the States and Territories to enable mothers to be screened for depression, provide training to health professionals, improve care and support for women at risk, and continue research and data collection. **$2 million** will be provided to *beyondblue* to support the implementation of this initiative. Only this provision is included in the Budget – the additional funds are provided through the NP on Health Services.

Contributions of **$35 million** will be sought from the State and Territory Governments for this work.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.5	0.5	0.5	0.5
Treasury	-	-0.5	-0.5	-0.5	-0.5
Total	-	-	-	-	-

Previous federal funding in the 2008-09 Budget was **$55 million / 5 years**, comprising **$30 million** to State and Territory Governments, **$5 million** to *beyondblue* and an additional **$20 million** to the Access to Allied Psychological Services (ATAPS) program. It is not clear if funding for the ATAPS program is included in the forward estimates. State and Territory Governments were previously expected to contribute up to **$30 million**. In fact they contributed **$43.4 million**.[96]

Department of Veterans' Affairs – expansion of mental health services

$25.3 million / 4 years is provided for expansion of mental health care for Veterans and their families. This builds on the **$165 million / year** provided for mental health services for Veterans

96 http://www.health.gov.au/internet/main/publishing.nsf/Content/4F86A664D19162DFCA257B18007A8A91/$File/perinat.pdf

and former members of the ADF.[97] This new funding for mental health services means savings of $**6.5 million / 3 years** for DoHA.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DVA	-	1.3	8.2	10.2	12.5
DHS	-	-	..	..	..
DoHA	-	-	-1.7	-2.1	-2.7
Total	-	1.3	6.5	8.0	9.8
Related Capital (DVA)	-	0.9	-	-	-

Of this funding:

- **$14.6 million** will go to extending existing arrangements which support immediate treatment for diagnosed Post Traumatic Stress Disorder, other anxiety disorders and depression, without the need to lodge a compensation claim. The arrangements will be extended to include treatment for alcohol and substance misuse disorders.
- Around **$1.1 million** will also go towards the establishment of a post discharge GP health assessment for former ADF members.
- In addition, a range of initiatives designed to build mental health resilience will be funded.

Support for people affected by forced adoption practices

(this provision is in the Budget papers under Attorney General's jurisdiction)

$7.6 million / 4 years is provided to assist in provision of counselling and mental health services arising from the response to forced adoptions. In addition **$2.5 million** for additional ATAPS services will be provided from within the DoHA budget.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	1.5	0.4	0.3	0.3
FaHCSIA	-	0.5	1.6	1.5	1.5
AG	-	-	-	-	-
Total	-	2.0	2.0	1.8	1.8

[97] http://www.minister.defence.gov.au/2013/05/03/prime-minister-minister-for-defence-and-minister-for-defence-science-and-personnel-joint-media-release-2013-defence-white-paper-support-to-adf-personnel-2/

Mental health counselling for Tasmanian forestry workers

As part of the an additional **$94.5 million / 5 years** provided in the Department of Agriculture, Fisheries and Forestry budget to support the implementation of the Tasmanian Forests Agreement, **$1.0 million / 2 years** is provided for the continuation of the existing mental health and wellbeing counselling services for affected forestry workers. This program is currently being delivered through the Tasmanian Government Rural Alive and Well program.

Ageing and Aged Care

Last year the Gillard Government introduced the **$3.7 billion / 5 years** *Living Longer Living Better* aged care reform package, with a commitment that this package would lay the foundations for longer-term reform down the road. A number of significant aspects of this package will be implemented in 2013-14.

These include:

- The Aged Care Gateway will be introduced and will include the My Aged Care website and a national contact centre. Phased implementation of needs assessment in the Aged Care Gateway will occur from early 2014, with full operation of all assessment levels from 1 July 2014.
- All new Home Care Packages allocated from 1 July 2013 will be offered on a Consumer Directed Care basis. Two new Home Care Packages will be introduced resulting in a total of four package levels.
- The new Dementia and Veterans' Supplements will be payable for eligible people in Home Care, residential care and other programs.
- Eligible aged care providers will be able to access up to $1.2 billion in funding that will provide higher wages for aged care workers.
- A centralised aged care data clearing house will be established at AIHW to increase the availability, accessibility and coordination of aged care data for the community.
- Issues around funding levels, means testing for residential aged care, and pricing policies will also need to be addressed.

The Australian Government assumed funding and operational responsibility of HACC services for people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander peoples) in all States and Territories except Victoria and Western Australia from July 2012. However under the National Health Reform Agreement, there will be no substantial changes to HACC service delivery until July 2015 when the new Commonwealth Home Support Program will commence.

In the 2012-13 Budget, the Government announced funding of **$4.7 million / 4 years** to establish a new ongoing Advisory Panel on Positive Ageing. One of the objectives of this panel is to follow up the recommendations made in the reports of the Panel on Economic Participation of Senior Australians[98] and the Forum on Mature Age Participation.[99] The 2013-14 Budget provides **$127 million** for the *Supporting Senior Australians* package to improve the wellbeing of Australia's ageing population and to promote a positive ageing agenda. This funding, only **$4.9 million** of which is allocated to the Health and Ageing portfolio, follows the recommendations of the Report from the Advisory Panel on Positive Ageing.

[98] http://epsa.treasury.gov.au/EPSA/content/publications/grey_gold/default.asp

[99] http://deewr.gov.au/consultative-forum-mature-age-participation

These funded provisions include:

- **$112.4 million** for a three-year trial to assist senior Australians to downsize their home without putting their eligibility for the Age Pension at risk.
- **$9.9 million** to extend the Broadband for Seniors initiative which provides senior Australians with access to computer and internet facilities in their local area.
- **$4.6 million** for the establishment of the Andrew Fisher Applied Policy Institute for Ageing.

Aged Care workforce supplement

$90 million / 4 years in savings is taken from the 2012-13 Budget measure that was designed to assist aged care providers to attract and retain skilled employees. This is achieved by excluding those aged care providers whose employees are paid under State and Territory awards or public sector enterprise agreements.[100]

Some of this money **($30.2 million**) is used to include the service providers for the Veterans's Home Care and Community Nursing programs.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	-7.3	-16.3	-28.6	-37.8
DVA	-	4.6	5.8	8.3	10.0
Total	-	-2.7	-10.9	-20.2	-27.8
Related capital DVA	-	1.5	-	-	-

The 2012–13 Budget provided **$1.2 billion / 5 years** to address long-standing workforce pressures in aged care. This additional funding is to be delivered through a Workforce Compact developed by an independently chaired Strategic Workforce Advisory Group, in consultation with the aged care sector. There has been dissent over the Compact, which is scheduled to start in July 2013.[101]

Accommodation bonds insurance

The Government has deferred implementation of the requirement for providers of residential aged care to insure any accommodation bonds they hold for residents entering aged care on or after 1 July 2012. This is in response to provider concerns.

[100] Note that they will be eligible if the enterprise agreement is amended to be consistent with the Compact.

[101] http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201314/AgedCare

This type of insurance is effectively based on the solvency of the aged care provider and so it can be expensive. The Budget Papers state that 'If a provider becomes insolvent or bankrupt and is unable to pay outstanding bond balances to aged care residents, the Australian Government will repay the balance owing to each resident.'

This measure is described as extending an existing contingent liability, and so has no cost against it, although there surely will be a cost in later years.

Staying at home – improvements

The changes that are to be made in the name of 'improvements' in the Home Care program are not readily discerned from the Budget Papers. These are described as:

- Consistent leave provisions across the different Home Care Package levels;
- Broadening eligibility for the oxygen and enteral feeding supplements to all home care consumers who have a clinical need; and
- Introduction of a new top-supplement for existing Extended Aged Care at Home Dementia (EACHD) consumers.
- Ensuring that there is no reduction in funding for existing consumers of Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages with the introduction of the new home care arrangements.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	0.8	-0.4	-0.8	..
DHA	0.1	0.3	-	-	-
Total	0.1	1.0	-0.4	-0.8	..

In the 2012-13 Budget **$955.4 million / 5 years** was provided to assist older Australians in need of care to stay at home. There was also a commitment that the Government would review the types of services delivered through the new Commonwealth Home Support program, including meals on wheels, transport services, home modifications and home maintenance to ensure more consistent and equitable service delivery arrangements and more national consistency in the fees people contribute to the cost of these services. This review is apparently underway.[102]

Andrew Fisher Applied Policy Institute for Ageing

The Government will provide **$4.6 million / 4 years** to establish the Andrew Fisher Applied Policy Institute for Ageing. The Institute will provide evidence-based advice across a range of fields, including demographic change, community engagement and participation, health and wellbeing, and infrastructure for an ageing world.

[102] http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/staying-at-home

The Institute will be established in an existing research organisation as an Australian regional hub which will draw on expertise from the public, private and academic sectors.

	2012-13 $m	2013-14 $m	2014-15 $m	2015-16 $m	2016-17 $m
DoHA	-	1.1	1.2	1.2	1.2

Wound management scoping study

$0.3 million is provided in 2013-14 to fund a scoping study and cost benefit analysis of options to better address chronic wound management for senior Australians. The cost of this measure will be met from within the existing resources of the Department of Health and Ageing

Other health-related provisions in the Budget

One-year continuation of NP on Homelessness

$159 million is provided in 2013-14 for what is described as a one-year transitional NP to ensure the continued provision of homelessness services. This will be matched by funds from all the States and Territories, bringing total funding to **$320 million**.[103] However it is interesting to note that a 14 May media release from the Minister for Housing and Homelessness states that Queensland, WA and the Northern Territory have yet to sign up.[104]

The previous NPA on Homelessness provided **$1.1 billion / 4 years**. The Budget Papers state that the Government is working to negotiate an 'integrated and holistic response" to homelessness beyond 2014.

DisabilityCare Australia

The Budget provides **$14.3 billion / 7 years** in additional funding from 2012-13 to move to full implementation of DisabilityCare Australia by 1 July 2019. The Government will provide a total of **$19.3 billion / 7 years** to DisabilityCare Australia, inclusive of the redirection of existing disability funding.

To date, seven States and Territories have agreed to fully implement DisabilityCare Australia — New South Wales, Victoria, South Australia, Tasmania, Queensland, the Australian Capital Territory and the Northern Territory. Beginning is 1 July 2013, this new program will launch in six locations - in South Australia (for children aged 0-14 years), Tasmania (for young adults aged 15-24 years), the Hunter region in New South Wales, the Barwon area of Victoria, and later in the Australian Capital Territory and the Barkly region in the Northern Territory from 1 July 2014. Over this 3-year launch phase around 26,000 people will benefit.

To provide a stable funding stream for DisabilityCare Australia, the Government will increase the Medicare levy by half a percentage point from 1.5 to 2 per cent of taxable income from 1 July 2014. This increase in the Medicare levy is expected to raise **$20.4 billion** between 2014-15 and 2018-19. This will be placed into a Fund for 10 years and will be drawn upon to fund the additional costs of delivering DisabilityCare Australia. A fixed amount of the money flowing into the Fund each year will be set aside for the States and Territories. This amount will be **$825 million** in 2014-15, increasing by 3.5% per year. Over 10 years, the States and Territories will be allocated a total of **$9.7 billion**.

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[103] 2013-14 Budget Paper No 1

[104] http://savetenantservices.net.au/2990/npa-on-homelessness-5-states-territories-sign-but-queensland-not-yet/

Update on health initiatives that are not included in the 2013-14 Budget

Dental health

The Government's **$4.1 billion** Dental Reform package, announced in August 2012,[105] contains three initiatives:

- Grow Up Smiling, a child dental benefits schedule, which will commence from 1 January 2014, replacing the Medicare Teen Dental Plan. Funding of **$2.7 billion** is for a capped ($1,000 / 2 years) benefit entitlement for basic dental services for children. Around 3.4 million children aged 2-17 in families who meet the means test will be eligible for benefits each year.
- A NP for Adult Public Dental Services which will provide **$1.3 billion** to States and Territories from 1 July 2014 to expand services for adults in the public dental system. The funding will assist up to 1.4 million low income adults to receive dental services. This measure builds on the 2012-13 Dental Waiting List NP **($515.3 million** in the 2012-13 Budget), which is focused on treating the 400,000 adults currently on public dental waiting lists.
- A Flexible Grants Program which will provide **$225 million** for dental infrastructure (both capital and workforce) in outer metropolitan, rural and regional areas to assist in reducing access barriers for people living in these areas. The grants may also be used for targeted programs to address other gaps in service delivery such as innovative models of care to help reach people in more isolated locations and dental facilities in aged care accommodation.

Primary Care

There are no new provisions in primary care in this Budget.

The DoHA Portfolio Budget Statements provide some sense of the work that will be done in primary care over the next 12 months. It appears that a National Primary Health Care Strategic Framework has been agreed (although this is not yet available on the internet) and DoHA states that it 'will work with the states and territories to develop bilateral plans for primary health care by July 2013.'

A major focus will be on the 61 Medicare Locals which, under the Gillard Government, have assumed an increasingly important role in primary care. It remains to be seen what will happen to Medicare Locals if there is a change of government in September. In October 2012, DoHA

105 http://www.health.gov.au/internet/ministers/publishing.nsf/Content/46AB706087A8C494CA257A6A0006510C/$File/TP290812.pdf

called for tenders for a national evaluation of Medicare Locals. This evaluation is due in May 2014.[106] Undoubtedly there will be great scrutiny applied by the government of the day to this report.

In 2013-14 DOHA will implement a new Medicare Locals Accreditation Scheme to support Medicare Locals to meet best practice organisational management and service delivery processes. Accreditation is one aspect of a broader quality framework for Medicare Locals, which will seek to promote transparency, information sharing, and a culture of continuous quality improvement.

The Medicare Locals were required to undertake an assessment of their population's health needs and to use this information in their planning and priority setting activities. These reports were due in May 2012.[107] Some of these are available on the internet but there does not appear to be a collection in any one place. It is obvious that for many Medicare Locals there were time constraints in developing these Needs Assessment Reports.

The Government has committed around $650 million to the development of over 60 GP Super Clinics.[108] There have been problems with the rollout of these. Thirteen of the 28 GP Super Clinics which were in the 2010 list have not started construction and others are only providing early services. Senate Estimates in June 2013 was told that out of the 64 planned, there are 29 that are at least partly operational, 31 that are under construction, and another 10 that are in the planning stage.[109]

In addition to the SuperClinics, DoHA is overseeing around 425 Primary Care Infrastructure Grant projects across Australia (but only 29 in 2013-14).

Private Health Insurance

As of December 2012, 54.6% of the Australian population held some form of private health insurance and 46.9% held hospital cover.

The Australian Government Rebate (AGR) encourages people to take out private health insurance by contributing an income tested rebate to private health insurance premiums. The cost to government of the rebate was estimated to be around **$5.56 billion** in 2012–13, up from

[106] https://www.tenders.gov.au/?event=public.atm.showClosed&ATMUUID=00B30856-0F23-DDCC-9F03AB4D48A7ABDB

[107] http://www.gpnnt.org.au/client_images/339323.pdf

[108] http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinic-about

[109] http://bit.ly/13P90ts

$5.31 billion in 2011–12.[110] Means testing of the rebate was introduced on 1 July 2012, together with changes to the Medicare levy surcharge to encourage people to purchase the appropriate level of private patient hospital cover.

In the 2012–13 MYEFO the Government announced two reforms around the private health insurance rebate –the removal of the private health insurance rebate from the Lifetime Health Cover (LHC) loading component and indexing the rebate amount to the lesser of the CPI or the commercial premium increase. These were intended to generate savings in order to help fund the Dental Health Reform package announced in August 2012 and also help fund DisabilityCare. However the Explanatory Memoranda for the bills talk about make the AGR sustainable.

The payment of the Rebate on a base premium will result in savings to the Government of $699.7 million / 4 years. The removal of the rebate on the LHC will result in savings to the Government of $386.3 million / 4 years.

Legislation to implement these measures has been introduced but they both have yet to be enacted into law.[111]

[110] http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1213a/13bd123

[111] *Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012* and *Private Health Insurance Legislation Amendment (Base Premium) Bill 2013*