CENTRE FOR THE
HEALTH ECONOMY

MACQUARIE
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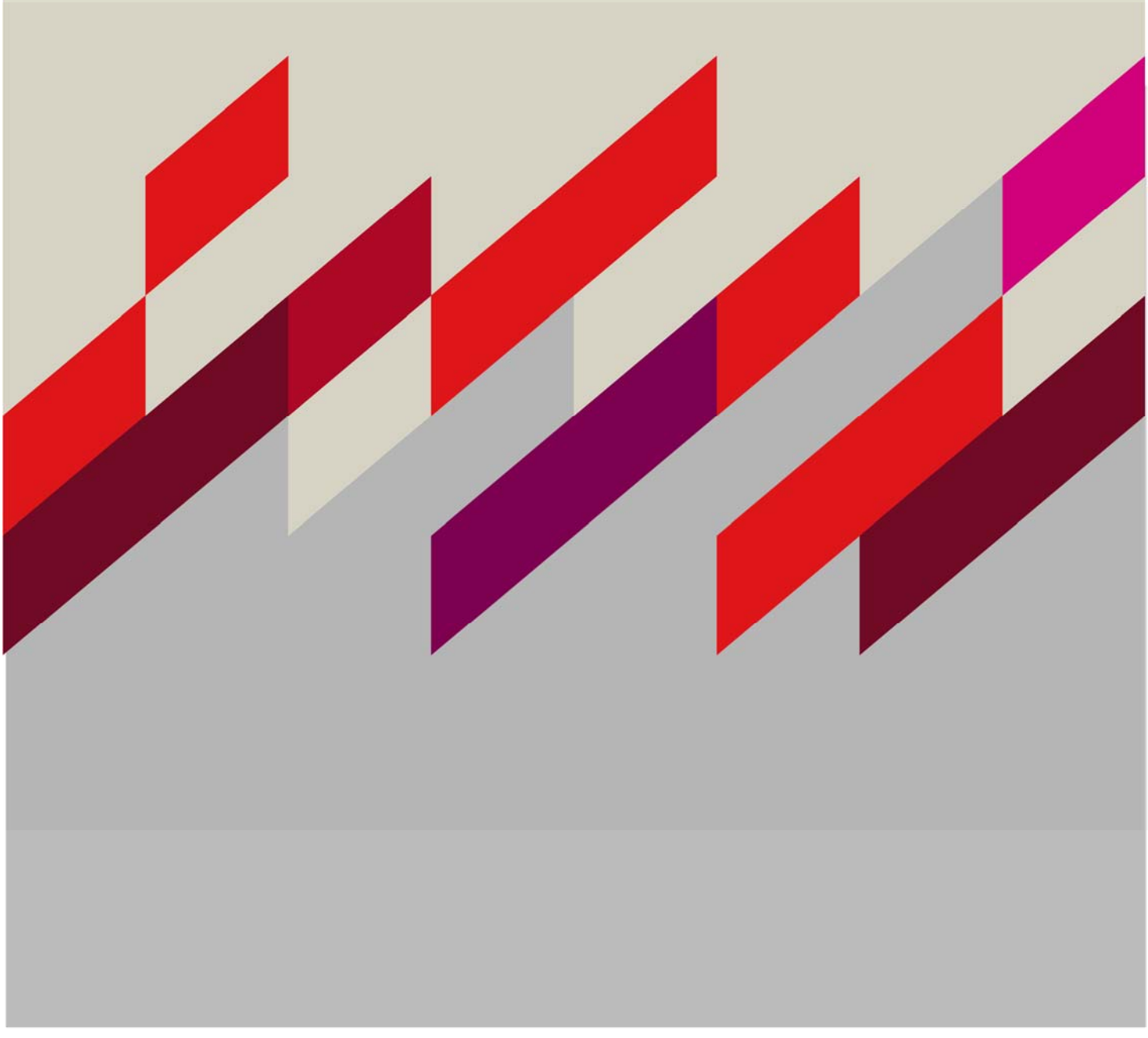
An overview of the 2017-18 federal health budget

11 MAY 2017



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About MUCHE

Macquarie University is recognised as one of Australia's leading research universities, with an enviable reputation for excellence. While still relatively young, success of the past 50 years has positioned our distinctive approach to deliver ground-breaking research with world-changing impact.

Recently, we have invested heavily in infrastructure, with over $1 billion spent on facilities and buildings. We have also significantly expanded our teaching and research capacity in health, for example, with the development of a new Faculty of Medicine and Health Sciences, and relocation of the Australian Institute of Health Innovation from the University of NSW.

The University's objectives are to accelerate world-leading research; to prepare world-ready higher degree research candidates; to actively engage externally as a world-recognised research collaborator and partner of choice. We believe collaborating with industries, governments, communities, professions and academic colleagues around the world is paramount to our success.

Macquarie University's Centre for the Health Economy (MUCHE) was recently established as a strategic initiative to undertake innovative research on health, ageing and human services. Our vision is to create a world where decision makers are empowered with applied, trusted and influential research into health and human services policy and systems. Our mission is to deliver leading innovative research by operating professionally, collaboratively and sustainably.

To this end, we undertake research for government, business, and not-for-profit organisations, which is used to inform public debate, assist decision-making, and help formulate strategy and policy.

We are interested in investigating the Health Economy at the macro level, with particular focus on the interdependencies of these systems with each other, and the broader economy. This includes investigating factors beyond the health and human services sectors that impact the health and wellbeing of populations.

Our point of difference lies in our approach to research. While MUCHE primarily consists of specialist health economists, we recognise that researching the Health Economy requires many skill sets and experience. Solving problems within health and human services now requires teams with multi-disciplinary skills working closely together.

We therefore work collaboratively with our partners, and across the University, including the Faculty of Business and Economics, Faculty of Human Sciences, and the Faculty of Medicine and Health Sciences. We also work with Macquarie University's world renowned research hubs, such as partners within the Australian Hearing Hub and the Australian Institute of Health Innovation.

We take pride in combining our professional approach to partner engagement, with our academic approach to methodology, to deliver innovative translational research.

Dr Henry Cutler
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Budget overview

Australia has one of the healthiest populations in the world, ranking sixth among OECD countries when comparing life expectancy. A male born today can expect to live until they are 82 years old, while a female can expect to live until they are 84 years old.[1]

Our long life expectancy is the outcome of a combination of lifestyle, behaviours and health and social care systems. In 2013 the Commonwealth Fund ranked the Australian health care system fourth against 11 developed countries, behind the UK, Switzerland and Sweden in that order. We were ranked 2nd for quality behind the UK.[2]

Our worst health care ranking was access to services due to high costs. Australians pay more for their health care than most other developed countries, and only the US had a greater proportion of patients with excessive out of pocket costs. This has led to some major battles between the government, providers and society, with the 2014-15 Budget attempt to introduce a minimum $7 copayment for general practitioner, pathology and diagnostic imaging services failing miserably.

Health care funding has always been a battleground. That is because Australians are passionate about affordable, good quality health care, and believe access to public health care is part of the 'fair go' Australian story.

Another fierce health care battle began immediately after the 2016-17 Budget, which was brought forward to accommodate an election call on 8 May 2016. That budget had implicitly asked consumers to pay more for their health care by pausing index arrangements for Medicare Benefits Schedule items and the private health insurance rebate.

The Labor party launched its election campaign strategy, with a flanking manoeuver concentrated on health care. Dubbed the Medi-Scare campaign, it managed to convince a substantial proportion of the electorate that a coalition government would privatise health care if re-elected. Not only had the coalition government extended a pause in index arrangements within the 2016-17 Budget, it had also sought to privatise the Medicare payments system.[3]

According to Sun Tzu (an ancient Chinese military strategist) '*the supreme art of war is to subdue the enemy without fighting*'. The Labor party may have won the battle in 2016, but this Budget and the 2016 Mid Year Economic and Fiscal Outlook (MYEFO) budget has definitely firmed up the flank against future attacks.

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[1] OECD 2017, OECD Health Statistics 2016. http://www.oecd.org/els/health-systems/health-statistics.htm, accessed 10 May 2017

[2] Davis K, Stremikis K, Squires D, Schoen C, 2014, *Mirror, mirror on the wall. How the performance of the US health care system compares internationally*, The Commonwealth Fund, http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf, accessed 10 May 2017

[3] Political commentators suggest the Medi-Scare campaign directly resulted in several lost seats for the coalition, which only marginally retained government.

Overall, the health portfolio will experience a 2.0 per cent increase in expenditure, which is relatively sedate considering expenditure increased by 6.7 per cent in 2016-17.

However, the Australian Government has invested in the Medicare payments system (rather than selling if off), and has started to remove the pause in indexation arrangements for MBS items, starting with GP bulk billing consultations. This will cost the Australian Government around $1.0 billion over the forward estimates.

It will also spend around $1.2 billion on new and amended listings to the Pharmaceutical Benefits Scheme (PBS), providing greater access to drugs. This will be paid for through drug price reductions, saving the Australian Government around $1.8 billion between 2016-17 and 2021-22.

The Australian Government has also established the Medicare Guarantee Fund, which will receive $33.8 million in 2017-18 and provide funding to cover MBS and PBS expenditure. It is uncertain why such a fund is needed given MBS and PBS expenditure is currently funded by consolidated revenue. But it will help the coalition fend off any attack around publically funded health care, and may provide a useful reference point when negotiating future MBS and PBS prices.

Some sectors have avoided any major changes, including public hospitals, private health insurance and aged care. Private health insurance and aged care sectors are expected to undergo large reforms in the coming years, as a result of current reviews. The Australian Government has put its 'money where its mouth is' when it comes to mental health care, although the sector will be expecting more once the Fifth National Mental Health Plan is completed.

Overall, the Australian Government has delivered a relatively balanced health and human services budget with little controversy. However, pressure to increase expenditure in future years will continue, driven by population ageing and growth, chronic disease, and expensive new health technology. The Australian Government will need to work with state and territory governments to find additional efficiencies within the system if they are to continue providing good quality, but affordable health care.

Aged care

Last year's Budget was a horror story if you were a residential aged care provider. Having reviewed the growth in Aged Care Funding Instrument (ACFI) funding, the Australia Government decided to reign in a potential budget blow-out by reducing aged care expenditure by $1.2 billion over four years. This was to be achieved through changes to the scoring matrix of the Aged Care Funding Instrument (ACFI), and reducing indexation of the Complex Health Care component of the ACFI by 50 per cent.

However, the sector managed to convince the Australian Government that funding cuts will significantly impact their ability to meet the demand for residential aged care over the coming years. The 2016 MYEFO budget round saw the Australian Government reverse these changes, instead introducing a one year indexation pause of all ACFI domains in 2017-18, and an additional 50 per cent indexation pause for the Complex Health Care component in 2018-19.

Any substantial reduction in ACFI funding will impact the ability of residential aged care providers to attract investment funding. Despite the residential aged care sector receiving some concessions, the sector will still face funding cuts, and the process has left deep scares by highlighting the significant political risk an investor faces. After the announcement last year, there were substantial share price devaluations for the three listed aged care providers, which are still yet to rebound to previous highs.

The Australian Government has since decided to review the ACFI to determine whether it is 'fit for purpose'. A University group has been commissioned to develop an alternative aged care assessment, classification system and funding model. The Australian Government also allocated $2.4 million in the 2016 MYEFO budget round to undertake a small pilot to test alternative funding models.

Other significant changes are expected for the aged care sector. The Australian Government continues to work on developing a 'Single Aged Care Quality Framework'. This will provide additional information to consumers on My Aged Care to help them compare alternative providers when making a choice.

There is also a review on the potential impact of uncapping supply side restrictions in aged care (i.e., exposing the sector to more competition) which if pursued, may have wide reaching impacts on quality, workforce and sustainability.[4]

Finally, a Senate Committee on the 'Future of Australia's Aged Care Workforce' is due to report at the end of June 2017. The Australian Government seems to have pre-empted their findings to some degree, with the Budget allocating $33 million from 2017-18 to 2019-20 to help aged care and disability care service providers located in rural, regional and outer suburban areas to attract additional workers into the sectors. The Australian Government has also committed to spending $1.9 million over the next two years to develop an aged care workforce strategy.

Disability

The National Disability Insurance Scheme (NDIS) is currently being rolled out across Australia, and when it becomes fully operational, will cost approximately $21.0 billion. The Australian Government will contribute just over half at $10.8 billion.

This Budget has seen a substantial increase in allocated funding for the NDIS. Western Australia finally signed up in 2017, costing the Australian Government $868.2 million over 2017-18 to 2019-20.

It has also allocated $209.0 million between 2017-18 and 2020-21 to establish the National Disability Insurance Scheme Quality and SafeGuards Commission. This Commission will use the NDIS Quality and Safety Framework released in December 2016 to ensure NDIS recipients can exercise their choice and control of services, while being protected from poor service delivery leading to poor health outcomes. The Commission will also put in place important workforce measures to ensure the NDIS workforce is competent and safe.

The Australian Government estimated that the NDIS would have created a $3.8 billion shortfall in 2019-20. It has therefore increased the Medicare Levy by 0.5 per cent starting on 1 July 2019, which will bring the Levy up to 2.5 per cent of taxable income. The NDIS will only take one fifth of the Medicare Levy revenue, with the remainder going into the new Medicare Guarantee Fund.

Hospitals

Expenditure on public hospitals is the second biggest health budget item for the Australian Government, and the largest recurrent expenditure item for state and territory governments (greater

[4] Cutler H, 2016, 'The real bellwether of reform success', Media article, 27 July 2016, http://www.australianageingagenda.com.au/2016/07/27/the-real-bellwether-on-reform-success/, accessed 10 May 2017

than primary and secondary education, police and justice, and disability services). Public hospital funding is therefore always a hot button issue.

Public hospitals were allocated an additional $2.9 billion over three years in the 2016-17 budget. This was to reverse a previous decision by the Abbot government to remove substantial amounts of funding from public hospitals, and abandon activity based funding and a national efficient price.

However, the additional funding came with a catch, as state and territory governments were required to commit to begin implementing health care reforms to improve health care efficiency and health outcomes, and reduce hospital demand. These reforms included:

- developing coordinated care for patients with chronic and complex conditions;
- incorporating quality and safety into hospital pricing and funding;
- reducing potentially avoidable hospital readmissions; and
- reforms to primary care to reduce avoidable hospital admissions. [5]

This year, public hospital funding has been relatively untouched, except for $59.3 to support hospital infrastructure and $730.4 million to support the operation the Mersey Community Hospital in Tasmania (with the Australian Government to recoup around $250.6 million the following four years).

The Australian Government will still spend $19.6 billion in 2017-18 on providing assistance to states and territories for public hospitals. An additional $3.1 billion was budgeted in the forward estimates to 2020-21. The Minister for Health is expected to finalise a hospital funding agreement in 2018 with state and territory governments, which will provide clarity around the Australian Government's contribution to public hospitals post 2020-21.

A small proportion of this expenditure will be offset by some hospital savings. The Department of Veterans Affairs is expected to save $171 million over 2016-17 to 2020-21 in private hospital payments. This will result from improved contracting arrangements with private hospitals, and reduced prices for surgically implanted medical devices.

Mental health

The *National Partnership for Supporting National Mental Health Reform* was established through Coalition of Australian Governments (COAG) as part of the Australian Government's mental health reforms announced in the 2011-12 Budget. Within that agreement, the Australian Government made available $200 million between 2011-12 to 2015-16 for states and territory governments. This funding was to address mental health service gaps for people with severe and persistent mental illness and complex needs. Last year's Budget saw $45.3 million allocated to states and territories, representing what should have been the last tranche of funding under this National Partnership agreement.

Over that period the National Mental Health Commission (NMHC) developed and released its national review of mental health programmes and services, calling for a person centred approach to mental health care that focused on prevention. The Australian Government responded in November 2015, one

[5] This was established under a three year Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding, due to commence 1 July 2017 and cease 30 June 2020.

year after the report was released, and established a reform pathway for 2016 to 2019. By the end of this period, the Fifth National Mental Health Plan is expected to be complete.

As part of its commitment, the Australian Government budgeted an additional $194.5 million to mental health services between 2016-17 and 2019-20 within the 2016 MYEFO budget round. This funding will be used to support early psychosis youth services and additional services for young people in rural and regional areas, invest in suicide prevention trial sites, develop and test new technologies to help people with mental health issues, and develop a new workforce model. Funding of $2.5 million was also allocated in 2016-17 to continue exploring a Digital Mental Health Gateway.

In this Budget, $9.1 million has been allocated over 2017-18 to 2020-21 to improve access to telehealth psychological services for people living in regional, rural and remote locations. $80 million has also been allocated over the same period to help people with mental illness to access community mental health services, who are not covered by the National Disability Insurance Scheme. The catch is that states and territories must match this funding. An additional $15 million has been allocated over the next two years to mental health research. [6]

Suicide prevention has also received additional funding by the Australian Government within this Budget, which is a direct reflection of its response to the NMHC review of mental health programmes and services. In addition to that allocated within the 2016 MYEFO budget round, $11.1 million has been allocated between 2017-18 and 2019-20 to purchase infrastructure and support Lifeline to prevent suicide. The Department of Veterans Affairs will also receive $9.8 million over the same period to improve mental health services and prevent suicide.

Pharmaceuticals

The pharmaceutical sector seems to be the 'go to' sector when budget savings are required. While the 2016-17 Budget saw relatively little change, the sector was still feeling the aftershocks of the prior budget, through a reduction in pricing for innovative pharmaceuticals (F1 schedule), a quicker reduction in pricing for drugs that come off patent through the price disclosure arrangements, and additional savings through amended prices.

It seems the reprieve is over. Through a five year agreement with Medicines Australia, this Budget has made some additional changes to the price reduction arrangements, with the Australian Government budgeting $1.8 billion worth of savings between 2016-17 and 2021-22. These changes include:

- extending the current 5 per cent reduction for F1 medicines to 2022 (by two years);
- increasing the price reduction from 16 per cent to 25 per cent for medicines moving from F1 to F2 (from 1 October 2018 to 30 June 2022);
- introducing a one-off 10 per cent price reduction for F1 medicines that have been listed on the PBS for 10-14 years (with subsequent reductions as medicines reach their 10 year anniversary through to 2021); and
- introducing a one off 5 per cent reduction for F1 medicines listed on the PBS for 15 years or more, from 1 June 2018 (with subsequent reductions as medicines reach their 15 year anniversary through to 2021).

[6] An additional $7.2 million has been allocated under the *National Partnership for Supporting National Mental Health Reform*, although this looks like money owing to NSW and the Northern Territory.

While budget savings will start immediately, they will gradually ramp up when the Australian Government will save $539 million in 2021-22. In addition, the Australian Government is expecting to save $270.2 million between 2016-17 and 2020-21 through amending prices of specific medicines currently listed on the PBS.

The Australian Government argues that savings will be ploughed back into the Pharmaceutical Benefits Scheme (PBS). Indeed, the Budget has allocated $1.2 billion for new and amended listings on the PBS between 2016-17 and 2020-21, in addition to the $141 million allocated between 2016-17 and 2019-20 in the 2016 MYEFO budget round. The MYEFO budget round also included an extra $83.7 million worth of expenditure over 2016-17 to 2020-21 for price amendments of specific medicines listed on the PBS.

However, in net terms the pharmaceutical sector will face lower revenue from the Australian Government, with Budget estimates for pharmaceutical benefits and services reducing from $12.7 billion in 2016-17 to $11.9 billion in 2020-21.

Pharmacy

The five year Sixth Community Pharmacy Agreement (6CPA) between the Minister for Health and the Pharmacy Guild of Australia took effect from 1 July 2015, outlining pharmacy funding and pricing arrangements and community pharmacy programs. It commits the Australian Government to $15.5 billion worth of expenditure.

This Budget has seen $225 million allocated over 2018-18 to 2019-20 to community pharmacies and pharmaceutical wholesalers because prescription volumes were lower than forecasted within the 6CPA, and pharmacies are expected to receive less through medicine price reductions negotiated within the five year agreement with Medicines Australia.

The Budget also reaffirms the Australian Government commitment to developing legislation to ensure pharmacy location rules are extended to 2020. These Rules mean that certain location criteria must be met before the Australian Community Pharmacy Authority can approve a new pharmacy, or the relocation or expansion of an existing pharmacy.

These location rules restrict competition by not allowing new pharmacies to open within 1.5 kilometres or 10 kilometres of an existing pharmacy depending on the location, distance to the nearest pharmacy, and the number of supermarkets and medical practitioners in the area.[7]

Commitment by the Australian Government to these location rules is contentious. As recommended within the Competition Policy Review, the location rules '*should be removed in the long term interests of consumers*'.[8]

The location rules are also misaligned with the broader direction of the Australian Government, which has allocated $300 million over two years in the Budget (under the National Partnership on Regulatory Reform) to '*incentivise the States and local governments to lessen the regulatory burden on small businesses and remove other restrictions that hinder economic growth and competition*'.[9]

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[7] Harper I, Anderson P, McCluskey S, O'Bryan M, 2015, Competition Policy Review. Final Report, Commonwealth of Australia.

[8] Ibid.

[9] Budget 2017-18, Paper No. 1

Primary care

Primary care has been the focus of budget saving measures since 2013-14, when the Labor government introduced a four year freeze on Medicare Benefit Schedule (MBS) rate indexation, and subsequent coalition governments extended that freeze.

This is no surprise considering Medicare benefits are the largest health portfolio budget item, estimated to cost $23.0 billion in 2017-18. It was accompanied by the establishment of the Medicare Benefits Schedule Review in 2015 to ensure MBS items represent 'contemporary clinical evidence', by removing obsolete and low value items, and changing prices that do not reflect current practice or technology.

Since the freeze began, the Australian Medical Association and the Royal Australian College of General Practitioners have argued it has increased General Practitioner (GP) fees, leading to increased out-of-pocket costs, and potentially worse health outcomes as people delay treatment.

Despite there being no evidence to suggest fee increases would not have occurred regardless of the freeze, the Australian Government has listened. It has committed $1.0 billion over four years from 2017-18 to reintroduce indexation for some MBS items. GP bulk billing consultations will be indexed first, then standard consultations, and finally specialist procedures and allied health service items. This commitment will increase medical benefits expenditure by 10.9 per cent in real terms over the period 2017-18 to 2020-21.

The Australian Government has also committed another $44.2 million to continue the MBS Review through the MBS Review Taskforce. An interim report from the MBS Review Taskforce was provided to the Minister for Health in 2016, outlining an approach to using Clinical Committees to review a set of MBS items allocated by the Taskforce. According to the Budget, 65 clinical committees have now been established, with around 2,500 MBS items currently under review.

The Australian Government continues to commit to the establishment of its Health Care Homes model of coordinated primary health care, as outlined in the 2016-17 Budget. This will initially involve 20 selected general practices and Aboriginal Community Controlled Health Services from 1 October 2017 (yet to be announced), but will be extended to 200 primary care providers from 1 December 2017. Health Care Homes will coordinate care for around 65,000 patients with chronic conditions that have voluntarily enrolled, and receive a bundled payment for their coordination activities. The total cost is estimated to be $104 million.

Finally, one of the most surprising announcements within the Budget by the Australian Government is the establishment of a Medicare Guarantee Fund. This will receive $33.8 billion in hypothecated funding in 2017-18, to be spent on MBS and PBS. The motivation for this fund is unclear, given there was no indication that funding for the MBS and PBS were not 'guaranteed'. However, the title suggests this may be a political move to neutralise any attempt by the Labor party to revive the Medi-Scare campaign.

Private health insurance

The Australian Government private health insurance (PHI) rebate is expected to cost $26.5 billion between 2017-18 and 2020-21, although expenditure will remain virtually unchanged compared to the previous Budget.

In times of fiscal hardship there is a strong incentive to focus on reviewing costly expenditure items, such as the PHI rebate, particularly given the uncertain net benefits to the Australian Government.[10] But if further justification is required, the Australian Government does not have to search too far. Their wide ranging consultation process in 2015 found many people believe they are not getting value for money from their private health insurance.

And no wonder. Prices have increased by an average 5.6 per cent since 2010,[11] equating to a 55 per cent increase when compounding effects are taken into account. Add the rebate reduction in 2012,[12] and suddenly a substantial proportion of PHI members have experienced a price increase of 70-99 per cent. It seems the Medicare Levy Surcharge 'stick' is holding up a precarious private health insurance sector.

Despite relatively no change to private health insurance in this Budget, the Australian Government was very clear in their 2016-17 budget that private health insurance reform was firmly in their sights. In particular, the Australian Government promised to:

- establish the Private Health Sector Committee (PHSC) to provide technical and specialist advice on designing and implementing the Government's private health insurance reforms; and
- improve the listing and reimbursement process for prostheses by reconstituting the Prostheses List Advisory Committee (PLAC).

Private health insurance reforms

Since its inception, the Private Health Ministerial Advisory Committee (PHMAC)[13] has focused on changing private health insurance product design, including the potential to introduce Basic Bronze, Bronze, Silver and Gold categorisations according to exclusions and excess amounts. The aim is to remove the complexity faced by consumers when considering alternative PHI products.

The PHMAC has also explored reform options for PHI contracting and second tier default benefit arrangements, and canvassed options to reform the current practice of private patients admitted into public hospitals. It has also explored alternative reform options to deregulate premium settings.

Prosthesis pricing reform

Since its inception, the Prosthesis List Advisory Committee (PLAC) has focused on developing a methodology to undertake targeted prosthesis reviews, and developing a benefit setting framework. The aim is to ensure the Prosthesis List provides benefits for clinically effective and cost effective medical devices, while ensuring prices reflect current market rates.

While the PLAC continues its work, the Australian Government has pursued some early wins, announcing a reduction in price by 10 per cent for cardiac devices and intraocular lens and 7.5 per cent for hip and knee replacements from 20 February 2017. This will impact around 2,440 of the 11,000 medical devices listed on the Prostheses List.

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[10] See Cheng TC 2014, 'Measuring the effects of reducing subsidies for private health insurance on public expenditure for health care', *Journal of Health Economics*, Vol. 33, pp. 159-179

[11] This year was the lowest increase at 4.84 per cent.

[12] Rebates were reduced in 2012 for singles earning over $90,000 per year, or families earning over $180,000 per year in 2012. The level of rebate reduction depended on the level of income, with Tier 1 income experiencing a 10 per cent reduction, while Tier 3 income experiencing the complete removal of rebates (i.e., a 30 per cent reduction).

[13] This was named the Private Health Sector Committee (PHSC) when introduced in the 2016-17 budget.

While these price reductions will reduce costs for private health insurers ($86 million in the first year and $500 million over six years), it has allowed the Australian Government to achieve lower PHI price increases with the sector. Consequently, some cost savings have already been passed onto PHI members. The Australian Government will also benefit, through a lower PHI rebate expenditure.

Other notable changes

Health ICT

The Australian Government has allocated $67.3 million to modernise the health and aged care payments system. This is in addition to $31.5 million allocated in 2016-17 through the 2016 MYEFO budget round. The expenditure is a direct result of the Australian Government deciding it will not privatise the payments system, after being pushed into a corner by the Labor party within its Medi-Scare campaign in the lead up to the 2016 election.

My Health Record continues to receive more funding from the Australian Government, being allocated $374.2 million between 2017-18 and 2018-19. This is to expand services after the Australian Government decided that people should opt out, rather than opt in, to receive a health record.

Dental care

The Australian Government's Child and Adult Public Dental Scheme (CAPDS) announced in the 2016-17 Budget has been reversed. This was worth $1.7 billion from 2015-16 to 2019-20, and was meant to be delivered by the states and territories under a National Partnership Agreement (NPA). [14]

However, the CAPDS was dropped in the 2016 MYEFO budget round because some states did not support the scheme.[15] Instead, the Australian Government has retained the Child Dental Benefits Schedule (CDBS) and committed another $163.6 million between 2016-17 to 2020-21 in this Budget to increase the two year cap on benefits from $700 to $1,000, and avoid price reductions on the CDBS.

Medical Research Future Fund (MRFF)

Development of the Medical Research Future Fund (MRFF) continues, with a board established to determine medical research priorities, and the release of the Australian Medical Research and Innovation Priorities 2016-2018. These have been developed for the Minister of Health to consider when allocating funds from the MRFF.

The Budget has allocated $65.9 million over 2016-17 to 2018-19 from the MMRF, to help research into cancer impacting adolescents and young adults, preventative health, and to develop rapid research translation through Advanced Health Research and Translation Centres (AHRTCs) and Centres for Innovation in Regional Health (CIRHs)

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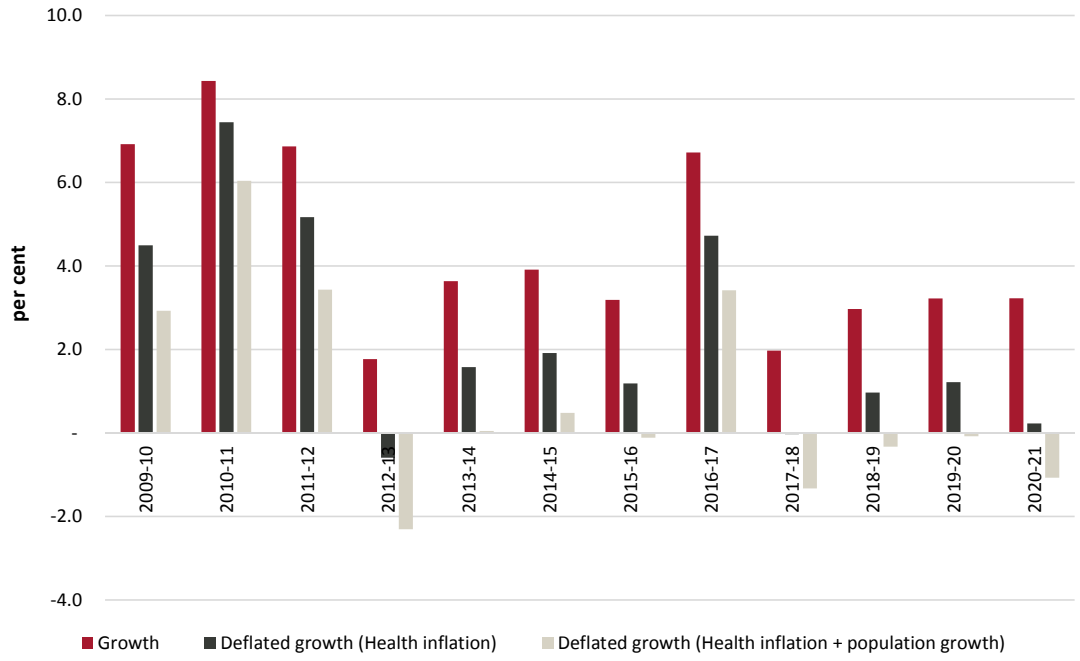
[14] This merely replaced the Child Dental Benefits Schedule and the National Partnership Agreement on Adult Public Dental Services. In reality, the federal government would have saved $17.3 million between 2015-16 and 2019-20.

[15] The Hon Sussan Ley MP, '*Continued dental funding for States from 1 January 2017*', Media Release, 15 December 2016.

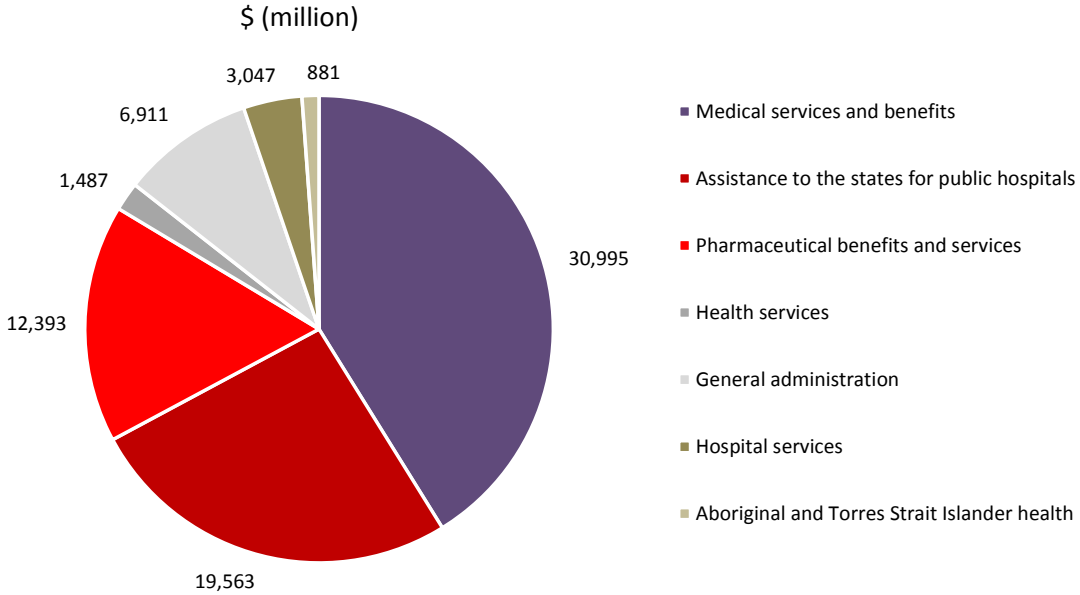
The budget in pictures

Chart 1: Annual change in net federal budget health expenditure



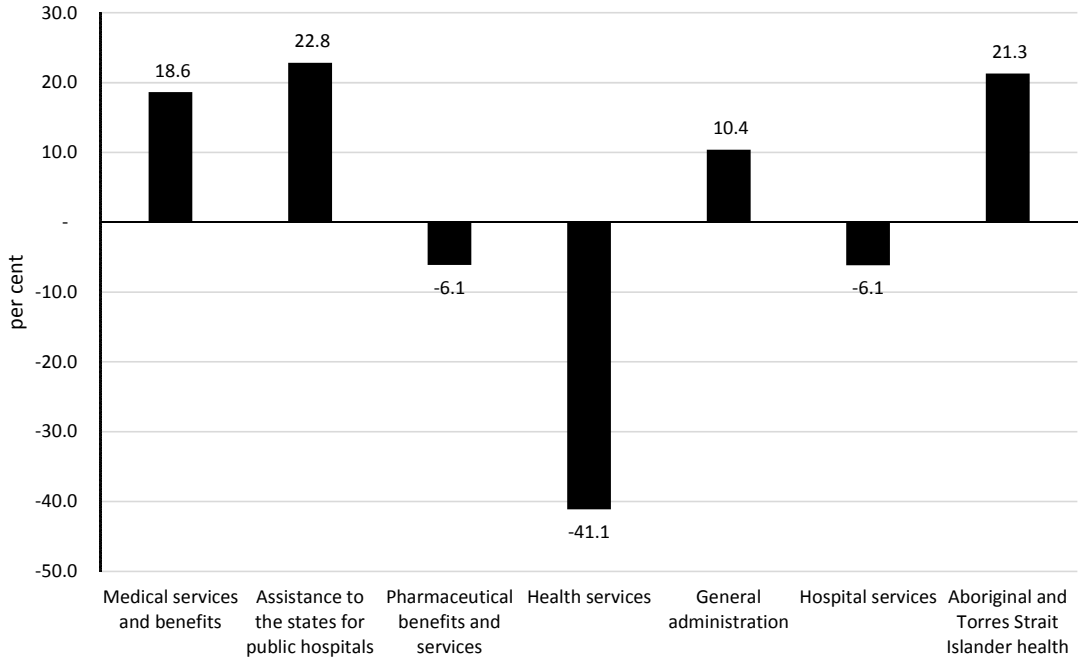
Source: MUCHE calculations based off Budget Paper No.1

Chart 2: Composition of the federal health budget, 2017-18



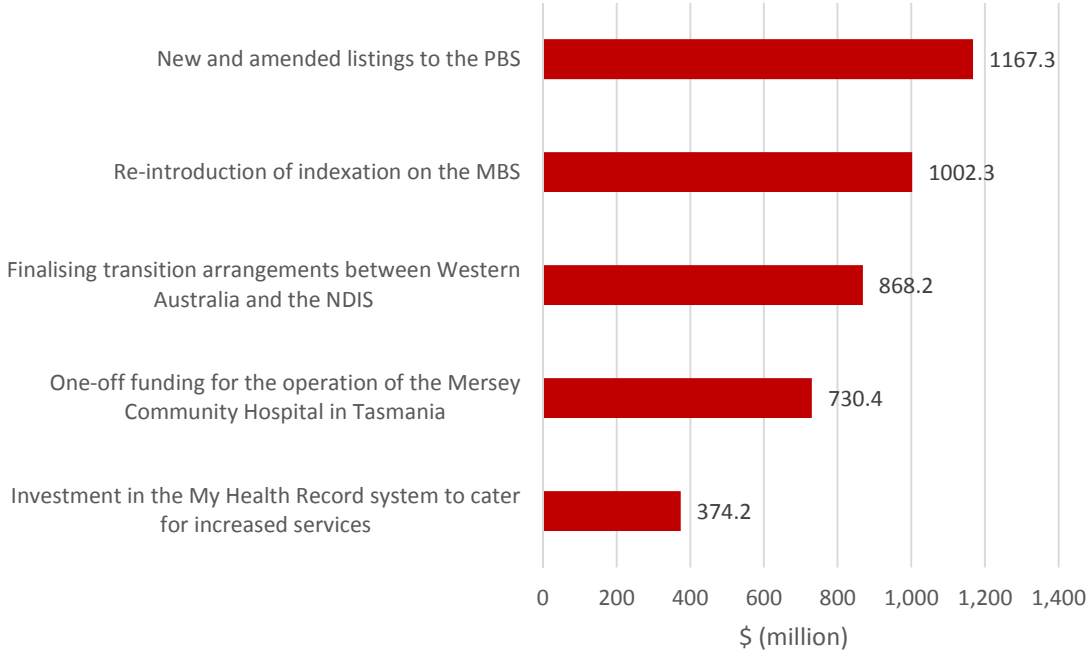
Source: Budget Paper No.1

Chart 3: Estimated proportional change in expenditure, from 2016-17 to 2020-21



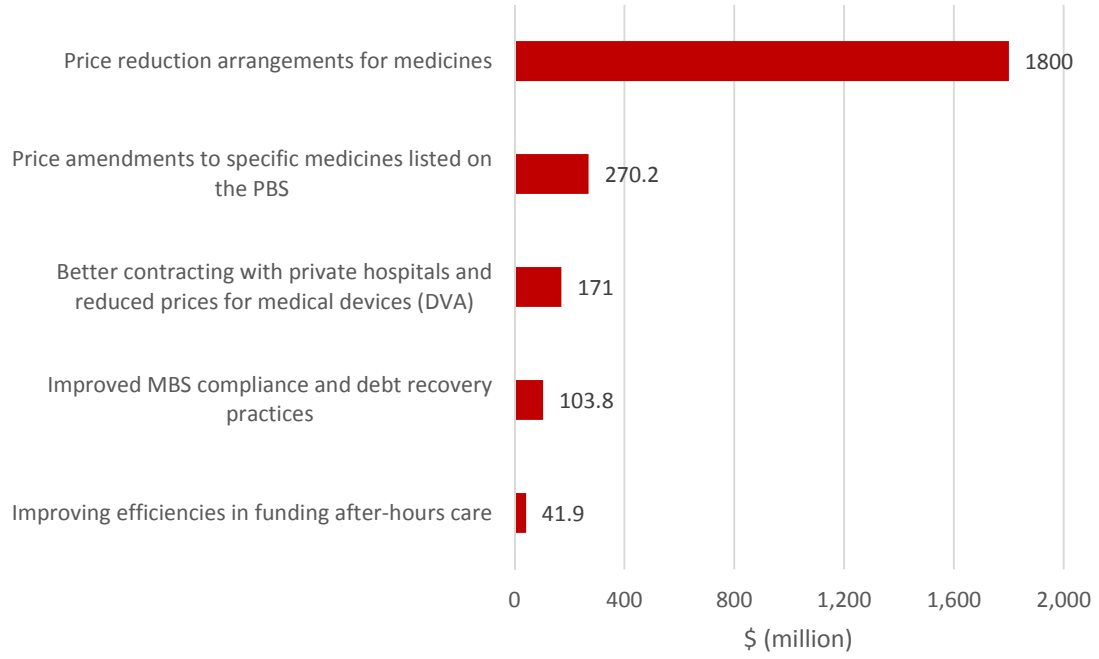
Source: Budget Paper No.1

Chart 4: Top five increases in expenditure, 2017-18



Source: Budget Paper No.2

Chart 4: Top five budget savings measures, 2017-18



Source: Budget Paper No.2