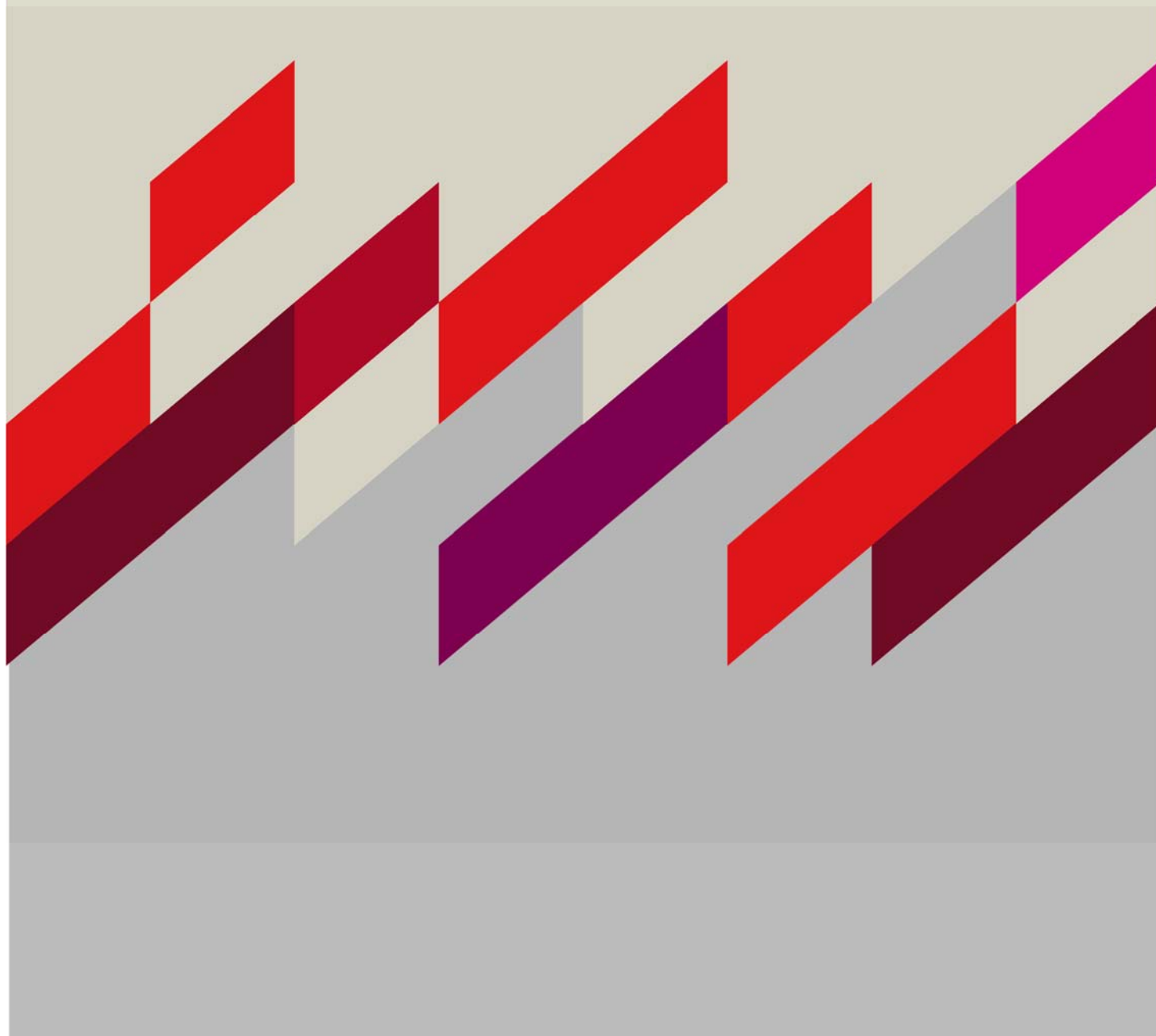




# An overview of the 2016-17 federal health budget

6 MAY 2016



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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.



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# Budget overview

The federal government has sharply focused on the health care budget over the last decade, primarily driven by the continued pressure on expenditure from population growth and ageing, and greater expectations from society around access to quality care.

The election of the Labor government in 2007 led to an increase in federal government health care expenditure, as the government attempted to ameliorate any effects from the Global Financial Crisis and reform the health care system. Nominal annual federal health care expenditure growth was around 7.5 per cent between 2009-10 to 2011-12, but this petered out to an increase of just under 2 per cent in the 2012-13 budget, and just under 4 per cent in the 2013-14 budget.

While nominal expenditure growth has averaged just under 4 per cent since the 2012-13 budget, real expenditure growth has been closer to zero once adjusted for inflation and population growth. This means expenditure has not kept pace with greater health care needs from obesity, ageing and new health technology, placing additional pressure on the health care system and forcing the federal and state governments to continue their search for greater efficiencies.

The two budgets delivered under the Abbot government were straight out of a Dickens book. To quote the Tale of Two Cities, “It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness...”.

Last year’s budget (2015-16) was relatively sedate. Major items included changes to pharmacist arrangements through an increase in co-payments and the safety net threshold (building on the theme of a greater user pays health care system), and reductions in pricing for pharmaceuticals.

This was in stark contrast to the 2014-15 budget, whereby the Abbott government attempted to remove \$7.9 billion from the health care system over 2014-15 to 2017-18, and introduce a minimum \$7 co-payment for general practitioner, pathology and diagnostic imaging, which was subsequently reversed in the 2015-16 budget.

The 2016-17 budget builds on the 2014-15 budget legacy in some ways, despite the government’s continual attempts to correct the political fallout from that budget. For example, the government has extended pausing index arrangements for the Medicare Benefits Schedule, and the private health insurance rebate.

This year’s budget also draws from the many federal health care reviews undertaken over the last year, including the Primary Health Care Taskforce, the MBS Review, and public consultations on the value of private health insurance. The aged care sector has also seen large expenditure cuts through adjustments to the aged care funding instrument (ACFI), which is primarily driven by the larger than expected government expenditure around one ACFI domain (complex health care)

Overall, the biggest winner from the 2016-17 health budget is the federal government and state and territory governments through an increase in public hospital funding.

The biggest losers are private providers reliant on the MBS, and aged care providers reliant on ACFI funding. The willingness and ability of providers to mitigate lost revenue through increased co-payments will ultimately determine whether this budget results in reduced quality of care, or hurts the hip pockets of Australians in need.

## Primary care

The first round of recommendations from the MBS Review has been included in the budget, albeit with a relatively small effect. Twenty four items will be removed from the MBS, while two diagnostic imaging items will be restricted in their application to patients less than 16 years old. Savings to the government is estimated to be \$5.1 million from 2016–17 to 2019–20.

There have been other changes to the MBS based on Medical Services Advisory Committee (MSAC) recommendations and regulatory changes, with several new and amended listings saving the government another \$51.4 million from 2016-17 to 2019-20. But the government has also introduced better screening for diabetic retinopathy, by listing photography with non-mydratric retinal cameras on the MBS, costing around \$33.8 million from 2016-17 to 2019-20.

The government has also started to explore alternative ways to tackle costs associated with managing chronic care patients, through establishing a trial of health care homes, requiring additional expenditure of \$21.3 million between 2015-16 and 2018-19. There is little detail around its mechanics, or how the bundled payment funding model would fit within the broader health care funding system. State governments have been seriously attempting to reduce the cost of chronic patients for the last five years with little success. While there are many challenges in delivering integrated care, one of the greatest is changing patient behaviour, which can be extremely difficult.

General Practitioners (GPs) are one of the biggest losers in the health care budget, which is reminiscent of the 2014-15 budget. This is no surprise considering medical services and benefits (which includes MBS and private health insurance rebate) is the greatest expenditure item at \$30.2 billion in 2016-17. The next largest expenditure item is assistance to public hospitals, at around \$17.1 billion. Two changes that will impact GP funding include:

- extending the pause of MBS indexation arrangements, saving the government \$925.3 million between 2018-19 to 2019-20; and
- simplifying the Practice Incentives Program by changing the incentive structure, saving the government \$21.2 million from 2015–16 to 2019–20.

There has been some focus on improving support for rural and remote GPs, but these have not led to additional funding, rather a re-appropriation within the current MBS and Rural General Practice Grants Program.

# Hospitals

Public hospitals will receive an additional \$2.9 billion over the next three years, which has been established under the new three-year Heads of Agreement recently signed between the Commonwealth and the states and territories. This includes the continuation of activity based funding and a national efficient price, which was a major reform recently introduced across states and territories, but under threat from the Abbot government.

The state and territory governments had sought much more funding to cope with increasing public hospital demand. Indeed, health care is the most expensive budget item for states and territories (greater than education and infrastructure), driven primarily by hospitals. Approximately 25 per cent of state and territory revenue goes directly towards health expenditure.

However, the federal government has argued more work needs to be undertaken by state and territory governments to seek efficiencies within the public hospital sector, and to keep patients out of hospital....the health care blame game continues, and patients continue to wait for elective surgery.

Over the last three years the federal government has also invested in new data analytic techniques to ensure providers are using the MBS appropriately. The government can now determine whether a public patient has been charged as a private patient within a public hospital, which would effectively constitute 'double dipping' (i.e., payment through activity based funding and MBS). This may occur through administration errors, or outright fraud. The investment is expected to save the government \$66.2 million between 2016-17 to 2019-20.

# Private health insurance

Private health insurance is firmly in the sights of the federal government. This stems from its belief that most members do not value their policies, based on responses from members through a national consultation process held in 2015.

As a first step, the federal government will continue to pause indexation thresholds at which people qualify for the Government's private health insurance premium rebate (originally introduced in the 2014-15 budget). This will continue from 1 July 2018 until 30 June 2020, saving the government \$370.9 million.

But, the private health insurance rebate will continue to trouble the federal government. Costing \$6.2 billion in 2015-16 and projected to increase to \$7.1 billion by 2019-20, the government has a strong incentive to reduce the rebate over time

While removing the private health insurance rebate altogether would result in a net cost savings to the federal government (even if it funded the expected additional public hospital visits),<sup>1</sup> the

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<sup>1</sup> 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.

private health insurance lobby group has been effective in convincing the government it should keep the rebate.....so far.

To this effect, the federal government has announced reform to private health insurance regulation. In particular, the government will:

- 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). The PLAC will be enhanced to include additional expertise as recommended by the Industry Working Group on Private Health Insurance Prostheses Reform (the Prostheses Working Group).

No doubt changes to private health insurance arrangements and operation of the prosthesis list will be evident within the 2017-18 federal budget.

## Pharmaceuticals

The pharmaceutical sector took the brunt of expenditure cuts within last year's federal budget. This included 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. Pharmacists were also impacted, with changes to co-payment arrangements and an increase in the safety net threshold by 10% in addition to annual indexation.

This budget has seen relatively little change within the PBS and pharmacy, although pharmaceutical companies continue to feel the effect of prior policy change. For example, the estimated savings from the price disclosure arrangements have increased from \$8.5 billion in the previous budget to \$12.1b in this budget for the period 2016-17 to 2018-19.

There are some new and amended listings costing the government \$57.5 million and small pricing adjustments. The Life Savings Drug Program will see an additional expenditure of \$12.3 million. There is also greater access to hepatitis C medications through the PBS, and some expenditure re-juggling within the National Immunisation Program to offer greater access to influenza vaccines, which is being funded by a reduction in dosing for the human papilloma virus vaccine.

## Aged care

Aged care has come out of the last two federal budgets relatively unscathed. This is understandable given the need to support the sector after the Living Longer Living Better (LLLB) reforms were introduced in 2014.

The sector is now two years into the LLLB reforms, which has left providers vulnerable to budget cuts. This may continue as the government takes a closer look at aged care in the lead up to its five year review of the LLLB reforms.



Recently there has also been debate between government and providers on why ACFI funding has grown stronger than forecast. Aged care providers believe there is a genuine increase in need as residents are entering residential care later, while the government has suggested aged care providers are gaming the system to boost profits. To this end, the government will:

- reduce aged care expenditure by \$1.2 billion over four years through changes to the scoring matrix of the Aged Care Funding Instrument (ACFI) that determines the level of funding paid to aged care providers; and
- reduce indexation of the Complex Health Care component of the ACFI by 50 per cent in 2016-17.

These cuts will significantly impact the ability of aged care providers to continue investing in the sector, thereby increasing the likelihood that providers will not fill the significant residential aged care gap (up to 80,000 beds) in the next decade.

Positive announcements for the aged care sector include an additional \$136.6 million to improve access to aged care information for consumers, and an additional \$102.3 million in subsidies to regional aged care providers, over 2016-17 to 2019-20.

## Disability

The focus on disability services within the federal budget has primarily been around ensuring the National Disability Insurance Scheme (NDIS) is fiscally sustainable. To this end, the budget revealed the federal government would establish a NDIS savings fund to ensure funding for expenditure is hypothecated for the intended roll out across Australia in 2020.

The aim is to accrue \$2.1 billion by 2020, and will cover just under half of the expected gap in funding (circa \$5 billion). Most of this will come from expected savings to welfare payments, including:

- removing Carer Allowance backdating provisions;
- abolishing the Energy Supplement for new recipients of social security payments;
- reviewing current Disability Support Pension recipients medical qualification to determine whether they meet eligibility criteria; and
- stopping the Single Income Family Supplement for new customers.

The big question is whether current DSP recipients who become ineligible for payments after their review are capable of working. Some may fall through the cracks by not meeting the search or training requirements to receive the Newstart Allowance. This will significantly reduce their welfare, and put additional pressure on not-for-profit organisations in their attempt to care for these people.

The government has also allocated \$2.2 million over two years to consider selling Australian Hearing Services. This stems from recommendations made in 2014 by the National Commission of Audit, that the National Hearing Service and the National Acoustic Laboratory be privatised. A scoping study was commissioned by the Department of Finance and conducted by PwC in 2015, but the study was never

released and the government delayed privatisation pending further consultation. Subsequently, the Select Committee on Health recommended Australian Hearing should not be privatised based on concerns raised by stakeholders.

While the government has not sought proposals from the market, a consortium including the Royal Institute for Deaf and Blind Children, Cochlear Limited and Macquarie University has since approached government with a proposal to transfer ownership to them, in order to establish a not-for-profit organisation to deliver current and expanded hearing services.

## Other notable changes

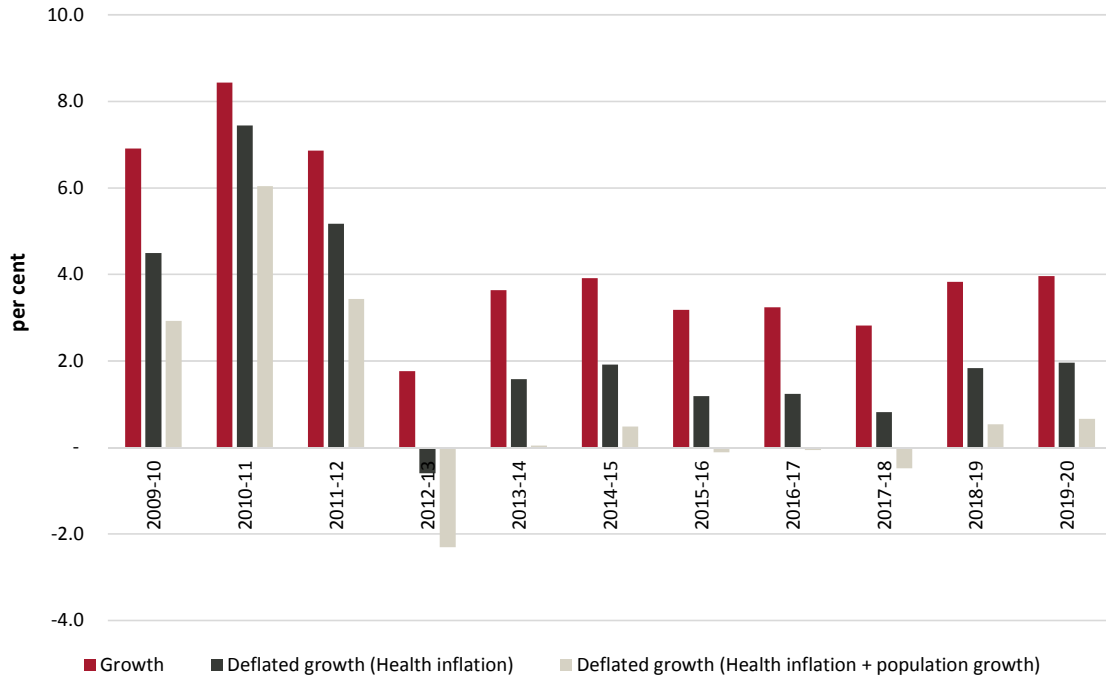
At first glance it seems the federal government has committed to developing a publically funded dental scheme for children and adults with low income. Indeed, it announced the Child and Adult Public Dental Scheme, worth \$1.7 billion from 2015-16 to 2019-20, which will be delivered by the states and territories under a National Partnership Agreement (NPA). But this merely replaces the Child Dental Benefits Schedule and the National Partnership Agreement on Adult Public Dental Services. In reality, the federal government will save \$17.3 million between 2015-16 and 2019-20.

While there are other changes within the health portfolio, they are relatively small in terms of budget impacts. But large changes are on the horizon. Mental health reforms will begin through demonstration sites, and the government will start work on the national mental health digital gateway.

The development of the Medical Research Future Fund (MRFF) also continues, with a board recently established to determine medical research priorities, and the first provision of funds to researchers expected in 2016-17, estimated to total \$60.9 million. The \$20 billion target is still being pursued, but the estimated \$1 billion in annual funding allocated to medical researchers will not start until 2021-22.

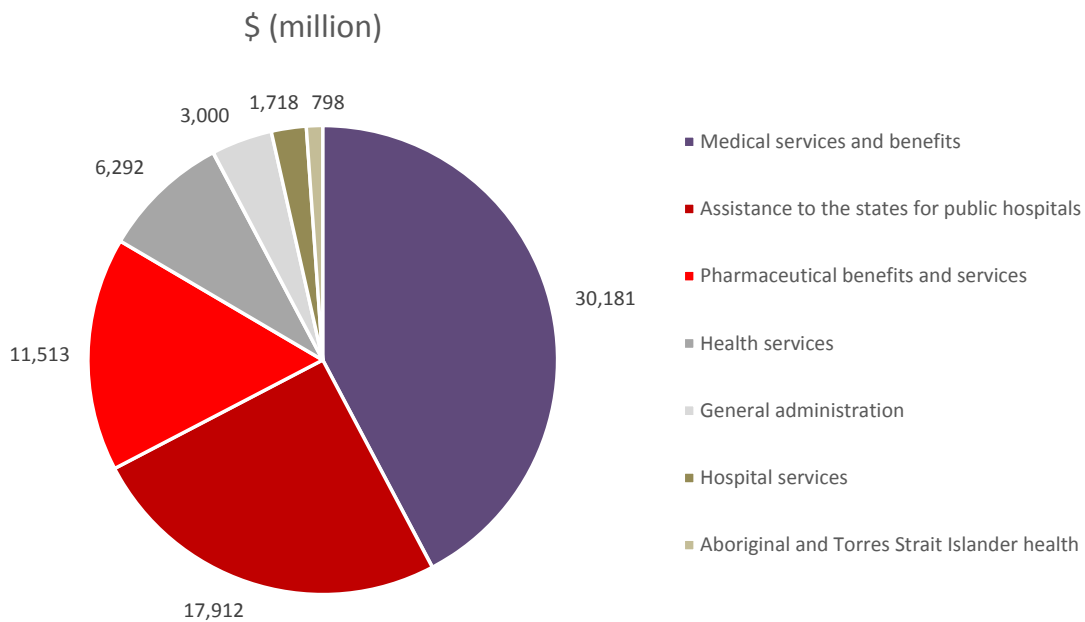
# The budget in pictures

**Chart 1: Annual change in net federal budget health expenditure**



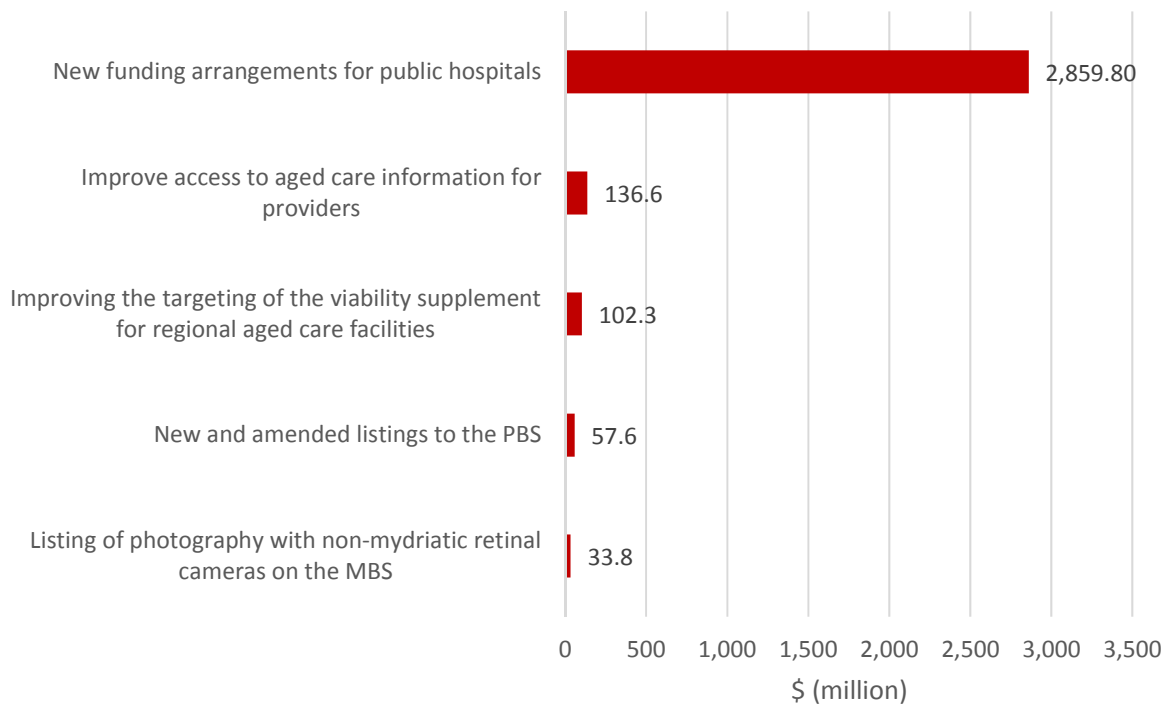
Source: MUCHE calculations

**Chart 2: Composition of the federal health budget, 2016-17**



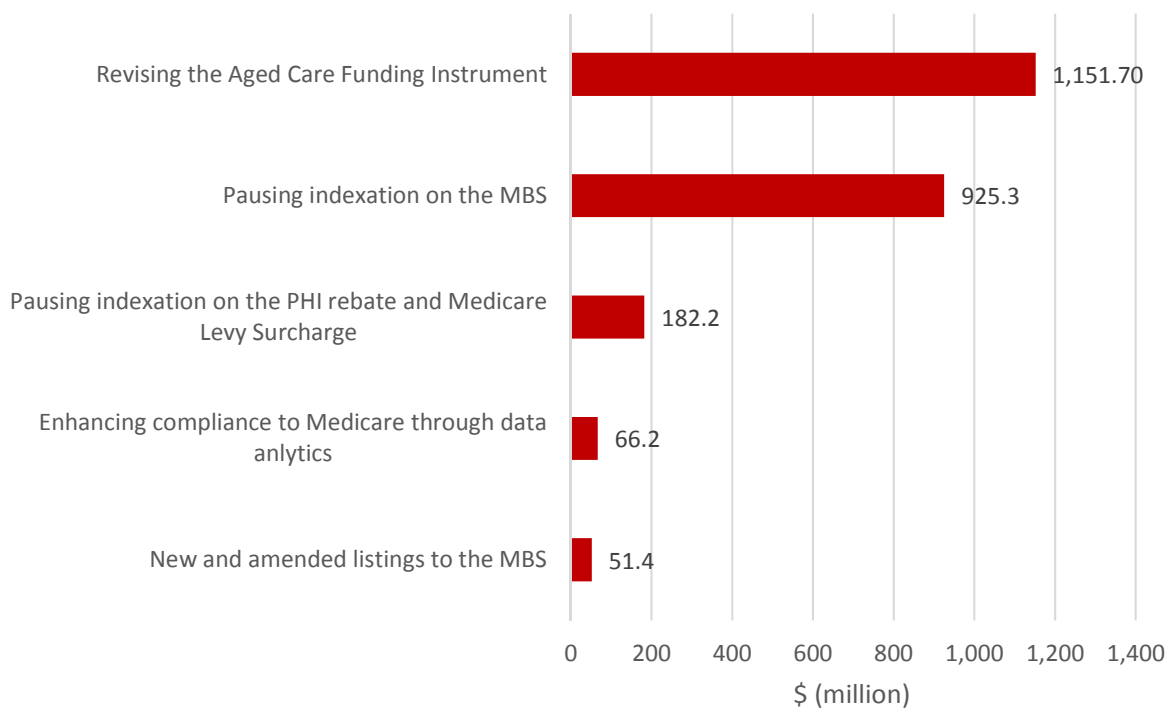
Source: Budget Paper No.1

**Chart 3: Top five increases in expenditure, 2016-17**



*Source: Budget Paper No.2*

**Chart 4: Top five budget savings measures, 2016-17**



*Source: Budget Paper No.2*