



# The MUCHE Health Report 2023

ANALYSIS OF THE 2023-24 FEDERAL BUDGET



# DISCLAIMER

This report may not be reproduced in any form without express written permission from Macquarie University. All data and information contained within this report are considered proprietary.

Neither Macquarie University nor its employees undertake any responsibility for third party reliance placed on this report.

# PREPARED BY

This report was prepared by:

Professor Henry Cutler (Inaugural Director, MUCHE)

Mona Aghdaee (Research Fellow, MUCHE)

Dr Anam Bilgrami (Research Fellow, MUCHE)

Dr Antonio Ahumada-Canale (Research Fellow, MUCHE)

Professor Martin Hoyle (Senior Research Fellow, MUCHE)

Professor Jeffrey Braithwaite (Founding Director, AIHI, Director, CHRIS)

For further information on this report, or about MUCHE, please contact:

Professor Henry Cutler

Inaugural Director

P: + 61 2 9850 2998

M: +61 409 770 946

E: [henry.cutler@mq.edu.au](mailto:henry.cutler@mq.edu.au)

[health-economy.mq.edu.au](http://health-economy.mq.edu.au)

# ACKNOWLEDGEMENTS

We would like to thank Professor Anthony Scott (Director, Centre for Health Economics, Monash University) for reviewing Chapter 7. We would like to thank Chrissy Clay (AIHI) and Ashley Soytemiz (MUCHE) for helping develop, market and distribute this report.

# 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. We are consistently ranked in the top 1% of universities worldwide.

The University's objectives are to accelerate world-leading research, to prepare world-ready higher degree research candidates, and 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.

The Macquarie University Centre for the Health Economy (MUCHE) is a strategic university initiative created to undertake innovative research on health and aged care. We are one of four research centres within the Australian Institute of Health Innovation (AIHI), Australia's largest and most integrated health systems research institute.

MUCHE's vision is to create a world where decision makers and the public are empowered with trusted and impactful research. Our mission is to be Australia's most influential health economics research centre in academic and public policy debate.

We undertake research funded by competitive academic grants and by government and non-government organisations. We actively promote our research through clear communication to inform public debate, assist decision-making, and help formulate strategy and policy.

We investigate the Health Economy at the macro level, focused on the interdependency of these systems with each other and the broader economy. We investigate factors beyond the health and aged care sectors that impact the health and wellbeing of populations.

Researching the Health Economy requires many skill sets and experiences. Solving complex problems within health and aged care requires teams with multi-disciplinary skills working closely together.

We actively collaborate with Macquarie University academics within the Macquarie Business School, Faculty of Medicine, Health and Human Sciences, and Faculty of Science and Engineering. We collaborate with Macquarie University research hubs and centres and collaborate with world-leading academics from universities in Australia, Europe and Asia.

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



Professor Henry Cutler  
Inaugural Director  
Macquarie University Centre for the Health Economy (MUCHE)  
Australian Institute of Health Innovation  
Macquarie University Business School

15 May 2023

# Contents

---

Executive summary .....	1
1. The Health Portfolio.....	3
2. Aged care .....	13
3. Hospitals.....	17
4. Mental Health .....	20
5. Pharmaceuticals.....	23
6. Pharmacy .....	26
7. Primary Care .....	30
8. Private health insurance.....	36



# Executive summary

This Budget has a coherent healthcare story running through it. It's about optimising the health and aged care workforce, using evidence to make hard decisions, and investing in digital health to enable reform. It's not perfect, with some questions looming large over the centrepiece bulk billing announcement, but it's a good start.

Health Portfolio expenditure is projected to decrease by \$1.2 billion in 2023-24, but this comes off a high base associated with COVID-19. Expenditure is projected to increase along its long run average over the next four years. This will fall short of need unless the Government can reduce waste and improve productivity.

The Government continues to implement reforms in response to the Royal Commission into Aged Care Quality and Safety. This Budget allocated \$10.9 billion to substantially increase AN-ACC and home care package prices to cover the cost associated with Fair Work Commission Aged Care Work Value case.

This funding sends a strong signal that the Government wants a flourishing aged care sector. Increased prices will allow providers to increase wages and help retain their workforce. Providers that already pay above the award wage will need to pass on the additional revenue to staff, although how this will be monitored and enforced is unclear.

The Government has not allocated more funding to public hospitals, relative to past agreements, despite their continued performance decline. Public hospital elective surgery waiting lists and emergency department waiting times continue to increase, shaped by workforce constraints and increased demand. The Government announced an independent review of the National Health Reform Agreement 2020-25.

This Budget allocated funding to reduce emergency department pressure, including an increase in GP bulk billing incentives to shift excess non-urgent demand on emergency departments back onto GPs. The Government will spend more to improve access to primary care after hours and to connect frequent hospital users to general practice. This Budget allocated more funding to build Urgent Care Clinics.

The extent to which these policies will reduce pressure on emergency departments remains uncertain. Successfully shifting more patients to GPs requires spare capacity, which is lacking in many parts of Australia. More GPs are moving away from full time work and many GPs are feeling burnt out.

There is not much extra in the Budget for mental health despite research suggesting an increased need. Just before Christmas, Minister Butler announced the Government will not extend the 10 additional mental health sessions funded under Better Access throughout the COVID-19 pandemic. This was a hard but good decision, highlighting this Government's willingness to implement evidence-based policy.

This Budget allocated funding to extend psychosocial support to people with severe mental illness and survivors of torture and trauma. It allocated some funding for additional psychological placements and a redesign of psychology higher education pathways, but not enough. The mental healthcare workforce is in crisis with critical shortages across the spectrum.

New medicines have been allocated funding upon recommendations made by the Pharmaceutical Benefits Advisory Committee. There are no surprise policy changes for the pharmaceutical sector but reform is on the horizon.

Leading into this Budget, the Government announced the extension of medicine supply from 30 to 60 days, saving \$1.2 billion in dispensing fees. It was met with harsh criticism from the Pharmacy Guild of Australia, which has since launched a 'grass roots' campaign claiming the policy will exacerbate medicine shortages.

While savings will be reinvested back into the community pharmacy sector, with over half being repurposed to expand pharmacist services, there will be some winners and some losers. This is often expected and necessary when sectors undergo structural change. However, pharmacy trials underway in states offer further opportunities to increase their scope of practice and new revenue opportunities.

The signature Budget announcement was an increase in bulk billing incentives for GPs worth \$3.5 billion. This was a Government response to recent declines in bulk billing rates for GP non-referred attendances, from 92.5 per cent to 80.5 per cent in the last 2.5 years. While the policy sentiment should be applauded, two major uncertainties may render this policy inefficient.

The recent steep decline in bulk billing rates may not reflect a future trend. Bulk billing rates dropped from a historical (but artificial) high, created because GPs were required to bulk bill temporary telehealth appointments and COVID-19 vaccines. GPs can now charge copayments for telehealth appointments and vaccinations have dropped since their peak in 2021-22.

Many GPs are also unlikely to increase their bulk billing rates. The average fee received from a patient is \$41 for a standard consultation and the bulk billing incentive is \$20.65 in metropolitan areas. Many GPs will receive less revenue if they bulk bill more services, and some GPs are in financial distress according to the Australian Medical Association.

Other announcements in primary care align with the Government's desire to optimise the healthcare workforce. This Budget allocated funding to GPs so they can hire more nursing and allied health professionals. That will promote patient access to more multidisciplinary teams. This Budget also allocated funding to upskill nurses and expand their scope of practice.

Despite two recently completed government reviews of policy settings and insurer risk-pooling arrangements, private health insurance warranted no mention in this year's Budget. The premium rebate cost \$7 billion last year and is projected to cost another \$30 billion over the next four years. There is still no clear research that shows the rebate provides value for money.

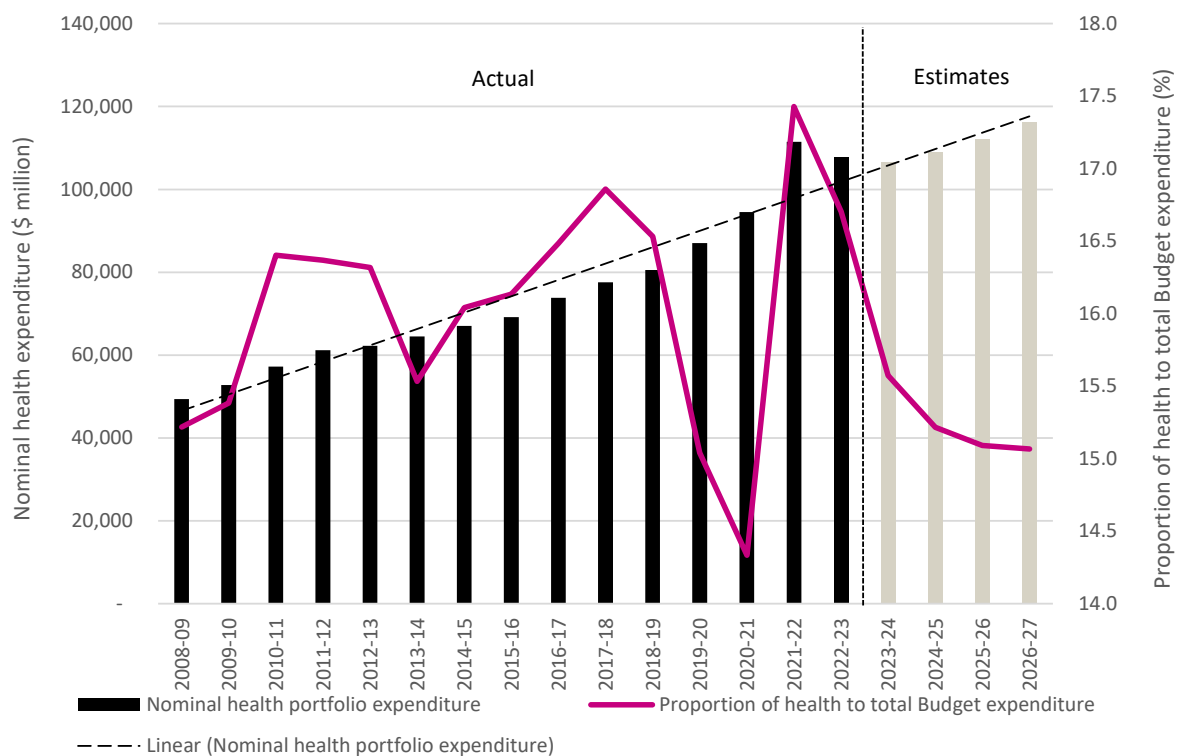
Healthcare reform requires vision, leadership and patience. Every Budget is an opportunity to iteratively improve the healthcare system, but 'big bang' changes require political capital. The possibility of wholesale healthcare system reform has become stronger, so long as Minister Butler can secure a strong health and aged care workforce. This Budget starts that journey.

# 1. The Health Portfolio

The Health Portfolio experienced a large increase in expenditure over the height of the COVID-19 pandemic. Since then, related expenses have substantially decreased, which has seen the nominal health portfolio expenditure decline over the last two years. Health Portfolio expenditure is projected to decrease by \$1.2 billion in 2023-24 (see Chart 1) but then trend upwards again over the forward estimates.

This Budget realigns the allocation of expenditure across portfolios. The proportion of Health Portfolio expenditure to total budget expenditure is projected to decline from 16.7 per cent in 2022-23 to 15.1 per cent in 2026-27. Most of this reallocation will go towards Social Security and Welfare, which is projected to increase its share of Budget expenditure from 35.1 per cent to 37.4 per cent over the same period.

**Chart 1: Actual and estimated nominal Health Portfolio expenditure**



Source: Budget Paper No.1 for 2022-23 to 2026-27. All other health expenses were taken from Budget Paper No.1 released in previous Budget years.

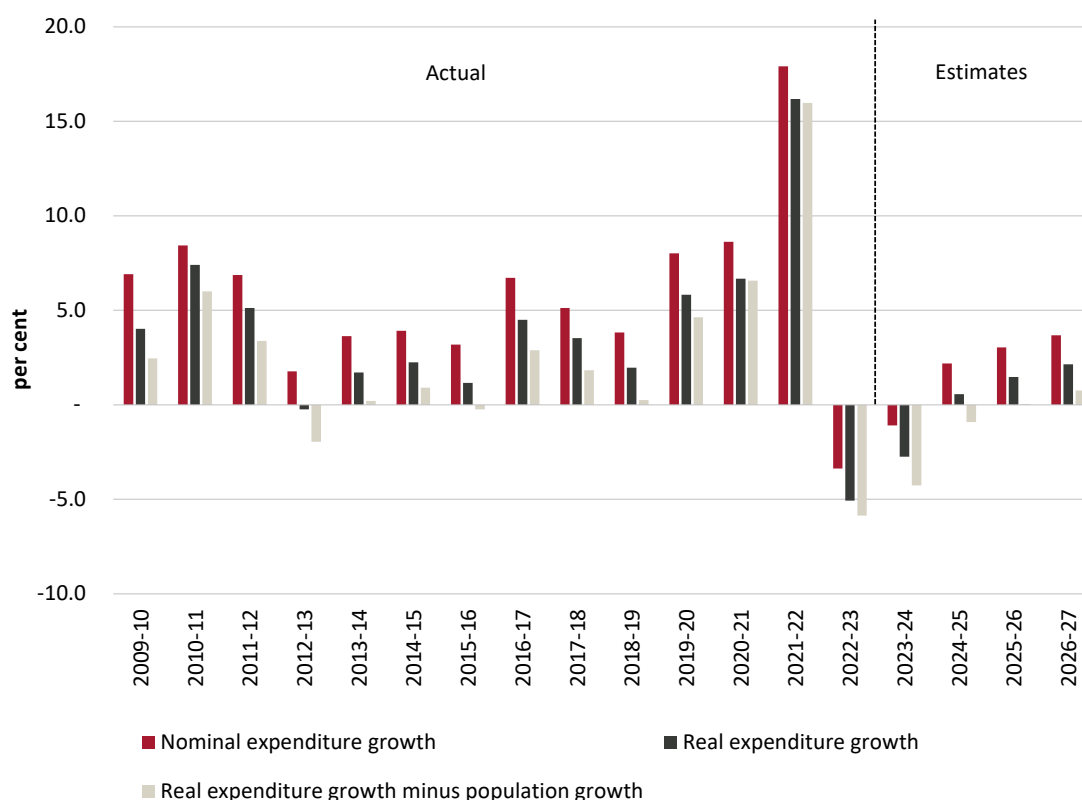
The reduction in Health Portfolio expenditure becomes clearer when looking at the annual change in expenditure (see Chart 2). Nominal Health Portfolio expenditure declined by 3.7 per cent in 2022-23 as the Government wound back COVID-19 programs. It is projected to decrease further in 2023-24 by 1.1

per cent, bringing expenditure for the next four years in line with long term Health Portfolio expenditure trends.

Projected expenditure trends are unlikely to cater for changing healthcare needs and costs associated with an ever-increasing demand for services, especially related to chronic disease prevalence. Real Health Portfolio expenditure is projected to increase only 1.6 per cent between 2022-23 and 2026-27. Accounting for population growth, real Health Portfolio expenditure per person is projected to decrease by 4.2 per cent over the same period.

Demand for healthcare services is likely to increase at a more rapid pace than healthcare expenditure growth. For example, Medicare statistics show that the number of services for all Medicare items per 100,000 people increased by an average of 4.1 per cent per year between 2017-18 and 2021-22. That means the Government needs to reform the system to reduce waste and increase productivity.

**Chart 2: Annual change in Health Portfolio expenditure**



Note: 1. 'Real expenditure growth' was estimated using the Australian Institute of Health and Welfare (AIHW) annual rates of health inflation found in Table 6 of Australia's Health Expenditure 2020-21 report. A linear forecast was used for years 2021-22 to 2026-27. 2. 'Real expenditure growth minus population growth' was estimated using the Australian Bureau of Statistics (ABS) Series B population estimates and projections. Population growth rates were adjusted down for 2019-20, 2020-21, 2021-22 and 2022-23 to align with population projections presented in prior Budgets to account for population growth reductions from border restrictions from COVID-19.

Source: MUCHE calculations based on Budget Paper No.1

It is the first time since the 2019-20 Budget that primary care has taken the spotlight within a Budget. The largest single expenditure item in the Health Portfolio is the substantial increase in bulk billing incentives for GPs (see Chart 3). That is expected to cost \$3.5 billion over five years from 2022-23. The



other large expenditure item is for new and amended listings on the Pharmaceutical Benefits Scheme, responding to recommendations made by the independent Pharmaceutical Benefits Advisory Committee.

Projected expenditure is being partially covered by saving initiatives identified within the Budget. The Government projects a \$2.2 billion saving from reducing the residential aged care provision ratio (see Chart 4). This is somewhat of a budget adjustment and there should be no impact on provider revenue from the announcement, so long as forecasted demand for residential aged care is correct.

Another saving noted in Budget Paper 2 was what the Government described as ‘Reinvesting in Health and Aged Care Programs’. It suggests the Government will save \$1.7 billion over four years by reorganising funding across 15 different programs (see Table 1).

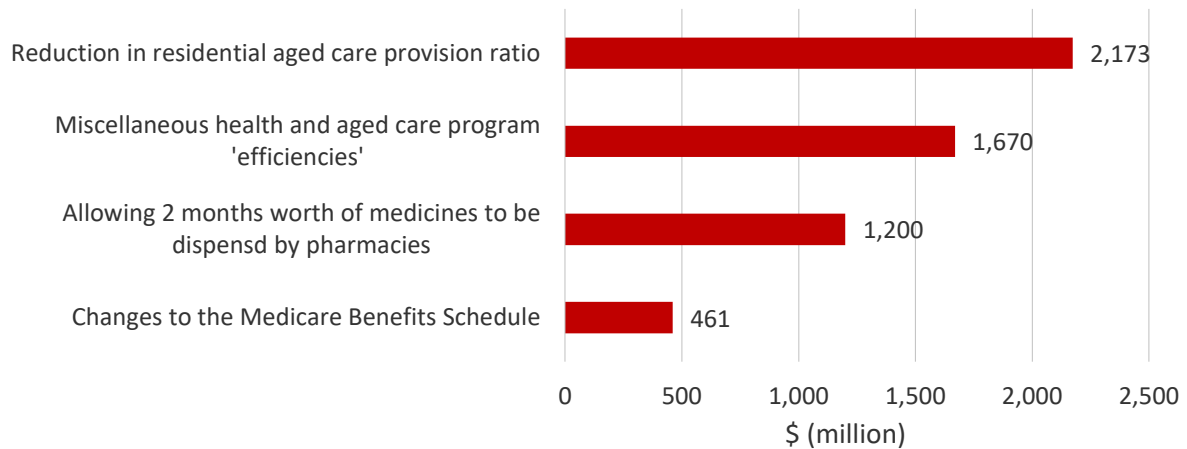
The third largest saving in Budget Paper 2 is for allowing two months’ worth of medicines to be dispensed by pharmacies for more than 300 common medicines, thereby saving the Government \$1.2 billion in dispensing fees. This will be reinvested back into pharmacies, mostly to increase community pharmacy services, but there will be some revenue redistribution within the sector.

**Chart 3: Top 10 Health Portfolio item payment increases**



Note: Budget funding for PBS new and amended listings represents gross funding and does not include any rebates the Government may receive within purchasing agreements.

Source: Budget Paper No.2

**Chart 4: Top Health Portfolio item savings**

Source: Budget Paper No. 2

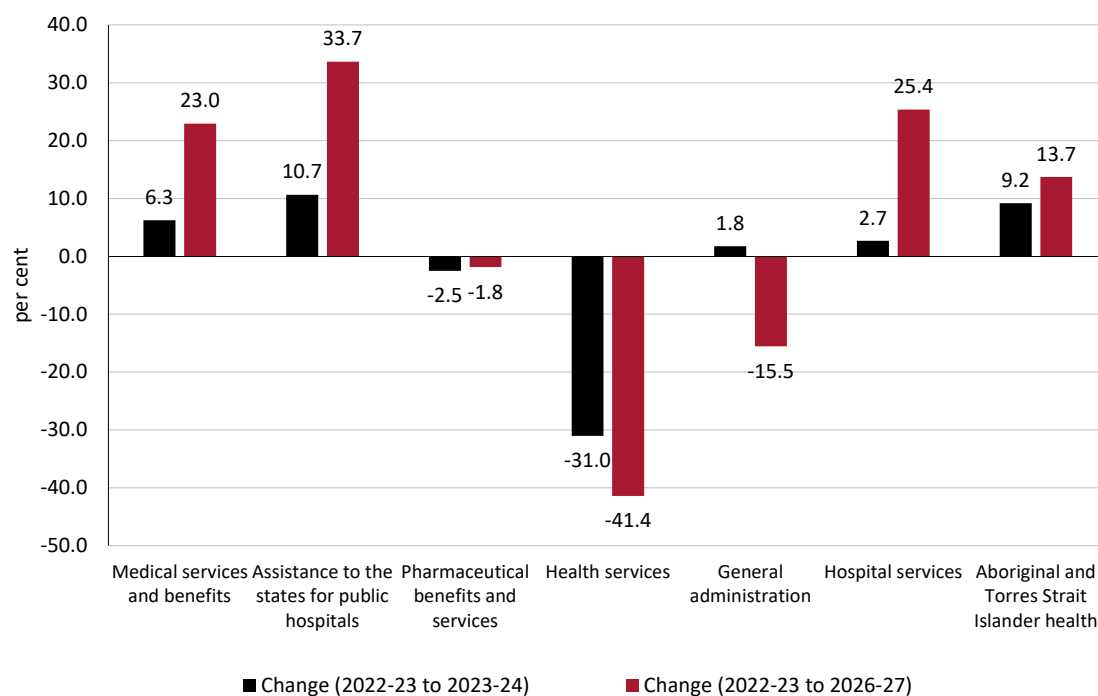
**Table 1: Miscellaneous savings broken down by Health Portfolio Programs**

Program	Description	2023-24	2024-25	2025-26	2026-27	Total
		\$ (000s)	\$ (000s)	\$ (000s)	\$ (000s)	\$ (000s)
1.1	Health Research, Coordination and Access	5,840	4,280	3,400	3,360	16,880
1.2	Mental Health	54,120	55,400	50,240	49,840	209,600
1.3	First Nations Health	48,280	51,280	49,840	48,960	198,360
1.4	Health Workforce	41,920	42,520	42,600	41,840	168,880
1.5	Preventive Health and Chronic Disease Support	20,720	19,200	18,120	16,800	74,840
1.6	Primary Health Care Quality and Coordination	20,560	18,880	18,760	17,280	75,480
1.9	Immunisation	1,160	1,200	1,200	1,240	4,800
2.1	Medical benefits	640	680	680	680	2,680
2.3	Pharmaceutical benefits	18,160	19,080	19,480	19,920	76,640
2.4	Private health insurance	360	200	200	200	960
2.6	Health benefit compliance	680	680	680	680	2,720
2.7	Assistance through aids and Appliances	80	80	80	80	320
3.1	Ageing and aged care	26,040	25,920	26,120	26,160	104,240
3.2	Aged care services	162,120	167,040	176,120	185,160	690,440
3.3	Aged care quality	13,520	9,120	9,000	8,880	40,520
Total		415,720	417,080	418,160	422,880	1,673,840

Source: Heath and Aged Care Portfolio Budget Statements.

The primary expenditure driver within the Health Portfolio is for assistance to the states for public hospitals, and for medical services and benefits (see Chart 5). Public hospital funding is dictated by the National Health Reform Agreement 2020-25. The projected increase in funding comes from the Government's commitment to fund 45 per cent of the efficient growth of Activity Based Funding (ABF) service delivery subject to a national funding cap. It is purely driven by projected hospital activity.

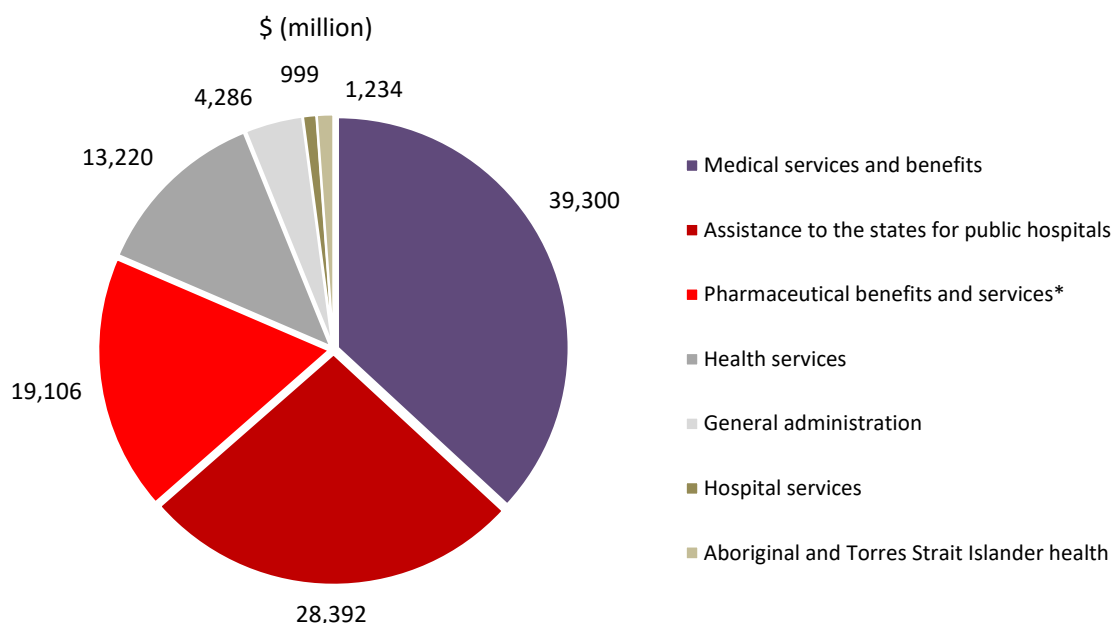
**Chart 5: Estimated proportional change in Health Portfolio expenditure**



Note: The significant reduction in Health Services and General Administration is primarily due to the cessation of some COVID-19 emergency response measures.

Source: Budget Paper No.1

Medical services and benefits remain the largest Health Portfolio expense, projected to cost \$39.3 billion in 2023-24 (Chart 6). Payments from the Medical Benefits Schedule make up \$30.4 billion while private health insurance makes up \$7.2 billion, of which \$6.9 billion is for the rebate and incentive payments. Aged Care Services expenditure, which is included in the Budget's Social Security and Welfare function, is projected to be \$32.7 billion in 2023-24, making it a larger expenditure item than assistance to the states and territories for public hospitals.

**Chart 6: Composition of Health Portfolio expenditure, 2023-24**

Source: Budget Paper No.1

## Towards healthcare reform

The COVID-19 pandemic brought our healthcare system into the spotlight. Health is top priority for the National Cabinet in 2023,<sup>1</sup> and what better time to pursue healthcare reform? The Labor Party leads all state, territory and federal governments (except Tasmania). This creates an opportune moment for governments to align values and to cooperate and converge towards future-proofing our healthcare system.

While the Government substantially increased GP revenues in this Budget, throwing more money at the healthcare system is not the sustainable answer. With government net debt remaining above pre COVID-19 levels until 2033-34, the government cannot afford to pay for waste in our healthcare system.

The Australian Government is sending the right signal that it wants wholesale healthcare system reform. The Strengthening Medicare Taskforce Report effectively set the Government's vision. It wants the healthcare system to deliver more equitable and affordable care, through better integrating

---

<sup>1</sup> See <https://www.health.gov.au/news/national-cabinet-statement-on-a-better-future-for-the-federation>, accessed 9 May 2023

providers to deliver holistic care, facilitated by better technology and supported by change management and cultural change.<sup>2</sup>

Implicit in the Strengthening Medicare Taskforce Report was a shift from Medicare's fee-for-service funding model to a funding model that encourages providers to work together and rewards providers for better health outcomes.

This journey has started within this Budget, which includes \$445.1 million over five years to encourage GPs to work within multidisciplinary teams and employ more nurses, allied health and other professionals, along with \$79.4 million to support Primary Health Networks (PHNs) to commission allied health services to improve access to multidisciplinary care.

There is no indication that the Government has progressed towards any innovative funding environment such as blended funding, despite promises from Minister Butler in January 2023 when discussing the release of the Medicare Taskforce Report.<sup>3</sup> However, this Budget is starting to build the fundamentals by investing in necessary digital technology.

This Budget includes \$19.7 million to establish MyMedicare to allow patients to voluntarily register to a GP practice. While not a large funding amount, it represents a fundamental shift in the way government and stakeholders are thinking about healthcare delivery. Suggesting patient registration a decade ago would have been heresy. This announcement is supported by \$429 million to improve My Health Record and \$325.7 million to ensure the Digital Health Agency remains open and relevant.

The vision outlined in the Strengthening Medicare Taskforce Report will hopefully carry through into the current review of the National Health Reform Agreement 2020-25, where state, territory and federal governments are far behind on their initial schedules to deliver reform.

Australian healthcare policy has mostly neglected to harness financial incentives to improve value. Fragmented funding models keep providers apart. A paper that provides a roadmap towards scalable value-based payments in Australian healthcare recommended:<sup>4</sup>

- Developing a cohesive national vision and ambitious national 10-year plan for value-based payment integration into the Australian healthcare system.
- Creating an independent national payment authority to implement the national plan through strong relationships with relevant federal government agencies and with state and territory governments.
- Improving cost and outcome data collection, analysis and access among government and providers, aiming for seamless, low cost collection and effective flow of information.

---

<sup>2</sup> Australian Government 2022, Strengthening Medicare Taskforce Report, [https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report\\_o.pdf](https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_o.pdf), accessed 9 May 2023

<sup>3</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-melbourne-press-conference-23-january-2023?language=en>, accessed 11 May 2023

<sup>4</sup> Cutler H, 2022, A roadmap towards scalable value-based payments in Australian healthcare, [https://ahha.asn.au/system/files/docs/publications/deeble\\_issues\\_brief\\_no\\_49\\_a\\_roadmap\\_towards\\_scalable\\_value\\_based\\_payments\\_final\\_o.pdf](https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_no_49_a_roadmap_towards_scalable_value_based_payments_final_o.pdf), accessed 9 May 2023.



- Supporting provider education, training and innovation by identifying and promoting best practice care, developing provider assistance tools and training packages, and promoting peer-to-peer learning.

Reforming funding models to pay for value and outcomes will require a strong vision. It will threaten embedded healthcare provider business models. History has shown that even when you have a good health policy that benefits all patients, it can be derailed by special interest groups and political foes.

Take the introduction of Medicare for example. When the Labor Party came into government in 1972 it took a double dissolution and joint sitting of Parliament in 1974 to pass key Medibank (a precursor to Medicare) bills. Medibank was systematically dismantled and abolished in 1981 by the Coalition Party while in government, returning to private health insurance with public subsidies. It wasn't until 1984 that Medicare was introduced in its current form.<sup>5</sup>

While funding reform will be challenging and expensive, the status quo is unsustainable for delivering a contemporary healthcare system that meets patient needs. Funding reform must start with what can be agreed upon by the various interest groups, aiming for a shared purpose among stakeholders. It must be driven by unwavering leadership to push through any potential constitutional challenge by providers.<sup>6</sup> It will experience some failures. Any reform should embed a strong and transparent evaluation and learning culture to help continually improve.<sup>7</sup>

## Workforce

Workforce shortages are a perennial problem for the Australian healthcare system. Addressing them will require strong collaboration among government departments and agencies, public and private healthcare organisations, and education and training providers.

The prior government released several workforce strategies. These are long term and not much was done in the way of implementation. Examples include:

- 10 year National Medical Workforce Strategy.
- 10 year National Nursing Strategy.
- 10 year Nurse Practitioner Strategy.
- 10 year National Mental Health Workforce Strategy.
- Aged Care Workforce Action Plan 2022-25.

This Government seems more concerned with filling workforce gaps in the short term compared to the prior government. This Budget includes a 12 per cent increase in expenditure for 2023-24 for the

---

<sup>5</sup> Boxall A-M, Gillespie JA, 2013, Making Medicare. The politics of universal health care in Australia, UNSW Press

<sup>6</sup> McDonald F, Duckett S, Campbell E, 2023, Commonwealth Power to Improve Access, Quality, and Efficiency of Medical Care: Does section 51 (xxiiiA) of the Constitution Limit Politically Feasible Health Policy Options Today?, Federal Law Review, <https://journals.sagepub.com/doi/full/10.1177/0067205X231165872>, accessed 9 May 2023

<sup>7</sup> Cutler H, 2022, A roadmap towards scalable value-based payments in Australian healthcare, [https://ahha.asn.au/system/files/docs/publications/deeble\\_issues\\_brief\\_no\\_49\\_a\\_roadmap\\_towards\\_scalable\\_value\\_based\\_payments\\_final\\_o.pdf](https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_no_49_a_roadmap_towards_scalable_value_based_payments_final_o.pdf), accessed 9 May 2023.

Health Workforce, which includes additional funding and several initiatives to help fill workforce gaps. Examples include:

- \$445.1 million to help GPs employ more nurses, allied health and other health professionals in practices;
- \$238.5 million to build workforce capability and capacity to improve First Nations cancer outcomes; and
- \$91.3 million over 5 years from 2022–23 for additional psychology placements.

The Government has committed \$10.9 billion in aged care price increases to ensure residential and home care package providers can cover increased wage costs associated with the Fair Work Commission Aged Care Work Value case. This Budget will also redistribute \$654.9 million in savings from reduced dispensing fees to expand the scope of practice for community pharmacies.

Despite these investments, Australia still needs to attract more overseas health and aged care workers, improve working conditions, expand telehealth services, and increase the scope of practice for non-specialist practitioners.

State and territory governments need to support the use of technology to improve workforce productivity. Ongoing investment in education and training for health and aged care workers will reduce Australia's exposure to global competition for skilled migrants.

An independent review of overseas health practitioner regulatory settings commissioned by National Cabinet noted the process to migrate and register as a health professional in Australia is not competitive.<sup>8</sup> Coming to Australia from overseas and registering as a health professional is substantially more time-consuming and costly for applicants compared to our strongest competitors, including New Zealand, Canada, the United Kingdom and the United States.

An interim report recommends reducing the migration and registering journey from 6-12 months to under three months by:

- removing duplication and aligning evidentiary requirements across regulators and agencies;
- enabling more cohorts from trusted countries to be 'fast-tracked' through competent authority pathways;
- better recognising overseas health practitioners' experience and skills;
- providing applicants with greater flexibility in demonstrating their English language competency; and
- removing or suspending labour market testing requirements for employers sponsoring priority health practitioners.

The Government will also explore how non-specialist practitioners can deliver more services in an efficient, effective and safe way. It has announced that a National Scope of Practice Review will start in 2023. The Review will identify barriers and incentives for all health professionals to work to their full

---

<sup>8</sup> See <https://www.health.gov.au/independent-review-of-health-practitioner-regulatory-settings>, accessed 10 May 2023

scope of practice,<sup>9</sup> particularly in rural and remote areas where healthcare worker shortages are much more acute.

This type of review was recommended by the Productivity Commission in 2015, which noted greater healthcare workforce flexibility could improve efficiency, a more responsive workforce and improve healthcare quality and safety.<sup>10</sup> While outcomes from this review will help fill healthcare workforce gaps while increasing healthcare system efficiency, it will likely face some opposition from lobby groups that represent providers currently delivering those services. Let's hope all stakeholders truly have benefits to the patient in mind.

---

<sup>9</sup> See <https://www.health.gov.au/resources/publications/summary-of-strengthening-medicare-policies?language=en>, accessed 9 May 2023.

<sup>10</sup> Productivity Commission, 2015, Efficiency in Health, <https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf>, accessed 11 May 2023

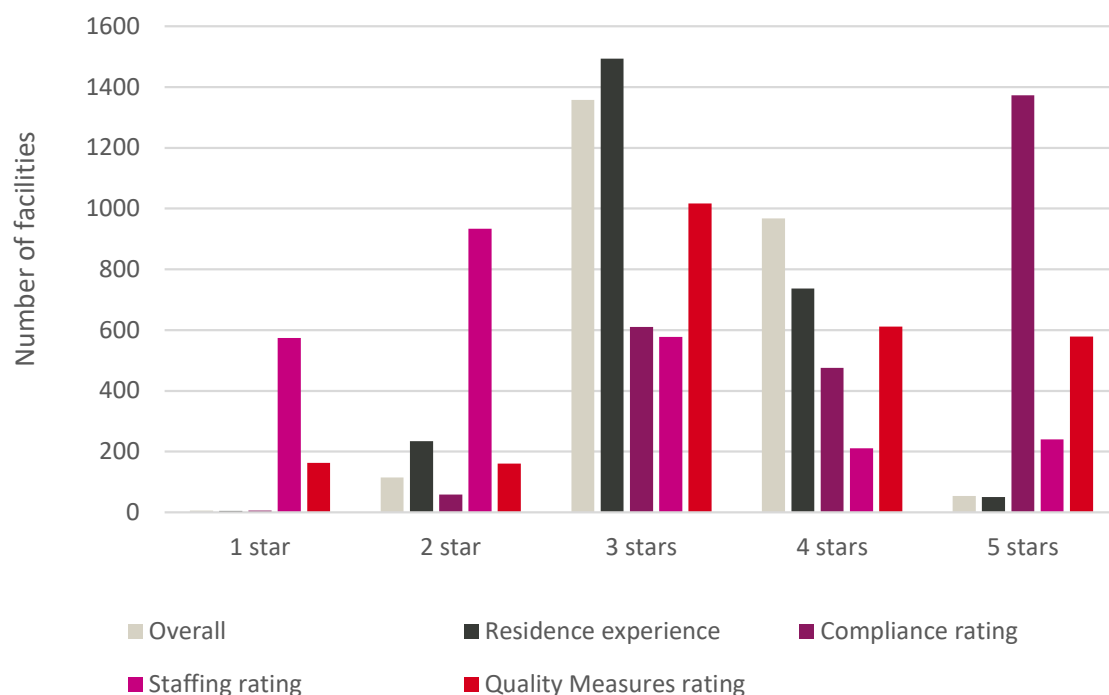
## 2. Aged care

The aged care sector continues to undergo reform to meet Royal Commission into Aged Care Quality and Safety recommendations. A major change for residential aged care providers this financial year was the introduction of Star Ratings for residential aged care services.

All residential aged care homes now receive a Star Rating between 1 and 5 stars based on residence experience, compliance with regulation, staffing and quality. While many providers initially expressed their displeasure that star ratings were based on 'old data', other initiatives of this kind internationally suggest that the Star Ratings data will mature, and that such initiatives are necessary to harness competitive forces to encourage greater quality.

The Star Ratings data show there is substantial variation in residential aged care quality, although most providers are delivering neither very poor nor very good quality (see Chart 7).

**Chart 7: Distribution of Star Ratings across facilities and quality metrics**



Source: Department of Health and Aged Care

Based on US experience, Star Ratings in Australia should help consumers avoid lower quality (1 and 2 Star) residential aged care facilities and help consumers choose higher quality (4 and 5 star) residential

aged care facilities. This will raise the average level of quality received by residents within the sector based on changing consumer preferences alone.<sup>11,12</sup>

The Star Ratings will also send a strong signal to providers that consumers care about quality, thereby encouraging further investment in quality production. Provider response to Star Ratings will depend on their starting quality position and market characteristics. Effects could be stronger for facilities that have relatively low occupancy rates and facilities that operate in a more competitive environment.<sup>13</sup>

Research that has assessed the strengths and weakness of the current reform pathway suggests there are specific mechanisms through which providers are incentivised to produce better quality.<sup>14</sup> In summary, quality will increase:

- with greater competition faced by the provider;
- as the sensitivity of consumer demand and market share to quality increases;
- as the provider's total demand increases;
- as the regulated price for care increases; and
- as the marginal cost of care quality and quantity decreases.

Market failure persists within residential aged care. This justifies government intervention. Market-oriented reforms can increase provider quality, but provider response will vary. It is uncertain whether Australia will reflect international experience. There will also be extreme differences in metropolitan versus rural markets.

The Australian Government needs more reform to support its market-oriented approach to improving quality. This might include expanding the National Aged Care Advocacy Program to help consumers engage with quality information.

While AN-ACC prices for delivering care will increase in a couple of months to reflect increased marginal costs associated with current levels of care (e.g., increased wages), AN-ACC prices still need to incorporate the expected increased marginal costs associated with delivering better care quality in the future.

The Australian Government must also develop a program to manage the sector's transition to more competition. That includes facilitating sector consolidation and ensuring no resident is left without access to care. It should remove the Aged Care Provision Ratio altogether and invest in research to improve provider efficiency and care models.

---

<sup>11</sup> Werner R, Konetzka RT, Polsky D, 2016, Changes in consumer demand following public reporting of summary quality ratings: An evaluation in nursing homes, *Health Services Research*, Vol. 51, No. 3, Part II, pp. 1291-1309.

<sup>12</sup> Zhao, X, 2016, Competition, information, and quality: Evidence from nursing homes, *Journal of Health Economics*, Vol. 49, pp. 136-152.

<sup>13</sup> Perrailon MC, Konetzka T, He D, Werner RM, 2019, Consumer response to composite ratings of nursing home quality, *American Journal of Health Economics*, Vol. 5, No. 2, pp.165-90.

<sup>14</sup> Cutler H, Gu Y, Bilgrami A, Partington A, 2023, The 2021 proposal to increase market forces in the Australian residential aged-care sector, *Health Policy*, Vol. 127, pp. 60-65



This Budget has projected that expenditure for aged care will increase by \$10.9 billion from increased AN-ACC and home care package prices. This will ensure residential and home care package providers can cover the interim 15 per cent minimum wage increase associated with the Fair Work Commission Aged Care Work Value case for the following employees.

- Direct care workers under the Awards.
- Head Chefs/Cooks under the Aged Care Award.
- Recreational Activities Officers/Lifestyle Officers under the Aged Care Award.

An additional \$311 million was allocated to help cover wage costs for Commonwealth Home Support Programme providers.

Providers that already pay above the award wage will need to pass on the additional revenue to staff, although how this will be monitored and enforced is unclear. While wage increases won't solve the aged care workforce shortage, it's a good start. The sector also needs to improve career development opportunities, reduce high workloads, and improve management to retain staff.

This Budget contains additional expenditure for the Government to continue implementing recommendations of the Royal Commission into Aged Care Quality and Safety, building on announcements made within the October 2022 Budget.

It allocated \$139.9 million to improve the Star Rating system, \$72.3 million to strengthen the Aged Care Regulatory Framework, and \$25.3 million to the Aged Care Quality and Safety Commission. These three measures should encourage providers further to produce better care quality.

This Budget allocated another \$536.6 million to aged care providers to cover additional costs incurred in response to COVID-19 outbreaks before 31 December 2023. This builds on the \$845.4 million allocated to aged care providers for the same purpose in the October 2022 Budget.

Residential aged care providers will need to adjust their business models to operate within a more competitive market and to ensure compliance within a strengthened regulatory and monitoring environment. This Budget allocates \$98.7 million for a Market Adjustment Program and to provide business advisory services. This will hopefully reduce the likelihood that residents are not left in the lurch because of provider financial distress.

A large proportion of new aged care expenditure within the Budget is coming from a \$2.2 billion projected saving between 2024-25 and 2026-27. This saving comes from a temporary reduction in the residential aged care provision ratio from 78 places to 60.1 places. That will reduce the number of bed licenses otherwise budgeted by over 60,000 per year.

This won't impact residential aged care provider revenue or access to residential aged care so long as either the Department of Health and Aged Care has forecasted demand accurately, or the Government continues to hand out licenses if demand exceeds projections.

The Government must keep a vigilant eye. An ageing population is likely to increase demand for residential aged care quicker than before. The average age on admission to permanent residential aged care was 83 years for men and 85 years for women.<sup>15</sup> The growth in males aged 83 years and females

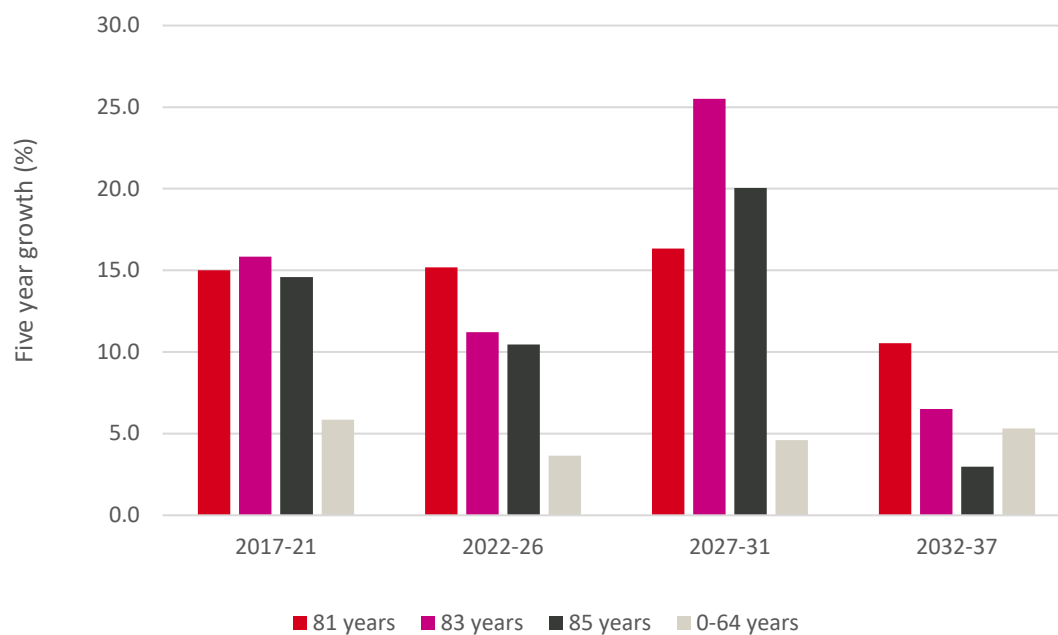
---

<sup>15</sup> Department of Health and Ageing Care 2022, 2021-22 Report on the Operation of the Aged Care Act 1997, [https://www.gen-agedcaredata.gov.au/www\\_ahwgen/media/ROACA/22506-Health-and-Aged-Care-ROACA-2021-22-Web.pdf](https://www.gen-agedcaredata.gov.au/www_ahwgen/media/ROACA/22506-Health-and-Aged-Care-ROACA-2021-22-Web.pdf), accessed 8 May 2023

aged 85 years will be twice the rate between 2027-31 compared to 2022-26 (see Chart 8). That suggests the new ratio announced in this Budget has a short 'half life'.

The Government must ensure the residential aged care sector is attractive for investment so providers can start building new facilities. Investors should be comforted with this Budget as it signals the Government wants a strong and flourishing aged care sector. Prices will further reflect costs as further data is collected by IHACPA and methods for pricing mature.

**Chart 8: Australian population growth driving future aged care expenditure**



Note: The average age for receiving a home care package is 81 years for men and women, while the average age on admission to permanent residential aged care was 83.3 years for men and 85.2 years for women.

Source: Australian Bureau of Statistics – Population projections by age and sex - Series B.

## 3. Hospitals

There are 697 public hospitals in Australia. The National Health Reform Agreement (NHRA) 2020-25 contains agreements between state, territory and federal governments on roles and responsibilities for delivering and managing public hospitals, public hospital funding arrangements, and long-term health reform principles, among other elements of agreement.

The Government announced an independent review of the NHRA in February 2023 to determine whether its objectives are being met, including:

- the impact of external factors (such as the COVID-19 pandemic) on the demand for hospital services and the flow-on effects;
- the performance of small rural and small regional hospitals;
- the implementation of the long-term reforms and other governance and funding arrangements; and
- any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes.<sup>16</sup>

There are many pressures on the public hospital system. Waiting times for public hospital elective surgery were getting longer before the COVID-19 pandemic and have only worsened with the associated suspension of elective surgery.<sup>17</sup> State and territory governments have yet to rein in the increase in public hospital elective surgery waiting times.

Public hospital emergency department performance has also worsened. Only 67 per cent of 8.7 million patients were seen within the recommended time in 2021-22. Performance varies across states, with NSW having the best performance and the ACT having the worst (see Chart 9).<sup>18</sup> Despite the median waiting times declining slightly in some states, the proportion of people seen on time in emergency departments has declined across all states and territories.

The demand for emergency department care is mostly predictable. Chart 8 shows a regular pattern of emergency department demand across all days, with a peak in demand occurring between 10am and 12 pm. Demand then drops slowly until 6am the following morning.

---

<sup>16</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/review-of-national-hospital-funding-agreement>, accessed 9 May 2023

<sup>17</sup> Cutler H, Bilgrami A, Aghdaee M, 2022, The MUCHE Health Report 2022. Analysis of the 2022-23 federal health budget, Macquarie University

<sup>18</sup> Australian Institute of Health and Welfare, 2023, Emergency department care 2021-22: Australian hospital statistics, <https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care>, accessed 9 May 2023

**Chart 9: Change in public hospital use and emergency department performance**

Note: Data for the last three years must consider the impact COVID-19 had on service use. A decline in emergency department presentations in 2019-20 was primarily due to COVID-19 lockdowns and people choosing to stay at home. Declines in elective surgery admissions are also likely to be impacted by the intermittent suspension of elective surgery in public hospitals.

Source: Australian Institute of Health and Welfare.

Problems with access to emergency departments occur when there is an unexpected deviation from this pattern of demand, such as increased COVID-19 cases or a bad flu season. There is no slack in emergency departments to counter large demand spikes because of reduced access to staff from burnout and illness, and a lack of investment by government.<sup>19</sup>

AMA analysis suggests that public hospitals are currently performing poorly. The AMA has called for performance-based funding, increased investment in beds and staff, keeping people out of hospital through more out-of-hospital care, and increased federal government funding.<sup>20</sup>

The Government hopes this Budget will help divert some demand away from emergency departments. It announced \$3.5 billion to triple the incentive for GPs to bulk bill patients on low income and

<sup>19</sup> See <https://theconversation.com/emergency-departments-are-clogged-and-patients-are-waiting-for-hours-or-giving-up-whats-going-on-184242>, accessed 11 May 2023

<sup>20</sup> Australian Medical Association, 2023, Hospital exit block. A symptom of a sick health system, <https://www.ama.com.au/articles/hospital-exit-block-symptom-sick-system>, accessed 9 May 2023

children. An increase in bulk billing rates if they materialise (see Chapter 7 for a full discussion) will encourage people to see their doctor rather than attend an emergency department. That could appeal to patients that visit the emergency department for non-urgent and semi urgent presentations, which make up 46 per cent of all presentations.<sup>21</sup>

This Budget allocated a further \$143.9 million to improve access to primary care after hours, and \$98.9 million to connect frequent hospital users to general practice to reduce the likelihood of hospital re-admission.

The Government's lead policy to reduce emergency department pressure is the introduction of Urgent Care Clinics across Australia. It allocated \$235 million in the October 2022 Budget to co-develop and pilot Urgent Care Clinic models with states and territories to improve care pathways.

This Budget allocated another \$358.5 million (although only \$84.8 million in new funding) to establish more Urgent Care Clinics. This funding means there will be 58 Urgent Care Clinics operating around Australia.

The extent to which these policies will reduce pressure on emergency departments is uncertain. First, patients need a GP appointment if bulk billing is to entice them away from an emergency department. This may be difficult for some patients. The latest national data found:

- 23 per cent of patients waited longer to see a GP than felt acceptable;
- 39 per cent of patients who saw a GP for urgent medical care waited for 24 hours or more; and
- 9 per cent of GP clinics are not taking on new patients.<sup>22,23</sup>

GP waiting times will deteriorate if patients switch from otherwise attending an emergency department unless GP practices increase their supply. This seems unlikely to any great extent, with more GPs moving away from full-time work and 73 per cent of GPs reporting they have experienced feelings of burnout over the past 12 months.<sup>24</sup>

The biggest risk for the success of Urgent Care Clinics is the lack of staff. If staff shift from emergency departments or GPs, they are unlikely to reduce emergency department pressure. Either healthcare workforce shortages must be resolved,<sup>25</sup> or Urgent Care Clinics must become more productive in caring for patients. This underscores the importance of the Government addressing healthcare workforce shortages quickly through increased capacity and scope of practice.

---

<sup>21</sup> AIHW 2023, Emergency department care 2021–22: Australian hospital statistics, <https://www.aihw.gov.au/getmedia/02c6e120-99e5-4a3c-b1d8-cbd1da785486/Emergency-Department-Care-2021-22.xlsx.aspx>, accessed 11 May 2023

<sup>22</sup> Australian Bureau of Statistics, 2022, Patient Experiences, <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#data-downloads>, accessed 11 May 2023

<sup>23</sup> Cleanbill, 2023, Blue Report. National General Practitioner Listings, <https://cleanbill.com.au/wp-content/uploads/2023/01/Cleanbill-Blue-Report-January-2023.pdf>, accessed 12 May 2023

<sup>24</sup> Royal Australian College of General Practitioners, 2022, General Practice Health of the Nation 2022, <https://www.racgp.org.au/getmedia/80c8bdc9-8886-4055-8a8d-ea793b088e5a/Health-of-the-Nation.pdf.aspx>, accessed 11 May 2023

<sup>25</sup> See <https://theconversation.com/emergency-departments-are-clogged-and-patients-are-waiting-for-hours-or-giving-This-Budget-up-whats-going-on-184242>, accessed 11 May 2023



## 4. Mental Health

Better Access was the big news story to impact the mental healthcare sector this financial year. Just before Christmas 2022, Minister Butler announced that the Government will not be extending the 10 additional sessions funded under Better Access throughout the COVID-19 pandemic.<sup>26</sup> The stated reason was because Better Access had exacerbated inequitable access to mental healthcare for low socioeconomic patients and patients living in rural and remote regions.

Understandably, members of the Australian Psychological Society (APS) were not happy. It called on the Government to reconsider their policy position. Compared to the Government, the APS had a different view on the independent University of Melbourne report that reviewed Better Access. The APS suggested the report recommended the Government keep the additional 10 sessions in place.<sup>27</sup>

The Better Access review suggested the Better Access program needed repositioning in the broader mental healthcare system. It noted:

- The Better Access program had increased the number of services delivered for mental ill health, but the increase disproportionally went to high-income patients living in metropolitan regions.
- The Better Access program was not well targeted. Services were delivered to patients with low levels of need that could be treated more efficiently through digital services. Services were also delivered to patients with more complex needs than otherwise intended.

The University of Melbourne research team made 16 recommendations to the Government.

Recommendation 12 noted *'The additional 10 sessions should continue to be made available and should be targeted towards those with complex mental health needs'*.<sup>28</sup>

However, the evidence was relatively weak on whether the additional 10 sessions added value. They seemed to allow existing patients to crowd out new patients from seeing a psychologist, and the relationship between better mental health outcomes and additional sessions was weak. It seemed the recommendation was made on the preference of consumers and providers.<sup>29</sup>

This Budget allocated \$260.2 million to extend Commonwealth psychosocial support for people with severe mental illness who are not covered by the National Disability Insurance Scheme. It also allocated \$136 million to support the mental health of survivors of torture and trauma before moving to Australian humanitarian grounds.

---

<sup>26</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/improving-better-access-for-all-australians>, accessed 12 May 2023

<sup>27</sup> See <https://psychology.org.au/for-members/news-and-updates/news/2022/presidents-message-on-better-access-changes>, accessed 12 May 2023.

<sup>28</sup> Pirkis J, Currier D, Harris M, Mihalopoulos K, 2022, Evaluation of Better Access, <https://www.health.gov.au/resources/collections/evaluation-of-the-better-access-initiative-final-report>, accessed 12 May 2023

<sup>29</sup> Ibid.

This Budget allocated relatively small amounts of funding to continue postintervention services for people experiencing grief from suicide loss, to support Head-to-Health services, to support child and youth mental health and to continue the National Mental Health Commission's National Workplace Initiative.

There is a current workforce crisis happening in mental health care. A survey noted that one third of Australian psychologists have closed their books and are not taking on any new patients, which has led to patients waiting long periods to get access or missing out on access altogether.<sup>30</sup>

The National Mental Health and Suicide Prevention Agreement was signed in 2022, outlining the joint roles and responsibilities of state, territory and federal governments to support the development of an appropriately skilled workforce and to attract and retain additional workforce from overseas. It noted there were critical shortages in:

- psychiatry;
- psychology;
- mental health nursing;
- Aboriginal and Torres Strait Islander mental health and suicide prevention workers;
- lived experience (peer) workforce; and
- other relevant allied health professions.

This Budget has sought to rectify workforce shortages to some degree. It allocated \$91.3 million for additional psychological placements and a redesign of higher education pathways for clinical psychologists.

This Budget also allocated \$17.8 million to upskill the mental health capabilities of the broader health workforce through training, and \$8.7 million to establish and operate two independent national mental health lived experience peak bodies. These will advise on mental health policies and programs and support lived experience research.

It seems evident that more government funding is required to support the mental healthcare workforce. More funding is also required to support better access to psychological services. The Australian Psychological Society called for bulk billing and other rural and remote practice incentives for psychologists, equivalent to those provided for GPs, in their pre-budget submission.<sup>31</sup> Options to increase affordability, such as bulk-billing incentives, were also recommended in the Better Access Review.<sup>32</sup>

---

<sup>30</sup> Pirkis J, Currier D, Harris M, Mihalopoulos K, 2022, Evaluation of Better Access, <https://www.health.gov.au/resources/collections/evaluation-of-the-better-access-initiative-final-report>, accessed 12 May 2023

<sup>31</sup> Australian Psychological Society, 2023, Build, Support, Prepare: Investing in Australia's Future, <https://psychology.org.au/getmedia/20167248-602e-4031-9f41-51b5ecbb0644/aps-2023-24-pre-budget-submission.pdf>, accessed 12 May 2023

<sup>32</sup> Pirkis J, Currier D, Harris M, Mihalopoulos K, 2022, Evaluation of Better Access, <https://www.health.gov.au/resources/collections/evaluation-of-the-better-access-initiative-final-report>, accessed 12 May 2023

It's hard to argue that low socioeconomic patients with mental ill health are any less deserving compared to those who will benefit from this Budget's centrepiece GP bulk billing announcement. Only 35 per cent of Better Access services were bulk billed in 2021 and the average copayment per session was \$90 in 2022.<sup>33</sup> A media release from Minister Butler noted, when referring to the Better Access program, that *'people are paying more for their care and when they can't afford those fees, they go without'*.<sup>34</sup>

---

<sup>33</sup> Pirkis J, Currier D, Harris M, Mihalopoulos K, 2022, Evaluation of Better Access, <https://www.health.gov.au/resources/collections/evaluation-of-the-better-access-initiative-final-report>, accessed 12 May 2023

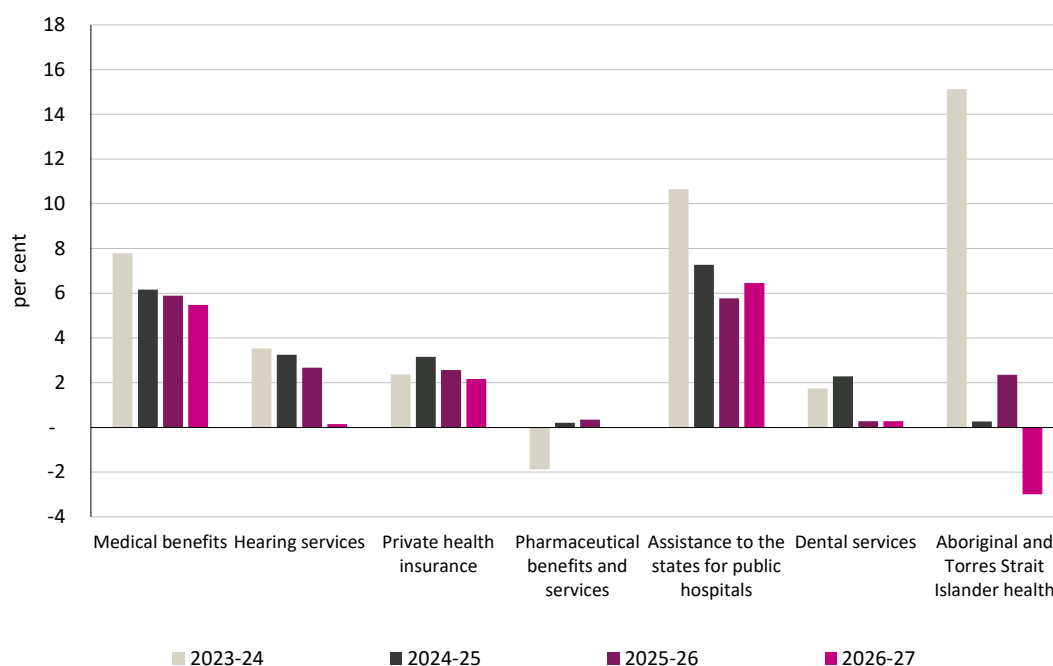
<sup>34</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/improving-better-access-for-all-australians>, accessed 13 May 2023

## 5. Pharmaceuticals

There were no substantial policy changes for pharmaceuticals announced in this Budget. It allocated \$2.2 billion for new and amended listings, with most of that spent through the PBS. These new medicines are listed based on recommendations made by the independent Pharmaceutical Benefits Advisory Committee.

The lack of any surprise policy change reflects a steady approach outlined in the five year strategic agreement between Medicines Australia and the Government, introduced in 2021. However, there is sector concern that the lack of projected expenditure growth on pharmaceuticals will not allow Australia to keep up with better but more expensive new medicines (see Chart 10).<sup>35</sup>

**Chart 10: Projected annual nominal expenditure growth across service sectors**



Source: Budget Paper 1 and Health and Aged Care Portfolio Budget Statements

Substantial policy change may be on the horizon. Australia's National Medicines Policy is a high-level framework focused on the availability and the use of medicines and medicines-related services.<sup>36</sup> It is a

<sup>35</sup> See <https://www.medicinesaustralia.com.au/media-release/federal-budget-government-confirms-commitment-to-build-a-21st-century-health-system/>, accessed 12 May 2023

<sup>36</sup> See <https://www.health.gov.au/resources/publications/national-medicines-policy?language=en>, accessed 12 May 2023

cooperative endeavour to bring about better health outcomes for all Australians, focusing especially on people's access to, and wise use of, medicines.

Consultation on a revised National Medicines Policy (NMP) ended in September 2022, and the revised policy was implemented at the end of 2022. This was delayed due to the COVID-19 pandemic and a change of government. The NMP covers a broad range of stakeholders, including the medicines industry, government, academia, healthcare professionals, individuals and carers. The aims are to ensure:

- all Australians have fair, timely, reliable, and affordable access to high-quality medicines and medicines services;
- medicines are used safely and correctly. People have the information they need to make informed choices, and healthcare is well organised and based on their needs; and
- there is support to encourage world-class innovation and research. This includes research that results in new treatments, medicines, and medicine services in Australia.

The revised NMP covers a “broad range of therapeutic options, products and interventions used to prevent, treat, monitor, manage or cure a disease or health condition”, including gene therapies, cell and tissue engineered medicines and vaccines. The central pillars of the revised NMP are:

- Equitable, timely, safe, and reliable access to medicines and medicines-related services, at a cost that individuals and the community can afford.
- Medicines meet the required standards of quality, safety, and efficacy.
- Quality use of medicines and medicines safety.
- Collaborative, innovative, and sustainable medicines industry and research sectors with the capability, capacity and expertise to respond to current and future health needs.

The NMP also restates the need for rigorous health technology evaluation. The ongoing and delayed Health Technology Assessment (HTA) Review was originally announced as part of the strategic agreement between Medicines Australia and the Government.<sup>37,38</sup> The Review includes a Reference Committee and an HTA expert panel.

The Terms of Reference have been announced,<sup>39</sup> and the first consultation period runs from April to June 2023.<sup>40</sup> The Review will cover medicines on the Pharmaceutical Benefits Scheme, the Medicare Benefits Schedule, the Life Saving Drugs Program, and vaccines on the National Immunisation Program. The Terms of Reference emphasise the need for input from people with direct experience into health technology assessment, including patients. They also include the need to increase transparency in health technology decision-making.

---

<sup>37</sup> See <https://www.health.gov.au/resources/publications/health-technology-assessment-policy-and-methods-review-terms-of-reference>, accessed 10 May 2023

<sup>38</sup> See <https://www.medicinesaustralia.com.au/policy/strategic-agreement-2022-2027/>, accessed 10 May 2023

<sup>39</sup> See <https://www.health.gov.au/resources/publications/health-technology-assessment-policy-and-methods-review-terms-of-reference>, accessed 10 May 2023

<sup>40</sup> See <https://ohta-consultations.health.gov.au/ohta/hta-review-consultation1/>, accessed 10 May 2023



The current methods guide for PBAC was last updated in 2016 and so is arguably due for revision. However, the latest guide to the methods of MSAC were published much more recently, in 2021.

The Review will sit within the overall framework of the revised National Medicines Policy. It will also consider the recent recommendations of the Standing Committee on Health, Aged Care and Sport inquiry into approval processes for new drugs and novel medical technologies in Australia.<sup>41</sup> For example, it will consider cooperation between different health technology assessment and regulatory bodies in Australia and overseas and increased use of managed access programs.

The Review will consider both policy and methods of health technology assessment. It will therefore be broader than the recent review of the methods of health technology assessment by the National Institute for Health and Care Excellence (NICE) in England.<sup>42</sup> The Review should, and doubtless will, consider the recent changes in methods at NICE. The deadline for the whole Review is the end 2023.<sup>43</sup> Given the very broad scope of the Review, this deadline appears optimistic. The narrower review of methods at NICE lasted well over a year.

---

<sup>41</sup> See [https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024755/toc\\_pdf/TheNewFrontier-DeliveringbetterhealthforallAustralians.pdf;fileType=application%2Fpdf](https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024755/toc_pdf/TheNewFrontier-DeliveringbetterhealthforallAustralians.pdf;fileType=application%2Fpdf), accessed 10 May 2023

<sup>42</sup> See <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/chte-methods-consultation>, accessed 10 May 2023

<sup>43</sup> See <https://www.health.gov.au/resources/publications/health-technology-assessment-policy-and-methods-review-terms-of-reference>, accessed 10 May 2023

## 6. Pharmacy

The pandemic brought swift changes to the pharmacy sector such as electronic prescribing, COVID-19 vaccinations, and rapid antigen tests for concessioner card holders. The Government has since shifted its attention to other areas, such as:

- adding on-site pharmacists for residential aged care facilities;
- reducing the Pharmaceutical Benefits Scheme (PBS) copayment from \$42.5 to \$30;
- reducing the Safety Net threshold for pensioners and concession card holders by 25 per cent; and
- increasing income limits for Commonwealth Seniors Card holders to provide 44,000 more seniors with access to concession rate prescriptions.

The Government reimburses the pharmacy sector according to the Seventh Community Pharmacy Agreement (7CPA), valid from 2020 to 2025. For the first time, the 7CPA included the publication of Key Performance Indicators (KPI) reports released in 2022. These reports evaluate whether the 7CPA achieves its objectives and improves health outcomes. Although informative in assessing costs and resources used, there remains a gap in informing the 7CPA impact on health outcomes.

Leading into this Budget, the Government announced the extension of prescriptions from 30 to 60 days, saving \$1.6 billion in out-of-pocket expenses to Australians and \$1.2 billion to the Government from dispensing fees over the next four years, by halving visits to GPs and pharmacies.

This initiative will start gradually from 1<sup>st</sup> September 2023, with about one third of more than 300 common medicines becoming progressively available for two month dispensing. The Government claims 60 day prescribing will save up to \$180 per general patient.

The Pharmacy Guild declared this will increase medicines shortages and financially impact pharmacies, consequently laying off staff, with some even closing for good.<sup>44</sup> The Guild also claimed the policy will lead to fewer point-of-care interventions and medication wastage.<sup>45</sup>

The Government dismissed claims of medicine shortages given overall medicine demand would remain unchanged. The Consumers Health Forum of Australia backed the policy because it will benefit patients with minimal risk.<sup>46</sup> Research from the UK showed that dispensing for three months instead of 28 days

---

<sup>44</sup> See <https://www.guild.org.au/news-events/news/2023/millions-of-patients-will-lose-unless-government-guarantees-no-one-is-worse-off-under-budget-cuts>, accessed 10 May 2023

<sup>45</sup> See <https://www.guild.org.au/news-events/news/2023/8-in-10-australians-reject-federal-budget-proposal-due-to-medicine-shortages>, accessed 1 May 2023

<sup>46</sup> See <https://www.theguardian.com/commentisfree/2023/apr/28/despite-tears-and-panic-from-the-pharmacy-lobby-labors-medicine-reforms-wont-cause-the-world-to-end>, accessed 8 May 2023

for chronic patients might increase medication waste but overall reduces costs and increase health gains.<sup>47,48</sup>

This Budget announced that the Government will re-invest the \$1.2 billion saved by extending medication supply back into community pharmacies. This includes:

- \$654.9 million will be invested in services agreed upon in the 7CPA, such as medicines review and dosing administration aids.
- \$377.3 million will fund the Opioid Dependence Treatment Program in community pharmacies benefiting more than 50,000 patients.
- \$114.1 million will allow pharmacists to deliver vaccination services from the National Immunisation Program at no cost to patients.
- \$79.5 million will be used to increase the Regional Pharmacy Maintenance Allowance doubling the previous budget by providing support to pharmacies in rural areas.

This Budget also allocated \$111.8 million to provide electronic prescription delivery infrastructure and services, including mandating the use of e-prescribing for high risk and high cost medicines.

The Opioid Dependence Treatment Program is long overdue, as described in a post market review by having high out-of-pocket expenses, lack of access to the PBS Safety Net, and lack of financial viability for pharmacists, among other pitfalls.<sup>49</sup>

How these new initiatives will be implemented remains to be seen. While the Government can claim the money saved from the dispensing policy is being reinvested in the pharmacy sector, it will redistribute some revenue across community pharmacies. There will consequently be some winners and some losers, which is wholly expected and often necessary when sectors undergo structural change.

This Budget also included a change in policy direction. The prior government allocated \$345.7 million to residential aged care facilities to employ on-site pharmacists to ensure the quality use of medicines.<sup>50</sup> This has now been shifted to community pharmacies without clear justification.

It remains to be seen how community pharmacists will keep up with their current duties while trying to comply with recommendations in the Royal Commission into Aged Care Quality and Safety report. These recommendations include conducting medication management reviews on a person's entry and annually thereafter, or more often if required.<sup>51</sup>

---

<sup>47</sup> Miani C, Martin A, Exley J, Doble B, Wilson E, Payne R, Avery A, Meads C, Kirtley A, Jones MM, King S., 2017, Clinical effectiveness and cost-effectiveness of issuing longer versus shorter duration (3-month vs. 28-day) prescriptions in patients with chronic conditions: systematic review and economic modelling. *Health Technology Assessment*, Dec;21(78):1-128. doi: 10.3310/hta21780.

<sup>48</sup> These results were highly uncertain as the quality of the evidence was poor.

<sup>49</sup> See <https://www.pbs.gov.au/reviews/post-market-review-of-opiate-dependence-treatment-program/ODTP-PMR-Stakeholder-Consultation-Forum-Summary.pdf>, accessed 10 May 2023

<sup>50</sup> See <https://www.health.gov.au/our-work/aged-care-on-site-pharmacist?language=en>, accessed 10 May 2023

<sup>51</sup> Royal Commission into Aged Care Quality and Safety, 2021, Final Report - Volume 1: Summary and Recommendations, <https://agedcare.royalcommission.gov.au/publications/final-report-volume-1>, accessed 10 May 2023

The Commission also suggested that non-dispensing pharmacists should be included, as community pharmacists often do not have the necessary clinical information. Further, the Government pursued a consultation process about on-site pharmacists where the idea was supported, and no suggestions about changing the model to be delivered by community pharmacists were made.

State governments are also pushing to widen pharmacists' scope of practice to increase access to the treatment of common illnesses. This was suggested by the Productivity Commission Report on Efficiency in Health, which identified full-scope pharmacists to be an effective way to improve access.<sup>52</sup>

The NSW government is conducting a trial where pharmacists treat uncomplicated urinary tract infections in women aged 18 to 65 and continue prescriptions of low-risk oral contraceptives.<sup>53</sup> Victoria is piloting pharmacists delivering similar services, but also travel medications and minor skin conditions.<sup>54</sup>

The North Queensland Community Pharmacy Scope of Practice pilot is more ambitious and will trial pharmacists prescribing medicines for nausea and vomiting, reflux, rhinitis, and mild pain.<sup>55</sup> The trial will allow pharmacists to provide contraception services, oral health screening, weight management, and aids for quitting smoking. They will also provide structured disease management programs for reducing cardiovascular risk, asthma, and chronic obstructive pulmonary disease.

The Government supports all professionals working at their full capacity to satisfy rising healthcare demand. It is discussing with state and territory health ministers how to harmonise a shift towards a greater scope of practice for pharmacists.<sup>56</sup>

Despite resistance from the Australian Medical Association and Royal Australian College of General Practitioners,<sup>57,58</sup> international evidence shows that increasing the scope of practice for pharmacists can be beneficial to the healthcare system and patients. For example, an increased scope of practice among

---

<sup>52</sup> Productivity Commission, 2015, Efficiency in Health, <https://www.pc.gov.au/research/completed/efficiency-health>, accessed 10 May 2023

<sup>53</sup> See <https://www.health.nsw.gov.au/pharmaceutical/Pages/cp-pharmacists-Information.aspx>, accessed 10 May 2023

<sup>54</sup> See <https://www.dtf.vic.gov.au/sites/default/files/document/Election%20Costing%20Request%20067%20-%20Australian%20Labor%20Party%20-%20Backing%20pharmacists%20to%20boost%20our%20health%20system%20-%202024%20November%202022.DOCX>,

<sup>55</sup> See <https://www.health.qld.gov.au/ahwac/html/nqpharmacypilot/overview>, accessed 10 May 2023

<sup>56</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-press-conference-19-february-2023>, accessed 10 May 2023

<sup>57</sup> See <https://www.ama.com.au/ama-rounds/14-april-2023/articles/only-medical-degree-can-train-pharmacist-prescribe>, accessed 11 May 2023

<sup>58</sup> See <https://www.racgp.org.au/advocacy/reports-and-submissions/view-all-reports-and-submissions/2023-reports-and-submissions/racgp-response-to-the-australian-pharmacy-council>, accessed 11 May 2023

Canadian pharmacists was found to reduce cardiovascular risk, reduce costs and increase health gains.<sup>59,60</sup>

---

<sup>59</sup> Al Hamarneh YN, Johnston K, Marra CA, Tsuyuki RT. Pharmacist prescribing and care improves cardiovascular risk, but is it cost-effective? A cost-effectiveness analysis of the Rx EACH study. *Can Pharm J (Ott)*. 2019 Jun 10;152(4):257-266.

<sup>60</sup> Marra C, Johnston K, Santschi V, Tsuyuki RT. Cost-effectiveness of pharmacist care for managing hypertension in Canada. *Can Pharm J (Ott)*. 2017 Mar 21;150(3):184-197.

## 7. Primary Care

The Government released the Strengthening Medicare Taskforce report early this year, outlining recommendations to modernise Medicare and strengthen GPs.<sup>61</sup> The report focused on improving patient access, making care affordable and equitable and taking the pressure off public hospitals. It proposed promoting comprehensive care within the community, fostering multidisciplinary team-based approaches, embracing technology advancements, and implementing innovative blended funding models.

The RACGP welcomed the recommendations but believed more action was needed. In particular, the RACGP stated the Strengthening Medicare Taskforce report was “*silent on measures such as boosting Medicare rebates and increasing incentives for bulk-billing*”.<sup>62</sup>

Minister Butler was resolute, stating that “*more of the same is simply not going to cut it*” and that “*simply adding more money to the existing structures is not going to deliver the quality, wraparound care, particularly people with complex chronic disease need and deserve*”<sup>63</sup>

Meanwhile, the Australian Broadcasting Corporation (ABC) 7.30 program uncovered allegations claiming fraud and errors in Medicare billing and servicing potentially cost taxpayers up to \$8 billion.<sup>64</sup> The program revealed instances where doctors billed deceased individuals and manipulated records.

This prompted an Independent Review of Medicare Integrity and Compliance (the Phillip review). The Review estimated the value of non-compliance in the system could range from \$1.5 billion to \$3 billion, indicating the potential for significant fraud if adequate controls are not in place.<sup>65</sup> It recommended:

- tighter controls around new business models and practices;
- accreditation of billing software;
- greater practitioner responsibility;

---

<sup>61</sup> Australian Government, 2022, Strengthening Medicare Taskforce Report, [https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report\\_o.pdf](https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_o.pdf), accessed 10 May 2023

<sup>62</sup> See Medicare report contains promising elements, but reform must go further , <https://www.racgp.org.au/gp-news/media-releases/2023-media-releases/february-2023/racgp-medicare-report-contains-promising-elements#:~:text=RACGP%3A%20Medicare%20report%20contains%20promising%20elements%2C%20but%20reform%20must%20go%20further&text=The%20Royal%20Australian%20College%20of,future%20of%20general%20practice%20care>, accessed 10 May 2023

<sup>63</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/minister-for-health-and-aged-care-melbourne-press-conference-23-january-2023?language=en>, accessed 11 May 2023

<sup>64</sup> See, <https://www.abc.net.au/news/2022-10-17/medicare-leakage-fraud-waste/101537016>, accessed 10 May 2023

<sup>65</sup> Philip P, 2023, Independent Review of Medicare Integrity and Compliance, final report, [https://www.health.gov.au/sites/default/files/2023-04/independent-review-of-medicare-integrity-and-compliance\\_o.pdf](https://www.health.gov.au/sites/default/files/2023-04/independent-review-of-medicare-integrity-and-compliance_o.pdf), accessed 10 May 2023

- continuous monitoring; and
- re-designing the Medicare payment to support accessibility, quality, and safety of health services.<sup>66</sup>

This Budget allocated \$29.8 million to combat Medicare fraud and reinforce the integrity of the Medicare system. The Department of Health and Aged Care will also establish a taskforce to identify and disrupt instances of fraud and serious non-compliance before they occur.

## Bulk billing

Early this year the media reported survey results that showed a decline in bulk billing rates for general practice.<sup>67</sup> The report highlighted that 42.7 per cent of 4,188 general practices surveyed bulk billed all patients and estimated average out-of-pocket cost for a standard consultation at \$40.25.<sup>68</sup>

This aligned with views from the RACGP and the AMA, with both having previously called for bulk billing incentive increases to stop the decline in bulk billing.<sup>69,70</sup>

In response, this Budget allocated \$3.5 billion to triple the bulk billing incentives for GP visits by concession card holders and patients under 16. While the policy sentiment should be applauded, it may only increase GP incomes rather than bulk billing rates.

There are two major uncertainties that may render this policy inefficient.

- Bulk billing rates for non-referred GP attendances are dropping from a historical high, so the recent steep decline may not reflect what would have happened in the future.
- GPs may not substantially increase their bulk billing rates as the incentive will still be less than the copayment currently received for many GPs.

While bulk billing for GP non-referred attendances has declined over the last year (see Chart 11), it has dropped from a historical high in the second quarter of 2020. This high was effectively manufactured by government policy as GPs were required to bulk bill for ‘temporary’ telehealth services during the COVID-19 pandemic, and were required to bulk bill for COVID-19 vaccinations.

Bulk billing requirements for telehealth were removed in October 2020 and rates came down. Similarly, COVID-19 vaccinations administered by GPs peaked in 2021-22, and have since decreased substantially, adding to the decline in GP non-referred attendance bulk billing rates.

---

<sup>66</sup> Ibid.

<sup>67</sup> Cleanbill, 2023, Blue Report, National General Practitioner Listings, <https://cleanbill.com.au/wp-content/uploads/2023/01/Cleanbill-Blue-Report-January-2023.pdf>, accessed 10 May 2023

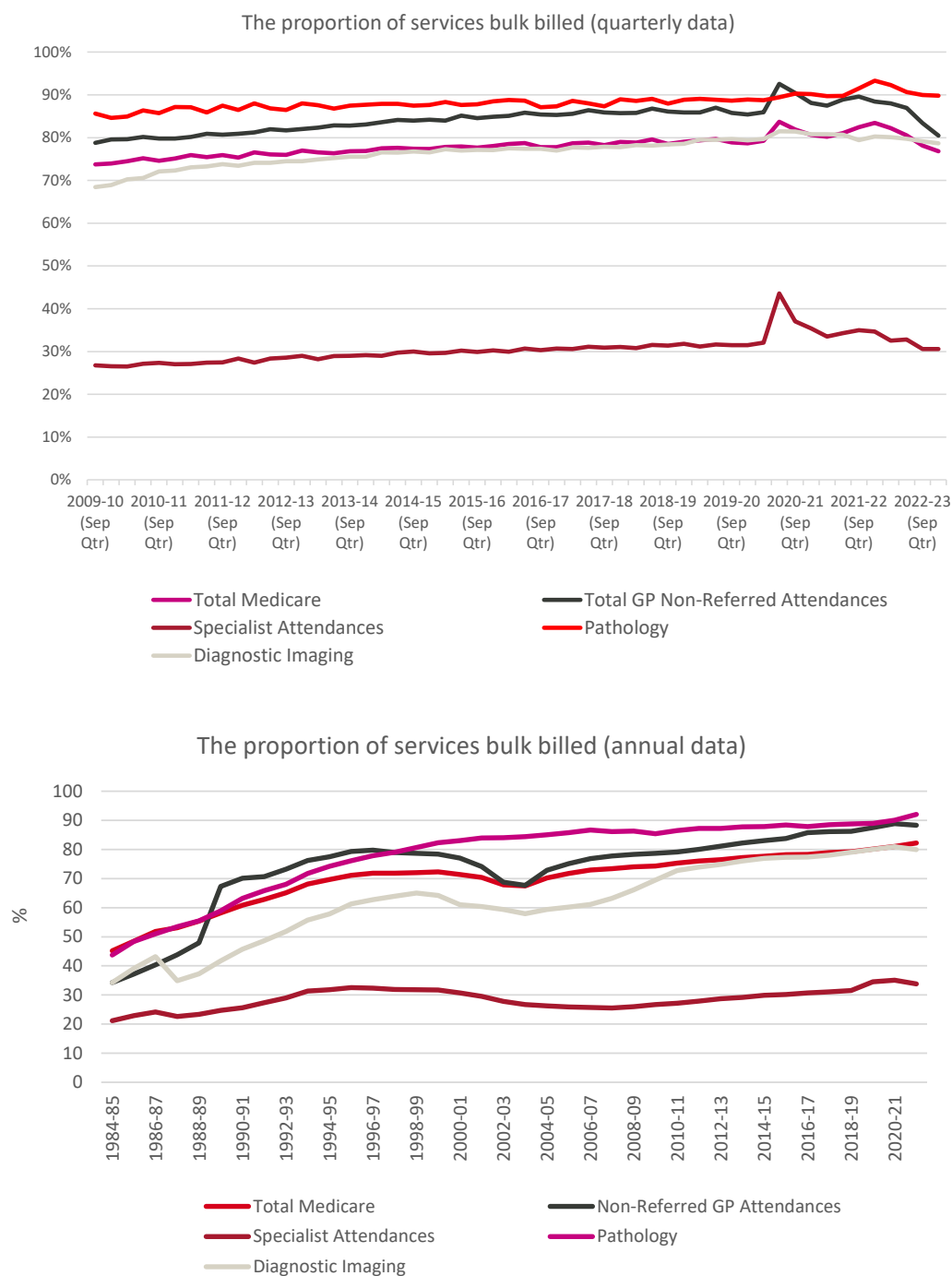
<sup>68</sup> Ibid.

<sup>69</sup> See <https://www1.racgp.org.au/news/gp/professional/falling-bulk-billing-rates-a-sign-of-things-to-come>, accessed 10 May 2023

<sup>70</sup> See <https://www.ama.com.au/media/dr-danielle-mcmullen-bulk-billing-and-gp-shortages>, accessed 10 May 2023



**Chart 11: A change in bulk billing rates over time**



Note: Incentives to bulk bill non-referred GP attendances were introduced in 2003-04, while incentives to bulk bill diagnostic imaging services and pathology were introduced in 2009-10.

Source: Department of Health and Aged Care

The recent decline in bulk billing rates may therefore just reflect rates coming back to their long run average. For example, while GP non-referred attendance bulk billing rates are currently 81 per cent and

are lower than rates just prior to the pandemic (85 per cent), they are only 1 per cent lower than the average bulk billing rates over the decade prior to the pandemic (see Chart 11).

It is uncertain whether bulk billing rates will increase in response to the incentives announced within this Budget. GPs are not obliged to increase their bulk billing rates. This comes from a historical Australian High Court decision, which stated that any attempt of the government to determine how much GPs can charge for their services was unconstitutional because it amounted to ‘civil conscription’.<sup>71</sup>

Bulk billing incentives have worked in the past, which is reflected in the 2004-05 trend reversal in non-referred GP attendances (see Chart 11). That initial bulk billing incentive was \$5 for bulk billing Commonwealth concession card holders and children under 16. It represented a 20 per cent increase in revenue for a standard bulk-billed consultation.

This Budget will deliver a much stronger incentive. It increases the current incentive from a 15 per cent increase in fees for a standard consultation to a 50 per cent increase in fees for a standard consultation. GPs will receive even more incentives relative to the rebate if they deliver that consultation within rural or remote locations.

All GPs will receive additional incentives for the patients they already bulk bill. Some GPs will not increase the number of patients they bulk bill even with the additional incentives. This was confirmed by the president of the RACGP.<sup>72</sup>

Most GPs will only increase bulk billing rates if the incentive is greater than the copayment they currently receive. This is especially the case given the AMA argues GPs are in financial distress due to low rebates (a hangover from the MBS rebate freeze).<sup>73</sup> Given the average fee received from a patient is \$41,<sup>74</sup> and the bulk billing incentive is \$20.65 in metropolitan areas, many GPs will not increase their bulk billing rates.

It is unclear why the Government did not take a more targeted, and less expensive, approach to incentivise GPs to increase bulk billing. The Government could have paid GPs a bonus to increase their bulk billing rates. This approach is used in residential aged care. Providers receive a 33 per cent increase in their accommodation subsidy if they have 40 per cent or more residents with low means.<sup>75</sup>

---

<sup>71</sup> McDonald F, Duckett S, Campbell E, 2023, Commonwealth Power to Improve Access, Quality, and Efficiency of Medical Care: Does section 51 (xxiiiA) of the Constitution Limit Politically Feasible Health Policy Options Today?, Federal Law Review, <https://journals.sagepub.com/doi/10.1177/0067205X231165872#:~:text=We%20argue%20that%20the%20civil,contemporary%20analysis%20of%20it%20warrants>, accessed 11 May 2023

<sup>72</sup> See <https://www.abc.net.au/news/2023-05-10/budget-2023-medicare-and-bulk-billing-doctors-changes-costs/102324460>, accessed 12 May 2023

<sup>73</sup> See <https://www.ama.com.au/media/ama-launches-plan-address-critical-problems-facing-general-practice>, accessed 15 May 2023

<sup>74</sup> See <https://www.health.gov.au/resources/publications/medicare-statistics-year-to-date-summary-tables-july-to-december-2022-23?language=en>, accessed 12 May 2023

<sup>75</sup> Department of Health and Aged Care, 2023, Aged Care Subsidies and Supplements, <https://www.health.gov.au/sites/default/files/2023-03/schedule-of-subsidies-and-supplements-for-aged-care.pdf>, accessed 12 May 2023

## Potential unintended consequences

Some unintended consequences may result from the announced increase in bulk bill incentives. By design, they are meant to help shift people from overcrowded emergency departments back into GPs. However, if GP supply does not increase, this shift in demand will only increase GP waiting lists (see Chapter 3 for a full discussion).

Increased bulk billing incentives may also encourage some GPs to work less. They can now receive the same income compared to current earnings while delivering fewer services. Research suggests some GPs have a 'backward bending' labour supply curve, especially female GPs with children. This means they are likely to decrease their work hours from the increased bulk billing incentive.<sup>76</sup> If GPs were to reduce their hours by 10 per cent it could result in a 12 per cent increase in average patient waiting time.<sup>77</sup>

## Other announcements

The Government has reaffirmed its commitment to introduce a Voluntary Patient Enrolment (VPE) initiative between patients and GPs. This initiative was first announced by the prior government in the 2021-22 Budget.<sup>78</sup> This Government has relabelled the initiative My Medicare and allocated \$19.7 million toward this initiative in this Budget.

MyMedicare aims to establish a platform that further binds the relationship between the patient and GP. It will serve as the foundational infrastructure at first to help the government incentivise better, multidisciplinary care for people with chronic conditions. However, it also represents one step closer to introducing blended funding models, as patients must register for these, and other value based payment models, to operate effectively.

This Budget pushes primary care further down the multidisciplinary team path. It allocated \$445.1 million to incentivise GPs to hire additional nursing and allied health professionals. This measure is a response to the findings of the Strengthening Medicare Taskforce Report.

This Budget allocated \$227 million across nine programs to grow and upskill the primary care workforce, mainly through facilitating an increased scope of practice for nurses. The two largest programs include \$50.2 million to establish a Primary Care and Midwifery scholarship program and \$46.8 million to increase MBS schedule fees for nurse practitioner attendance items and to enable nurse practitioners to participate in multidisciplinary case conferences. Nurse practitioners and participating midwives will be authorised to prescribe PBS medicines and services under Medicare.

The Government has made some amendments to the MBS. This Budget allocated \$125.6 million to improve access to primary care services and introduce a new Medicare rebate worth \$98.2 million for patients who require consultations lasting over 60 minutes. This Budget has also allocated \$250.5 million to extend the availability of MBS items for PCR pathology testing for COVID-19 and other

---

<sup>76</sup> Kalb G, Kuehnle D, Scott A, Cheng T, 2017, What factors affect physicians' labour supply: Comparing structural discrete choice and reduced-form approaches, *Health Economics*, Vol. 27, pp. e101-e119

<sup>77</sup> Swami M, Gravelle H, Scott A, William J, 2018, Hours worked by general practitioners and waiting times for primary care, *Health Economics*, Vol. 27, pp. 1513-1532

<sup>78</sup> The Treasury, 2021-22, Budget paper No.2, Budget 2021-22, Australian Government, Canberra

respiratory pathogens until the end of 2023. However, this Budget will save \$461.3 million from MBS amendments, primarily by changing the Chronic Disease Management planning items and introducing a minimum consultation time for Level B items.

The Government has also taken steps to increase GP funding to alleviate the strain on hospitals, including to offer after-hours programs, offering more care to frequent hospital users and more Urgent Care Clinics (see Chapter 3 for more detail).

## 8. Private health insurance

Despite two recently completed reviews of policy settings and insurer risk-pooling arrangements, private health insurance reform warranted no mention in this year's Budget. The premium rebate cost \$7 billion last year and is projected to cost another \$30 billion over the next four years.

Both Private Healthcare Australia (PHA) and the AMA appealed for an increased rebate for groups including low-income earners.<sup>79,80</sup> This is not good long-term policy, particularly on the pretext that it cost-effectively reduces public hospital expenditure.<sup>81</sup> Both the PHA and AMA also asked for an increase in the Medicare Levy Surcharge (MLS).

Nevertheless, the Government is yet to release findings from the policy settings review,<sup>82</sup> and large projected Budget expenditure suggests an unwillingness to touch the rebate, a politically sensitive area,<sup>83</sup> even more so during a cost-of-living crisis.

Rebate expenditure was, in fact, 1.8 per cent higher than previously projected, driven by membership growth. Abating earlier 'death spiral' fears,<sup>84</sup> the last quarter of 2022 saw net increases in private hospital membership for working-age individuals,<sup>85,86</sup> and even a net increase for younger people aged 25-29 years.

While the hospital insured pool continues to age over the long term, with an over 40 per cent increase in members aged 70 years and over since early 2015 (see Chart 12), the number of members aged 20-39 has increased since mid-2020. Several factors may explain this, including earlier reforms to attract young people into hospital cover, including premium discounts for those aged 18-29 (implemented in 2019) and an increase in the maximum allowable age for dependents on family cover from 24 to 31 years (implemented in 2021).

---

<sup>79</sup> Private Healthcare Australia (PHA), Private Healthcare Australia Federal Budget submission, <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Pre-Budget-Submission-2023-24-Final.pdf>, accessed 5 May 2023.

<sup>80</sup> Australian Medical Association (AMA), Pre-Budget Submission 2023–24, accessed 5 May 2023.

<sup>81</sup> Cheng T, 'Measuring the effects of reducing subsidies for private insurance on public expenditure for health care', *Journal of Health Economics*, 2013, 33: 159-179.

<sup>82</sup> See <https://consultations.health.gov.au/medical-benefits-division/ongoing-consultation-phi-mls-rebate/>, accessed 5 May 2023.

<sup>83</sup> See <https://theconversation.com/the-private-health-insurance-rebate-has-cost-taxpayers-100-billion-and-only-benefits-some-should-we-scrap-it-181264>, accessed 3 May 2023

<sup>84</sup> See <https://theconversation.com/youth-discounts-fail-to-keep-young-people-in-private-health-insurance-121803>, accessed 3 May 2023

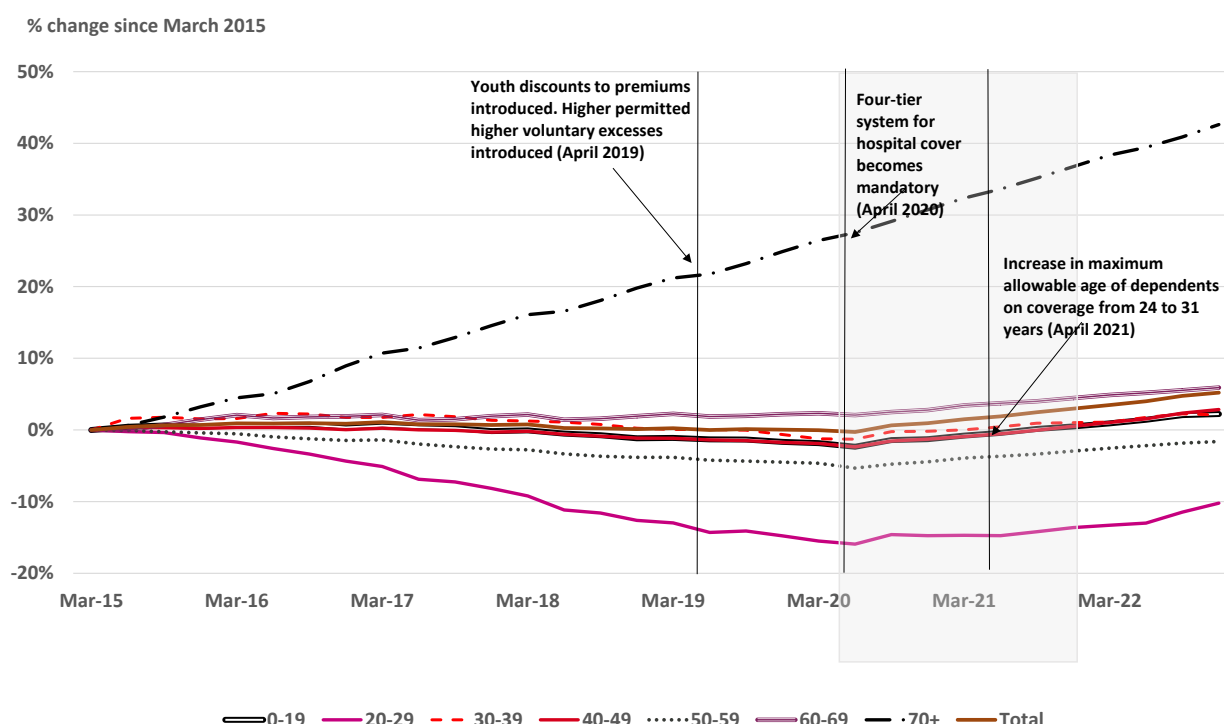
<sup>85</sup> 'Net changes' adjust for individuals moving across age groups due to cohort ageing.

<sup>86</sup> The Australian Prudential Regulation Authority (APRA), 2023, Private health insurance membership and coverage December 2022, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>, accessed 3 May 2023

Since research suggests consumers do not respond much to price changes in their coverage decisions,<sup>87,88</sup> the increase in membership for 20-29 year olds is more likely to have occurred from the latter reform. This is also suggested by Chart 12, which shows hospital cover for 20-29 year olds continued to decline the year after youth-based discounts were introduced.

The income threshold at which people become liable for the MLS also remained ‘frozen’ for seven years (set to increase in 2023-24).<sup>89</sup> This may have pushed working-age individuals into cover, with more uninsured workers becoming liable for the MLS due to wage increases.

**Chart 12: Proportional change in people with hospital cover from March 2015, by age group**



Source: Australian Prudential Regulatory Authority

<sup>87</sup> Kettlewell N, et al., 2018, Premium subsidies and demand for private health insurance: results from a regression discontinuity design, *Applied Economics Letters*, 25(2):96-101.

<sup>88</sup> Bilgrami A, et al., 2021, The impact of means-tested premium rebates and tax penalties on the demand for private hospital cover in Australia', *Economic Record*, 97(317), 170-211.

<sup>89</sup> Australian Taxation Office (ATO), 2023, Income thresholds and rates for the private health insurance rebate, <https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/income-thresholds-and-rates-for-the-private-health-insurance-rebate/>, accessed 5 May 2023.

A blowout in public hospital elective surgery waitlists may also explain recent growth,<sup>90</sup> a residual effect of temporarily stopping some elective surgery during lockdowns. While concern has been expressed around new consumers being ‘hit and run’,<sup>91</sup> research has found inertia in health insurance decisions, with people less likely to drop cover once they’ve taken it up, even with changes in financial incentives.<sup>92</sup>

Overall, the sector has seen sustained growth over nine consecutive quarters, and 45.1 per cent of Australians now hold hospital cover.<sup>93</sup> Given the cost-of-living strain and eight increases in the cash rate over 2022,<sup>94</sup> these recent developments are somewhat unexpected. It suggests the perceived value of private health insurance may have increased since the COVID-19 pandemic.

Unlike 2021, hospital benefits paid out per insured person decreased over 2022 (-6.5 per cent), including a drop in all three categories of accommodation and nursing (-6 per cent), medical (-8 per cent) and prosthesis benefits (-6.2 per cent). This was due to lower claims made, including during the Omicron wave of March 2022. Deferred claim liabilities from the pandemic rose to their highest level in June 2022.<sup>95</sup>

Despite higher membership and lower benefit payouts, insurer profits were 33.6 per cent lower from depressed investment income,<sup>96</sup> compared to last year’s profit surge (+229 per cent). The extent to which ‘missed claims’ start arising over 2023-24 will influence future profits.

After the Government announced a below average annual premium increase of 2.9 per cent this year,<sup>97</sup> many insurers deferred passing this on, expressing their commitment to return pandemic profits.<sup>98</sup> Nonetheless, recent data suggest policyholders are footing higher bills during hospital stays.

---

<sup>90</sup> See [https://www.aihw.gov.au/news-media/media-releases/2021/december/covid-19-disruptions-led-to-lowest-number-of-publi#:~:text=In%202021%E2%80%939322%2C%20public,Adrian%20Webster%20\(PhD\)](https://www.aihw.gov.au/news-media/media-releases/2021/december/covid-19-disruptions-led-to-lowest-number-of-publi#:~:text=In%202021%E2%80%939322%2C%20public,Adrian%20Webster%20(PhD),), accessed 5 May 2023.

<sup>91</sup> See <https://www.smh.com.au/national/hit-and-run-patients-may-be-driving-up-record-private-health-insurance-numbers-20230217-p5cldc.html>, accessed 5 May 2023.

<sup>92</sup> Buchmueller T, et al., 2021, The effect of income-based mandates on the demand for private hospital insurance and its dynamics, *Journal of Health Economics*, 75: 102403.

<sup>93</sup> The Australian Prudential Regulation (APRA), 2023 Private health insurance membership and coverage December 2022, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>, accessed 10 May 2023

<sup>94</sup> See <https://www.rba.gov.au/monetary-policy/int-rate-decisions/2022/>, accessed 5 May 2023.

<sup>95</sup> Australian Competition and Consumer Commission (ACCC), 2022, Report to the Australian Senate - On anti-competitive and other practices by health insurers and providers in relation to private health insurance, [https://www.accc.gov.au/system/files/Private Health Insurance Report 2021-22.pdf](https://www.accc.gov.au/system/files/Private%20Health%20Insurance%20Report%202021-22.pdf), accessed 5 May 2023.

<sup>96</sup> The Australian Prudential Regulation Authority (APRA), 2022, Quarterly private health insurance statistics - highlights, [https://www.apra.gov.au/sites/default/files/2023-02/Quarterly Private Health Insurance Statistics Highlights December 2022.pdf](https://www.apra.gov.au/sites/default/files/2023-02/Quarterly%20Private%20Health%20Insurance%20Statistics%20Highlights%20December%202022.pdf), published 1 March 2023, accessed 3 May 2023.

<sup>97</sup> See <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/annual-private-health-insurance-premium-rise>, accessed 5 May 2023.

<sup>98</sup> See <https://www.9news.com.au/national/health-insurance-nib-and-medibank-postpone-annual-premium-rises/6bf8e1b7-c805-4484-9e01-be073ac1e9ba>, accessed 5 May 2023.



The average gap for a hospital episode increased by 11.8 per cent over 2022 (compared to a small decrease last year),<sup>99</sup> including a 6 per cent higher gap for in-hospital medical services. The proportion of hospital policies with relatively 'high' excess amounts also jumped from 10 per cent to 14 per cent over 2022,<sup>100,101</sup> having risen dramatically since higher excesses were permitted in 2019.

Both citing cost-of-living pressures faced by consumers, PHA asked the Government to review low-value care and provider fraud, and eliminate 'surprise billing' by doctors,<sup>102</sup> while the AMA asked for mandated minimum payout ratios on premiums paid and increased regulatory oversight.<sup>103</sup>

The PHA criticised the previous Government's deal with the Medical Technology Association of Australia (MTAA), which still locks in device prices over four years and sets a 'floor' on prosthesis benefit reductions, a concern also raised by the Australian Competition and Consumer Commission.<sup>104</sup>

The Government recently released findings from a review of insurer risk-pooling arrangements to support community-rating. The final report suggests moving away from a system that retrospectively shares claims costs to one that prospectively compensates insurers for 'expected' claims to sharpen insurer incentives to operate efficiently and deter risk-selection.<sup>105</sup>

The two recent reviews and the strong growth in private health insurance membership signal that the time is ripe for further reform. So far, there appears to be hesitancy from the Government in implementing potentially bold, evidence-based policy changes required to promote sector efficiency and sustainable government support. This may change if cost-of-living pressures come down.

---

<sup>99</sup> The Australian Prudential Regulation Authority (APRA), 2023 Quarterly private health insurance statistics December 2022, <https://www.apra.gov.au/sites/default/files/2023-02/Quarterly Private Health Insurance Statistics December 2022.pdf>, accessed 3 May 2023.

<sup>100</sup> An excess > \$500 per policy covering one person and excess > \$1,000 for all other policies.

<sup>101</sup> The Australian Prudential Regulation Authority (APRA) 2023, Private health membership and benefits December 2022, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>, accessed 5 May 2023.

<sup>102</sup> Private Healthcare Australia (PHA), Private Healthcare Australia Federal Budget submission, <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Pre-Budget-Submission-2023-24-Final.pdf>, accessed 5 May 2023

<sup>103</sup> Australian Medical Association (AMA), Pre-Budget Submission 2023–24, <https://www.ama.com.au/articles/ama-pre-budget-submission-2023-24#:~:text=The%20AMA%20Pre%20Budget%20Submission,health%20system%20for%20the%20future>, accessed 5 May 2023

<sup>104</sup> Australian Competition and Consumer Commission (ACCC), 2022, Report to the Australian Senate - On anti-competitive and other practices by health insurers and providers in relation to private health insurance, <https://www.accc.gov.au/system/files/Private Health Insurance Report 2021-22.pdf>, accessed 5 May 2023

<sup>105</sup> Department of Health and Aged Care, Risk equalisation: Final report, 2022, [https://consultations.health.gov.au/medical-benefits-division/consultation-on-the-private-health-insurance-phi-a/supporting\\_documents/Finitys Risk Equalisation Report.pdf](https://consultations.health.gov.au/medical-benefits-division/consultation-on-the-private-health-insurance-phi-a/supporting_documents/Finitys Risk Equalisation Report.pdf), accessed 5 May 2023