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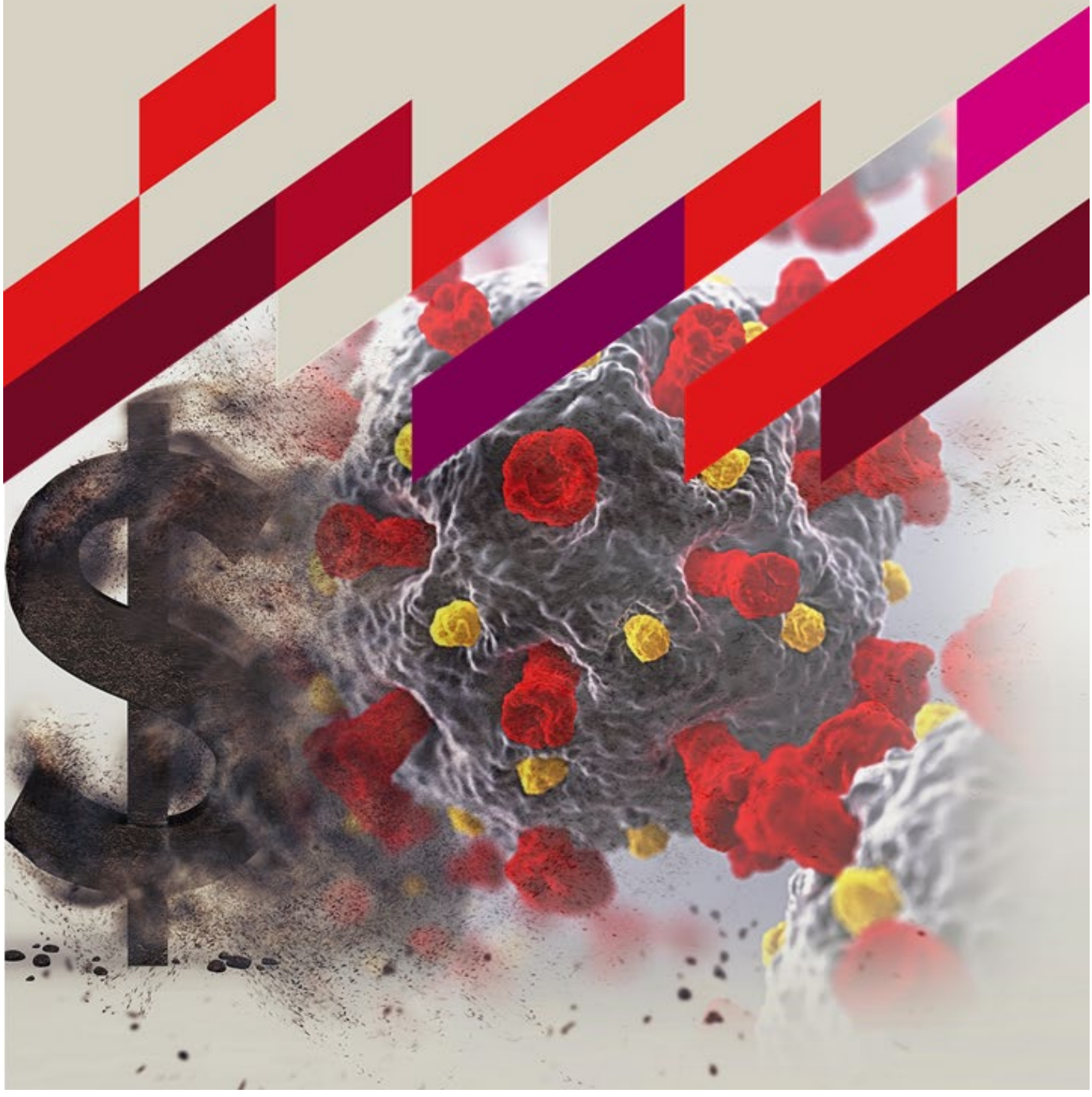
The MUCHE Health Report 2022

ANALYSIS OF THE 2022-23 FEDERAL BUDGET



DISCLAIMER

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About MUCHE

Macquarie University is recognised as one of Australia's leading research universities, with an enviable reputation for excellence. While still relatively young, success of the past 50 years has positioned our distinctive approach to deliver ground-breaking research with world-changing impact. 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; 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 university strategic 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, most integrated, and highly influential health systems research institute.

Our 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.

While MUCHE primarily consists of specialist health economists, researching the Health Economy requires many skills sets and experience. 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 widely 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 methodology, to deliver innovative and translational research.

Professor Henry Cutler
Inaugural Director
Macquarie University Centre for the Health Economy (MUCHE)

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Executive summary

The last time this Government tabled a Budget just before an election was in 2019. That was a 'cash splash' Budget with large tax breaks. While Health portfolio funding growth was subdued, its allocation was strategic, aimed at grassroots voters by dispersing funds across many individual programs.

This Budget is straight from the same playbook. There are no big ticket reform announcements, but lots of smaller funding allocations targeted at specific groups and programs. It comes at a time when affordability of care and medicines is a substantial problem for many Australians.[1]

Health portfolio funding will be reduced by $5.7 billion in 2022-23 compared to 2021-22. This equates to a nominal reduction of 5.1 per cent, but a real reduction of 7.5 per cent once health inflation and population growth are considered.

Funding will be tighter in 2023-24, with another $3.2 billion reduction. Most of the funding reduction in the next two years is from the cessation of COVID-19 emergency measures. However, real funding in 2025-26 is also estimated to be 6.0 per cent lower than in 2021-22.

Aged care has received more funding, but mostly to battle COVID-19. The largest item is $215 million over two years to provide bonuses to aged care workers. The sector has argued these one off payments are insufficient to retain and attract workers.

While more funding will come online from last year's $17.7 billion Budget announcement, aged care needs another $5 billion annually to meet expected quality standards. That doesn't all have to come from Government, but unsecured future aged care funding remains a perennial problem and many providers are still struggling financially. It will be impossible to increase quality if marginal costs are not covered.

Hospitals are heading further into crisis territory with COVID-19 blowing out public hospital elective surgery waiting lists. Around 5 per cent of public patients in Victoria waited more than 365 days in 2020-21, while it was 11 per cent in NSW. Non-urgent elective surgery was again suspended within the Delta and Omicron waves, most likely blowing out waiting times further.

States will receive another $984 million for the *National Partnership on COVID-19 Response*, building on $752 million allocated in the MYEFO.[2] However, some states claim that activity based funding prices may also need to be adjusted upward, because public hospital costs have substantially increased from changed delivery models in response to COVID-19.

There is a strong argument for the Government to lead on improving elective surgery waiting times. This should be achieved through greater investment and an amendment to the National Health Reform Agreement. Ensuring timely access to care is not explicit within its long term health reform principles.

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[1] Zurynski Y, et al 2022, The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey. Report prepared for the Consumers Health Forum of Australia, ISBN: 978-1-74138-491-8

[2] Mid-Year Economic and Fiscal Outlook (MYEFO)

This Budget has allocated more funding to a mental health care package with $303.2 million in new funding since the MYEFO. Funding is spread across 27 items related to mental ill health prevention and early detection, suicide prevention activities, treatment services, and workforce and governance. Suicide rates seemed to have turned a corner, coming down slightly in the latest Australian Bureau of Statistics data for 2020, despite the lockdowns and financial upheaval of COVID-19.

The Government is yet to seriously expand the mental health workforce or tackle the structural change recommended by the Productivity Commission. This is despite the National Mental Health Workforce Strategy and the National Mental Health and Suicide Prevention Agreement recently being finalised. They could have informed further reform in this Budget.

The pharmaceutical sector received some good news with several 'big ticket' medicines recommended by the Pharmaceutical Benefits Advisory Committee (PBAC) newly listed on the Pharmaceutical Benefits Scheme. The Government and Medicines Australia signed a landmark five year agreement in 2021. It will include reviewing health technology assessment processes and improving consumer engagement processes, along with guaranteed expenditure on medicines.

Big consumers of prescription medicines will also benefit from this Budget. The Government announced a reduction in the Safety Net threshold, costing the Government $525 million over four years. This will reduce the cost of prescriptions for big consumers, aligning with announcements to reduce the cost of living made in other portfolios.

The Government will further embed pharmacies into the health and aged care sectors. Pharmacies were allowed to help vaccinate people for COVID-19, albeit relatively late in the vaccine rollout, and will now help deliver more flu vaccinations. The Australian Medical Association (AMA) had pushed back on allowing pharmacies to dispense vaccines. Regardless, this Budget announced $345 million to get pharmacists more involved in dispensing medicines onsite in residential aged care facilities.

The greatest recent upheaval in primary care business models has been the spread of telehealth, with over 100 million services since it was introduced temporarily at the start of COVID-19. Telehealth services have now become permanent, although with some tweaks to limit telephone consults to minor consultations.

This Budget sees a continued focus on responding to the COVID-19 pandemic. The Government allocated $892.1 million over two years to improve access to COVID-related services. This primarily consists of $546 million to extend temporary MBS pathology items for COVID-19 detection and diagnosis in 2022-23, and $248.1 million for the continuation of General Practitioner Led Respiratory Clinics Program. The Government also announced a Women's health package, allocating $112 million in new funding across 20 different items.

Private health insurance prices continue to increase beyond health inflation, but at an historically low rate rise of 2.7 per cent in 2022. Prosthesis list reforms are expected to save the private health insurance sector around $900 million over four years, translating into a $50 per year saving for families (less than 2 per cent). That relies on private health insurers passing on the savings, but even that won't subdue the increased pressure on prices. That requires more investment from insurers to keep people out of the hospital.

The private health insurance rebate continues to drain the Health portfolio budget. It cost nearly $7 billion this year and is estimated to cost another $29 billion in the following four years. The Department of Health is looking at changing the rebate and Medicare Levy Surcharge, but removing the rebate seems off the table. This is despite no evidence that the rebate provides a sufficient return on investment.

COVID-19 hasn't gone away, which is reflected in this Budget. The Government will allocate another $2.1 billion mostly to administer vaccines, supply more personal protective equipment in aged care, and

to continue the COVID-19 Rapid Antigen Test (RAT) Concessional Access Program. This builds on the $1.1 billion allocated in the MYEFO for vaccine distribution and administration.

The Hon Greg Hunt's legacy will primarily be the Government's healthcare response to the COVID-19 pandemic. Under his watch, reform started in aged care and mental health, and several '10 year plans' were developed, mostly in the last year, but substantial implementation is still lacking.

Our health system is still in urgent need of reform, and it will be difficult, lengthy and expensive. This must occur even as future Budgets groan under the weight of increased debt. It will require increased health system productivity and less waste.

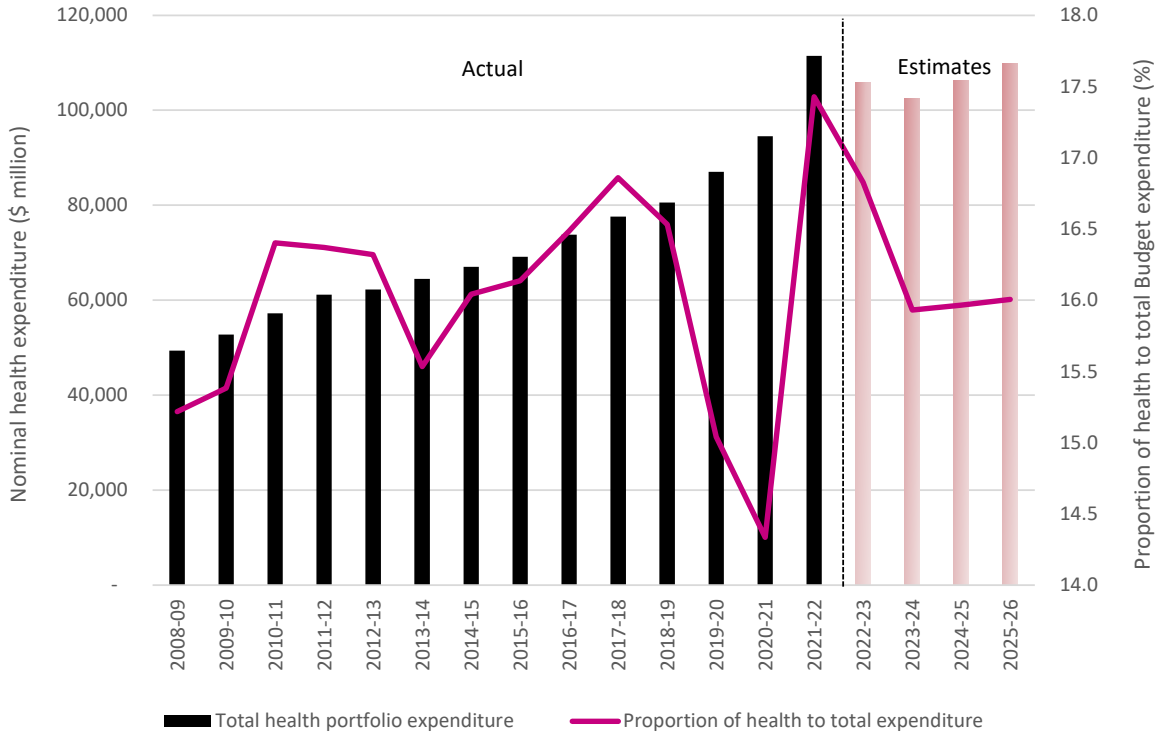
Any new health minister (regardless of political persuasion) must be strategic and considered. Health system sustainability can only be achieved by understanding where investment will generate the most value, relying on evidence and not being persuaded by special interest groups, and continuously aiming to improve care quality.

1. The Health portfolio

The Heath portfolio experienced a rapid increase in funding over the last two years, primarily due to the Government's response to COVID-19, along with aged care and mental health reform announcements. This saw a peak in Health portfolio funding last year at $111 billion, which is $13 billion more than estimated in last year's Budget for 2021-22. It seems responding to healthcare needs had caught the Government off guard.

The Budget in 2022-23 is estimated to decrease by $5.7 billion in 2022-23 (see Chart 1). This equates to a nominal reduction of 5.1 per cent, but a real reduction of 7.5 per cent once health inflation and population growth are considered (see Chart 2).[3] Funding will be tighter in 2023-24, with another $3.2 billion reduction. Overall, real funding in 2025-26 is estimated to be 6.0 per cent lower than 2021-22.

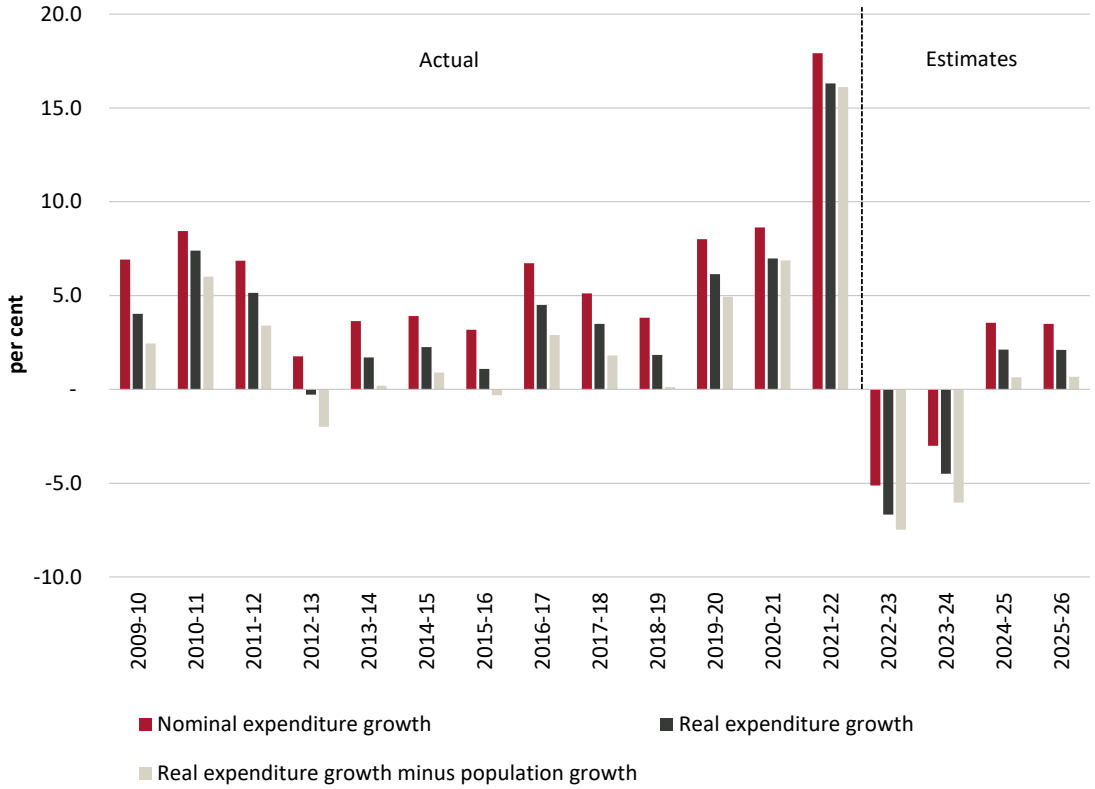
Chart 1: Actual and estimated nominal health portfolio expenditure



Source: Budget Paper No.1 for 2021-22 to 2025-26. All other health expenses were taken from Budget Paper No.1 released in previous Budget years.

[3] This seems like a conservative estimate. Budget Paper 1 states that Health portfolio spending will decrease by 8.3 per cent in real terms between 2021-22 and 2022-23 and decrease by 4.4 per cent in real terms over 2022-23 to 2025-26. Differences relate to the use of alternative inflation estimates.

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 2019-20 report. A linear forecast was used for years 2020-21 to 2025-26. 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 off Budget Paper No.1

It seems the Government is trying to wrangle Health portfolio funding back in line with long term funding growth trends. There are no big ticket reform items announced, with the largest increase in funding going to the continued COVID-19 response (see Chart 3).

Health portfolio expenditure will make up 16.8 per cent of all general Government expenses in 2022-23, and then 16 per cent for the next three years (See Chart 1). That is the average since 2008-09, although COVID-19 pushed that proportion below 15 per cent in 2020-21 due to massive spending on social security and welfare.

The estimated reduction in funding for 2022-23 is due to the cessation of some COVID-19 emergency response measures. This is not guaranteed given COVID-19 continues to mutate. Annual funding does not increase again until 2024-25, despite significant funding increases estimated for public hospitals as part of the National Health Reform Agreement (see Chart 4). That came into effect nearly two years ago, which means there are no new commitments to funding regular public hospital activity in this Budget.

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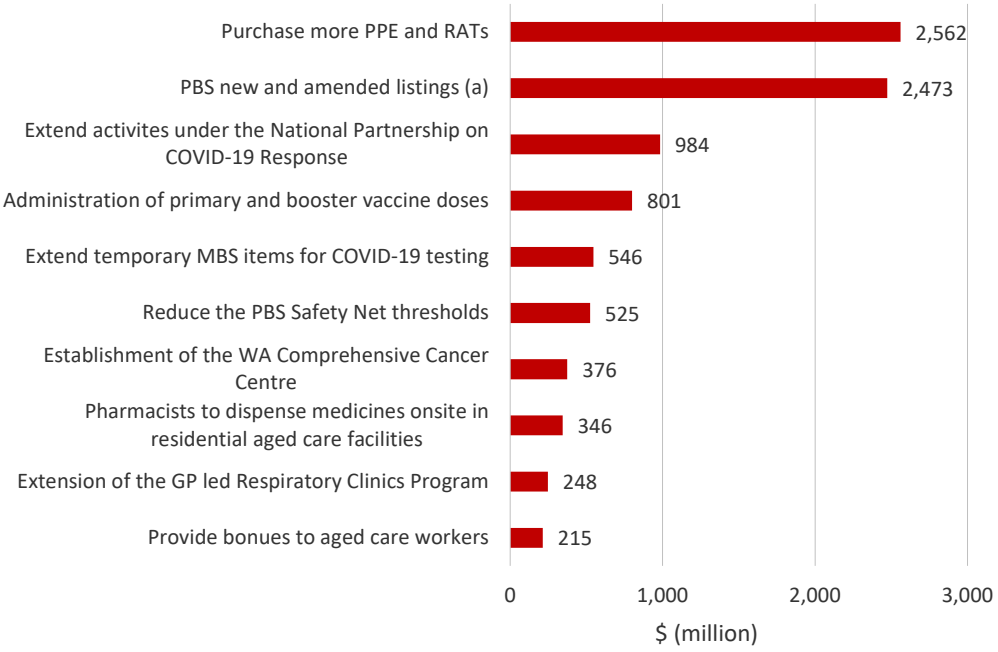
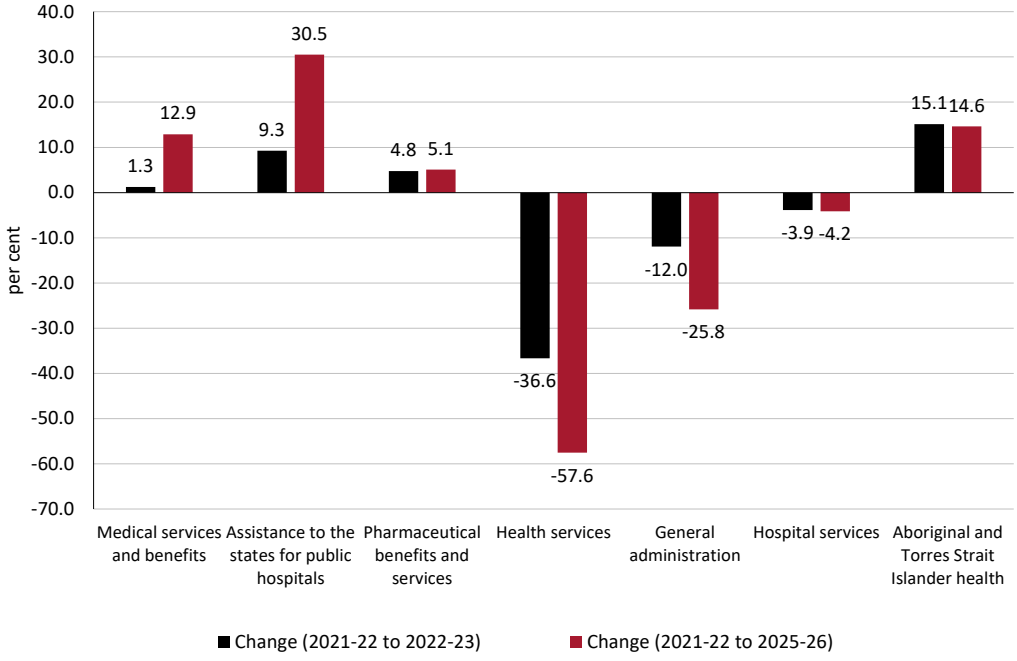
Chart 3: Top 10 Health portfolio item expenditure increases



Note: (a) 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: 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

There are other significant estimated funding decreases announced in this Budget unrelated to COVID-19. This includes real funding reductions in:

- Medicare Benefits Schedule (MBS) funding of 2.2 per cent for 2022-23
- Private health insurance rebate of 0.6 per cent over the forward estimates
- Pharmaceutical benefits and services of 7.7 per cent over the forward estimates
- Veterans' hospital services of 8.2 per cent over the forward estimates.

There will never be enough funding in the Government coffers to meet all Budget demands. Budgeting is an exercise in rationing limited funds against unlimited wants.

As net Government debt is forecasted to climb another $233 billion over the next four years, and as increased interest rates put pressure on debt servicing costs, it will become harder for future Health portfolios to meet growing health and aged care needs.

Government coffers are running dry, and history suggests there is no appetite to reallocate funding from other portfolios to the Health portfolio or to raise taxes. Despite this, population growth, ageing and increased health technology prices will continue to put cost pressure on the Health portfolio.

The Government has identified further healthcare system change requiring substantial investment over the next decade, although most of that is not reflected in this Budget. Last year the Government established reform agendas in aged care and mental health. The Government has also released several medium term strategies, such as:

- National Women's Health Strategy 2020-30
- National Preventative Health Strategy 2021-30
- National Obesity Strategy 2022-32
- 10 year Primary Healthcare Plan
- 10 year Stronger Rural Health Strategy

The most pressing issue is workforce shortages. With the Budget projecting unemployment dropping below four per cent, there will be less spare labour capacity within the economy to increase the supply of health and aged care services.

There is a shortage of aged care workers, disability care workers, nurses, some specialist types, mental health care workers and others, particularly in rural and remote regions. Shortages lead to poor quality care, longer waiting times and on some occasions, missed care and worse health. These sectors will buckle if a mutated COVID-19 strain can significantly reduce vaccine effectiveness (without another lockdown).

Workforce shortages are an endemic, multifaceted, cross jurisdictional problem within the health and aged care systems. COVID-19 has amplified issues but poor planning and funding constraints by federal and state governments over the last decade must shoulder some of the blame.

The Government is starting to address some workforce issues, and has recently released (or is finalising) several workforce strategies, including:

- 10 year National Medical Workforce Strategy
- 10 year National Nursing Strategy

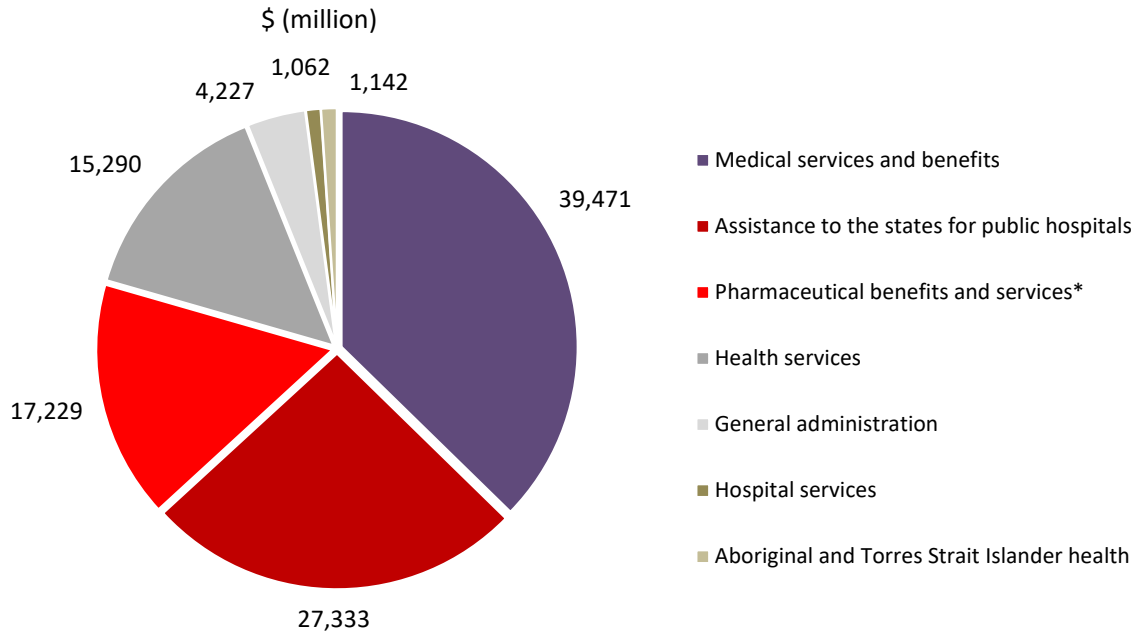
- 10 year Nurse Practitioner Strategy
- 10 year National Mental Health Workforce Strategy
- Aged Care Workforce Action Plan 2022-25.

Implementing these plans will be expensive. While the Government can ask for more out of pocket contributions in health, that would be a political hot potato, especially when cost of living is already running high and wages growth is stagnant.

A recent assessment of healthcare by 5,100 consumers was released this week by the Consumers Health Forum in conjunction with Australian Institute of Health Innovation (AIHI). Affordability of care and medicines was a substantial problem, especially for the disadvantaged or vulnerable groups.[4]

There is a pressing need to find more savings in the Budget by continuing to focus on removing low value care and by pushing a productivity increasing agenda within health and aged care. That should include substantial funding reform in primary care to reduce the incentive for over servicing the population the current fee for service model embeds. Funding for MBS services accounts for 40 per cent of all Health portfolio funding (see Chart 5).

Chart 5: Composition of health portfolio expenditure, 2022-23



Source: Budget Paper No.1

Funding reform must also happen in public hospitals. While the National Health Reform Agreement (2020-25) seeks to introduce payment based on value and outcomes, little has changed. Similarly, a

[4] Zurynski Y, et al 2022, The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey. Report prepared for the Consumers Health Forum of Australia, ISBN: 978-1-74138-491-8

nationally cohesive health technology assessment process to ensure services delivered through public hospitals are efficient has not yet been established.

Other productivity improvements could include further private health insurance reform, expanding the roles of less costly health professionals in a safe and effective way, more investment in health information technology (and its required workforce), better use of information and data to make clinical and policy decisions, and better use of evidence based guidelines to reduce unwarranted clinical variation.[5]

There is also the need to substantially increase investment in preventative health activities that change health behaviours and environments. The National Preventative Health Strategy 2021-2030 calls for greater investment in preventative health and health promotion, highlighting that the circumstances in which people grow, live, work, play and age are strong determinants of health.[6]

This Budget has started to address some issues, allocating $30 million in eight different prevention activities, although not much is allocated to innovative new programs. While programs such as the Sporting Schools are funded to continue, overall this Budget is unlikely to make a substantial difference to national health inequities, poor physical activity trends, or reduce obesity to the extent pursued within the National Obesity Strategy 2022-32.

[5] Productivity Commission, 2015, Efficiency in Health, Australian Government, accessed 30 March 2022.

[6] Department of Health, 2021, National Preventative Health Strategy 2021-30, Australian Government, accessed 31 March 2022

2. Sector analysis

This Budget comes at a time when the health and aged care systems are at their most valued. With stretched workforce and resources over the last two years, the heath and aged care systems have demonstrated remarkable resistance, minimising the impact of COVID-19 on health outcomes and saving lives.

While we work towards a new normal, with greater freedoms and the release of pent-up demand for social activities, our health and aged care systems are still in urgent need of reform.

The 2021 Australian Health Consumer Sentiment Survey released the same week of the Budget reported that while 84 per cent of Australians were satisfied with the health services they received, respondents were critical of aged care, with 23 per cent reporting that residential aged care services were 'bad' or 'very bad'.[7]

The Survey found affordability of care and medicines was also substantial problem for many, especially the disadvantaged or vulnerable groups. Worryingly, 14 per cent of people with chronic conditions could not pay for some aspect of healthcare or medicine, and 24 per cent did not fill a prescription or omitted doses of medicine, with over a third of these saying this was because of cost.

Around 58 per cent of respondents reported having private health insurance. The reasons for not having it were because of affordability, and that it offered poor value for money.

Access to care also remains a problem. Around 55 per cent of respondents in regional and remote Australia said they needed more doctors, nurses and health workers, and 23 per cent reported being disrespected or discriminated against when accessing care. Some 24 per cent of Australians reported serious levels of psychological distress, and 34 per cent had difficulty accessing care out of hours or on weekends.

Aged care

The aged care sector was the biggest winner in last year's Budget, receiving a $17.7 billion commitment over five years. It was the Government's response to the Royal Commission into Aged Care Quality and Safety, and was accompanied by five pillars of reform within a five year plan that contained 29 reforms.

The Government believes it has delivered significant reform one year after the Royal Commission into Aged Care Quality and Safety released its final report. It highlights a reduction in the number of people on waiting lists for Home Care packages and additional training places for people wanting to work in aged care, among other changes.[8]

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[7] Zurynski Y, et al 2022, The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey. Report prepared for the Consumers Health Forum of Australia, ISBN: 978-1-74138-491-8

[8] The Hon Greg Hunt, 2022, Aged care reform delivered a year after Aged Care Royal Commission, Media Release, 28 February 2022

The aged care sector is not so sure. The Australian Aged Care Collaboration noted low sector confidence and not enough progress had been made to address workforce shortages or quality assurance and improvement.[9] Many providers also remain under financial stress, limiting their ability to maintain quality, let alone improve it.

Most reform funding will come online for aged care providers between 2022-23 to 2024-25 (see Chart 6). For the first time in 2022-23, total expenditure on Aged Care Services will be greater than the Government's expenditure on public hospitals. This continues through the forward estimates.

Chart 6: Expected funding across time associated with aged care reforms announced in 2021

Source: The Budget 2021-22

The AN-ACC will replace ACFI in October 2022, and the Independent Hospital Pricing Authority (IHPA) is expected to provide price information for next year's Budget.[10] Many providers will need a significant increase in funding if they are to increase quality.

This Budget has allocated more funding to aged care but mainly to cover COVID-19 response related costs. This includes $458.1 million over five years in new funding, which primarily comprises $215.3 million over two years to provide bonuses to aged care workers, and $124.9 million in 2022-23 to help providers manage and prevent outbreaks of COVID-19. Funding was also allocated for vaccination delivery by aged care workers, infection prevention and control, PCR testing and supplying RATs.

The Government also announced $468.3 million over five years to further implement its response to the Royal Commission into Aged Care Quality and Safety, although only $122.6 million is new funding.

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[9] Australian Aged Care Collaboration, 2021, Aged care reform scorecard, December 2021, accessed 30 March 2022

[10] The IHPA is expected to change its name to the Independent Health and Aged Care Pricing Authority this year.

Furthermore, $345.7 million will go to pharmacists so they can dispense medicines onsite in residential aged care facilities.

The most pressing issue for aged care currently is an underpaid and exhausted workforce, with ever increasing labour supply gaps. A workforce strategy for aged care was released in 2018 but this seems to have derailed.

The Government released the Aged Care Workforce Plan 2022-25 alongside this Budget and committed $49.5 million over two years to provide an additional 15,000 low fee and fee-free training places in aged care courses under the JobTrainer Fund. The Productivity Commission has also been tasked with reviewing aged care employment models and their relation to care quality.[11]

While more training is welcome, along with making it easier to attract and retain aged care workers from overseas, ultimately the aged care workforce can only flourish if wages increase. The sector needs to bring wages up to par with the health sector and provide better working conditions.

While the Government is not explicitly responsible for aged care wages, it will fund most of any increase given it's the primary source of provider funding. The only way to ensure providers can deliver increased wages is to increase funding through the AN-ACC. The first opportunity for that will be in next year's Budget through prices recommended by IHPA.

Hospitals

Public hospital funding for regular activity is dictated under the National Health Reform Agreement, where the Government has agreed to fund 45 per cent of the efficient growth of Activity Based Funding (ABF) Service delivery, subject to the operation of the national funding cap. This Agreement means there will be substantial increases in Government funding over the coming years, mostly due to increased activity, but this Budget has not announced any new funding associated with regular public hospital activity.

States will receive another $984 million for the *National Partnership on COVID-19 Response*, building on $752 million allocated in the MYEFO. Some jurisdictions claim that ABF prices may need to be adjusted upwards because public hospital costs have substantially increased from changed delivery models and patient management processes in response to COVID-19, along with increased costs for PPE. [12] The AMA also noted that public hospitals are chronically underfunded, leading to a decline in performance and putting lives at risk.[13]

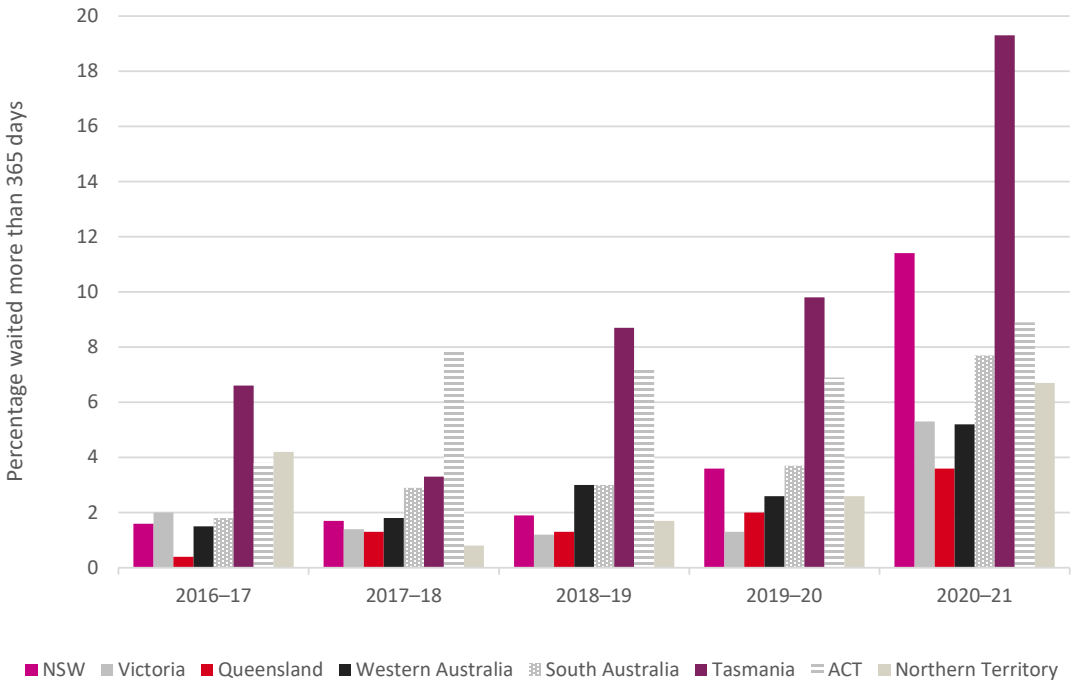
[11] Productivity Commission, 2022, Aged care employment, accessed 30 March 2022.

[12] NSW Health, 2021, NSW submission to the Independent Hospital Pricing Authority (IHPA), Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23, accessed 28 March 2022

[13] AMA, 2022, AMA Pre-Budget submission 2022-23. Chapter 1: Public hospitals in crisis, accessed 30 March 2022

Hospitals are heading further into crisis territory with COVID-19 blowing out public hospital elective surgery waiting lists. Around 5 per cent of public patients in Victoria waited more than 365 days in 2020-21, while it was 11 per cent in NSW (see Chart 7). Nationwide, the proportion of patients waiting more than 365 days for their elective surgery increased from 2.8 per cent in 2019-20 to 7.6 per cent in 2020-21.[14]

Chart 7: Waiting time statistics for admissions from waiting lists for elective surgery



Source: AIHW 2022, Elective Surgery Waiting Times 2020-21 data tables

Non-urgent elective surgery was again suspended within the Delta and Omicron waves. This will most likely blow out waiting times further.

There is a strong argument for the Government to lead on improving public hospital elective surgery waiting times. This should be achieved through more investment and an amendment to the National Health Reform Agreement. Ensuring timely access to care is not explicit within its long term health reform principles.

In the short term, governments could increase their use of private hospitals to help treat public patients. While some of this already occurs, and more so during the pandemic, it's a small amount relative to the total surgery load and hasn't stopped public hospital elective surgery waiting times from increasing.

Long term, the public hospital system and its integration with private hospitals should be strengthened to manage waiting times better. The public hospital system also needs to build more of its own elective surgery capacity. A mechanism to ensure targeted public funding for infrastructure and workforce, agreed between the federal and state governments, is needed.

[14] AIHW, 2022, Elective surgery, Australian Government, accessed 20 March 2022.

Public investment must sit within a hospital reform agenda. Public hospitals need to better plan for growing surgery demand and better manage internal processes to increase productivity. The healthcare system must attract more specialist time into public hospitals by ramping up migration and substantially increasing specialist training places.

There is also some low hanging fruit. Large waiting time disparities across public hospitals located close to each other highlight an inefficient allocation of resources and a mismatch of demand and supply. Proactively matching patients with hospitals that have shorter waiting times would reduce long waiting times for many.

Mental Health

The mental health care sector was a big winner in last year's Budget. The Government announced a $2.3 billion investment into mental health and suicide prevention, framed around five pillars of expenditure within its National Mental Health and Suicide Prevention Plan. The pillars of prevention, early intervention and suicide prevention reflected a seismic shift in the national response.

While most of the reform funding was allocated to expand existing mental health services through headspace and Head to Health networks, suicide prevention attracted almost $300 million to establish a National Suicide Prevention Office. The purpose was to oversee a whole-of-government approach to suicide prevention, expand leadership and support, and sustain the former National Suicide Prevention Trial sites.

Suicide rates seem to have turned a corner, coming down slightly in the latest Australian Bureau of Statistics data for 2020 (see Chart 8), [15] despite the lockdowns and financial upheaval that came with COVID-19. That does not reflect the investment announced in last year's Budget given suicide data was for the year prior, however it will hopefully help continue the downward trajectory.

The Government prefaced its reforms by noting that recommendations require collaboration with state and territory governments, pursued jointly through a new National Mental Health and Suicide Prevention Agreement. National Cabinet provided in-principle endorsement of the Agreement in December 2021,[16] but the Agreement is being finalised.

Missing from last year's Budget was serious investment in reform to deliver a comprehensive and integrated workforce, and to deliver the type of structural change to the sector recommended by the Productivity Commission. The 2022-23 Budget hasn't addressed those gaps in any substantial way.

The Government may be waiting on guidance from the National Mental Health Workforce Strategy and National Mental Health and Suicide Prevention Agreement. However, the former is being finalised while the latter came into effect in March 2022, so they could have informed further reform in this Budget.[17]

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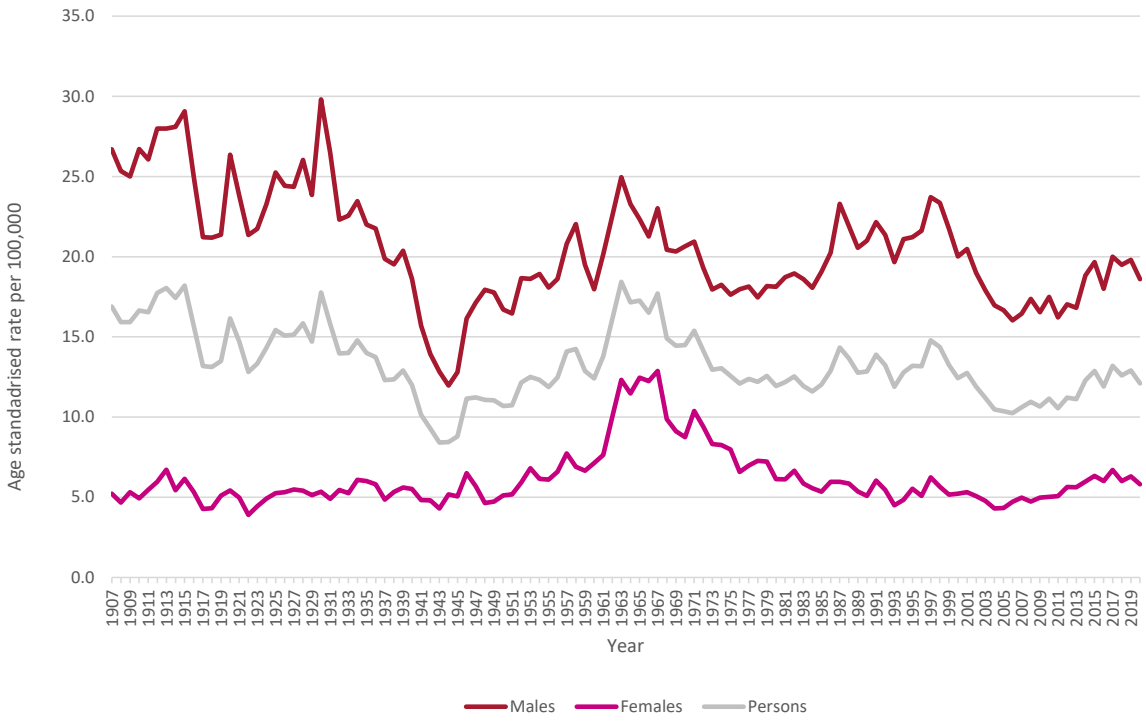
[15] ABS, 2021, Causes of Death, Australia, accessed 28 March 2022.

[16] Suicide Prevention Australia, 2021, National Cabinet provides in-principle endorsement of National Mental Health and Suicide Prevention Agreement, accessed 30 March 2022.

[17] Commonwealth of Australia, 2022, National Mental Health and Suicide Prevention Agreement, accessed 31 March 2022.

Chart 8: Suicide rates by year of registration of death and sex, 1907 to 2020



Note: Deaths are counted according to year of registration of death, not necessarily the year in which the death occurred.
Source: AIHW National Mortality Database and from the Australian Bureau of Statistics (Causes of Death, Australia, 2020).

The Government announced a further $547 million over five years for mental health, although only $303 million is new funding. Prevention and early intervention activities will receive $76.4 million, including $52.3 million for *Lifeline*. Suicide prevention activities will receive $46.7 million over two years, mostly targeted at regional initiatives.

Another $285 million over five years will increase treatment, primarily for vulnerable young Australians at risk of psychosis through the Early Psychosis Youth Services (EPYS) program delivered by headspace. Services targeting other vulnerable populations will receive $44.9 million over four years, while $24.3 million over four years will help develop innovative eating disorder models of care and fund current services.

The Government is addressing some workforce issues in this Budget although much more is required to reform the workforce. A total of $64.7 million has been allocated across six programs, including $28.6 million over three years to increase the size of the psychiatry workforce, and $18.3 million over three years for a national mental health 'pathways to practice' program for nursing, allied health and psychology students.

Pharmaceuticals

Big news for the pharmaceutical sector since the last Budget was a landmark five-year strategic agreement between Medicines Australia and the Government. The Agreement aims to ensure that

Australians receive quick access to cost effective innovative medicines, and that consumers have a greater voice in the assessment of new medicines.[18]

The Pharmaceutical Benefits Advisory Committee (PBAC) makes recommendations to the Minister of Health on which new medicines should be listed on the Pharmaceutical Benefits Scheme (PBS). Health technology assessment (HTA) uses evidence and best practice methods to assess the quality, safety, clinical effectiveness, and cost effectiveness of medicines. The PBAC considers outcomes from HTA commentaries when making recommendations to list a new medicine.

A major review of health technology assessment (HTA) methodologies and medicine purchasing practices will begin in July 2022. This will include an analysis of recent HTA reforms in other countries, such as the United Kingdom. The Agreement outlines several other activities to be undertaken. These include:

- Developing an Enhanced Consumer Engagement process to ensure consumer and patient perspectives are included early within the PBAC assessment process.
- Revising conditional listing and funding arrangements that build on the Therapeutic Goods Administration (TGA) fast track registration process.
- Implementing minimum stockholding requirements for important medicines
- Implementing an annual Horizon Scanning Forum to identify and better prepare for advances in healthcare.[19]

The Agreement sits within the broader context of the 31 recommendations made within the Inquiry into Approval Processes for New Drug and Novel Medical Technologies in Australia,[20] and the ongoing review of the National Medicines Policy.

There were two major spends for pharmaceuticals announced in this Budget. The Government has allocated $2.4 billion for new and amended listings on the PBS. This is a gross amount as some of this funding will be returned to the Government from rebates negotiated through purchase agreements. While the Government was quick to tout this allocation, the medicines were recommended for listing by the PBAC, and while PBAC is only an advisory body, convention among successive governments has been to accept PBAC recommendations to list medicines on the PBS.[21]

Big consumers of prescription medicines will also benefit. The Government will reduce the Safety Net threshold, costing $525 million over four years. It suggests concessional patients will need 12 fewer scripts and general patients two fewer scripts to reach the Safety Net Threshold. Reducing the Safety Net Threshold aligns with announcements to reduce the cost of living made in other portfolios (e.g., halving the fuel excise tax).

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[18] Medicines Australia, 2021, Strategic Agreement 2022-27. Building a future for earlier access to new medicines, accessed 31 March 2022.

[19] Ibid.

[20] House of Representatives Standing Committee on Health, Aged Care and Sport, 2021, The New Frontier – Delivering better health for all Australians, accessed 30 March 2022

[21] BioPharmaDispatch, 2020, The PBAC at arms-length but it is not independent in law or in practice, accessed 31 March 2022.

Pharmacy

In 2020, the Seventh Community Pharmacy Agreement (7CPA) was signed by the Australian Government, Pharmacy Guild, and the Pharmaceutical Society of Australia to ensure Australian patients have adequate and timely access to subsidised medicines.[22] The Agreement provides a degree of certainty and stability for community pharmacies and pharmaceutical wholesalers, although it had contentious location rules that restrict pharmacy competition.

The Australian Government committed to investing $18.3 billion in remuneration for dispensing PBS subsidised medicines, professional pharmacy programs, and community pharmacy management services over the five years through 7PCA.[23] For the first time within Community Pharmacy Agreements, Key Performance measures (KPM) were developed to provide a framework to evaluate the operation of 7PCA and answer the questions of whether 7PCA objectives and health outcomes are met and whether it represents value for money.[24] The KPM focuses on four main areas, including:

- transparency and accountability in supplying PBS medicines
- supplying the National Diabetes Services Scheme (NDSS) products through community pharmacies
- supporting professional initiatives for pharmacists
- supporting access to medicines and pharmacy services for people in regional, rural and remote areas.

KPM reports will be completed biannually, and reporting responsibilities are divided between different stakeholders.[25] None have yet been produced despite the Agreement being two years old.

The COVID-19 pandemic had a significant impact on the methods of service delivery in pharmacies. Electronic prescribing was due to roll out in 2021 but it was brought forward to mitigate the spread of infection in the community.[26] More than 37 million electronic prescriptions have been issued since May 2020, and more than 31,000 GPs and nurses have been engaged in ePrescribing.[27]

Pharmacies also played a prominent role in dispensing COVID-19 vaccines and their booster shots, although were brought in to administer vaccines relatively late in the vaccine rollout. More than six million vaccine doses have been administrated through pharmacies as of 29th March 2022, although that only represents 12 per cent of the total number of vaccines administered.[28]

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[22] Department of Health, 2020, Seventh Community Pharmacy Agreement, accessed 30 March 2022

[23] The Hon Greg Hunt MP,2020, More essential support for Australian patients through community pharmacy, Media Release, accessed 30 March 2022

[24] Department of Health, 2022, Seventh Community Pharmacy Agreement, Key Performance Measures and Monitoring Arrangements, accessed 30 March 2022

[25] Ibid.

[26]The Royal Australian College of General Practitioners, 2022, Electronic prescribing, accessed 30 March 2022

[27] Australian Digital Health Agency, 2022, Electronic prescriptions, accessed 30 March 2022

[28] Australian Government,. COVID-19 Vaccine Roll out, Operation COVID Shield, accessed 30 March 2022

Allowing pharmacies to administer COVID-19 vaccines ruffled the feathers of the Royal Australian College of General Practitioners (RACGP) and the Australian Medical Association (AMA).[29,30] They raised concerns about the lack of pharmacists' vaccine-related expertise and equipment, patient safety, and believed the vaccination should remain in the hands of GPs. It is no coincidence that their position also aligns with securing more GP funding for vaccinations. However, the inclusion of pharmacies in the rollout led to higher vaccination rates and helped meet a vaccine demand surge in the winter of 2021.

This Budget further embeds pharmacies into the health and aged care sectors. The Government announced $345 million for on-site pharmacists and community pharmacy services in government funded residential aged care facilities. Vaccinating pharmacies will receive additional access to PPE from the National Medical Stockpile, access to additional pulse oximeters, and will continue to supply free RATs to concession card holders through local community pharmacies.

Primary Care

In August 2019, the Government announced the development of a Primary Health Care 10 Year Plan as part of Australia's Long Term National Health Plan.[31] While during the years 2020 and 2021, primary care providers were inundated by the COVID-19 pandemic, many primary care measures introduced in response to the pandemic laid the foundation for the Plan.[32]

The Plan was developed through consultations with a wide range of stakeholders and aimed to empower patients and provide integrated care.[33] General practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, allied health services, mental health services, community health, and community nursing services are the plan's central focus.

While the stakeholders welcomed most changes introduced in the plan, RACGP argued that investment was insufficient and called for the adoption of further measures to address the remaining gap. RACGP suggestions included introducing permanent telehealth items, introducing telehealth for longer consultations, supporting GPs to adopt technology and new models of care delivery, and providing incentives to ease the GPs shortage in the rural area.[34]

The extensive adoption of temporary MBS telehealth services during the pandemic shaped a new normal for GPs and other primary service providers. More than 16 million Australians have used telehealth, with over 100 million services since it was introduced temporarily at the start of COVID-19.[35] There is strong community support for telehealth consultations, with 71 per cent of Australians saying they are as good

[29] newGP, 2021, Concerns raised over pharmacists' role in COVID vaccine rollout, accessed 30 March 2022

[30] AMA, 2021, AMA has 'significant reservations' about the role of pharmacists in vaccine rollout, Media Release, 11 February 2021, accessed 30 March 2022

[31] Department of Health, 2019, Australian Long Term National Health Plan, accessed 30 March 2022

[32] The Hon Greg Hunt MP, 2021, Consultation opens on draft Primary Health Care 10 Year Plan, Media Release, , accessed 30 March 2022

[33] Ibid.

[34] RACGP, 2021, Submission to the Primary Health Care 10-Year Plan, accessed 30 March 2022

[35] The Hon Greg Hunt, 2022, Telehealth hits 100 million services milestone, Media Release, accessed 31 March 2022

or better than face to face consultations.[36]

The Government announced an additional $106 million in the MYEFO to support the continuation of MBS telehealth services introduced due to the COVID-19 restrictions.[37] Patients can now permanently access GPs, specialists, and allied health via telehealth. However, having an existing clinical relationship with a GP telehealth provider remains the eligibility criteria for accessing telehealth services. There was also a gap in funding for telehealth for longer MBS consultations.[38]

This Budget sees a continued focus on responding to the COVID-19 pandemic. The Government allocated $892.1 million over two years to improve access to COVID-related services. This primarily consists of $546 million to extend temporary MBS pathology items for COVID-19 detection and diagnosis in 2022-23, and $248.1 million for the continuation of *General Practitioner Led Respiratory Clinics Program*.

Minor changes were made to extend the temporary MBS telehealth items over two years from 2021-22, restricted to COVID-19 positive patients only. It includes $20.4 million for longer specialist and GP telehealth consultations and $23.4 million to extend Healthdirect, Australia's national triage service to support COVID-19 positive patients.

This Budget allocated $423.7 million to cancer treatment and testing over the next five years, although only $380.5 million is new funding. Of the total, $375.6 million was allocated to establish the Western Australian Comprehensive Cancer Centre in Perth. It also includes $28.1 million to establish Genomics Australia and $15 million to fund an Australian Cancer Research Foundation Cancer Genome Facility over four years.

This Budget allocated $131.3 million over five years to update the MBS with new and amended listings, although only $40.3 million is new funding. Funding is mostly allocated to providing access to genetic testing for some genetic disorders, including cystic fibrosis, spinal muscular atrophy and fragile X syndrome. Other investment in Medicare includes $66 million for improved access to subsidised magnetic resonance imaging in regional, rural and remote areas.

This Budget committed $230.7 million to improve access to primary care health services. Of this, $108.5 million was allocated to continue the Federation Funding Agreement of Public Dental Services for Adults. This funding is a contribution to the states to provide public dental services to patients at high risk of major oral health problems, Indigenous patients and patients from rural and remote regions. It is not a new initiative, merely a continuation of an established relationship between the Government and states.

There was $56 million allocated in 2022-23 to support Primary Health Networks to commission after-hours health care services. This is a thorny, long standing deficit in care offerings.

This Budget has addressed some strategic items within the Stronger Rural Health Strategy, introduced in 2018. That includes boosting the rural and remote workforce, allocating $99.3 million over four years

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[36] Zurynski Y, et al 2022, The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey. Report prepared for the Consumers Health Forum of Australia, ISBN: 978-1-74138-491-8

[37] The Treasury, Mid-Year Economic and Fiscal Outlook 2021-22, Australian Government, Canberra

[38] The Hon Greg Hunt MP, 2021, Permanent telehealth to strengthen universal Medicare, Media Release, accessed 30 March 2022

to fund an increase in the number of medical students studying in rural and remote locations, and $36.2 million to fund two new University Departments of Rural Health in Queensland and Western Australia.

This Budget also introduced a 'Women's Health Package' to boost Australian women's health agenda. It includes $163.3 million over four years across 20 different items to improve women's health, support the implementation of the National Women's Health Strategy (2020-2030), and support women with Endometriosis, Breast and Ovarian cancer.

Private health insurance

Last year's Budget included a modest additional outlay of $30.2 million on private health insurance,[39] accompanied by promises of future reform, including Prosthesis list reforms and a review of policy settings.

No new spending has been allocated to private health insurance this year. The Government's big announcement instead was a deal with the Medical Technology Association of Australia, which will reduce medical device prices on the Prosthesis List, decreasing the difference between listed prices and Medicare-paid prices in the public system by 10 per cent, on average.[40]

This is expected to deliver savings of $900 million over four years to insurers. If insurers pass these onto members, it will equate to a $50 per year saving in premiums for families, which is less than two per cent saving on an average policy.

The Government has delivered the lowest average annual premium increase (2.7 per cent) in just over two decades. The Health Minister noted that this will increase premiums by $2.42 per week for families (around $125 per year).[41]

The price increase will be around 1 per cent greater than annual health inflation. Members should expect further premium increases. This year's price increase also exceeds annual wage growth, which is around 2.3 per cent,[42] meaning premiums will take up a greater proportion of household budgets.

Premium increases are being driven mostly by increased average use of hospitals across members (see Chart 9). Some have criticised the 2.7 per cent increase,[43] given the strong recovery in insurer

[39] Australian Government, 2021, Budget 2021-22, Budget Paper no. 2.

[40] N Robinson, 'Greg Hunt's prostheses deal to save on health insurance', The Australian, 16 March 2022, accessed 29 March 2022.

[41] The Hon Greg Hunt MP, *Delivering Australia's lowest private health insurance premium change in 21 years*, [media release], 23 December 2021, accessed 29 March 2022.

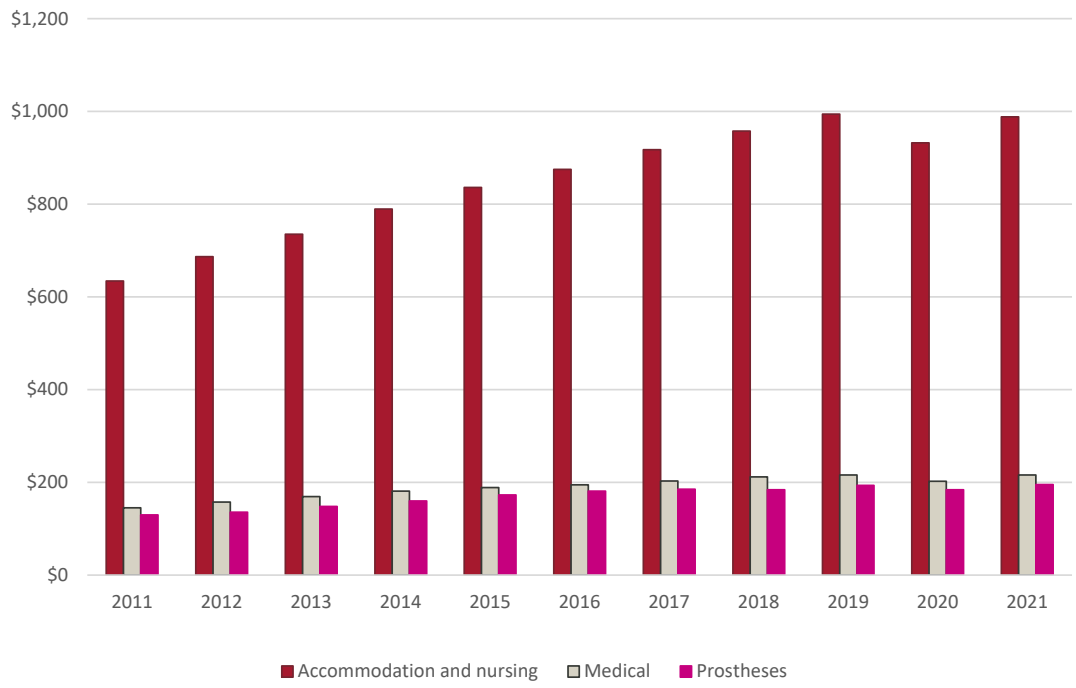
[42] Australian Bureau of Statistics (ABS), *Annual wage growth increases to 2.3%*, [media release], 23 February 2022, accessed 30 March 2022.

[43] C Maskell-Knight, 'A rubbish decision? Why private health insurance premium rises should have been rejected', Croakey, 19 January 2022, accessed 30 March 2022.

profitability in the year to December 2021. Net profits surged by 229 per cent, driven by higher investment income.[44]

Private health insurance membership continued to grow in the past year with 44.9 per cent of the population holding hospital cover in December 2021 (compared to 44.1 per cent in December 2020). The insured pool, nonetheless, continued to age – the largest net increase in hospital coverage was for 75-79 year olds, with a net decrease in coverage for 25-29 year olds.[45]

Chart 9: Hospital benefits per insured person over time



Source: Australian Prudential Regulatory Authority.

While reduced medical device prices deliver on the Government's announcement of Prosthesis list reform, thy are not enough to stop upward pressure on hospital benefits and premiums from the continued ageing of the insured pool. Hospital treatment benefits per person increased by 6 per cent in the past year from $1,324 to $1,406.[46] Stemming these costs will require more investment from insurers to keep people out of hospital. Some insurers are starting to vertically integrate into hospitals to reduce their costs.[47]

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[44] The Australian Prudential Regulation (APRA), *Quarterly private health insurance statistics – highlights December 2021*, published 2 March 2022, accessed 30 March 2022.

[45] The Australian Prudential Regulation (APRA), *Quarterly private health statistics December 2021*, published 2 March 2022, accessed 30 March 2022.

[46] Ibid.

[47] J Lynch, 'Medibank set to invest in third hospital to slash out-of-pocket costs', The Australian, 25 February 2022, accessed 30 March 2022.

The private health insurance rebate also continues to be a drain on Health portfolio funds. The Government spent nearly $7 billion on the rebate last year and is projected to spend another $29 billion over the next four years. While the Government review of rebate and Medicare Levy Surcharge (MLS) policy settings is currently ongoing, removing the rebate seems off the table, despite no evidence that it provides a sufficient return on investment.

Vaccines

After initially slow vaccination uptake early last year marred by concern over vaccine side effects, bungled vaccine rollouts[48] and changes in age thresholds for the Oxford/AstraZeneca vaccine,[49] Australia now sits comfortably at a double vaccination rate of over 95 per cent for those aged 16 years and over.[50]

Booster vaccine rollout is continuing with 51 per cent of the eligible population vaccinated, as is rollout of the vaccine for children, with 25 per cent of 5-11 year olds and 80 per cent of 12-15 year olds double vaccinated.[51]

With surging COVID-19 cases in Australia (55,000 per day, on average, over the past week)[52] and the recent advent of super-infectious variants,[53] the pandemic is far from over. As Australia continues to navigate the pandemic and tailor responses to COVID-19 spread, the focus has shifted to the duration of vaccine effectiveness and the need for additional booster doses.[54]

These developments are reflected in this Budget, with COVID-related spending announcements spread across different areas of the Health portfolio and a substantial amount committed to supporting vaccination and testing.

This year's Budget commits approximately $1 billion over two years from 2021-22 to 2022-23 to supporting ongoing vaccination, continuing the booster dose program and supporting the rollout of vaccines to newly eligible cohorts. The Government notes this will support potential primary course vaccinations for children under four years, boosters for children five years and over and fourth 'winter boosters' for priority populations.

Planned vaccine spending includes $839.8 million to support continued access to COVID-19 vaccines through current administration channels (primary care, community pharmacies, private health

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[48] B Worthington, 'Australia secures additional Pfizer vaccine following AstraZeneca concerns'. ABC, 9 April 2021, accessed 30 March 2022.

[49] Department of Health, *ATAGI statement on AstraZeneca vaccine in response to new vaccine safety concerns*, 8 April 2021, accessed 30 March 2022

[50] Department of Health, COVID-19 Vaccine Roll-out, 29 March 2022, accessed 30 March 2022

[51] Ibid.

[52] Our World in Data, 2022, *New cases and deaths Australia*, accessed 30 March 2022.

[53] A Tsirtsakis, 'What does the Omicron sub variant mean for Australia's pandemic response?', The Royal Australian College of General Practitioners (RACGP) newsGP, 6 February 2022, accessed 30 March 2022.

[54] Department of Health, *ATAGI statement on recommendations on a winter booster dose of COVID-19 vaccine*, 25 March 2022, accessed 30 March 2022.

networks and targeted vaccinations for priority populations), $70.9 million to extend the current operations of the National COVID Vaccine Taskforce to support the planning and delivery of COVID-19 vaccines and $66.7 million to support data and digital systems underpinning rollout.

The Government has also allocated $69.3 million over two years to the 2021-22 for the National Partnership on COVID-19 Response for vaccines.

The Government announced an agreement with Moderna Inc to establish a sovereign mRNA vaccine manufacturing capability in collaboration with the Victorian Government. The planned facility will be based in Victoria and is intended to provide Australia with priority access to mRNA vaccines, support research and development and ensure domestic preparedness for possible future pandemics. Funding for this measure has not been released due to commercial-in-confidence sensitivities.

Other spending announcements related to vaccination include:

- $100.0 million over five years from 2021-22 to the Coalition for Epidemic Preparedness Innovations, and a further $85.0 million to access vaccines for low income counties through the COVAX Facility.
- An extension to the COVID-19 Vaccine Claims Scheme to include children aged 0 to 4 years and fourth doses for priority cohorts to access compensation for claims related to the administration of COVID-19 vaccines (figures commercial-in-confidence).
- $43.3 million in support for the Remote and Indigenous Response to COVID-19 and the transition to living with COVID, which will include targeted communications about COVID-19, vaccinations and boosters.

The Government claims these new investments bring total expenditure on COVID-19 vaccines and the vaccine rollout to over $17 billion since the pandemic began.[55]

A non-COVID-related public health development has been the recent outbreak of the Japanese encephalitis virus, which has a 25-30 per cent fatality rate among symptomatic people. It has been discovered in sites across Victoria, New South Wales, Queensland and South Australia over the past month.

The Government has been swift in its response, with a 'Japanese Encephalitis Virus National Plan' that has been allocated $69.0 million in funding over two years from 2021-22. This includes the purchase of 125,000 doses of the Imojev vaccine (Sanofi-Aventis Australia) and 10,000 doses of the JEspect vaccine (Seqirus).

[55] Department of Health, *Response to the COVID-19 pandemic – Protecting 19 Australia with COVID-19 vaccines*, 29 March 2022, accessed 30 March 2022.