The MUCHE Health Report 2021
ANALYSIS OF THE 2021-22 FEDERAL BUDGET
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About MUCHE

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

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

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

Macquarie University’s Centre for the Health Economy (MUCHE) is a strategic initiative to undertake innovative research on health and aged care. Our vision is to create a world where decision makers and the public are empowered with trusted and influential 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 using a clear communication strategy to inform public debate, assist decision-making, and help formulate strategy and policy.

We investigate the Health Economy at the macro and micro levels, 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.

Our point of difference lies in our approach to research. 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 now 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. These include partners within the Australian Hearing Hub, the Australian Institute of Health Innovation, H:EAR, and the Centre for Emotional Health. Our collaborations extend to world leading universities in 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.

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Executive summary

The Government is playing catch up in this Budget after resources were shifted to the COVID-19 pandemic response last year. It has spent big on aged care and mental health care, responding to landmark reviews. But there are still significant gaps in this Budget that could leave the Government exposed.

Nominal growth in health expenditure will be 4.0 per cent in 2021-22. This is half the growth the health portfolio experienced in the two previous Budgets. Health expenditure will also be much tighter in 2022-23, around 4.7 per cent less in real terms once health inflation and population growth are considered. It seems the Government had an election in mind when developing this Budget, and pushed some hard funding decisions into the future.

Aged care will receive a $17.7 billion injection, but more is required. Most consists of $6.5 billion for another 80,000 Home Care packages, $3.9 billion to help frontline workers meet a mandated allocation of time spent with residential aged care recipients, and $3.2 billion to increase the Basic Daily Fee supplement by $10 per day. This funding should have occurred years prior.

However, increased aged care funding is not the main story here. This Budget has ushered in a fundamental shift in thinking on how the residential aged care market should be structured. The Government is looking to harness the power of competition to improve quality and hand market power back to consumers.

This Budget allocated $102.1 million to discontinue the current bed license and the Aged Care Approvals round process from 1 July 2024. That will remove significant barriers to entry for new providers and allow better providers to grab more market share.

The Government will strengthen aged care quality monitoring and enforcement. The Aged Care Quality and Safety Commission will receive another $262.5 million, and a star rating system will be introduced to measure and report on provider quality. Consumers will be able to evaluate the quality of residential aged care facilities like restaurants and hotels.

While additional funding, strengthened quality frameworks and harnessing competition is a welcome start to aged care reform, there is more the Government must do. Otherwise, all of this could amount to naught.

Providers need more funding to promote innovation. Around 42 per cent of providers reported a net loss in 2018-19. This Budget won’t help their cause despite a $279.8 million viability supplement.

Aged care prices must increase to reflect the cost of delivering high care quality. This Budget expands the Independent Hospital Pricing Authority (IHPA) to advise the Government on aged care prices. However, the Royal Commission recommended IHPA determine aged care prices. Under this Budget, providers still face funding uncertainty given the Government still has control over prices.

This Budget hasn’t addressed the problem of poorly paid workers in aged care. Providers will find it challenging to attract the additional workers needed for Home Care packages and mandated time requirements in residential aged care.
Aged care will likely need another $5 billion a year to meet the quality standards imagined by the Royal Commission. This Budget has not asked care recipients to pay more, or raised taxes to secure future aged care funding. Instead, the national credit card has been used. Debt is unsustainable, so the only long-term solution is having both users and taxpayers contribute substantially more to aged care.

This Budget has also tackled mental health reform, allocating $2.3 billion to mental health and suicide prevention, framed around five pillars. These are $248.6 million for early intervention and prevention, $298.1 million towards suicide prevention, $1.4 billion for mental health treatment, $202 million to workforce and $107 million targeted towards vulnerable groups. This reflects a solid investment in mental health care, although it falls short of delivering structural change.

This Budget does not extend to a full mental health reform agenda that the Government could have embraced. Instead, it addressed some priority Productivity Commission recommendations. These include screening and supports for new parents, a national stigma reduction strategy, first stages of digital and person-centred transformation, follow up care for people after a suicide attempt, regional treatment centres and empowering Indigenous communities to prevent suicide.

Suicide prevention is a key focus of this Budget, attracting almost $300 million to establish a National Suicide Prevention Office to oversee a whole-of-government approach.

Nearly half of additional mental health expenditure is committed to treatment, essentially to expand existing services. This is particularly evidenced in the $820.1 million committed to the Head to Health and Headspace networks. A realigned focus towards youth and child mental health (worth $332.8 million) and towards regional areas is applauded.

This Budget has committed to establishing navigable person-centred mental health infrastructure, with $11.6 million provided to enable Head to Health to deliver comprehensive online and face to face supports, services and referrals.

However, this Budget’s commitment to mental health workforce expansion and reconfiguration are tokenistic. Perhaps the Government is awaiting future guidance from the Mental Health Workforce Strategy. Nonetheless, this Budget does not capture the breadth of the investment required to deliver a comprehensive and diverse mental health workforce for the future, nor address immediate workforce shortages.

Of course, COVID-19 has not gone away. After the Government tripped over the starting line with its vaccination strategy, it has now asked states and territories to play a much greater role in vaccinating Australians. The vaccination rollout is still slow, and lags behind many other countries, but this Budget allocates $1.9 billion to help it get back on track.

Primary care also wins. Another $204 million was allocated in this Budget to telehealth services, although reimbursement arrangements will change from July 2021. The Government allocated $480.9 million to improve primary care access, but only $297.4 is an additional expenditure, and of this, $288 million is for repetitive Transcranial Magnetic Stimulation for severely depressed patients. The My Health Record system gets another $301.8 million.

This Budget has not addressed many grand challenges permeating the Australian healthcare system. The Government closed down all unnecessary elective surgery last year in response to COVID-19. That blew out public hospital elective surgery waiting times when many people were already waiting more than a year. Nobody should have to wait this long when suffering.

Our public hospital system must do better. The Government should work with state and territory governments to substantially reduce public hospital waiting times, by spending more on infrastructure and workforce. That should include building on private hospital partnerships established within the National Partnership Agreement (NPA) on COVID-19 Response to undertake more public patient elective surgery in private hospitals.
This Budget allocated $23.1 million for Prosthesis list reform. While private health insurers will welcome this spend, it won’t significantly reduce their cost pressures. That requires insurers to invest more to keep people out of the hospital.

The private health insurance rebate continues to cost the Government $6.7 billion every year. That is more than it costs to run the entire South Australian public hospital system. This Budget projects $27.7 billion will be spent on the rebate over the next four years.

The rebate’s return on investment has never been established. Quantifying this return is paramount for fiscal responsibility, especially when this Budget is dripping with red ink. Any review must include a comprehensive review of private health insurance and policy settings to increase its sustainability without unduly draining Government resources.

Overall, this Budget has attempted to address some long standing problems within aged care and mental health. But handing over buckets of money and planning for change is the easy part. The hard part is implementation and evaluation. The Government must now demonstrate it has the leadership capabilities required. Failing to deliver will frustrate the thousands of providers that deliver care every day and could lead to real harm.
1. Aged care

The Royal Commission into Aged Care Quality and Safety finished in February 2021. It cost the Australian taxpayer $91.7 million and took over two years to complete. It delivered a final report that consisted of five volumes and thousands of pages of analysis derived from 25 public hearings, 30 research and consultation papers, and eight background papers. We know more about the aged care system than ever before.

But the Royal Commission let Australians down. It could not agree on a governance structure or implementation plan, and without those, the Government was not given a clear direction. This is despite the prime minister claiming that ‘there is a clear roadmap to improve respect and care for our older Australians’.¹

A lack of direction makes it harder for aged care providers to undertake long term investment, given the future is no less uncertain. It makes it harder for Australians to hold the Government to account for undertaking the right mix of systemic reform needed.

There were lots the two Commissioners agreed upon. This included a greater consumer focus, workforce improvement, care quality improvement, universal entitlement, and a significant injection of additional funding into aged care. While many proposed aged care system changes were fully explored and supported within other aged care reviews before the Royal Commission, the final report has significantly pushed the aged care debate forward.

The Commissioners ultimately had differing views on who should shoulder the most blame for the state of the aged care system. One Commissioner blamed government stewardship while the other Commissioner blamed providers and ‘the market’. This formed their views on aged care system governance. One Commissioner suggested a commission independent of the Department of Health should govern, while the other suggested the Department of Health should continue to hold the reigns, although with some governance adjustments.

Many recommendations made by the Royal Commission could improve the aged care market significantly. Creating an entitlement approach and improving quality information for consumers could substantially bolster provider incentives to improve care. However, the Commissioners rejected some market mechanisms by seeking to keep price controls on daily living expenses and care services, and by tightening price controls on accommodation. Price controls are only needed if price and quality information is poor and competition is weak.

The Commissioners recognised the importance of getting aged care pricing right, given it drives behaviours and investment decisions, and recommended an independent aged care pricing authority. But they couldn’t agree on the best approach. One Commissioner recommended a new agency, while the other recommended the Independent Hospital Pricing Authority (IHPA) undertake the role.

¹ The Hon Greg Hunt MP, Respect, Care and Dignity – Aged Care Royal Commission $452 million immediate response as Government commits to historic reform to deliver Respect and Care for Senior Australians, [media release], 1 March 2021, accessed 4 May 2021
The Commissioners squarely blamed the Government for systemic aged care failures by characterising it as a miser. The Commissioners recognised the sector needs substantially more funding to improve quality and sustainability, but did not indicate cost. One Commissioner estimated there was $9.8 billion less in the 2018-19 budget for aged care because of skimping and rationing undertaken by the Government over the last 20 years.²

A ‘back of the envelope’ calculation suggests recommendations would cost between $10-$20 billion each year. Big-ticket items include removing co-contributions to care, extra funding for daily living expenses, mandating minimum staff time spent on residents, making the aged care workforce more attractive, shifting Home Care to an entitlement based approach, increased provider returns to improve sustainability, and shifting to small scale congregate living.

The Government initially responded to the Royal Commission’s report by announcing $432 million in March to improve provider governance, attract more workers into the sector, and bolster residential aged care revenue.³ This is chump change compared to what is required in this Budget and expected by the aged care sector.

The Government has also invested more in Home Care packages, announcing another $859.4 million in the Mid Year Economic and Fiscal Outlook (MYEFO) over four years from 2020-21. While this builds upon significant funding increases in the past three years, billions more must be injected into Home Care before it meets the needs of older Australians.

To date, the Government has only stopped a blowout in unmet Home Care package need. There are still 60,456 people seeking a Home Care package at their approved level that have not yet received one, and another 36,403 people seeking a Home Care package at their approved level but have received one at a lower level.⁴ While waiting times to obtain a Level 1 package have fallen since 2017, they have increased for Level 2 to 12+ months and remained the same at 12+ months for Level 3 and 4.

**Significant Budget announcements**

K-POW. That’s the sound of a $17.7 billion dollar injection into the aged care system. It’s not a knock out blow to the complex problems identified by the Royal Commission. Rather the Government is playing catch up to spending that should have occurred years prior. The Government must still strengthen its leadership and prove it can implement reform before the aged care system can meet Australia’s expectations, and much more funding is required.

This Budget has three big spends in aged care. The largest spend is $6.5 billion to fund another 80,000 Home Care packages over the next two years (40,000 in 2021-22 and 40,000 in 2022-23). That should significantly reduce the waiting times for Home Care packages and get many older Australians off the waiting list. But it falls short of the Royal Commission’s recommendation to introduce an entitlement

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² Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, dignity and respect, Volume 1. Summary and Recommendations, Commonwealth of Australia, Canberra

³ The Hon Greg Hunt MP, Respect, Care and Dignity – Aged Care Royal Commission $452 million immediate response as Government commits to historic reform to deliver Respect and Care for Senior Australians, [media release], 1 March 2021, accessed 4 May 2021

approach. The bulk of the baby boomers needing Home Care packages are around the corner, which means more funding will be required.

Residential aged care providers will receive $3.9 billion to help frontline workers meet a mandated allocation of time spent with aged care recipients. It will undoubtedly improve quality for some residents, but it may not be money well spent overall. Investment in better staff training, enhanced care models, systems to collect and monitor quality information, and alternative governance structures could also improve quality and cost less.

Residential aged care providers will also receive an extra $3.2 billion by increasing the Basic Daily Fee supplement by $10 per day. Most of this should be spent on better food, which will be welcomed by the many thousands of residents who eat boring sub-standard meals every day. The Government will ask providers to report on nutrition, while food quality will also feed into a new provider star rating system. But there is a big question mark over whether this is enough. Recent analysis suggests providers need $20 per day to get back in the black for everyday living expenses.5

All up, these three measures account for more than three quarters of the total aged care expenditure within this Budget. But they are not the main story. Peel away the hype and this Budget reveals a fundamental shift in Government thinking towards residential aged care, which could transform aged care quality for good.

The aged care system is heavily regulated to ensure providers deliver a minimum level of quality. And that is what has been provided, a minimum level of quality that is unacceptable to Australians. This Budget flips the onus onto providers to deliver more than just the minimum. The Government is looking to harness the power of competition to improve quality by reducing barriers to entry and by handing market power back to consumers.

This Budget has allocated $102.1 million to discontinue the current bed license and the Aged Care Approvals round process from 1 July 2024. That will remove significant barriers to entry for new providers and allow better providers to grab more market share. Providers with run down facilities, or those delivering sub standard care, will now face brand new facilities with best practice care models opening across the road.

That will scare many providers. However, average quality within residential aged care should increase by pushing out providers with poor quality. Many will be providers with limited access to capital, weak management practices, or poorly trained staff. These providers are likely to be purchased by large providers that can more efficiently train staff, enhance care models, and invest in systems that collect and monitor quality information.

The quality monitoring and enforcement framework will also be strengthened. This Budget has allocated $262.5 million to the Aged Care Quality and Safety Commission (ACQSC) and $200.1 million to introduce a new star rating system to measure and highlight the quality of residential aged care providers. Consumers will be able to go online and assess residential aged care facilities like restaurants and hotels. That will further incentivise providers to increase their quality, and allow providers to compare themselves to others down the road.

5 Aged Care Financing Authority, 2021, The role of the Basic Daily Fee in Residential Aged Care, Australian Government, Canberra
While additional funding is welcomed, and a shift to a more competitive market is essential for improving quality, this Budget is incomplete. It outlines only half the job required to harness the power of competition and falls short of funding. Without further change, all this could amount to naught.

Providers need more funding to improve their capacity to increase care quality. Profitability has decreased substantially in recent years, with 42 per cent of providers reporting a net loss in 2018-19.\(^6\) That has virtually wiped out their capacity to innovate and invest in their workforce, and kept additional equity out of the market. This Budget won’t help their cause despite a $279.8 million viability supplement. It effectively locks providers into trying to improve care by increasing staffing alone. Large amounts of equity won’t flood into the sector until return on investment significantly improves.

Aged care prices must increase if they are to reflect the cost of high quality care. This Budget has allocated $49.1 million to expand the Independent Hospital Pricing Authority to collect cost information and advice the Government on aged care prices. However, this falls short of the Royal Commission’s recommendations, which suggested an independent pricing authority should determine aged care prices. It seems the Government was unwilling to lose some control of the Budget reins. That means providers will still face funding uncertainty given the Government still has control over prices.

Having the Independent Hospital Pricing Authority price aged care is potentially problematic. Aged care pricing must take a broader approach than hospital pricing. It should consider the economic cost of production, like hospital pricing, but also consider appropriate rates of return, asset valuations, and the need to promote competition. Prices must protect consumers from price gouging and boost efficiency. They must consider borrowing and investment opportunities, and quality of services, technology adoption, and meeting changing aged care preferences.

A big question remains over whether the aged care sector can attract enough workers. This Budget has allocated $228.2 million to create a workforce that can undertake a single assessment of older Australians as they enter and progress through aged care. They won’t be delivering care. Another $91.8 million will support the training of 13,000 new Home Care workers over two years from 2021-22, and $76.6 million will expand the number of places in the Aged Care Transition to Practice Program and Aged Care Scholarship Nursing program. It will also improve dementia care.

This Budget hasn’t addressed the problem of poorly paid workers in aged care. Only $135.6 million will be provided to eligible registered nurses if they stay with the same provider for more than 12 months. It will be difficult to attract workers to service the additional Home Care packages and to meet the mandated time requirements in residential aged care if wages are not increased. This Budget does not give providers any real option to do that.

While this Budget has allocated buckets of funding to aged care, it has fallen short by about half compared to how much it would cost to implement the Royal Commission’s recommendations. While these recommendations should not be treated as gospel, significantly more funding is required to improve provider sustainability, increase care quality, and attract and train a skilled workforce. That will probably cost another $5 billion a year. If the sector moves towards small scale congregate living, as recommended by the Royal Commission, that will cost billions more.

This Budget has taken off the table charging aged care residents more or raising taxes. Instead, it relies on the national credit card. This is something of a fudge, given taxpayers will ultimately pay off the debt.

\(^6\) Aged Care Financing Authority, 2021, *Eighth report on the funding and financing of the Aged Care industry*, Australian Government, Canberra
The Government accepts that aged care should be financed according to the ability to pay. It rejected the Royal Commission’s recommendation to remove the need for some residents to pay for their care services. The Government should now consider asking residents to pay more for better quality care, especially those with assets worth millions in housing. Many residents would be willing to pay more if they received much better care.

The Government wants us to trust it will deliver the additional funding required to improve care quality into the future. It has rejected recommendations by the Royal Commission to establish a levy through the tax system to shore up future funding. This leaves the aged care sector exposed to inadequate funding in the name of managing Budgets, which was a primary criticism of past Government behaviour. That will reduce investment in the sector that could have otherwise occurred if future funding was more certain.

Considering substantial amounts of additional funding is required before the aged care sector can deliver sustainable care quality, the only long-term solution is having both users and taxpayers contribute substantially more to aged care. That is because future Budgets will need a tighter leash, while aged care funding pressures will continue to increase. Debt is not a long-term solution, so the Government will need to find the courage to ask for more.

**Other significant announcements**

This Budget states that it will allocate $698.3 million to improve governance, but most of that is rhetoric. Of this funding, $397 million will fund capital grants for improving and building new facilities, $126 million is additional funding to cover off high operation costs in remote facilities, and $106 million is to develop an indigenous workforce in aged care to help Aboriginal and Torres Strait Islander people better navigate the system. None of this could be considered governance enhancing.

Despite calls from one Commissioner to completely overhaul the governance of the aged care system, the Government has decided to keep the governance structure pretty much unchanged. The Department of Health will retain absolute control of aged care policy, prudential and quality monitoring, regulation and funding.

The Government has agreed to draft a new Aged Care Act and has allocated $26.7 million over four years. However, this Budget has provided only a token nod to improving governance, picking up on the other Commissioner’s recommendations by establishing more advisor committees. It has included $21.1 million to establish a National Aged Care Advisory Council, Council of Elders, and an Inspector-General of Aged Care. These committees may provide a valuable perspective to how the aged care system should operate but will ultimately be nothing more than toothless tigers.

Access to primary care and medication management for aged care recipients will be improved, costing this Budget $365.7 million. None of this funding will accrue to aged care providers, instead going to primary care. This includes $42.8 million for GPs to visit aged care facilities, $37.3 million for Primary Health Networks to expand palliative care and $178.9 million to Primary Health Networks to support GPs for telehealth, out of hours support for residential aged care, dementia care pathways and better health screening to support people living at home.

This Budget has also allocated $189.3 million to introduce the Australian National Aged Care Classification (AN-ACC) funding model into residential aged care, to replace the Aged Care Funding Instrument (ACFI). Funding will soon be allocated to providers more closely aligned to the care needs of the consumer. However, this does not guarantee more funding for the residential aged care sector. That lever is still tightly held in the Government’s hand.
2. Hospitals

Hospitals have experienced a year like no other. Just as the federal, state and territory governments wrapped up the 2020-25 National Health Reform Agreement Addendum, outlining a partnership to fund hospitals and direct hospital reforms, Covid-19 struck. The Government ceased all unnecessary elective surgery (all of Category 3 and most of Category 2) in March 2020. These were later eased (but not all lifted) a month later in April. Victoria only returned to full capacity in November 2020.

The Government developed the National Partnership Agreement (NPA) on COVID-19 Response. This promised a 50–50 split with state and territory governments of the costs of diagnosis and treatment of COVID-19 related patients, along with funding for respiratory clinics and drive-through testing services.

All up, the Government allocated $4.8 billion. Of this, $3.1 billion was allocated to states and territories, and $1.7 billion was allocated to the private hospital viability guarantee.

The private hospital guarantee, which acted as an insurance contract, was unprecedented. It established potential access for public healthcare systems to 657 private hospital facilities (acute care, psychiatric and day hospitals) to provide care for public patients, including intensive care units and accommodation for quarantine and isolation cases.

While public hospitals expected and prepared for a Category 5 COVID-19 storm, they got a Category 1. Hospitals were spared the nightmare scenes seen worldwide of people dying in hospital halls, reception areas, and ambulances. The storm has now passed, and every day more Australians receive a vaccine, the clearer the sky becomes.

However, the Government's response to COVID-19 did impact public hospitals. Access to Emergency Departments and specialists in outpatient clinics declined when movement restrictions were in place. There was also an overall decrease in elective surgery waiting list admissions by 9.2 per cent between 2018-19 and 2019-20, due to elective surgery cancellations. This pushed elective surgery back for around 70,000 Australians.

Public hospitals still haven't caught up and waiting times have blown out. For example, median waiting times for non-urgent patients in NSW public hospitals increased 83 days to 320 days in October to December 2020, compared to the same period last year. Only 68.3 per cent of non-urgent public hospital patients in NSW received their surgery in the recommended time over that period.

Public hospital elective surgery waiting times were already problematic. While half of all patients are admitted to elective surgery within 39 days (the median waiting time), the wait depends on how urgent the elective surgery is, what type of surgery is received, and in which hospital the surgery takes place. There is substantial variation across Australia for the same type of surgery. For example, 9.8 per cent of elective surgery patients in Tasmania waited more than 365 days in 2018-19, compared to 1.3 per cent.

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in Victoria.\textsuperscript{9} Median waiting times have increased in three states (Queensland, Western Australia and South Australia) since 2015-16, while other states have reduced their waiting times, although only the ACT and Tasmania significantly.\textsuperscript{10,11}

Elective surgery waiting lists are an essential hospital performance indicator.\textsuperscript{12} They indicate gaps in hospital and specialist supply compared to the demand for elective surgery. Nobody should have to wait more than 365 days to receive elective surgery. Long waits inconvenience patients, lead to worse health outcomes because conditions deteriorate, and can cause economic hardship. The situation looks worse when we consider that waiting list times do not account for the initial wait to see a specialist before being put on a waiting list. This can add another three months.

**Significant Budget announcements**

There are no significant announcements in this Budget. However, the Government noted that higher than anticipated growth in public hospital services means its expenditure will increase by 9.5 per cent in real terms between 2020-21 and 2021-22. The Government is responsible for 45 per cent of the efficient growth in activity based services for public hospitals.

The perpetual struggle with elective surgery waiting times in public hospitals points towards two uncomfortable truths. Public hospitals do not have the resources to reduce waiting times, and governments won’t fund the additional resources required. Instead, governments have pushed their public health obligation to one side, allowing many patients to suffer months and sometimes more than a year while waiting for public hospital elective surgery.

Many Australians can jump the public hospital queue by purchasing private health insurance and seeking private hospital care. However, most low income earners cannot afford private health insurance, even with the rebate. Elective surgery access in Australia is a story about the ‘haves and have nots’, which the COVID-19 pandemic has exacerbated.

Our public hospital system must do better. The Government should work with state and territory governments to substantially reduce public hospital waiting times, by spending more on infrastructure and workforce.

The National Partnership on COVID-19 Response has set a precedent for integrating private hospitals into state and territory health systems. It ensured valuable private hospital sector resources and a skilled workforce were available to respond to COVID-19.\textsuperscript{13} The Government should continue with this theme and jointly fund, with state and territory hospitals, private hospitals to help public healthcare systems significantly reduce public hospital waiting lists.

\textsuperscript{10} Ibid.
\textsuperscript{11} The ACT and Tasmania had the longest median waiting time in 2015-16 at 59 and 72 days respectively.
\textsuperscript{12} JF Levesque, ‘Elective surgery waiting lists – what it does and doesn’t tell us about healthcare performance’, *Bureau of Health Information*, NSW Government, Sydney
\textsuperscript{13} Department of Health, 2020, *Annual Report*, Australian Government, Canberra
3. Mental health

Substantial reform to Australia’s mental health system is a *once in a generation opportunity*.\(^\text{14}\) This Budget occurs at a pivotal moment, where a spotlight on mental health care has been illuminated through consecutive natural disasters, the COVID-19 pandemic and heightened community awareness through National and State Inquiries. All come off the back of suicide rates that have stayed constant across the decade.

The Productivity Commission Inquiry into Mental Health, commissioned in 2018, was the broadest inquiry into mental health ever conducted.\(^\text{15}\) It concluded that mental healthcare system reform would produce large benefits; in quality of life, valued at up to $18 billion annually, and in increased economic participation, valued at up to $1.3 billion annually. Priority reforms would require an initial expenditure investment of up to $2.6 billion.

The Royal Commission into Victoria’s Mental Health System took a broad state-wide perspective of mental health care.\(^\text{16}\) Delivered in March 2021, it produced 65 recommendations across five chapters and concluded that the impact of mental ill health in Victoria was costing approximately $70 billion annually.

These reviews both revealed that previous mental health system reform attempts were unsuccessful. They highlighted that the mental healthcare system still requires further investment, lacks a trained workforce, focuses on clinical services at the expense of mental health determinants, is fragmented, hard to navigate, and has implementation failures. Governance has proven intractable.

The Government announced that it would respond to the Productivity Commission Inquiry in this Budget.\(^\text{17}\) While the Productivity Commission report was welcomed by most in mental health, there was growing sense of frustration that mental health reform was being kicked down the road, along with a

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\(^{17}\) The Hon Greg Hunt MP, *$1.335 million for Child, Youth and Perinatal Mental Health* [media release], 16 November 2020, accessed 6 May 2021
‘pandemic’ of reports and strategies, and piece-meals commitments by the Government to service expansion rather than undertaking complex ‘whole-of-government’ reform.\textsuperscript{18,19,20,21,22} The Government asserts it committed $5.7 billion into mental health care during 2020-21,\textsuperscript{23} though this is contested by some as realigned accounting and not new money.\textsuperscript{24} The 2020-21 expenditure was a piece-meal approach to mental health care expenditure primarily in response to COVID-19, encompassing the expansion of Headspace clinics,\textsuperscript{25} Early Psychosis Youth and Perinatal Mental Health Services,\textsuperscript{26} the scale up of services such as Lifeline, SANE and HeadtoHelp Clinics, media campaigns and universal telehealth. Government support for the Better Access Initiative doubled from 10 to 20 psychological support sessions.\textsuperscript{27}

The December 2020 MYEFO noted an additional mental health policy commitment of $1 million to a National Stigma Reduction Strategy across two years; $0.3 million in 2020-21 and $0.7 million in 2021-22, to be delivered by the National Mental Health Commission.\textsuperscript{28} It also reported that the Government plans to expand the Practitioner Review Program and the Professional Service Review to achieve efficiencies in Medicare payments (to specifically include telehealth) of approximately $157.2 million across four years from 2020-21.

Economic output directly impacts population mental health. JobKeeper was terminated in March despite the risk of significant COVID-19 outbreaks shutting down businesses. It’s too soon to gauge the longer-term economic and mental health effects of COVID-19, but the longer it takes for Australia to become vaccinated, the more risk businesses will face in being locked down due to COVID-19, and the greater potential for further mental health problems.

\textsuperscript{18} K Murphy, ‘Why mental health is the legacy-defining fight Scott Morrison can’t afford to lose’, \textit{The Guardian}, 21 November 2020, accessed 04 May 2021
\textsuperscript{19} R Clun, ‘Report after report: When will Australia finally deal with mental health?’, \textit{The Sydney Morning Herald}, 21 November 2020, accessed 04 May 2021
\textsuperscript{20} A Remeikis, ‘Landmark mental health report calls for $4bn upgrade to care from ‘moment’ a person is struggling’, \textit{The Guardian}, 16 November 2020, accessed 04 May 2021
\textsuperscript{22} S Rosenberg, ‘Productivity Commission charts familiar course for mental health’, \textit{Croakey}, 24 November 2020, accessed 04 May 2021
\textsuperscript{23} The Hon Greg Hunt MP, \textit{Government launches new headspace centre in Batemans Bay} [media release], 14 January 2021, accessed 04 May 2021
\textsuperscript{24} S Rosenberg and I Hickie, ‘Mental health funding boost: just nickels and dimes in the old shell game?’ \textit{Croakey}, May 04, 2021, accessed 04 May 2021
\textsuperscript{25} The Hon Greg Hunt MP, \textit{Steps toward better mental health for young Australians} [media release], 21 October 2020, accessed 04 May 2021
\textsuperscript{26} The Hon Greg Hunt MP, \textit{$13.6 million to support the mental health of new and expectant parents} [media release], 22 October 2020, accessed 04 May 2021
\textsuperscript{27} The Hon Greg Hunt MP, \textit{Caring for Mental and Physical Health during the pandemic} [media release], 14 October 2020, accessed 04 May 2021
\textsuperscript{28} The Treasury, \textit{Mid-Year Economic and Fiscal Outlook 2020-21}, Australian Government, Canberra
New mental health initiatives have been announced since the last Budget, including $15 million for innovative therapies for mental illness, $10 million for a new National Research Centre for Mental Health Care, and the launch of the first phase of the $89.5 million National Study for Health and Wellbeing. These funds were either committed previously or come from the National Health and Medical Research Council.

A more recent announcement was $114 million to extend universal telehealth coverage to the year end, captured in the 2021-22 May budget. However, consultations lasting more than 20 minutes are excluded from this extension and cease on 30 June 2021.

The House of Representatives established a Select Committee to inquire into Mental Health and Suicide Prevention with a broad ranging terms of reference to cover overlapping themes in recent Inquiries, Strategies, Plans and emerging evidence. Their final report is due in November 2021. A draft report identified five emerging themes of workforce, funding co-ordination, service accessibility and affordability, early intervention and stigma. The National Mental Health Workforce Strategy announced in the 2018 MYEFO is due mid 2021.

Little progress has been made to address the governance, cross portfolio and jurisdictional arrangements that fragment the funding flows for community mental health care, which also exacerbate the ‘missing middle’. A National Cabinet Reform Committee for Mental Health was established by the National Federation Reform Council in December 2020, to negotiate the process for a systematic, whole-of-government reform to be achieved through a National Agreement on Mental Health and Suicide Prevention. This is also planned for November 2021.

As the wheels of political change slowly pivot to consider how best to deliver universal mental health care, the Government must take responsibility for and lead the large whole system change recommended by the Productivity Commission. However, it will be at a loss to monitor its reform.

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29 The Hon Greg Hunt MP, $15 million for development of innovative therapies for mental illness [media release], 17 March 2021, accessed 04 May 2021

30 The Hon Greg Hunt MP, $10 million for National Mental Health Research Centre [media release], 16 March 2021, accessed 04 May 2021

31 The Hon Greg Hunt MP, National study of mental health and wellbeing gets underway [media release], 10 February 2021, accessed 04 May 2021

32 The Hon Greg Hunt MP, Universal Telehealth extended through 2021 [media release], 26 April, accessed 04 May 2021

33 Parliamentary Committee, The House Select Committee on Mental Health and Suicide Prevention, Terms of Reference, Australian Government, 2020

34 Parliament of the Commonwealth of Australia, Mental Health and Suicide Prevention - Interim Report, April 2021, accessed 04 May 2021

35 The Hon Greg Hunt MP, Major health investments in primary care and aged care in 2018–19 MYEFO [media release], 17 December 2018, accessed 04 May 2021

36 The Hon Scott Morrison MP, National Federation Reform Council Statement [media statement], 11 December 2020, accessed 04 May 2021
progress unless it also embeds a culture of evaluation for system delivery.\textsuperscript{37,38} Currently, data systems are not sufficiently linked to explore system change. High-level indicators, such as waiting times that indicate unmet need, are not broadly captured and are only available for Headspace services.\textsuperscript{39} Their national average wait is 14.5 days.\textsuperscript{40}

The likely economic benefits of mental health reform, which extend across portfolios and jurisdictions, potentially dwarf other macro-economic policy interventions.\textsuperscript{41} For mental health reform to be successful, it needs to be escalated as a priority across the central agencies of Treasury, Finance, Education, Justice and the other sectors beyond the Health, into ‘whole-of-government’ approaches.\textsuperscript{42} For a system that has been historically and systemically underfunded, an increase of appropriately invested funds will help to address the ‘missing middle’ in the community services. Using a parity of esteem approach would place commensurate funding for mental health care (12 per cent) at $22 billion.\textsuperscript{43}

**Significant Budget announcements**

In its seminal response to the Productivity Commission Inquiry report, the Government announced a record $2.3 billion investment into mental health and suicide prevention, framed around five pillars of expenditure. These are $248.6 million for early intervention and prevention, $298.1 million towards suicide prevention, $1.4 billion for mental health treatment, $202 million to workforce and $107 million targeted towards vulnerable groups including the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and for people with complex mental health needs, migrants, and multicultural communities.

The ballpark figure reflects a solid commitment to investment in mental health funding, approximates recommendations from the Productivity Commission Inquiry report and is welcomed. The pillars of prevention, early intervention and suicide prevention reflect a seismic shift in national response.

New funding commitments in this Budget show that the Government has broadened its lens to include mental health determinants by providing $77.1 million to the National Legal Assistance Partnership, Domestic Violence Units and Health Justice partnerships. Additionally, a navigable person-centred mental health infrastructure is being established and is in infancy, with $11.6 million provided to enable Head to Health to deliver comprehensive online and face to face supports, services and referrals.

\textsuperscript{37} Mental Health Coalition of South Australia (MHCSA), *Productivity Commission Report – A Once in a Generation Chance for Change*, 2021, accessed 04 May 2021

\textsuperscript{38} K Murphy, ‘Why mental health is the legacy-defining fight Scott Morrison can’t afford to lose’, *The Guardian*, 21 November 2020, accessed 04 May 2021

\textsuperscript{39} Australian Senate, Proof Committee Hansard, *Community Affairs Legislation Committee Estimates*, 24 MARCH 2021, accessed 04 May 2021

\textsuperscript{40} Ibid.

\textsuperscript{41} Mental Health Coalition of South Australia (MHCSA), *Productivity Commission Report – A Once in a Generation Chance for Change*, 2021, accessed 04 May 2021

\textsuperscript{42} The Royal Commission into Victoria’s Mental Health System, *Final Report*, Victoria, 2021, accessed 04 May 2021

\textsuperscript{43} Macquarie University Centre for Health Economy (MUCHE), *Funding models for mental health care*. Issues brief for the national mental health Commission Vision 2030, July 2020
Suicide prevention is the mental health budget’s darling, attracting almost $300 million to establish a National Suicide Prevention Office to oversee the whole-of-government approach to suicide prevention, to expand leadership and support, and to sustain the former National Suicide Prevention Trial sites. Activities in scope include aftercare services for all Australians discharged from hospital following a suicide attempt, national postvention services to help those bereaved or impacted by suicide and a national distress intervention program to reach people earlier in crisis.

This Budget does not extend to a full reform agenda that the Government could have embraced. Almost half of the mental health expenditure is committed to treatment centres, and essentially it expands the same mental health care services, many of whom were key recipients in the 2020-21 budget.

This is particularly evidenced in the $820.1 million committed to expanding the Head to Health and Headspace networks. A realigned focus towards youth and child mental health in this Budget (worth $332.8 million) and towards regional areas is applauded.

Funding for the Better Access Initiative is expanded to include supports for carers and group therapy, and $77.3 million is provided to sustain existing digital mental health services. $26.9 million is provided for people with eating disorders and for perinatal screening and support, which builds on the $18.5 million for a Perinatal Mental Health and Wellbeing Program Grant and $13.6 million to existing National Perinatal Mental Health Services, in October and November 2020, respectively.

Approaches to workforce expansion and reconfiguration are tokenistic, perhaps awaiting future guidance from the Mental Health Workforce Strategy. While the investments in this Budget lightly touch on Productivity Commission recommendations for workforce development, they do not capture the breadth of the investment required to deliver a comprehensive and diverse mental health workforce for the future.

The Government must commit to addressing gaps in the clinical and community workforce, new centres of learning, training, and innovation to expand skills and competencies, and develop a national approach to resolve geographical inequities. Irrespective, $58.8 million is ring-fenced in this Budget to grow the mental health workforce through psychiatrist training places ($11 million), Aboriginal and Torres Strait Islander representation ($8.3 million), scholarships and professional collaborations for mental health peer workers ($3.1 million) and $27.8 million to increase the number of nurses, psychologists, and allied health practitioners.

An expensive commitment worth 10.0 percent of the mental health budget allocation is $288.5 million for Repetitive Transcranial Magnetic Stimulation (rTMS) to be funded via the Medicare Benefits Scheme. This raises a challenge the Government will need to navigate. It represents an uncapped expenditure item likely to be led by psychiatrists in the private and metropolitan health sectors, subject to supplier induced demand. This may present a policy challenge to equitable servicing for populations at greatest need.

The NDIS funding model, expenditure management and its integration with other community mental health services are still proving intractable. Challenges persist for people with a severe psychosocial disability not yet eligible or able to participate in the NDIS. A budget commitment worth $171.3 million recognises this problem and provides for continuity of current psychosocial support services. As it progresses its mental health reform agenda, the Government will need to address the NDIS market maturity and the misalignment between NDIS services and siloes of federally funded mental health care in the community.

This Budget has committed $117.2 million to establish a comprehensive evidence base that measures whether Australia’s mental health system is ‘operating effectively’. There is currently no clarity as to
who or how this funding will be allocated, which organisations would drive measurement of progress, and whether this would take the form of audit, monitoring or an outcomes-led evaluation framework.

The Government prefaces its mental health budget by noting that recommendations require collaboration with state and territory governments, which will be pursued jointly through a new National Mental Health and Suicide Prevention Agreement. This Budget undoubtedly starts the reform agenda though falls short of delivering structural change.

However, it addresses the priority Productivity Commission recommendations. These include support for new parents, implementation of a national stigma reduction strategy, first stages of digital and person-centred transformation, follow up care for people after suicide attempts, treatment centres to expand into regional areas and the empowerment of Indigenous communities to prevent suicide.

Major reforms in mental health care will be complex, requiring strong leadership. Investment needs to include guaranteed funding commensurate with the level of reform, and there must be multi-layered cooperation in governance arrangements. The greatest risk to mental health reform is an exchange of short-term gains for longer-term reform. All governments and jurisdictions will need to align when progressing a reform agenda, and future budgets will need to herald greater and commensurate investment for mental health to achieve any parity of esteem.
4. Pharmaceuticals

The Zimmerman parliamentary inquiry was established to investigate the approval processes for new drugs and medical technologies in Australia, focusing on access to treatment of rare diseases and conditions with a high and unmet clinical need. Since September last year, public hearings have been held across Australia, with evidence taken from the Department of Health, academics, patient groups, medical devices companies, and many pharmaceutical companies. The inquiry continues to take evidence.

Many issues have been raised at the inquiry. One relates to the protection of confidential information. In March, the Government moved to table the National Health Amendment (Pharmaceutical Benefits Transparency and Cost Recovery) Bill 2021. It could give the Government the power to publish any information from a sponsor’s submission to the Pharmaceutical Benefits Advisory Committee (PBAC), including potentially effective drug prices, which are currently confidential under in the National Health Act 1953.

Pharmaceutical companies have been applying pressure to the Government to withdraw the bill, including at the Zimmerman inquiry, as they consider removing confidentiality would jeopardise timely access to medicines in Australia. Some in the industry have suggested there is an irony given that the Government bill could force pharmaceutical companies to reveal commercially sensitive information, while they consider that PBAC and the Medical Services Advisory Committee (MSAC) lack transparency.

In April, the UK National Institute of Health and Care Excellence (NICE) announced that, as part of a five year strategy, they will speed up patient access to the latest and most effective treatments. They also announced their intention to develop clinical guidelines that evolve in real time, while maintaining methodological rigour. NICE are currently revising their methods and processes for evaluating the effectiveness and cost-effectiveness of pharmaceuticals, medical devices, and diagnostic tests. The

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44 Parliament of Australia, Standing Committee on Health, Aged Care and Sport, Inquiry into approval processes for new drugs and novel medical technologies in Australia, 2020, accessed 04 May 2021
46 Pharma in Focus, ‘Pharma secrets at risk’, Pharma in Focus, 19 April 2021, accessed 04 May 2021
47 BioPharma Dispatch, ‘Committee needs to focus on impact of confidentiality change’, BioPharma Dispatch, 23 April 2021, accessed 04 May 2021
48 Ibid.
49 The UK National Institute for Health and Care Excellence (NICE), NICE launches ambitious strategy to provide quicker access to new treatments and innovations, 19 April 2021, accessed 04 May 2021
50 The UK National Institute for Health and Care Excellence (NICE), Changes we’re making to health technology evaluation, accessed 04 May 2021
plan is for these to be implemented in January next year. Some of the many proposed changes include:51

- favour funding for treatments for severe diseases;
- favour health technologies that reduce health inequalities, such as for patients from socioeconomically disadvantaged groups; and
- how to assess health technologies that provide less health benefit at lower costs.

Some of these changes may be adopted in Australia for the next revisions of the PBAC and MSAC guidelines. The methods guide for PBAC was last updated in 2016, and the guide for MSAC is currently being revised.52 Anyone of these proposed changes adopted within the PBAC process would have significant implications for assessing medicines in Australia. They would, therefore, likely change decisions on what medicines pharmaceutical companies decide to bring into Australia.

**Significant Budget announcements**

This Budget allocated $878.7 million over five years from 2020-21 for new and amended listings on the Pharmaceutical Benefits Scheme (PBS), the Repatriation Pharmaceutical Benefits Scheme (RPBS) and the Stoma Appliance Scheme. This compares with an additional $375.5 million over four years in last year’s Budget for the PBS and RPBS. There is some uncertainty about the true cost of these medicines, given revenue from rebates negotiated as part of listing agreements is not published.

One notable absence in this Budget relates to the review of Australia’s National Medicines Policy. The Policy aims to promote quality care responsive to people’s needs, incentivise preventive health and cost effective care, create better value for taxpayers’ dollars, more clearly define roles and responsibilities, and continue universal access to basic health services through Medicare.53

In October 2019, the Government announced there would be a National Medicines Policy review.54 The Review has been delayed by more than a year due to COVID-19, and the timing of the review was not announced in this Budget. Hence it is unlikely to proceed before the next election.

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51 The UK National Institute for Health and Care Excellence (NICE), *Reviewing our methods for health technology evaluation: consultation*, accessed 4 May 2021

52 Australian Government Department of Health, Medical Services Advisory Committee (MSAC), *Assessment Group Guidelines and Templates*, last updated 21 January 2021, accessed 04 May 2021


The COVID-19 pandemic dispelled any doubts about the necessity of digital transformation in the healthcare system. The fast track shift to telehealth and electronic prescriptions along with home delivery services have enabled patients to manage their medical problems from the convenience of their homes. This accelerated digital revolution will be one of the legacies of the pandemic, and has brought digital health innovation forward by around 10 years.

The Australian Digital Health Agency launched the electronic prescription (eScript) system in May 2020 across Australia. The eScript system allows health professionals to send prescriptions to patient’s electronic devices (email/SMS). It contains a token (QR code) that can be forwarded to the pharmacy. Since the implementation of the eScript, over 6.5 million original and repeat electronic prescriptions have been issued, and around 95 per cent of all Pharmaceutical Benefits Scheme (PBS) approved community pharmacies have been engaged in the system.

The next step in the digitalisation of prescriptions will be Active Script List (ASL), a pharmacy-assisted service that includes all the prescriptions and repeats for a patient. Patients register for the ASL and can set options for which health professionals access their information. This will particularly be beneficial for patients with several chronic conditions who often need multiple prescriptions. There will also be further developments allowing patients to request medication from their ASL through WhatsApp. The ASL rollout started from Tasmania in April 2021 and will be available nationally by the end of the year.

While community pharmacies have been at the forefront of routine immunisation programs, their role in the national rollout of Covid-19 is deferred to phase 2a. This would be disappointing for the pharmacy sector. The extra compliance, reporting and data collection requirements for Covid-19 vaccination are the main reasons for this lagged involvement.

Only the AstraZeneca/Oxford vaccine will be made available through pharmacies, which are expected to start administering shots in the middle of this year. Community pharmacies will be remunerated up to $48 for each person who receives the two doses of the vaccine, although they will receive less than half if only one shot is delivered. This funding will be based on a fee-for-service payment through the Pharmacy Programs Administrator (PPA).

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55 Australian Digital Health Agency. Electronic prescriptions, accessed 3 May 2021
56 Ibid.
57 Australian Digital Health Agency. Electronic prescribing, accessed 3 May 2021
59 Ibid.
60 Department of Health, COVID-19 vaccine rollout update – 4 May 2021, 4 May 2021, accessed 5 May 2021
61 Ibid.
Unfortunately for pharmacists this will be a missed opportunity to significantly increase revenue and cement the sector’s position as healthcare system service providers. Vaccine demand from pharmacists may be relatively small as GPs and states are currently administering the AstraZeneca/Oxford vaccine, and pharmacists will be excluded from administering the Pfizer/BioNTech vaccine to people 50 years and under.

**Significant Budget announcements**

There is no additional funding specifically allocated to pharmacies in this Budget. However, the Government is allocating $777.8 million over two years for the vaccination program, including funding for general practitioners and community pharmacies to administer vaccines. As community pharmacies are restricted to administering the AstraZeneca/Oxford vaccine, most of this funding may be allocated towards equipping general practices for storing and administrating the Pfizer/BioNTech vaccine.
6. Primary care

In March 2020, the Australian Government introduced temporary telehealth MBS items to guarantee continued access to essential services in response to restrictions imposed by the pandemic. This took the pressure off emergency departments and limited unnecessary exposure of patients and health professionals to COVID-19, by avoiding the need for patients to attend clinics.

Telehealth services spiked in April 2020, where 5.8 million consultations were delivered through telehealth, accounting for 35.6 per cent of all GP, specialist, mental health, nurse practitioner and allied health consultations. The trend started to reverse with the ease of lockdown in June 2020, and the uptake of telehealth gradually decreased and stayed steady at 20 per cent in the three months ending to February 2021. This showed that many patients still preferred face-to-face consultations.

The Government was aware the telehealth genie was being let out of the bottle. The increased convenience associated with telehealth had the potential to blow out the Government’s budget given Medicare Benefit Schedule funding is uncapped.

The temporary MBS telehealth items were initially due to end on 31 March 2021. They were extended until June 2021, and then until the end of 2021. It seems the Government is finding it challenging to cork the genie bottle. However, MBS support for telehealth consultations of longer than 20 minutes will end in June 2021, much to the disappointment of the RACGP. This change will most likely impact patients with complex conditions and patients with mental ill health.

The Government has tweaked telehealth reimbursement arrangements since extended telehealth was first introduced. In the early days, GPs and other medical professionals were required to bulk bill for telehealth services. There were also incentives to provide consultations to concession cardholders and children under 16. The requirement for bulk billing the patients and the incentives ceased in October 2020. Cue increased out-of-pocket costs to patients.

The extensive adoption of telehealth during the pandemic is shaping a new normal. The Government is consulting with peak bodies to design post-pandemic telehealth services. Although telehealth appeared attractive during the pandemic, transforming the health system permanently can be challenging. Since the rollout of telehealth services, more than 90 per cent of the consultation were delivered by

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63 Ibid.

64 The Hon Greg Hunt MP, Universal Telehealth extended through 2021 [media release], 26 April 2021, accessed 30 April 2021

65 M Woodley, ‘Longer phone consultations not part of telehealth extension’, RACGP, 27 April 2021, accessed 30 April 2021

66 Department of Health, Factsheets on the use of the temporary MBS telehealth and phone consultation item numbers, Last update : 25 March 2021, accessed 30 April 2021
telephone. While a phone consultation can promote timely delivery of healthcare, video consultations can vastly improve the accuracy of clinicians’ diagnosis. However, GP and practice characteristics such as age, familiarity with technology, and available infrastructure play critical roles in adopting video consultations.

Long term policies should be formulated to incentivise investment in technology, set up a secure data management system, provide proper training for health professionals and to devise a funding model that incentivises efficient healthcare delivery. Policies must promote cost-effective and equitable access to care to ensure taxpayer money is spent wisely.

Patient preferences should also inform these decisions. A survey of 1,058 Australians in January 2021 showed that a third of patients would use telehealth to consult with their GP or other healthcare providers if they are given the option. However, only 18 per cent of people over 65 would opt for telehealth as an alternative to a face-to-face visit.

Since the arrival of vaccines, primary care settings have been immunising Australians, and a total of 1.2 million doses of vaccines (53 per cent of total doses) have been administered in GP clinics. The Government has opted for a GP-led national immunisation programme in phase 1b of the Covid-19 immunisation strategy and has enrolled more than 4,500 general practices for this purpose.

From early May 2021, all Australians aged over 50 years can receive the AstraZeneca/Oxford vaccine in respiratory and GPs clinics, while the Pfizer/BioNTech vaccine will be reserved for people aged 50 years and under. However, the major hurdle ahead for GPs is the Pfizer/BioNTech vaccine cold chain requirement. It cannot be stored in the refrigeration systems found in a typical GP clinic. Logistics to distribute and store the Pfizer/BioNTech vaccine across Australia will further complicate the rollout. This may mean the role of GPs in vaccinating Australians becomes limited towards the end of 2021, instead the Government may rely on state and territory healthcare systems.

The battle to manage chronic disease also continues. The Government allocated $21.3 million to establish the Health Care Homes (HCH) trial over four years in the 2016-17 budget, an integrated and patient-centred model of care for patients with complex needs. Payment type was the centrepiece of the

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67 Ibid.
69 Ibid.
73 The Hon Greg Hunt MP, *Local GPs on board to roll out COVID-19 vaccines* [media Release], 7 March 2021, accessed 3 May 2021
74 A Dow and M Cunningham, ‘Time for a rollout reset, GPs say, with Pfizer freezers a major hurdle’, *The Sydney Morning Herald*, 12 April 2021, accessed 3 May 2021
HCH model, which was a shift away from fee-for-service and instead included an upfront grant and a bundled payment. This funding model was rejected by the AMA because it moved away from fee for service.\textsuperscript{75}

While the HCH was planned to coordinate care for around 65,000 patients with chronic conditions across 200 general practices with an estimated cost of $114.3 million,\textsuperscript{76} the interim evaluation reflected that only 8,959 patients from 120 practices are participating in the program.\textsuperscript{77} The trial was initially due to expire at the end of 2019. However, the Government extended the program for an additional 18 months.\textsuperscript{78} Where the HCH program continues after June 2021 is unclear, and the final evaluation is underway to inform the decisions on the future of the program.

Furthermore, in the 2019-20 Budget, the Government announced an investment of $448.5 million to support GPs to provide enhanced and coordinated care to their elderly patients through Voluntary Patient Enrolment (VPE) measure.\textsuperscript{79} This measure involved the voluntary registration of Australians over the age of 70 years with a GP to receive consistent and integrated care. VPE was put on hold due to the COVID-19 pandemic and the introduction of telehealth.\textsuperscript{80}

Concerns about the provision of primary care for aged care residents was raised within the Royal Commission into Aged Care Quality and Safety. The Australian Government started to address these concerns in the 2018-19 MYEFO budget by allocating $98 million through new Medicare Benefits Schedule (MBS) items for services provided by GPs in residential aged care facilities.\textsuperscript{81} These new items aimed to compensate for GPs’ non-consulting costs such as travel time.

While RACGP welcomed this change, it argued that the funding did not generate sufficient incentives for GPs to offer services to aged care residents.\textsuperscript{82} In its 2020-21 pre-budget submission, the Australian Medical Association (AMA) suggested that a substantial increase in funding for the items (at least 50 per cent) will adequately reflect GP time and care provided for an aged care patient.\textsuperscript{83}

Obstructionist behaviour from the sector whenever the Government tries to shift GP funding away from fee for service towards outcomes based funding has continued. The Royal Commission proposed a new primary health care model where GPs would be accredited for providing care to aged care residents, and would receive annual capitation payments based on the number of enrolled patients.

\textsuperscript{75} Australian Medical Association (AMA), \textit{AMA Position Statement on the Medical Home – 2015}, 30 November 2015, accessed 7 May 2021

\textsuperscript{76} Parliament of Australia, \textit{Health care homes: an update}, 22 May 2018, accessed 6 May 2021


\textsuperscript{78} Ibid.

\textsuperscript{79} The Treasury, \textit{Budget 2019-20, Budget Paper No. 1}, Australian Government, Canberra

\textsuperscript{80} Department of Health, \textit{Voluntary patient enrolment}, last update 18 March 2021, accessed 12 May 2021

\textsuperscript{81} The Treasury, \textit{Mid-Year Economic and Fiscal Outlook 2018-19}, Australian Government, Canberra

\textsuperscript{82} M Liotta, ‘\textit{RACGP sees room for improvement in changes to GP rebates in RACFs}’, RACGP, 28 February 2019, accessed 6 May 2021

\textsuperscript{83} Australian Medical Association (AMA), \textit{AMA Pre-Budget Submission 2020-21}, 1 March 2020, accessed 6 May 2021
The new model was frowned upon by RACGP. It noted that accreditation would create new barriers for GPs, and impose additional cost and administration burden on the system. The removal of fee-for-service also was not supported by RACGP, arguing it forms the basis of GP remuneration and changing it would only cause imbalances in workforce distribution.\textsuperscript{84} RACGP proposed a hybrid payment model with a combination of block funding and fee-for-service to ensure the quality and continuity of care.

**Significant Budget announcements**

The Government’s response to the COVID-19 pandemic continued within this Budget, allocating $879 million to extend temporary COVID-19 related Medicare Benefits Schedule items, although many of these expenditure items have been previously announced. Out of this funding, $557 million will be assigned to extend further MBS pathology items for COVID-19 testing and diagnosis.

Another $204 million was allocated to guarantee continued access to subsidised telehealth for GP, nursing, midwifery, allied health, mental health and specialist services until December 2021. This brings the total investment in telehealth to $3.6 billion since March 2020. However, the reimbursement arrangements of telehealth items are due to change from July 2021. There will also be additional funding of $87 million for Commonwealth respiratory clinics dedicated to diagnosing and managing COVID-19.

This Budget also allocated $480.9 million over the five years to improve access to primary care. Partial funding for these measures had previously been provided, and only an additional $297.4 million was allocated in this Budget. Of this, $288 million will be invested to subsidise repetitive Transcranial Magnetic Stimulation to treat patients with medication-resistant major depression. Another $79.1 million will be provided as additional one-year funding for Primary Health Network After Hours Program. This will guarantee continued access to after-hour care and take the pressure off emergency departments.

The Government also showed its commitment to Voluntary Patient Enrolment (VPE) by investing $50.7 million for developing the ICT infrastructure necessary for initiating the VPE. The new system will be called ‘MyGP’ and will provide a platform for facilitating the registration process. With HCH coming to an end in June 2021, VPE seems an alternative to provide coordinated care for patients with complex needs.

Other investment in health digitalisation includes providing $301.8 million for supporting My Health Record system, which currently has 22.9 million registered users.\textsuperscript{85} This additional funding will go towards COVID-19 related services, including notifying users about their COVID19 test results and vaccination eligibility status. The next My Health Record upgrade will also allow users to connect their information with their residential aged care facility for a smoother transition of care between healthcare settings.\textsuperscript{86}

\textsuperscript{84} Royal Australian College of General Practitioners, \textit{Submission to the Royal Commission into Aged Care Quality and Safety: Mental health, oral health and allied health services}, 13 August 2020, accessed 6 May 2021

\textsuperscript{85} Australian Digital Health Agency, \textit{My Health Record statistics}, March 2021, accessed 12 May 2021

\textsuperscript{86} Australia’s Digital Economy, Budget 2021–22 Fact Sheets, \textit{Enhancing Government service delivery}, 6 May 2021, accessed 12 May 2021
This Budget also addressed the concerns with the provision of care in rural and remote Australia. The Government is investing $65 million to boost bulk billing rebates aiming at improving access to care for patients in regional, rural and remote areas. According to the new arrangements, from January 2022, GPs will receive up to an additional $12.35 per consultation if their practice is located in a very remote area. The current rural bulk billing incentive payments do not differentiate the large regional areas from smaller ones, and is set at 150 per cent of the metropolitan area rate. However, the new incentive will take into account rurality, and GP remuneration will differ from 160 per cent to 190 per cent of metropolitan area rate depending on the remoteness of their practice location.

There was recognition of women-specific health needs in this Budget. The Government committed to provide $148 million over four years towards improving healthcare access for women. However, only $32.9 million represents new money, and the rest has been repurposed from elsewhere. This includes a boost of $67.6 million to improve breast cancer screening program for women aged 70 to 74 and $32.8 million for cervical cancer screening services for Victorian women. An additional $95.9 was allocated to the screening of embryos for abnormalities during the IVF process.

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87 The Rural Doctors Association of Australia, *Bulk-billing increase a game changer for 'Real Rural' towns*, 8 May 2021, accessed 12 May 2021
Private health insurers have weathered the COVID-19 storm, which left a noticeable dent in industry profitability. Over 2020, net profits fell 61.2 per cent to $0.6 billion and net margins declined to 1.9 per cent. This was despite people using their health cover less due to deferred elective surgeries, which some feared would create 'abnormal' high profits. Industry profits were hit in 2020 by a deferred April premium increase, payment concessions to policyholders, and much weaker investment earnings. The latest quarterly figures show profitability picked up after improved economic activity and premiums increased in October. Revenue increased 4.0 per cent in the December quarter, and investment earnings (driven by rising stock market prices) increased 121.3 per cent. Quarterly net profits tripled, but net margins remained below pre-COVID levels, although quarterly figures fluctuate. With community transmission of COVID-19 under control, there was a spike in people receiving general treatments to above pre-pandemic levels, while hospital treatments remained relatively flat.

An earlier feared 'death spiral' has not eventuated, although the sector is facing strong headwinds. While the proportion of the population with hospital cover had been falling since 2015, recent numbers suggest coverage has stabilised at around 44 per cent of the total population. In fact, there was an increase of 34,801 persons with hospital cover in the December quarter, after a substantial increase of 104,106 persons in the September quarter.

COVID-induced pressure on public hospital surgery waiting lists may have attracted some people to shorter private hospital surgery waiting times afforded by private health insurance, although this is minor compared to total public hospital elective surgery activity. State healthcare systems have pump-primed their elective surgery to clear the backlog after the National Cabinet suspended all non-urgent

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88 The Australian Prudential Regulation (APRA), Quarterly private health insurance statistics – highlights December 2020, published 23 February 2021, accessed 22 April 2021

89 B Butler, 'Australia's private health funds could reap windfall from coronavirus – report', The Guardian, April 6, 2020, accessed 22 April 2021

90 The Australian Prudential Regulation (APRA), Quarterly private health insurance statistics – highlights December 2020, published 23 February 2021, accessed 22 April 2021

91 The Australian Prudential Regulation (APRA), Quarterly private health insurance membership and coverage December 2020, published 23 February 2021, accessed 22 April 2021

92 S Duckett, 'Youth discounts fail to keep young people in private health insurance', The Conversation, 20 August 2019, accessed 22 April 2021

93 The Australian Prudential Regulation (APRA), Quarterly private health insurance membership and coverage December 2020, published 23 February 2021, accessed 22 April 2021

94 New South Wales Health, Record-breaking elective surgery activity in NSW, 17 March 2021, accessed 23 April 2021
and most semi-urgent surgery to free up resources for the national COVID-19 response. The exit of younger people from the market slowed, although there were still net decreases in hospital cover for the 20-29 year age groups.

Long-term challenges to industry viability from an ageing membership remain. Benefits paid per policy rose by 3.0 per cent in 2020, reflecting an ongoing trend. Reducing this expenditure depends on either reducing the volume of claims (admissions) or reducing the prices attached to claims (reducing health care prices or lengths of stay).

It has also become more difficult for private health insurers to raise prices to cover these costs, which has been the go-to strategy in the past. While the Australian Government is still willing to let the private health insurance sector raise annual prices by more than twice inflation, annual price increases have come down to their lowest level since 2001.

The Government is consulting with the sector on last year’s announced reforms to support industry sustainability. These include reducing admissions by expanding home and community-based care for rehabilitation and mental health care, and applying greater rigour to certification for hospital admission.

The Government is also targeting pricing through a review and reform of the Prostheses List by 2022. Current arrangements have been blamed for creating excessive numbers of listings, not adequately considering cost-effectiveness in listing decisions, and causing insurers to pay higher prices for the same device relative to prices paid by public hospitals.

Proposed reforms include: (i) reducing items in the list by removing low-cost/high-volume items and device components with a non-specific use (which currently represent a significant proportion of prostheses expenditure); (ii) listing a single benefit for devices used in a single medical procedure; or (iii) replacing the list with a model where benefits are set by diagnostic-related group. Reforms would also allow cost-effectiveness to be more explicitly considered in listing decisions. These changes would

95 Australian Institute of Health and Welfare (AIHW), Elective surgery, last update 17 December 2020, accessed 5 May 2021
96 The Australian Prudential Regulation (APRA), Quarterly private health insurance statistics December 2020, published 23 February 2021, accessed 22 April 2021
97 The Australian Prudential Regulation (APRA), Quarterly private health insurance statistics – highlights December 2020, published 23 February 2021, accessed 22 April 2021
98 Department of Health, Average annual increases in private health insurance premiums, last update 22 December 2020, accessed 3 May 2021
99 Department of Health, Consultation paper: Private health insurance reforms – second wave - December 2020, accessed 23 April 2021
100 Department of Health, 2020, Prostheses List reforms and reviews, 18 December 2020, accessed 22 April 2021
101 Menzies Centre for Health Policy and University of Sydney, Options for a revised framework for setting and reviewing benefits for the Prostheses List, December 2020, accessed 23 April 2021
improve efficiency and price transparency, with option (iii) having potential to deliver the most cost savings to insurers.\textsuperscript{102}

While these reforms would assist in reducing private health insurer costs, prostheses constitute a relatively small component of total annual hospital benefits paid out by insurers (14.3 per cent), relative to acute hospital care (69.8 per cent) and medical services (15.8 per cent)\textsuperscript{103}. Additionally, prosthesis benefits paid per item have been lower and more stable since early 2017, when listed prices were reduced by up to 10 per cent for several categories.\textsuperscript{104} In contrast, both benefits per episode and benefits per policy have steadily risen for hospital care.\textsuperscript{105}

Greater potential for controlling private health insurer costs therefore lies in programs that keep people out of hospital or reduce prolonged hospital stays. Expanding programs for home and community care is a positive step. However, private health insurers argued that changes are needed to align incentives within risk equalisation arrangements and encourage insurers to invest in preventative care programs. Risk equalisation is a bedrock of the private health insurance system because it significantly reduces the incentive for private health insurers to ‘cream skim’ healthier members.

Benefits paid to chronic disease management programs (CDMP) fell from $46.8 million in 2015 to $38.1 million in 2020,\textsuperscript{106} showing weak insurer incentives to encourage program uptake. Within existing arrangements, cost savings from reducing claims are redistributed across all insurers, which reduces individual insurer incentives to invest in programs that reduce hospital claims. A potential reform may be to impose a ceiling on the level of benefit payouts eligible for risk equalisation.\textsuperscript{107} A government funded study to examine risk equalisation settings is currently underway.

This still leaves questions around government intervention being used to ‘support’ coverage. While a study to evaluate Lifetime Health Cover has been commissioned, the elephant in the room remains the value to taxpayers from the $6.7 billion premium rebate paid by the Government each year.\textsuperscript{108} That equates to a weekly cheque of $127 million paid by the Australian Government to prop up private health insurance.

\textsuperscript{102} Ibid.

\textsuperscript{103} The Australian Prudential Regulation (APRA), Quarterly private health insurance statistics December 2020, published 23 February 2021, accessed 22 April 2021

\textsuperscript{104} Medical Technology Association of Australia (MTAA), Prostheses List Reform, accessed 30 April 2021.

\textsuperscript{105} The Australian Prudential Regulation (APRA), Quarterly private health insurance benefit trends December 2020, published 23 February 2021, accessed 22 April 2021

\textsuperscript{106} Ibid.


\textsuperscript{108} The Treasury, Budget 2020–21, Budget Paper No. 1, Australian Government, Canberra
Private Healthcare Australia has again appealed to the Government to restore the rebate to 30 per cent. However, the consensus in both older, and more recent studies, is that the rebate is ineffective in encouraging coverage, and provides windfall gains to groups who would have purchased cover anyway, including older Australians. Many Australians do not respond much to changes in private health insurance prices (demand is ‘sticky’ or price-inelastic). This would explain why premium discounts have done little to encourage younger consumers to buy private health insurance.

**Significant Budget announcements**

Private health insurance reform has received a relatively modest outlay of $30.2 million in this Budget. The Government has allocated $23.1 million over four years to Prosthesis list reform, $5.1 million over four years to improve certification for hospital admission, $1.1 million over two years to investigate private hospital benefit arrangements and $0.9 million over two years to improve modelling capabilities. The Government has said it will leave Medicare Levy Surcharge (MLS) and rebate settings unchanged for two years, while a review of MLS settings is undertaken.

The direction of some measures announced within this Budget is promising. Increasing attention has been given to supporting market sustainability by preventing inappropriate hospital care. An actuarial study funded last year may also provide insights on modifying risk equalisation settings to encourage preventative care.

There is also recognition that further research is needed to optimise current government policy settings. However, the Government is only proposing to review the MLS, which is just one side of the coin, with the premium rebate being the other. Research has identified the MLS as an effective policy lever. This proposed review should also include the premium rebate. While means-testing the rebate in 2011-12 helped slow Government rebate expenditure with minimal effect on membership, it is still a substantial and steadily growing Budget outlay. The Government spent $6.7 billion on the rebate last year, and is projected to spend $27.7 billion on the rebate over the next four years. To put this into

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111 A Bilgrami et al., The impact of means-tested premium rebates and tax penalties on the demand for private hospital cover in Australia’, *Economic Record*, 2021, https://doi.org/10.1111/1475-4932.12603


115 A Bilgrami et al., The impact of means-tested premium rebates and tax penalties on the demand for private hospital cover in Australia’, *Economic Record*, 2021, https://doi.org/10.1111/1475-4932.12603

116 Ibid.

For the Health Economy perspective, annual rebate expenditure is about $2 billion more than the cost of South Australia’s entire public hospital system ($4.7 billion in 2018-19). The rebate has never been reviewed for its return on investment, and research suggests it may waste significant amounts of Government funding each year. Reducing or removing the rebate would likely save the Government money, without the nightmare scenarios Private Healthcare Australia likes to paint regarding public hospital waiting lists. A review is strongly warranted and long overdue.

Private Healthcare Australia’s argument to support increased rebates to 30 per cent is flawed. It suggests that increasing private health insurance membership reduces pressure off public hospital waiting lists. While increase private health insurance membership does take elective surgery demand out of the public hospital system, it also takes out the supply of surgeons. Surgeons are more than happy to meet increased demand in the private hospital sector because they generally receive higher remuneration.

The evidence suggests increased private health insurance membership can increase public hospital waiting lists, and data comparing public hospital waiting lists to private health insurance membership suggests this has occurred in Australia. Figure 2 shows that private hospital cover increased from just over 30 per cent to 45 per cent between 1998-99 and 2000-01, yet public hospital waiting list times for the three popular surgeries (cataract extraction, knee replacement and hip replacement) increased. Waiting lists for these surgeries then continued to increase despite further increases in private hospital cover.

While a review of the premium rebate should be considered paramount for fiscal responsibility, especially when this Budget is dripping red ink, a comprehensive review of all policy settings and the role of private health insurance within our healthcare system is needed. Past ‘reforms’ introduced in 2017, billed by this Government as the most significant in a decade, have failed to deliver. Private health insurance premiums continue to increase each year at twice the rate of inflation. Young people continued to exit the market and costs continued to increase. It would be prudent to fully explore health insurance components most valued by younger consumers to support the future design of policies.

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Figure 1: Comparison of private hospital cover with public hospital elective surgery waiting times

Source: Waiting time data was sourced from the Australian Institute of Health and Welfare, while hospital cover membership data was sourced from the Australian Prudential Regulatory Authority.
8. Vaccines

Last year the question on everyone’s minds was ‘Will there be a COVID-19 vaccine, and when can I get it?’ As it turns out, the answer to this question was not straightforward. Nobody had successfully developed a vaccine against a coronavirus prior to 2020. Many believed it couldn’t be done.125

Given the uncertainty, the Government hedged its bets by signing advanced purchasing agreements for four different vaccines (one of each type of vaccine technology) and the COVAX facility, to provide 159.8 million doses for $3.2 billion, easily enough to cover the Australian population.126

The agreements were announced with much fanfare, with initial plans for everyone to be vaccinated by October 2021.127 But then came the usual trials and tribulations of vaccine development, which usually happen before the Government agrees to buy a vaccine and under much less public scrutiny (see Figure 1).

First, the University of Queensland/CSL vaccine development was abandoned because participants registered false-positive HIV test results. The Government attempted to mitigate this setback with agreements to purchase additional doses of the remaining vaccines.128 Italy and the European Union then blocked shipments of the University of Oxford/AstraZeneca vaccine to Australia.129 Then reports of blood clots associated with the same vaccine started to emerge.130

This spooked many people and put a big question mark over Australia’s vaccine strategy. It resulted in the Australian Technical Advisory Group on Immunisation (ATAGI) recommending the Pfizer/BioNTech vaccine for people aged under 50 years.131 Previously this vaccine was limited to frontline workers and people in aged care.

125 I Sample, 'Why we might not get a coronavirus vaccine'. The Guardian. 22 May 2020, accessed 5 May 2021
126 The Hon Scott Morrison MP, Australia secures a further 50 million doses of COVID-19 vaccine [media release], 5 November 2020, accessed 5 May 2021
127 N Evershed et al, 'Australia Covid vaccine data tracker: how is the rollout progressing and when will you get the coronavirus jab?', The Guardian, 10 May 2020, accessed 12 May 2021
128 The Hon Greg Hunt MP, Australia secures 20 million extra AstraZeneca vaccines [media release], 11 December 2020, accessed 5 May 2021
129 ABC, Italy, 'Italy, EU refuse AstraZeneca request to ship 250,000 doses of vaccine to Australia', ABC, 5 March 2021, accessed 5 May 2021
130 European Medicines Agency, COVID-19 Vaccine AstraZeneca: PRAC investigating cases of thromboembolic events - vaccine's benefits currently still outweigh risks – Update, 11 March 2021, accessed 5 May 2021
131 Department of Health, ATAGI statement on AstraZeneca vaccine in response to new vaccine safety concerns. 8 April 2021, accessed 5 May 2021
Figure 2: Timeline of the Government’s COVID-19 vaccine strategy and accumulated doses purchased

Public confidence in Australia’s vaccine strategy plummeted. Rates of people stating they would get vaccinated dropped from 86 per cent across all ages, to just 28 per cent of those aged 18-29 years and 61 per cent of those aged +70 years.\textsuperscript{133}

The Government had to rethink its vaccine strategy,\textsuperscript{134} and probably not for the last time. Additional doses of the Pfizer/BioNTech vaccine were purchased in April but will not be available until the end of 2021,\textsuperscript{135} assuming nothing else goes wrong. Access to vaccines for people under 50 years old has subsequently been delayed.

Only 2.7 million doses have been administered in Australia, with administration rates stagnating and significantly below the revised goal.\textsuperscript{136} At this rate, the Australian population will not even be close to herd immunity (at least 67 per cent of the population need to be fully vaccinated)\textsuperscript{137} by the end of 2021. The vaccination rollout will likely push into 2022. Australia’s vaccination rate lags significantly behind the US, UK and Europe, even after accounting for when the vaccines were first approved for use.\textsuperscript{138}

Under the initial vaccine program, state and territory governments were responsible for vaccinating frontline workers, with the Government responsible for vaccinating others. The plan was reliant on private providers vaccinating those in aged care facilities, and doctors and community pharmacies to vaccinate the rest of the community.\textsuperscript{139}

This strategy meant that the Government could take much of the credit for a successful vaccination program. This may have worked with the bulk of the population receiving the University of Oxford/AstraZeneca vaccine. But this approach was scuttled when the Pfizer/BioNTech vaccine became the preferred vaccine for people under 50 years old, due to its cold storage requirements\textsuperscript{140} and thus risk of wastage.

A slow vaccination rollout is problematic for older Australians, particularly those living in residential aged care facilities. More than 40 per cent of all residential aged care facilities have not yet received one vaccination, and less than half of all residential aged care residents have received two doses.\textsuperscript{141} This is

\begin{itemize}
    \item S Martin, ‘Essential poll: fewer than 50% of over-50s willing to get AstraZeneca vaccine’. The Guardian, 27 April 2021, accessed 5 May 2021
    \item The Hon Scott Morrison MP, National Cabinet Media Statement, 22 April 2021, accessed 5 May 2021
    \item B Worthington, ‘Australia secures additional Pfizer vaccine following AstraZeneca concerns’. ABC, 9 April 2021, accessed 5 May 2021
    \item Evershed op. cit.
    \item Evershed op. cit.
    \item Department of Health, COVID-19 vaccination – Australia’s COVID-19 vaccine national roll-out strategy, 7 January 2021, accessed 12 May 2021
    \item Therapeutic Goods Administration, Wider storage and transportation conditions for the Pfizer COVID-19 vaccine now approved, 8 April 2021, accessed 12 May 2021.
    \item Department of Health, COVID-19 vaccine rollout update – 4 May 2021, 4 May 2021, accessed 5 May 2021
\end{itemize}
Despite the Australian Defence Force being called in to help with residential aged care vaccinations.\textsuperscript{142} The slow vaccination rate among older Australians has significantly contributed to continued border closures and snap lockdowns undertaken by state governments.

In the MYEFO the Government also announced an additional $75.2 million over two years to support the COVID-19 Vaccination Program (e.g., tracking and monitoring systems, a communication campaign, program administration, preparation of clinical guidelines) and another $6.0 million over two years to support mandatory reporting of all vaccines to the Australian Immunisation Register. It also announced an undisclosed sum to develop a business case to inform future investments in onshore mRNA platform-based vaccine manufacturing capability and capacity.

**Significant Budget announcements**

This Budget included an undisclosed sum to cover advance purchase agreements for an additional 30 million doses of the Pfizer/BioNTech vaccine, which was previously announced (see Figure 1). While not explicitly mentioned, the agreements should be enough to vaccinate teenagers with the Pfizer/BioNTech vaccine, assuming the Therapeutic Goods Administration (TGA) agrees with the US Food and Drug Administration (FDA) that its appropriate for this cohort.\textsuperscript{143} The TGA has taken the first step towards this, granting Pfizer provisional approval for children aged 12 years or older.\textsuperscript{144}

Overall the Government claims to have spent $5.4 billion since March 2020 on COVID-19 vaccines.\textsuperscript{145} However, it is unclear whether the forward estimates include booster doses. There was no explicit funding to cover the administration of the vaccine in last year’s Budget. This has been rectified somewhat in this Budget, with the Government allocating $1.9 billion over five years or 35 per cent of the total amount spent on vaccines. In particular, this Budget includes:

- $777.8 million over two years from 2020-21 for the COVID-19 Vaccination Program, including for surge workforce, general practitioners and community pharmacies to administer vaccines;
- $510.8 million over two years from 2020-21 for the National Partnership on the COVID-19 Response for the states and territories to administer vaccines;
- $358.8 million over five years from 2020-21 to support the implementation, monitoring and reporting of the vaccine rollout; and
- $233.8 million over two years from 2020-21 for COVID-19 vaccine distribution, vaccine consumables, logistics and storage.

This Budget reflects the Government’s preference for the Pfizer/BioNTech vaccine for people younger than 50 years old and a new reliance on states and territories to administer vaccines.

\textsuperscript{142} Department of Health, *Defence support the vaccine rollout in aged care* [media release], 3 March 2021, accessed 4 May 2021


\textsuperscript{144} Therapeutic Goods Administration, *Provisional determination granted to Pfizer in relation to COVID 19 vaccine, COMIRNATY - for use in individuals 12 years of age and older* [media release], 12 May 2021, accessed 13 May 2021

This Budget also includes $6.7 million over two years from 2020-21 for the national communications campaign for the COVID-19 Vaccination Program. This is much needed funding given reduced public confidence in the vaccines. More should have been spent sooner. There is also academic debate about the need for a financial incentive to be vaccinated in order to reach the vaccination rates required to open Australia’s borders, although financial incentives such as these may be counter productive. \[146\]

Finally, the Government will provide an undisclosed amount of funding to develop an onshore mRNA vaccine manufacturing capability in Australia. This is blue sky thinking and one of the most strategic parts of the health portfolio budget. It won’t secure vaccine supply in the short term, but there are significant potential long-term applications that could help Australia cement its place as a worldwide medical research leader.

\[146\] J Savulescu, 'Beervax or bust: Let’s pay people to be vaccinated', The Sydney Morning Herald, 9 May 2021, accessed 12 May 2021.

The Budget in pictures

Chart 1: Nominal health portfolio expenditure

Source: Budget Paper No.1 for 2020-21 to 2024-25. All other health expenses were taken from Budget Paper No.1 released in previous Budget years.
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 2.6 of Australia’s Health Expenditure 2018-19 report. A linear forecast was used for years 2019-20 to 2024-25. 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 Budget Paper No.1.

Source: MUCHE calculations based off Budget Paper No.1
Chart 3: Composition of health portfolio expenditure, 2021-22

Source: Budget Paper No.1

Chart 4: Estimated proportional change in health portfolio expenditure

Source: Budget Paper No.1
Chart 5: Top five health portfolio expenditure increases

- **Release of an additional 80,000 Home Care packages**: $6,500 million
- **Mandating front line time spent on residents in aged care**: $3,900 million
- **New Basic Daily Fee Supplement of $10**: $3,200 million
- **New and amended listings on the PBS, RPBS and Stoma Appliance Scheme**: $879 million
- **Greater access to respite care services and payments to support carers**: $798 million

Source: Budget Paper No.2
Appendix A – References for Figure 1


3. The Hon Scott Morrison MP, *Australia secures a further 50 million doses of COVID-19 vaccine* [media release], 5 November 2020, accessed 5 May 2021


10. ABC, Italy, ‘*Italy, EU refuse AstraZeneca request to ship 250,000 doses of vaccine to Australia*’, ABC, 5 March 2021, accessed 5 May 2021


12. Therapeutic Goods Administration, *TGA approves CSL - Seqirus to manufacture AstraZeneca COVID-19 vaccine in Australia* [media release], 21 March 2021, accessed 5 May 2021


16. The Hon Scott Morrison MP, *National Cabinet* [media release], 22 April 2021, accessed 5 May 2021

17. The Hon Scott Morrison MP, *Australia secures Moderna vaccines* [media release], 13 May 2021, accessed 13 May 2021