CENTRE FOR THE HEALTH ECONOMY

MACQUARIE University

The MUCHE Health Report 2018

ANALYSIS OF THE 2018-19 FEDERAL BUDGET

DISCLAIMER

PREPARED BY

This report was prepared by:

Dr Henry Cutler

Dr Joanne Epp

Mona Aghdaee

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

Dr Henry Cutler
Director
P: + 61 2 9850 2998
M: +61 409 770 946
E: henry.cutler@mq.edu.au
health-economy.mq.edu.au

About MUCHE

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

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

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

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

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

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

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

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

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

Dr Henry Cutler
Director
Centre for the Health Economy
Macquarie University

Contents

Executive summary

For the average Australian taking an interest in their health, this year's Budget announcements would have you jumping for joy. After all, the Hon Greg Hunt MP has declared Australians will see record investment in health care.

Take a closer look and the real story emerges. Estimated Health portfolio expenditure for 2018-19 has only increased by 2.1 per cent, compared to last year's actual Health portfolio expenditure increase of 5.1 per cent. Accounting for health inflation, real Health portfolio expenditure will grow by 1 per cent less than population growth over the forward estimates, which means less money will be spent on a per capita basis.

The Australian Government needs to invest more to improve the wellbeing of Australians. Service gaps are growing in health, ageing and disability care, while improved quality remains stubborn. As the ever increasing march of ageing, health technology costs, and chronic disease continues unabated, Australians will either face worse health outcomes, or be asked to pay more for their health care if the Australian Government does not respond.

The centrepiece of the Australian Government's aged care announcement is 14,000 additional high level home care packages over four years costing $1.6 billion. But none of this is new money, and is being paid for by a 26,700 reduction in projected residential aged care places.

Given the Australian Government struggles to keep up with aged care costs, it must ask consumers to pay more for their care. That would firm up sector sustainability, and help aged care providers better meet consumer preferences.

But increasing co-contributions will not be enough. The Australian Government must also invest more in home care packages and residential aged care places. The additional high level home care packages falls way short of the 82,237 consumers currently awaiting an approved high level package. There is also a projected 94,200 gap in residential aged care places by 2025.

Investment in transparent residential aged care quality indicators must also happen as a matter of urgency. That would stimulate quality competition within the market. Removing supply restrictions must also be undertaken to allow consumers to choose better quality facilities.

The Australian Government will remove the 0.5 per cent rise in the Medicare levy hypothecated to the National Disability Insurance Scheme (NDIS) in last year's Budget. This is nothing more than a political move by the Coalition Party to firm up their defence against an Australian Labor Party attack in the lead up to the election.

This removal dramatically increases funding uncertainty for Australians with a disability. Now NDIS funding is once again reliant on the good fortunes of Australia's economy (which is cyclical), and if the Australian Government falls into a revenue hole (which it will), the disability sector will be exposed to bigger funding cuts than would have otherwise occurred.

The Australian Government should have used the levy to expand the NDIS, in particular mental health services for those with severe psychosocial disability. Around 166,000 people with severe psychosocial

disability will not be eligible for the NDIS. Those currently covered by the NDIS receive fewer services, and report lower satisfaction, compared to pre-NDIS.

While the Australian Government will provide more than $30 billion in increased funding to public hospitals, and $130.2 billion in total over five years from 2020-21, this primarily reflects population growth and health inflation.

Council of Australian Governments (COAG) Heads of Agreement on public hospital funding and health reform does outline several reforms to be pursued by States. This includes paying for value and outcomes within public hospitals.

Incentivising better hospital outcomes using financial means is complex, and international experience suggests often not successful, and at great expense. That doesn't mean States shouldn't try.

The Heads of Agreement has missed a major opportunity to improve quality and value within public hospitals. The Productivity Commission recommended in 2017 that the Australian Government work with States to increase choice for referred patients, and develop guidelines (with professional bodies) on how to support patient choice.

Our own research suggests Australians value choice, and are willing to travel and wait longer for a better quality public hospital. Empirical research from the UK suggests increased public hospital choice can improve hospital quality, and patient health outcomes.

This year the Budget was silent on private health insurance. That may be the eye of the storm. Pressure on prices will continue into the future, and hospital cover membership has decreased from 47.3 per cent in June 2015 to 46.0 per cent in June 2017.

Recent calls for a Productivity Commission review into private health insurance seem justified to ensure the sector remains valuable to consumers, and fiscally sustainable.

The private health insurance rebate must be reviewed. It is projected to cost the Australian Government $6.9 billion by 2012-22, and represents an inefficient way to fund hospital care. Research suggests a marginal decrease in the rebate would provide net savings to the Australian Government, even if it pays for any increased public hospital visits.

Overall, the Budget for health and human services is sedate. No real winners and no real losers. The courage to make real change to improve the wellbeing of Australians has been deferred for a future Government.

Sector specific impacts

Aged care

Perseverance is what comes to mind when describing the aged care sector. Since the introduction of the *Living Longer Living Better* (LLLB) aged care reforms in 2013, it has experienced perpetual reform, as part of the Department of Health's 10 year plan to shift the sector towards consumer directed care. This year is no exception, with several reviews and major changes occurring.

Things kicked off in June 2017 with the Community Affairs Reference Committee report on the *Future of Australia's aged care sector workforce*.[1] It found many providers were struggling to attract and retain workers, due to poorly defined career paths, low rates of remuneration, and poor quality of training programs. Its primary recommendation was to establish an Aged Care Workforce Strategy Taskforce. The Australian Government responded in November 2017, announcing the terms of reference and membership of the Taskforce. The work will be completed by June 2018.

The next cab off the rank was the *Legislated review of Aged Care 2017* report (otherwise known as the Tune Review) in September 2017.[2] Recommendation themes included a more flexible approach to regulating the supply of aged care, introducing higher levels of care to keep people at home longer, and a greater contribution from consumers to costs, through tougher means testing arrangements for residential care and removing contribution caps.

The *Review of National Aged Care Quality Regulatory Processes* was released in October 2017. A review focusing on aged care quality was well overdue, and should have been done around the same time as the LLLB reforms. Consumers still find it difficult to determine which residential care provider best meets their needs.[3] Evidence from the UK suggests publically reporting quality makes demand more sensitive to quality,[4] providing a clearer signal to providers around the importance of quality, and how much to invest to improve quality.

While the Australian Government deferred its response to the *Review of National Aged Care Quality Regulatory Processes*, it announced in April 2018 the establishment of an Aged Care Quality and Safety

---

[1] See https://engage.dss.gov.au/wp-content/uploads/2017/07/Aged-Care-workforce.pdf, accessed 3 May 2018.

[2] See https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/08_2017/legislated_review_of_aged_care_2017.pdf, accessed 3 May 2018.

[3] Australia is somewhat lagging in this regard, with the US publically reporting nursing home quality since 2002, and the UK publically reporting star ratings for nursing homes since 2008.

[4] Park J, Werner RM, 2011, Changes in the relationship between nursing home financial performance and quality of care under public reporting, *Health Economics*, Vol. 20, pp. 783-801.

Commission. It will replace the Australian Aged Care Quality Agency and Aged Care Complaints Commissioner, along with some aged care regulatory functions within the Department of Health.[5]

Budget announcements

The Budget announced a mishmash of expenditure items in aged care, responding (in part) to recommendations made in the *Legislated Review of Aged Care 2017* and the *Review of National Aged Care Quality Regulatory Processes*. The Australian Government is trying to increase aged care access, improve quality, and help seniors age 'better'. However, there is little new expenditure, with funding for most announcements taken from elsewhere in the aged care portfolio.

The centrepiece of the Budget is 14,000 new high level home care packages over four years costing $1.6 billion, which adds to 6,000 high level home care packages promised in the 2017-18 MYEFO. To put that into perspective, it equates to about 5,000 additional packages each year (on average), when the Australian Government funds around 23,000 high level home care packages (Level 3 and 4) each year.

However, there is no new money for these high level home care packages. They are funded entirely by a 26,700 reduction in projected residential care places between 2017-18 and 2020-21. This is short term thinking, given research suggests there will be a 94,200 gap in residential care places by 2025.[6]

While the new high level packages will help some of the 82,237 consumers awaiting an approved high level package,[7] it falls spectacularly short of need. That means demand for residential care should continue unabated, while its supply remains constrained. That is good for residential aged care providers looking to maintain their occupancy rates, but bad for consumers looking for choice.

Several recommendations made in the *Legislated Review of Aged Care 2017* have not been addressed. In particular, it seems the Australian Government was too scared to ask for more money from aged care consumers to cover their care costs and daily living expenses, as recommended. This could have increased the sector's sustainability, and helped fund better care, leading to improved wellbeing and greater investment into the sector.

The good news story for consumers is the Australian Government's focus on improving residential aged care quality, after the Oakden scandal in South Australia last year. That was not an isolated incident, with stories of poor quality in other residential aged care facilities trickling into the media over the years.

A focus on aged care quality is sorely needed. While unannounced quality audits will provide some incentive for providers to maintain quality (announced in the 2017-18 MYEFO), publically available

---

[5] See http://www.health.gov.au/internet/ministers/publishing.nsf/Content/8DF40633F3FD5DC9CA2582720079C7BC/$File/KW048.pdf, accessed 3 May 2018.

[6] See https://www.australianunity.com.au/~/media/corporate/documents/media%20release%20pdfs/practical%20innovation%20closing%20the%20social%20infrastructure%20gap%20in%20health%20and%20ageing.pdf, accessed 10 May 2018.

[7] See https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCP-Data-Report-2017%E2%80%9318-2nd-Qtr.pdf, accessed 9 May 2018.

aged care quality indicators are also required. Fortunately, the Budget has allocated $8.8 million over four years to improve the transparency of information on aged care provider quality.

This change alone could supercharge quality improvements, making demand more sensitive to quality, and providing a clearer signal to providers around the importance of quality. It could also drive quality competition, so long as the Australian Government removes supply restrictions to give consumers more choice. This Budget seems to have started that process, with the Australian Government announcing it will explore the potential to allocate residential aged care places to consumers, rather than providers. The Australian Government should be looking to remove all supply side restrictions if they really want choice to drive quality improvements.

The Australian Government has also shifted the risk of accommodation bond defaults onto providers by establishing a levy mechanism. Defaults are currently covered under the *Accommodation Payment Guarantee Scheme*.

There may be some cost increase to residential aged care patients if providers can shift any levy. The burden should not be great, with only $43 million paid to residents from the *Accommodation Payment Guarantee Scheme* since 1997. However, historical performance may not reflect future performance, particularly if the market becomes more competitive. If a large aged care provider were to go bankrupt due to market forces, imposing a levy on other aged care providers facing the same market forces could create a 'domino effect'.

A curious change in this year's Budget was the resuscitation of the Pension Loan Scheme. This is a Australian Government backed reverse mortgage scheme that currently allows some pensioners to access home equity to extract a regular income, at interest rates lower than commercial products. While this scheme is not specifically designed for aged care, it could help consumers pay for their aged care if they are brave enough to take out a loan on a home otherwise paid off. However, not many are, with only 1-2 per cent of seniors holding a reverse mortgage.[8]

Disability

The National Disability Insurance Scheme (NDIS) was launched as a trial program in July 2013 in four Australian locations with an initial budget of $1 billion. The full scheme rollout began in 2016 and is expected to cost $21 billion in 2019-2020 and beyond, delivering services to 475,000 people annually.

The Productivity Commission (PC) released its final *NDIS Costs* study report in October 2017.[9] It suggested that the current scale and time horizon of the NDIS rollout was extremely ambitious and provided several recommendations for better transition to the full scheme. These covered the following themes.

- Setting more realistic time frame to full rollout.
- Ensuring the quality of services.

[8] See https://www.pc.gov.au/research/completed/housing-decisions-older-australians/housing-decisions-older-australians.pdf, accessed 9 May 2018.

[9] See https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf, accessed 3 May 2018.

- Price regulation.
- Developing workforce market.
- Coordination among government, NDIS and providers.
- Transparency and regular reporting.

Last year's Budget allocated $209 million to establish the NDIS Quality and Safeguards Commission (QSC) to monitor NDIS service quality. The QSC will start operating in July 2018 in New South Wales and South Australia. The PC recommended the QSC monitor and review price caps set by the National Disability Insurance Agency (NDIA) in the interim, and to manage price setting by 2020.

The PC also recommended the Australian Government ensure an adequate and skilled disability sector workforce to meet growing demand. It estimated that 1 in 5 new Australian jobs will be created in disability care in the next five years, and suggested immigration policy should be adjusted to meet demand.

This recommendation seems particularly relevant given aged care will also need workers with similar skills and experience to deliver home care packages. Inadequate labour supply could drive up wages in both sectors and therefore provider costs. That could reduce the sustainability of some smaller providers, who find it more difficult to capture economies of scale.

The PC also found the NDIS operated under-budget at the end of the trial phase with only 76 per cent of services used in 2015-16. This suggests some people may not receive the care they demand under the NDIS, potentially leading to poorer wellbeing.[10] According to the PC, both supply and demand side factors have contributed to under-utilisation, including the following.

- Inadequate supply of support, particularly for specific supports (short term accommodation) or services in remote area.
- Participants face difficulty navigating the system and receive the care that it is planned for them.
- The scheme overestimated the number of supports participants needed.
- Participants did not have information on available supports.

There is still uncertainty on whether the NDIS market can adequately meet the needs of Australians with a disability. While the delivery of human services using a market based approach is not without precedent (after all, nearly the entire aged care sector is delivered by non-government organisations), the NDIS market is still immature.

An independent pricing review of NDIS released in February 2018 made 25 recommendations to improve the market structure, which were accepted by the NDIA. These broadly include enhancing the price setting process by including outcomes, establishing only one price guide, allowing for higher

[10] The National Disability Insurance Agency (NDIA) approved approximately 165 plans a day in 2017. However at least 500 plans need to be approved daily to reach to the estimated 475,000 participants in 2019-20.

prices when delivering care to people with complex needs, and facilitating greater carer mobility in rural areas by increasing travel allowances. [11]

More recently, the Coalition Party and Australian Labor Party (ALP) have engaged in a skirmish over NDIS funding. Last year's Budget estimated that a fully implemented NDIS would have created a deficit of $57 billion over ten years. The Australian Government therefore introduced a 0.5 percent rise in the Medicare levy, which was meant to help overcome this deficit. The ALP had proposed to restrict the levy increase to those earning more than $78,000 annually.

Budget announcements

This Budget has scrapped the 0.5 per cent rise in the Medicare levy, with the Hon. Scott Morrison noting the Australian Government has enough money to cover NDIS costs because our economy is strong. Tax cuts on small and medium-sized businesses have flourished, raising this year's tax revenue by $4.8 billion more than estimated in the 2017-18 MYEFO.

This is nothing more than a political move by the Coalition Party to firm up their defence against an ALP attack in the lead up to the election.

Unfortunately for Australians with a disability, removal of the additional Medicare levy will increase funding uncertainty in the disability sector. Now funding is once again reliant on the good fortunes of Australia's economy (which is cyclical), and if the Australian Government falls into a revenue hole (which it will), the disability sector will be exposed to bigger funding cuts than would have otherwise occurred. This uncertainty is also likely to increase investor's required rates of return, and may dampen future investment into the sector.

Hospitals

The big news in public hospitals this year was the Council of Australian Governments (COAG) Heads of Agreement on public hospital funding and health reform. This will form the basis of negotiations for a new five-year National Health Agreement (NHA) to span 1 July 2020 until 30 June 2025.[12]

The Heads of Agreement provides insight on future public hospital reforms. It outlines several long term system wide reforms the States must pursue, in addition to reforms currently ongoing (e.g., the introduction of pricing by the Independent Hospital and Pricing Authority (IHPA) to incentivise safety and quality). These new reforms will include the following.

- Paying for value and outcomes.
- Joint planning and funding at a local level.
- Nationally cohesive health technology assessment.

---

[11] See https://www.ndis.gov.au/medias/documents/ipr-final-report-mckinsey/20180213-IPR-FinalReport.pdf, accessed 4 May 2018.

[12] See https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-0, accessed 04 May 2018.

- Empowering people through health literacy.
- Prevention and wellbeing.
- Enhanced health data (including health system data and developing a Commonwealth-State primary and community care dataset to inform the development of quality indicators).

NHA negotiations are due to proceed throughout 2018, with Health Ministers due to sign before the end of 2018.

Budget announcements

The Hon Greg Hunt MP has touted that the Australian Government will provide more than $30 billion in increased funding to public hospitals, and $130.2 billion in total over five years from 2020-21 as the NHA kicks off (if the Australian Government manages to get Victoria and Queensland to sign the Heads of Agreement). However, expenditure in this year's Budget forward estimates totals $977.1 million, suggesting the majority of funding will be delivered beyond.

The increased public hospital funding is no surprise, and primarily reflects population growth and health inflation. The new NHA will include $100 million for a Health Innovation Fund accessible by States to fund trials that support health prevention and the better use of health data.

Probably the most controversial reform (from a clinician perspective) outlined within the Heads of Agreement is paying for value and outcomes. While it warms the cockles of a health economist's heart to think public hospital pricing could reflect service quality, incentivising hospital outcomes through financial means is quite complex, and often not successful at great expense.

Effectiveness will depend on the interrelationship between design characteristics, governance structures, infrastructure, and culture within the health care system. A model may need to be tailored to unique Local Health Network (LHN) circumstances, to account for these differences, and their capacity to improve performance. While States may baulk at the challenge, given clinicians are often sceptical of pay-for-performance mechanisms, it should be pursued for the sake of patients.

The Heads of Agreement was silent on a major recommendation made by the PC in their report *Reforms to the Human Services Sector* delivered to the Australian Government in October 2017.[13] It recommended the Australian Government work with States to increase choice for referred patients, and develop guidelines (with professional bodies) on how to support patient choice. This would encourage hospitals to be more responsive to patient preferences.

This omission seems like a missed opportunity for Australian patients. Our own research suggests Australians value choice, and are willing to travel and wait longer for a better quality public hospital.[14]

[13] See https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf, accessed 9 May 2018.

[14] See https://www.mq.edu.au/research/research-centres-groups-and-facilities/prosperous-economies/centres/centre-for-the-health-economy/documents/FINAL-COMM-REPORT.pdf, accessed 9 May 2018.

Empirical research from the UK suggest increased public hospital choice can improve hospital quality, and patient health outcomes.[15]

Mental health

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) and its Implementation Plan were endorsed by the Council of Australian Governments Health Council (COAG Health Council) on 4 August 2017.[16] The Fifth Plan seeks to establish a national approach for collaborative government effort from 2017 to 2022 across eight targeted priority areas, including the following.

- Achieving integrated regional planning and service delivery.
- Effective suicide prevention.
- Coordinated treatment and supports for people with severe and complex mental illness.
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.
- Improving the physical health of people living with mental illness and reducing early mortality.
- Reducing stigma and discrimination.
- Making safety and quality central to mental health service delivery.
- Ensuring that the enablers of effective system performance and system improvement are in place.

The Fifth Plan was criticised, most notably due to little detail on how services were to be integrated, and because there was no new funding attached.[17] While it placed great emphasis on the need for Primary Health Networks (PHNs) and LHNs to integrate to improve mental health services, there was little detail on how that could happen. One of the greatest challenges is overcoming funding silos for mental health services. After all, PHNs are funded by the Australian Government to provide primary care services, while LHNs are primarily State Government funded to provide mostly acute services. Developing an integrated approach is difficult due to conflicting financial incentives.

As the NDIS roles out, concern is growing that many people with severe psychosocial disability will be excluded, and those who are eligible will not receive appropriate planning and services. In April 2018, an NDIS evaluation undertaken by Flinders University found that the number of supports received by NDIS participants have nearly tripled compared to pre-NDIS, yet this increase did not occur across all types of disabilities.[18] People with psychosocial disability received less services and reported lower

---

[15] Cooper Z, Gibbons S, Jones S, McGuire A. 2011, Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms. Econ J (London), Vol. 121 (554):F228-60.

[16] See http://www.coaghealthcouncil.gov.au/, accessed 05 May 2018.

[17] Croaky 2018. More crack than floorboard – The 5th National Mental Health and Suicide Prevention Plan. https://croakey.org/more-crack-than-floorboard-the-5th-national-mental-health-and-suicide-prevention-plan/, accessed 5 May 2018.

[18] See https://www.dss.gov.au/sites/default/files/documents/04_2018/ndis_evaluation_consolidated_report_april_2018.pdf, accessed 10 May 2018.

satisfaction than pre-NDIS. Similarly participants with psychosocial disability and those with difficulty managing NDIS process were more likely to have poorer health outcome than pre-NDIS.

The University of Sydney's *Mind the Gap* report released in January 2018 investigated the impact of the NDIS on people with psychological disability and identified several concerns regarding engagement and application processes, and scheme assessments and plans.[19] It also suggested the supply of mental health services within the NDIS was lacking because service prices do not adequately cover costs.

The *Mind the Gap* report also noted that the NDIS will provide funding for only 64,000 people with severe psychosocial disability, despite the Australian Government estimating that 230,000 people with severe psychosocial disability will need ongoing support. It suggested those not eligible for the NDIS were receiving less support due to a loss of services. The Report called for greater leadership within the NDIA, ongoing monitoring of implementation for people with psychosocial disability, and better support for community services to help transition into the NDIS, among other recommendations.

Budget announcements

The Australian Government continues to invest in the Fifth Plan, albeit may would argue not enough has been committed. The Budget will provide $37.6 million over four years from 2018-19 to improve follow-up care for people discharged from hospital following a suicide attempt. $33.8 million over four years will be provided to Lifeline Australia to enhance its telephone crisis services. And $12.4 million over four years will go to the National Mental Health Commission to strengthen its role as recommended in the Fifth Plan.

Funding has also been reallocated within aged care to improve mental health. This includes $82.5 million over four years from 2018-19 to deliver mental health services in residential aged care, and $20 million over the same period to fund a pilot of mental health nurses to target people in the community at risk of isolation.

Nothing has been included in the Budget to address the potential shortfall of access to services for people with psychosocial disability in the NDIS. Many will be disappointed that the Australian Government removed the increased 0.5 per cent Medicare Levy hypothecated for the NDIS, because some of that money could have been spent on addressing those concerns.

Pharmaceuticals

The Department of Health maintains strict surveillance of Pharmaceutical Benefits Scheme (PBS) expenditure, and has employed a number of pricing levers to temper cost blow-outs. PBS represents the second largest expenditure item in the Health portfolio, totalling $13.2 billion in 2017-18, and projected to cost $47.4 billion in the forward estimates.

[19] See http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf, accessed 4 May 2018.

Last year's Budget really set the scene for the pharmaceutical sector, referencing a five year agreement with Medicines Australia estimated to save the Australian Government $1.8 billion between 2016-17 and 2021-22. These savings were primarily through price reductions including:

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

The public pressure to continue funding new and expensive drugs remains unabated. In the 2016-17 MYEFO, $2.1 billion was allocated for new and amended listings on the PBS and the Repatriation Pharmaceutical Benefits Scheme (RPBS) over four years from 2017-18.

Budget announcements

The Australian Government has stated investment in new medicines will increase by $2.4 billion over five years, although $1.7 billion was committed in the 2017-18 MYEFO. Only an additional $769.6 million was committed over the forward estimates in this Budget, and some of that will be offset by rebates negotiated as part of the purchase agreements. Most of this 'new' expenditure is covered by savings from price reduction arrangements announced in last year's Budget.

The pharmaceutical sector will take the brunt of Health portfolio expenditure cuts, although these are relatively small compared to previous years. This includes a $335 million cost saving to the Australian Government by encouraging the use of generic and biosimilar medicines through an awareness campaign. It also includes a $77.6 million cost saving from reducing unnecessary or inappropriate use of biological disease-modifying anti-rheumatic drugs and supporting the appropriate use of blood products. These will be delivered through targeted education programs for prescribers.

Pharmacy

It was a sad day for Australian consumers in February 2018 when legislation was passed to remove the Pharmacy Location Rules sunset clause. These rules mean that location criteria will still need to be met beyond 2020, for the Australian Community Pharmacy Authority to approve a new pharmacy, or the relocation or expansion of an existing pharmacy.[20]

[20] New pharmacies cannot open within 1.5 kilometres or 10 kilometres of an existing pharmacy depending on the location, distance to the nearest pharmacy, and the number of supermarkets and medical practitioners in the area.

While the Pharmacy Guild of Australia argued these rules provide 'certainty and stability for pharmacy small business',[21] they restrict competition. Consumers have less opportunity to shop around, and the incentive for pharmacies to offer a competitive price is somewhat muted. As recommended within the Competition Policy Review in 2015, the location rules '*should be removed in the long term interests of consumers*'.[22]

This now seems unlikely. The final *Review of Pharmacy Remuneration and Regulation* report released in September 2017 recommended that the Australian Government '*reform the Pharmacy Location Rules to remove barriers to community access and competition between pharmacies*'.[23] The Australian Government rejected this recommendation,[24] effectively locking in anti-competitive regulations, and in some cases local pharmacy monopolies, for the duration of the Sixth Community Pharmacy Agreement (6CPA).[25]

The Australian Government also rejected the Review's recommendation to undertake a tender process for listing generic medicines on the PBS. The idea was to stimulate price competition to reduce costs to the Australian Government, just like New Zealand, which has one of the lowest per capita expenditure on drugs among 10 high income countries, primarily due to price reductions.[26] The Australian Government's reasoning was that restricting access to generic drugs could limit patient and physician's choice, reduce market competition, and risk medicine shortages.

Budget announcements

This Budget responds to only some of the recommendations made in the *Review of Pharmacy Remuneration and Regulation* report. The Australian Government will change the administration arrangements for high cost medicines and those with special pricing arrangements, to help the 22 per cent of pharmacies currently unable to provide high cost medicines due to up-front costs.

Rather than receiving revenue rebates from paying higher prices for medicines with special pricing arrangements, the Australian Government will pay the price agreed with relevant medicine manufacturers. While that looks like a $5.4 billion saving in the forward estimates, the Australian Government also loses the corresponding revenue, so the net investment position is zero.

The Government also accepted a recommendation to increase the use of electronic prescriptions and medications records, allocating $28.2 million over five years to upgrade the e-prescribing software system used by prescribers. That should increase healthcare system efficiency and patient safety.

---

[21] See https://www.guild.org.au/resources/business-conditions-survey, accessed 8 May 2018.

[22] See http://competitionpolicyreview.gov.au/final-report/, accessed 8 May 2018.

[23] See http://www.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/$File/review-of-pharmacy-remuneration-and-regulation-final-report.pdf, accessed 3 May 2018.

[24] See http://www.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/$File/Pharmacy-Review-Aus-Gov-Response-3-May-2018.pdf, accessed 4 May 2018.

[25] See http://www.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/$File/review-of-pharmacy-remuneration-and-regulation-final-report.pdf , accessed 4 May 2018.

[26] Morgan SG, Leopold C, Wagner AK, 2017, *Drivers of expenditure on primary care prescription drugs in 10 high-income countries with universal health coverage*, Canadian Medical Association Journal, Vol. 189, No. 23.

Pharmacy will experience a small cost increase, with the Budget announcing a $5.3 million saving through recouping the cost of the PBS pharmacy approval process.

Primary care and medical services

Population aging and increased rates of chronic disease continue to place strain on Medicare (the largest Health portfolio expenditure item) with older patients needing more and longer GP appointments, more specialist visits and more diagnostic tests.

That is scary for an Australian Government trying to claw back a budget deficit because managing health service volume is tricky. It relies on getting supply side incentives right, which the Australian Government has some control over, and getting demand side incentives right, which the Australian Government seems to have no control over. Just think of the debacle created when the Abbott government tried to introduce a $5 mandatory Medicare co-payment in the 2014-15 Budget. It was in, and then scrapped six months later because it was so unpopular with voters.[27]

Over the last five years there has been numerous efforts to halt funding growth, starting with the Labor Government's MBS rebate freeze in 2014. This was extended by subsequent Coalition governments but it seems the political pressure was too much.[28]

Last year's Budget saw the Coalition commit $1.0 billion over four years from 2017-18 to reintroduce indexation for some MBS items. GP bulk billing consultations were indexed first, then standard consultations, and finally specialist procedures and allied health service items. This commitment increased medical benefits expenditure by 10.9 per cent in real terms over the period 2017-18 to 2020-21.

Healthcare affordability remains a concern for voters and politicians alike. Data on bulk billing rates are regularly monitored, and the Australian Government has fortunately not seen a decline in bulk billing rates in recent years, averaging around 85 per cent for GP visits.

International surveys have indicated that out-of pocket expenses for health care paid by Australians are among the highest in OECD countries. In particular, a recent Commonwealth Fund found 13 percent of elderly Australians had problems getting care due to high costs. Australia comes second after the US at 23 per cent.[29] This could be a crucial battle ground in the lead up to the election because out-of-pocket costs have not been addressed in this year's Budget.

---

[27] Arguably, this contributed to the demise of Tony Abbott. In Malcolm Turnbull's speech announcing his challenge to Tony Abbott, he notes "*The one thing that is clear about our current situation is the trajectory. We have lost 30 Newspolls in a row. It is clear that the people have made up their mind about Mr Abbott's leadership*".

[28] ALPs effective 'Mediscare' campaign during the 2016 federal election may have weighed heavily on the Coalition party. However, the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) also played a role, vigorously arguing their members had increased fees, leading to increased out-of-pocket costs, and potentially worse health outcomes as people delay treatment.

[29] See http://www.commonwealthfund.org/publications/in-the-literature/2017/nov/older-americans-sicker-and-faced-more-financial-barriers-to-care, accessed 4 May 2018.

The Australian Government trial of the Health Care Home model announced in the 2016-17 Budget has been taken up by nearly 200 practices and Aboriginal Community Controlled Health Services (ACCHS) around Australia. Health Care Homes are now providing services for up to 65,000 patients with chronic and complex conditions. Stage one implementation of a trial of Health Care Homes will run until November 2019. The evaluation of the HCH program stage one implementation will assess the extent whether it's achieving its objectives, and inform future directions for the program.

Budget announcements

The Hon Greg Hunt MP announced that Medicare funding will increase by $4.8 billion over the forward estimates, but most of this was committed in last year's Budget through the gradual thawing of the Medicare freeze. There was no mention of additional funding for the Health Care Home model in the Budget, as some health care watchers had hoped.

The Medicare Benefits Schedule Review Taskforce is still chipping away to align MBS items to 'contemporary clinical evidence'. The 2017-18 MYEFO claimed the Taskforce has saved the Australian Government $409 million over five years from 2016-17, but there is a long way to go (over 5,700 MBS items will be reviewed), with many clinical committees still yet to be established. This Budget sees an increase in expenditure of $49.4 million over the forward estimates in response to Taskforce recommendations.

The most significant primary care initiative in the Budget was funding to redress the maldistribution of medical services in rural and regional areas. The Budget included $83.3 million over the next five years to provide greater rural-based teaching and training opportunities for new doctors through a new medical school network. It will also include a Workforce Incentive Program to further incentivise doctors into rural areas, and for general practice to employ allied health professionals, among other initiatives.

Unfortunately for radiology providers, they are still waiting on a MBS freeze reprieve. The Australian Government had indicated it will start indexing targeted radiology services including mammography, fluoroscopy, CT scans and interventional procedures from 1 July, 2020. The Australian Diagnostic Imaging Association is lobbying for this to be brought forward, but this Budget hasn't delivered.

Private health insurance

The private health insurance (PHI) sector got off relatively scot-free in last year's Budget. As noted within our report, this was likely to be a temporary reprieve, with several Committees busily formulating recommendations to the Australian Government.

The last year has seen a wave of debate over private health insurance. This started with PHI reforms announced in October 2017, with the Australian Government's objective to make PHI 'simpler'. Key items included the introduction of Gold / Silver / Bronze and Basic product categories,[30] standard

[30] There was debate on whether a Basic product should be included, and many have argued rebates attached to that type of product should be removed.

clinical definitions for all product descriptions, and redevelopment of the government's PHI website (privatehealth.gov.au) to make it more useful to users.

The Australian Government was also hell bent on trying to make PHI more 'affordable'. It reduced minimum benefits payable for nearly all medical devices listed on the Prosthesis List, which was expected to save insurers over $1 billion between 2018 and 2021. Another key item was the introduction of hospital policy discounts (starting in 2019) to people aged 18 to 29 years old, which is the first time insurers have been allowed to offer discounts based on age (they can currently charge more based on age through the Lifetime Health Care policy). Due to risk equalisation and community rating arrangements, bringing low risk members into the PHI pool should reduce prices for all.

While this seems like a valiant effort to address the ever increasing cost of PHI (policy prices have increased by around 60 per cent since 2010 when compounding is taken into consideration), it will not be enough to stop the increasing trend in costs. After all, even the private health insurance sector agreed the primary cost driver is the continued increase in demand for services,[31] yet this was not addressed within the 2017 Reforms.

There was also debate about whether a 2-10 per cent discount is enough to entice someone under the age of 29 to enter the PHI market. The relatively low elasticity of demand found in PHI means response to price is somewhat subdued. Many young Australians may also find PHI too expensive (even with the discount) given their lower incomes, and other discretionary spending. After all, hipsters invented the 'smashed avocado'.

The Senate Community Affairs References Committee released its final report on the *Value and affordability of private health insurance and out-of-pocket medical costs* in December 2017, with 19 recommendations.[32] There was nothing untoward, nor very exciting.

Several recommendations were to improve price transparency within the private health care sector. This is sorely needed among specialists as no other market has such opaque pricing practices (except maybe the lawyers, but at least you know how much they charge by the hour).

One recommendation was to publish fees of individual practitioners in a searchable database, enabling people to shop around for the best price, and potentially stimulating price competition among practitioners.[33] Whether this could work is another matter. After all, specialists are likely to argue that every patient is different, which is the same argument used whenever someone suggest their performance should be measured.

January 2018 saw debate rage over approved PHI price increases. The Minister for Health, the Hon Greg Hunt MP, announced that the Department of Health had approved an average 3.95 per cent price increase, which was the lowest since 2001. While he speaks the truth, it's not that much of an

---

[31] See http://www.abc.net.au/radionational/programs/breakfast/private-health-significant-rise-in-some-premiums/9661920, accessed 4 May 2018.

[32] See https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Report, accessed 4 May 2018.

[33] It also included more transparency on informed financial consent for private patients in public hospitals, and more transparency on commissions intermediary organisations receive from private health insurers.

achievement when premiums have been increasing at a rate three times the CPI index, and the Department of Health has absolute control over prices.

The media called him out, arguing that income growth will be less than half the average premium increase. The ALP latched on to public sentiment, promising a 2 per cent increase for the next two years if elected. Neither outcome is great for PHI members. Under the Coalition Party strategy, PHI will continue to get super expensive, while any limited stay on price increases offered by the ALP could potentially be recouped after two years by insurers. All this sets the scene for a marvellous battle ground in the lead up to the election.

A nice segue from the debate on price increases was the subsequent debate over whether the annual $6.5 billion PHI rebate the sector receives each year from the Australian Government is worthwhile. While both the Coalition Party and ALP stated they would not remove the rebate (although the ALP suggested it may be removed for 'junk' policies), health economists have been arguing the rebate is poor policy since its inception.[34]

The Lifetime Health Cover was responsible for improving membership in the early 2000s, along with the Medicare Levy Surcharge keeping high income earners in PHI, so the argument that the rebate maintains membership is not backed by evidence.[35]

PHI rebate is also an inefficient way to subsidise hospital care. If the Australian Government were to divert this funding into public hospitals, 'back of the envelop' calculations suggest it could result in an additional 5.9 million public hospital bed nights per year. That would certainly help State Governments reduce those stubborn public hospital elective surgery waiting lists.

Even if there was a marginal decrease in the rebate, and the Australian Government promised to pay for all additional public hospital admissions, there could still be net savings to the Australian Government. Modelling suggest savings from the rebate is more than enough to cover the cost of increased public hospital use.[36] This is because the rebate provides subsidies to nearly everyone who owns PHI (except those earning the highest income) but only a sub-group of members use PHI each year. Furthermore, between one third and just under one half of people with PHI who need hospital care will still seek care through a public hospital anyway.

Some have argued that public sector could not cope with all that increased demand. Under current labour supply that is correct, but if demand were to switch from the private to public hospital sector then hospital specialists would follow.

There has also been suggestions that private specialists won't work in the public hospital system. However, many private specialists already work in the public sector (where they enjoy a right of private practice agreement). Furthermore, the public sector could commission services from the private

---

[34] When the Howard government bought the 30 per cent rebate into private health insurance in the late 1990s, the Productivity Commission noted that net budgetary effects will be negative because the rebate would be mostly going to people who are already members or would have purchased PHI anyway.

[35] Butler J 2003, 'Policy change and private health insurance: did the cheapest policy change do the trick?', *Australian Health Review*, 25(6): 33-41.

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

hospital sector (or even better, open it up to contestability), removing middle man for those members wanting to drop their cover. Commissioning private hospitals to undertake publically funded elective surgery is how many European countries have reduce their elective surgery waiting times over the last 20 years.

Budget announcements

This year the Budget is silent on private health insurance. But it may be the eye of the storm. Pressure on prices will continue into the future, and hospital cover membership has decreased over from 47.3 per cent in June 2015 to 46.0 per cent in June 2017.[37] While this may not seem like much, it represents a downward turning point from an otherwise long term, relatively stable, membership trend.

Recent calls for a Productivity Commission review into private health insurance seems justified to ensure the sector remains valuable to consumers, and fiscally sustainable. The private health insurance rebate must be reviewed. It is projected to cost the Australian Government $6.9 billion by 2012-22, and represents an inefficient way to fund hospital care.

Other notable changes

Health and medical research

While the Australian Government has announced $6 billion in funding for Australia's health and medical research sector, hardly any money is new or accounted for within the Budget. Take for example the announced $1.3 billion National Health and Medical Industry Growth Plan. The objective is to make Australia a global destination for medical jobs, research and clinical trials, and the Australian Government should be commended for their leadership. However, funds will be spent over 10 years, and only $49 million has been included in the forward estimates.

The Australian Government has also amended its research and development tax incentive program in response to the recommendations of the 2016 *Review of the R&D Tax Incentive*.[38] Some organisations have been too liberal with their interpretation of what constitutes an eligible activity or expense, reducing the fiscal sustainability of the program. Changes in the Budget include greater incentives for more R&D intensity, caps on refundable R&D tax offsets, and stronger compliance arrangements. Clinical trials have been exempted from these changes, highlighting the importance the Australian Government places on health and medical R&D to stimulate the economy.

The Australia Government has also announced its 'centrepiece' $500 million Australian Genomics Health Futures Mission. This is funded from the Medical Research Futures Fund (MRFF), which was established in the 2014-15 Budget to fund exactly these types of initiatives.

---

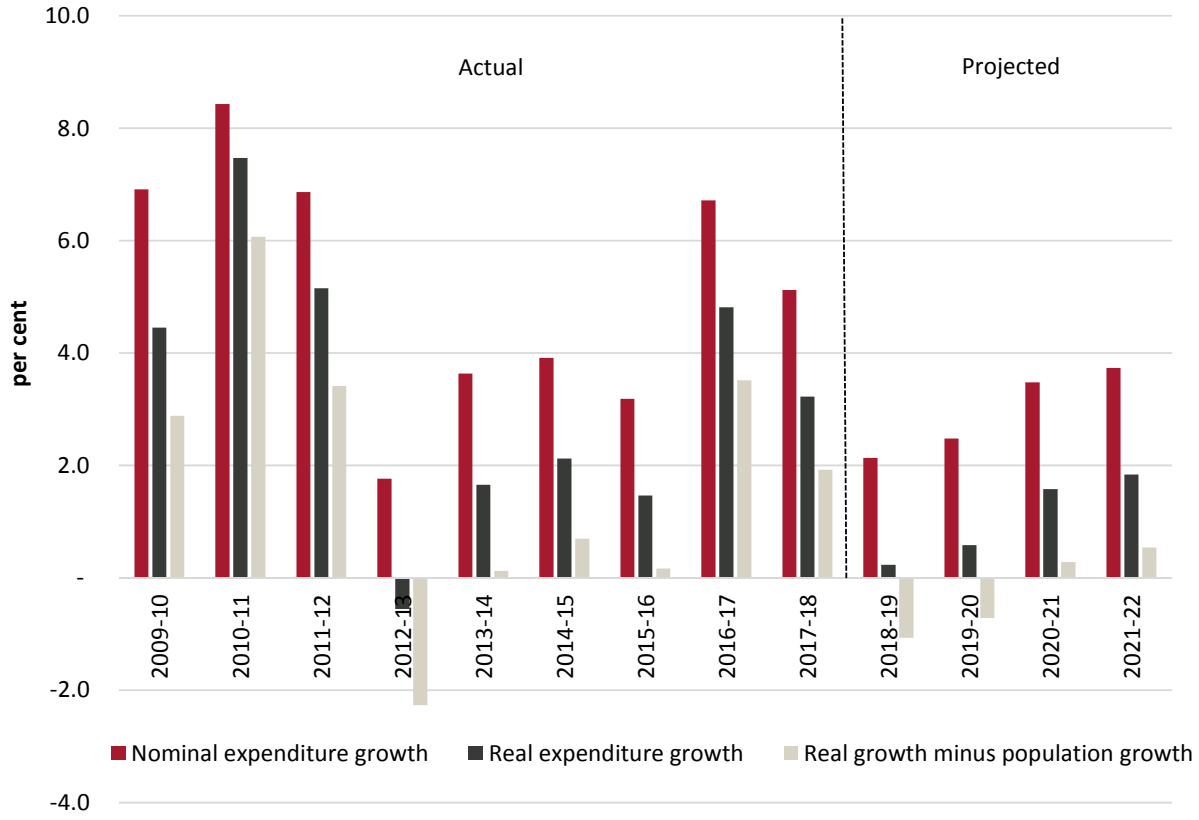
[37] See http://www.apra.gov.au/PHI/Publications/Pages/Membership-and-Coverage.aspx, accessed 9 May 2018.

[38] See https://www.industry.gov.au/innovation/InnovationPolicy/Research-and-development-tax-incentive/Documents/Research-and-development-tax-incentive-review-report.pdf, accessed 10 May 2018.

The Budget also included other MRFF funding allocations: $125 million over 10 years for a *Million Minds* Mental Health Research Mission which supports priorities under the Fifth Mental Health and Suicide Prevention Plan; and $18.1 million over four years for a *Keeping Australians Out of Hospital* program focused on preventative health and behavioural economics initiatives.

The Budget in pictures

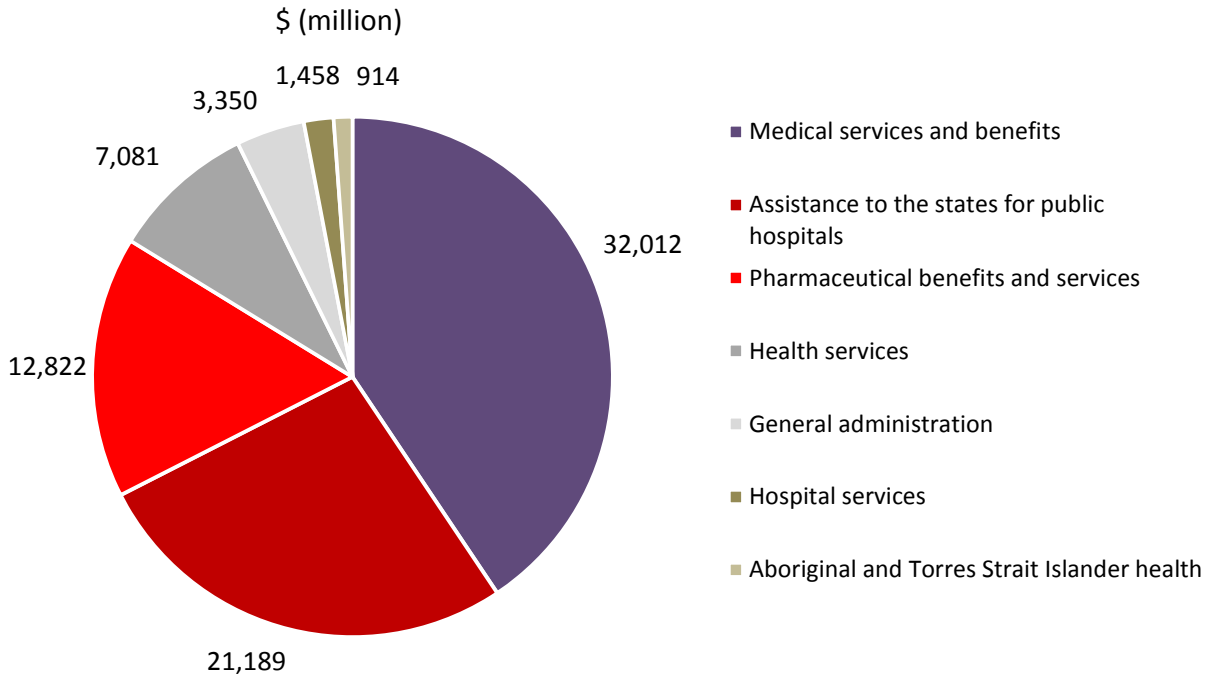
Chart 1: Annual change in net Budget health expenditure



Note: Adjusted for the expenditure impact from the Improved Pharmaceutical Benefits Scheme (PBS) payment administration.

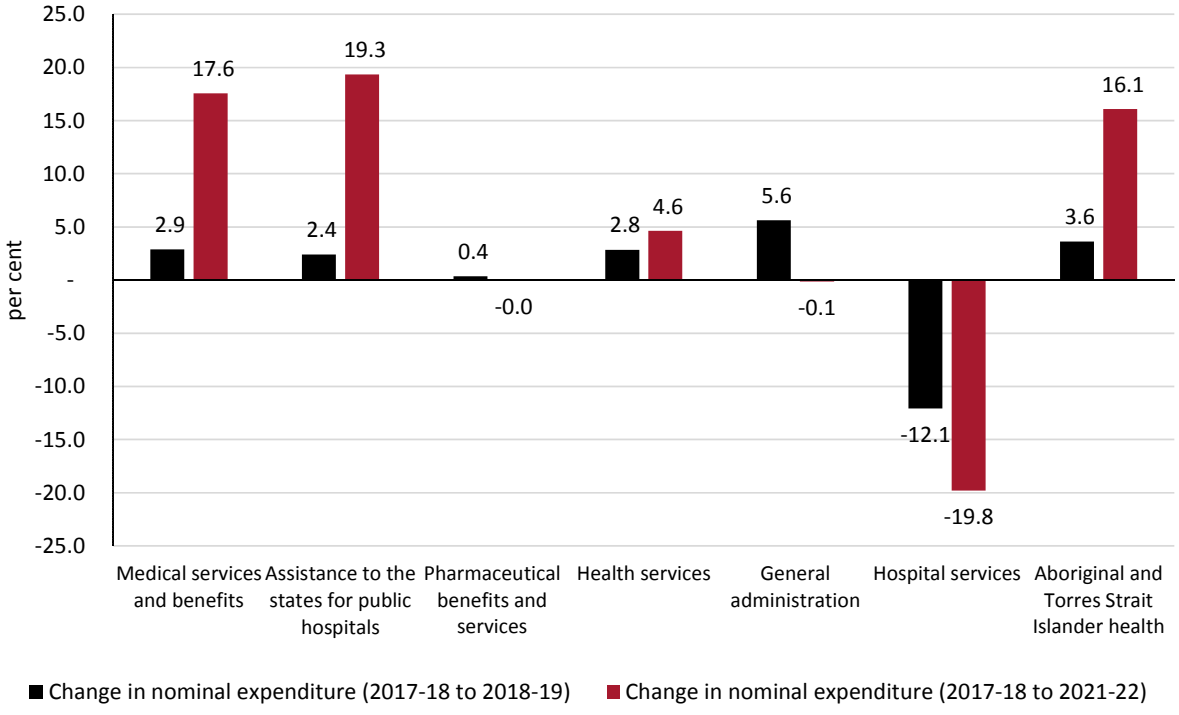
Source: MUCHE calculations based off Budget Paper No.1

Chart 2: Composition of the Health portfolio, 2018-19



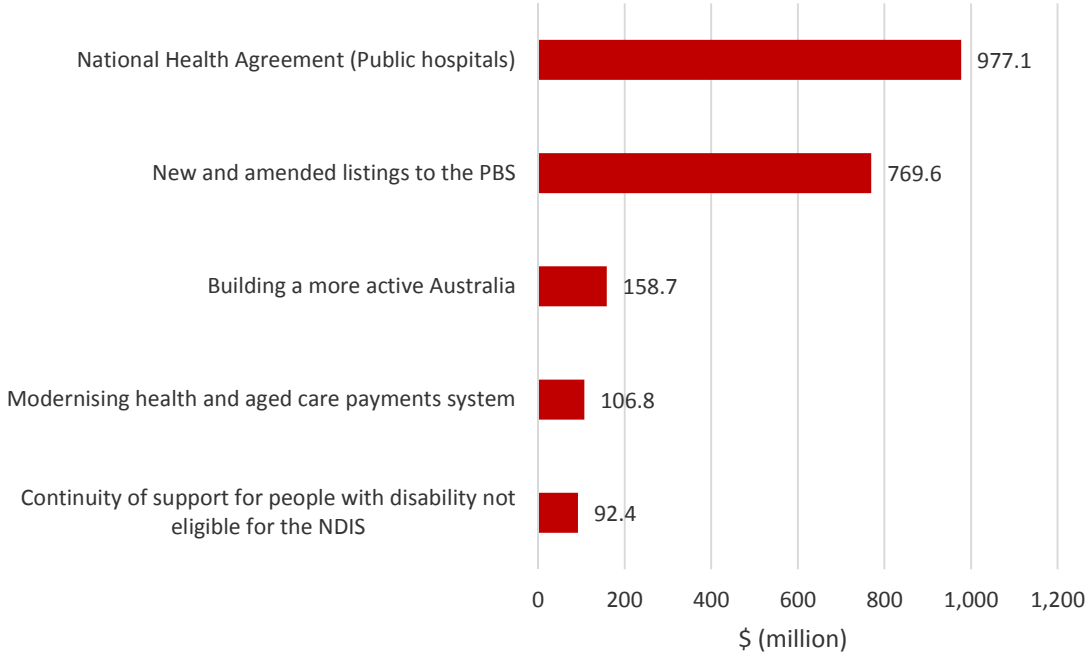
Source: Budget Paper No.1

Chart 3: Estimated proportional change in expenditure



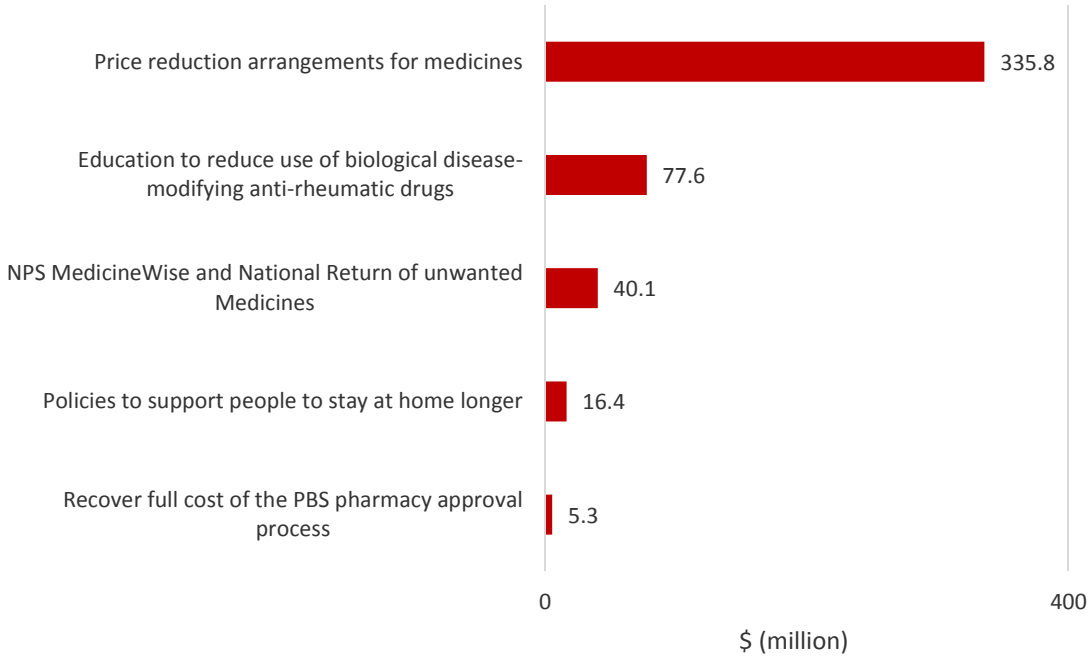
Source: Budget Paper No.1

Chart 4: Top five Budget increases in expenditure, 2018-19



Source: Budget Paper No.2

Chart 4: Top five Budget savings measures, 2018-19



Source: Budget Paper No.2