

The MUCHE Health Report 2019

ANALYSIS OF THE 2019-20 FEDERAL BUDGET



DISCLAIMER

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

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

PREPARED BY

This report was prepared by:

Dr Henry Cutler

Dr Joanne Epp

Mona Aghdaee

Andrew Partington

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	1
Sector specific impacts	5
Aged care.....	5
Budget announcements.....	7
Disability.....	8
Budget announcements.....	9
Hospitals.....	10
Budget announcements.....	11
Mental health.....	11
Budget announcements.....	13
Pharmaceuticals.....	13
Budget announcements.....	14
Pharmacy.....	14
Budget announcements.....	15
Primary care and medical services.....	16
Budget announcements.....	17
Private health insurance.....	18
Budget announcements.....	21
Other notable changes.....	21
Health and medical research.....	21
Sport.....	22
The Budget in pictures.....	23

Executive summary

This Budget is all about wooing voters. Besides handing out large tax breaks, what better way to win the hearts of Australians than through increased spending on healthcare and what better time to spend when there is a budget surplus.

While some have labelled this as a cash splash Budget, health portfolio expenditure has been shackled. This fits within a recent trend of ever lower annual expenditure growth since 2016-17, when it was 6.7 per cent. Headline estimated health portfolio expenditure has only increased by 1.5 per cent for 2019-20, compared to an average 5.2 per cent for the three years prior.¹

This Budget notes there will be a 2 per cent increase in real expenditure from 2019-20 to 2022-23. Accounting for population growth, that equates to a 0.4 per cent increase per capita. Most of this growth comes in the last two years of Budget projections. Australians face a reduction in per capita health portfolio expenditure over the next two years.

The Australian healthcare system is nearly the best in the world. We are ranked second best overall according to a 2017 Commonwealth Fund report, but are ranked number one on health outcomes and administrative efficiency.²

For all the international accolades our healthcare system receives, it should not go unchallenged. The question remains ‘Is this Budget the best for Australia’s future healthcare needs, or has the Australian Government delivered a safe and easy Budget for short term gain?’.

This is a grass roots Health portfolio budget, with the Australian Government looking to garner approval from local communities. This may be borne out of political necessity, with the Labor Party announcing health as a key battle ground in the lead up to the next election, given the 2016 ‘Medicare’ campaign was so effective.

The Australian Government has allocated funding to several individual infrastructure projects, health programs and not-for-profit groups. More so than in past Budgets. And there are no losers. This is unexpected given disinvestment should be part and parcel of a changing healthcare system.

The centrepiece Budget item is \$1.1 billion allocated over five years to support primary care. This goes towards lifting the indexation freeze for all GP items and diagnostic imaging services, a new chronic disease care funding model and a revised *Practice Incentive Program Quality Incentive (PIPQI)*.

Lifting the rebate freeze for GP and imaging services should allow providers to reduce patient co-payments. But there is no guarantee the additional funding will land in patient pockets, it may boost provider income. Only time will tell.

¹ This growth estimate is likely to be slightly underestimated as it does not reflect the revenue impacts of pharmaceutical benefit scheme rebates. These were not published in the 2019-20 Budget.

² The Commonwealth Fund 2017, Mirror Mirror 2017, <https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and>, accessed 17 August 2018

Aged care was allocated \$724.8 million over the next five years. Most of this funding was already announced, including a one-off increase in the basic subsidy for residential aged care and an additional 10,000 Home Care packages across all levels.³ Nearly half of the commitment will be spent in 2018-19.

More aged care funding is required to keep up with demand. There are still 121,000 people on the national prioritisation queue for Home Care packages.⁴ The Australian Government should ask for greater contributions from aged care recipients capable of paying. This would help it develop a good quality and financially sustainable aged care system.

The Australian Government continues to invest in aged care quality, with funding allocated to mandatory reporting within the National Aged Care Quality program, along with other quality initiatives. Performance information should be made publically available to help consumers choose better quality aged care facilities. Removing supply side restrictions under Aged Care Approvals Round (ACAR) arrangements would supercharge quality competition.

This Budget continues to build on the Fifth National Mental Health and Suicide Prevention Plan. It includes funding to trial eight mental health centres focused on delivering after-hours treatment to adults. Funding will also help reduce the alarming suicide rate among Australian youths. This includes expanding the *headspace* network and reducing its waiting times, and extending the *Early Psychosis Youth Services* program.⁵

No additional funding was allocated to public hospital activity. Under the \$1.25 billion *Community Health and Hospitals Program*, communities will benefit from additional funding to hospitals and healthcare centres, such as the \$100 million for a comprehensive children's cancer centre in Sydney. Funding for this program was already announced in the 2018-19 Mid Year Economic and Fiscal Outlook (MYEFO) Budget.

Redland Hospital and Bowen Hospital in Queensland have received infrastructure grants, along with Base Coast Health in Victoria. Funding was also provided to improve cancer treatment infrastructure in locations across Australia. Given these infrastructure investments are not part of a broader healthcare system strategy, they may not necessarily move the healthcare system towards true service integration.

No additional funding was allocated to the disability sector, although the Australian Government has allocated \$528 million to support a Royal Commission into 'violence, abuse, neglect and exploitation of people with disability'. There is currently an NDIS underspend given enrolment delays and difficulties identifying and contracting providers.

This Budget has made relatively little change in pharmaceuticals and pharmacy. Funding has been allocated for new PBS medicines, while pharmacists will receive top-up revenue through an Administration, Handling and Infrastructure fee. The only change to the private health insurance sector is \$5 million to help consumers navigate changes to new policy classifications.

³ Prime Minister of Australia, 10 February 2019, New \$662 Million Aged Care Package to Support Older Australians, <https://www.pm.gov.au/media/new-662-million-aged-care-package-support-older-australians>, accessed 29 March 2019.

⁴ Around 53 per cent of those waiting for a Level 3 or 4 package are currently receiving a lower level package.

⁵ This expenditure has not been included in the Budget estimates.

Australian healthcare is a big, complex and ever changing system. No one Budget will ever meet the immediate needs of a system under constant pressure. Yet some existing cracks are starting to look like crevices, which require constant Budget attention and future structural reforms. This Budget has missed an opportunity to help fill those gaps.

A strong healthcare system must manage health risks. One risk is obesity, with nearly two thirds of Australian adults overweight or obese, costing the Australian economy around \$9 billion per year. Managing obesity requires coordination and investment from the Australian Government to form a national approach to prevention. That is missing from this Budget despite recommendations from a Senate Select Committee.⁶

Efficiency gains can relieve some budget pressure, but big healthcare savings are elusive. The introduction of Activity Based Funding is one exception. Current projections suggest healthcare costs will rise exponentially as baby boomers enter into their 80's. That is only five years away.

Further funding reform is needed to better align financial incentives to health outcomes and cost effective healthcare, particularly within primary care. Additional funding within this Budget to explore new funding models for chronic disease and to refine the Practice Incentive Program Quality Incentive program is a step in the right direction. But they must be properly evaluated for their cost effectiveness.

Over half of all Australians rely on the public hospital system for elective surgery, yet waiting times continue to increase.⁷ The Australian Government argues that maintaining private health insurance membership helps take pressure off the public system. It pays \$6.3 billion each year to private health insurance funds to fulfil this goal.

Yet there is no empirical evidence that shows increased membership reduces public hospital waiting times. This money would be better spent working directly with State and Territory governments to help reduce their public hospital waiting lists.

We have a health equity problem. Aboriginal and Torres Strait Islander Australians still have much worse health outcomes, being 3.3 times more likely to have diabetes compared to non-indigenous adults, for example.⁸ The target to close the gap in life expectancy by 2031 is not on track.⁹

While the Australian Government spends nearly \$1 billion on Aboriginal and Torres Strait Islander health each year, annual real growth is relatively flat within this Budget, averaging 2.9 per cent. The \$10.0 million allocated to the Lowitja Institute (Australia's National Institute for Aboriginal and Torres

⁶ Commonwealth of Australia 2018, Obesity epidemic in Australia. Final report, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Obesity_epidemic_in_Australia/Obesity/Final_Report, accessed 1 April 2019.

⁷ Australian Institute of Health and Welfare 2018, Elective surgery waiting times 2017-18. Australian Hospital Statistics, <https://www.aihw.gov.au/getmedia/73b686ab-32e9-48b1-86f2-cd264b3cf073/aihw-hse-215.pdf.aspx?inline=true>, accessed 3 April 2019.

⁸ AIHW 2017, The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015, <https://www.aihw.gov.au/getmedia/584073f7-041e-4818-9419-39f5a060b1aa/18175.pdf.aspx?inline=true>, accessed 17 August 2018.

⁹ Department of Prime Minister and Cabinet 2018, Closing the gap. Prime Minister's report 2018, <https://www.pmc.gov.au/sites/default/files/reports/closing-the-gap-2018/sites/default/files/ctg-report-20183872.pdf?a=1>, accessed 2 April 2019

Strait Islander Health Research) is welcomed, along with \$5 million to implement Indigenous suicide prevention initiatives, but more work is required to close the gap in health outcomes.

Australians also face inequitable access to healthcare. Despite GP bulk billing rates being 86.1 per cent,¹⁰ a 2018 Australian Institute of Health and Welfare report showed we spent around \$30 billion from our own pocket on healthcare related expenses in 2015-16.¹¹ That's about \$1,200 per person. Some people do not access healthcare due to high costs, putting their health in danger, and increasing the risk of more expensive care when they enter hospital.

The Australian Government announced small measures in this Budget towards reducing hip pocket pressures, including \$7.2 million to develop a website to provide information on medical out-of-pocket costs for specialist services. That may stop a small amount of specialists charging excessive prices, but it will not improve access for the majority of Australians.

The Australian Government has started the Royal Commission into Aged Care, committed to a Royal Commission into Disability Care, and initiated the Productivity Commission inquiry into mental health. However, a better Budget would have focused on ramping up the healthcare reform process.

The silver tsunami of population aging is on the horizon, requiring early prevention and intervention responses, and further structural change to our healthcare system to mitigate the expected health expenditure increase. These take time to develop, test and implement. The longer we delay, the costlier our healthcare system will become.

¹⁰ The Hon Greg Hunt MP, 2018, Medicare bulk billing rate hits historic 86.1 per cent, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt111.htm>, accessed 3 April 2019

¹¹ AIHW 2018, Patients' out-of-pocket spending on Medicare services, 2016–17, https://www.myhealthycommunities.gov.au/our-reports/get-report-file/hc50/publication/AIHW_HC_Patients_out_of_pocket_spending_Aug_2018, accessed 17 August 2018

Sector specific impacts

Aged care

The 2018-19 Budget signalled a pivot in regulatory direction for the aged care sector. It focused on improving aged care quality, with the establishment of the Aged Care Quality and Safety Commission (ACQSC) to overview quality improvements in the sector, and other funding to improve regulatory arrangements.

The ACQSC became operational on 1 January 2019 and work is underway to develop a Charter of Rights and enforce a new Single Quality Framework.¹² The ACQSC plans to hire more compliance officers and have greater powers to act on facilities that provide substandard care.¹³ Providers are working around the clock to prepare for a single set of quality standards, to be operational by 1 July 2019.

The 2018-19 Budget also allocated \$50 million over two years to the Quality Care Fund, to help providers transition to the Single Quality Framework. Stronger quality standards and improved regulatory arrangements will require additional resources from a sector where many providers are already facing financial pressure.¹⁴ The Aged Care Financing Authority (ACFA) suggests the need to find economies of scale will drive more consolidation in the sector.¹⁵

The Australian Government has been chipping away at implementing some recommendations from the many reviews they previously initiated. Some response was light on commitment to new funding. For example, the Australian Government announced support for the Aged Care Workforce Strategy Taskforce report,¹⁶ although mainly referred to previously committed funding in prior Budgets.

¹² Department of Health, Ageing and Aged Care 2019, Single quality framework. <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers>, accessed 29 March 2019.

¹³The Hon Ken Wyatt AM, MP 27 November 2018, Powerful New Aged Care Quality and Safety Commission, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-wyatt169.htm>, accessed 29 March 2019.

¹⁴ StuartBrown 2019, Aged Care Financial Performance Survey. Sector Report. December 2018, <http://www.stewartbrown.com.au/images/documents/StewartBrown---ACFPS-Sector-Financial-Performance-Report-December-2018.pdf>, accessed 29 March 2019

¹⁵ Turner, S. and McInnes, W. 18 September 2018, Aged care sector becomes more risky ahead of royal commission, *The Australian Financial Review*, <https://www.afr.com/business/health/aged-care-sector-becomes-more-risky-ahead-of-royal-commission-20180918-h15jty>, accessed 19 March 2019.

¹⁶ Aged Care Workforce Strategy Taskforce, 2018, A Matter of Care Australia's Aged Care Workforce Strategy, https://agedcare.health.gov.au/sites/default/files/documents/09_2018/aged_care_workforce_strategy_report.pdf, accessed 29 March 2019

However, it has endorsed a new Industry Accord on the Remote Aged Care Workforce and supports the development of an Aged Care Industry Code of Practice.¹⁷

The ACFA published their annual report on aged care funding and financing issues in July 2018.¹⁸ It highlighted concerns about access to Home Care packages, problems of unspent funds in the Home Care packages sector, and noted that the current review of the Aged Care Funding Instrument (ACFI) was timely.

Then September rolled around with an ABC Four Corners report on abuse in residential aged care facilities, and other media reports conveying general public sentiment that expectations for quality care were not being met.¹⁹ In October the Australian Government responded by announcing a Royal Commission into Aged Care and Quality.²⁰

The remit of the Royal Commission is sensibly broad. It recognises the interconnectedness of quality, workforce improvements and financial sustainability. So far the Royal Commission has heard concerns about workforce shortages in aged care facilities and frustration with long queues for Home Care packages. All issues will be considered with an interim report due by 31 October 2019, and a final report by 30 April 2020.

The Australian Government has started to address some concerns either expected, or already raised, within the Royal Commission. While the 2018-19 MYEFO Budget allocated \$121.5 million for the Royal Commission, and its associated activities, it also included nearly \$500 million for aged care. This comprised bringing forward an additional \$287.3 million by one year for the release of 5,000 Level 3 and 5,000 Level 4 Home Care packages.

The 2018-19 MYEFO Budget also included \$111.2 million to increase residential aged care viability, with supplements to support people in residential aged care in regional, rural and remote areas of Australia and those at risk of homelessness. The Australian Government is also reducing the out-of-pocket cost for Home Care packages, allocating \$56.4 million over four years to reduce the maximum daily fee providers can charge.

Another \$98 million was allocated within the Medicare Benefits Schedule (MBS) to improve access to GPs in residential aged care facilities. This is sorely needed. It will help facility staff better manage residents, and keep some residents out of hospital.

¹⁷ The Hon Ken Wyatt AM, MP 13 September 2018, Blueprint for Professional Aged Care Workforce Growth, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-wyatt128.htm>, accessed 29 March 2019.

¹⁸ Department of Health, Ageing and Aged Care 2018 ACFA Annual Report on Funding and Financing of the Aged Care Sector, <https://agedcare.health.gov.au/reform/aged-care-financing-authority/2018-acfa-annual-report-on-funding-and-financing-of-the-aged-care-sector>, accessed 29 March 2019.

¹⁹ Australian Broadcast Corporation 2018, Four Corners, Who Cares?, <https://www.abc.net.au/4corners/who-cares/10258290>, accessed 29 March 2019, accessed 1 April 2019.

²⁰ Department of Health, Ageing and Aged Care 2019, Royal Commission into Aged Care Quality and Safety, <https://agedcare.health.gov.au/royal-commission-into-aged-care-quality-and-safety>, accessed 29 March 2019, accessed 1 April 2019.

Budget announcements

The Australian Government's focus on aged care continued with new funding commitments of \$724.8 million over the next five years. Most of this funding was already announced in February 2019, including \$320 million for a one-off increase in the basic subsidy for residential aged care and \$282.4 million for an additional 10,000 Home Care packages across all levels.²¹ Nearly half of the five year commitment will be spent in 2018-19.

The recent focus on funding home care has added 40,000 new packages over the past two years. This will provide much needed access to home care assistance, although more funding is required to further reduce the 95,000 people waiting for a Level 3 or 4 package.^{22,23}

The Australian Government also continued its commitment to improving aged care quality, with additional funding within this Budget for a risk based compliance and information sharing system within the Aged Care Quality and Safety Commission. It also provided \$2.6 million for 2019-20 to support implementation of the Aged Care Workforce Strategy.

Funding has also been committed to mandatory reporting within the National Aged Care Quality Indicator Program, which is not a moment too soon. This information should be made publically available to further drive quality improvement through competition. Benefits from performance reporting were experienced in the US Nursing Home Compare program.²⁴ The Australian Government must also remove supply side restrictions imposed by the Aged Care Approvals Round (ACAR), by allocating funding to the resident, not the provider.

While additional funding bodes well for aged care providers and care recipients, more funding is required. Providers will need additional resources to improve quality, and address other recommendations from the Royal Commission. This will place additional financial pressure on providers without compensatory revenue streams.²⁵

The *Legislated review of Aged Care 2017* recommended additional funding come from residents through greater means testing arrangements and removing contribution caps. This recommendation was ignored by the Australian Government, but is required to ensure providers can produce the quality demanded by society.

²¹ Prime Minister of Australia, 10 February 2019, New \$662 Million Aged Care Package to Support Older Australians, <https://www.pm.gov.au/media/new-662-million-aged-care-package-support-older-australians>, accessed 29 March 2019.

²² Around 53 per cent of those waiting for a Level 3 or 4 package are currently receiving a lower level package.

²³ Department of Health, 2018, Home Care packages program. Data report 4th quarter 2017-18, https://www.gen-agedcaredata.gov.au/www_ahwgen/media/Home_care_report/HCP-Data-Report-2017%E2%80%934th-Qtr-revised.pdf, accessed 2 April 2019.

²⁴ 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.

²⁵ Robertson, A. 14 March 2019, Aged care 'financially unsustainable' as industry braces for further hit from the royal commission. *Australian Broadcast Corporation*, <https://www.abc.net.au/news/2019-03-20/aged-care-under-financial-pressure-even-before-royal-commission/10919748>, accessed 29 March 2019.

Asking for greater contributions from aged care recipients may be difficult given a large proportion of residents are asset rich and income poor. Most of this wealth is tied up in the family home, despite compulsory superannuation.

One way to facilitate a more user pays system is for the Australian Government to introduce a simple, safe and ubiquitous financial product that allows older Australians to convert housing wealth into cash, such as a Government backed home equity release product, as recommended by the Productivity Commission, and supported by the Aged Care Roadmap.²⁶

Responsibility for more funding will likely to fall onto future Budgets. While work is underway to explore the Australian National Aged Care Classification (AN-ACC) as an alternative to the Aged Care Funding Instrument (ACFI), its implementation would only change the way funding is allocated.²⁷ The size of the funding pool would not change without commitment from the Australian Government.

Disability

The National Disability Insurance Scheme (NDIS) is the most significant social reform since the permanent introduction of Medicare. Its objective is to improve the quality of life of Australians with a significant and permanent disability, by funding care, social participation and recreational activities where other funding is not available.

The NDIS was estimated to cover 475,000 eligible people once fully operational in 2019-20. However, only 244,653 people were receiving NDIS funding at 31 December 2018.²⁸ Roll out of the NDIS was delayed in South Australia, as the National Disability Insurance Agency (NDIA) had difficulty finding and contracting service providers. Some areas in Western Australia, Victoria and Queensland are yet to receive NDIS funding. Transition to the full scheme is only complete in New South Wales.²⁹

The lower than expected enrolment means less money was spent on people with disability than predicted. Of the \$18.8 billion committed from 2013-14 to 2018-19, only \$12.3 billion was actually paid.³⁰ This represents around one third of committed funding that could have otherwise been spent on improving the wellbeing of NDIS eligible people.

While the NDIS is still maturing, it has improved outcomes for many, through more choice and control over life. Parents and carers of children with disabilities have also reported improved child

²⁶ Aged Care Sector Committee 2016, Aged Care Roadmap, https://agedcare.health.gov.au/sites/default/files/documents/04_2016/strategic_roadmap_for_aged_care_web.pdf, accessed 3 April 2019

²⁷ AHSRI 2019, AN-ACC: A national classification and funding model for residential aged care: synthesis and consolidated recommendations, https://agedcare.health.gov.au/sites/default/files/documents/03_2019/rucs_report_6_recommendations_o.pdf, accessed 29 March 2019

²⁸ COAG Disability Reform Council, 2019, Quarterly Report, 31 December 2018, <https://www.ndis.gov.au/about-us/publications/quarterly-reports>, accessed 28 March 2019.

²⁹ Ibid.

³⁰ Ibid.

communication and better family integration for those receiving the Early Childhood Early Intervention (ECEI).³¹

More work is required to help people with disability find employment, given Australia ranks below the OECD average employment-to-population ratio of people with disabilities. The NDIA and the Department of Social Services (DSS) established an Employment Taskforce in 2018 to improve employability and social participation of people with disability.

The NDIS provider network continues to grow, with the number of registered providers increasing by six per cent in December 2018, compared to the previous quarter. While there are 19,075 registered providers, only 55 per cent were active and offered services under NDIS.

Many providers believe current NDIS prices do not adequately cover their costs. The proportion of providers operating at a loss has increased, forcing some to merge, and potentially leading to service gaps.³² While further consolidation in the sector may improve efficiencies through economies of scale, it may also reduce choice. A delicate balancing act is required from the NDIA.

On 1 February 2019, the NDIA implemented another set of Independent Pricing Review (IPR) recommendations to provide greater support to providers that deliver complex support. This included three levels of pricing based on patient complexity, rather than two, to better reflect the different resources required to meet different needs.³³

However, therapists raised concerns regarding IPR recommendations to introduce price caps and a two tiered pricing structure based on therapist skill. They suggested it will force some therapists to withdraw from the market, thereby reducing access to services for some NDIS recipients, particularly those in rural and remote areas where markets are thin.³⁴ The NDIA responded by initiating its own review.

Budget announcements

This Budget is a win for disability right advocates. The Australian Government allocated \$528 million over five years to support a Royal Commission into 'violence, abuse, neglect and exploitation of people with disability', including \$148.8 million to assist people with disability to participate in the Royal Commission. This may bring sweeping changes to how the disability care sector measures and monitors service quality. The Australian Government is currently developing the Terms of Reference.

Providers and NDIS eligible persons may not be pleased with the \$1.6 billion underspend on the NDIS over four years from 2019-20, especially since it is a significant contributor to overall Budget surplus.

³¹ Ibid.

³² Centre for Social Impact 2019, How is the disability sector faring? A report from National Disability Services' Annual Market Survey, https://www.csi.edu.au/media/How_is_the_disability_sector_faring_FINAL12.3.pdf, accessed 28 March 2019

³³ NDIA 2018, Enhancements to pricing arrangements, <https://www.ndis.gov.au/news/1079-enhancements-pricing-arrangements>, accessed 26 March 2019.

³⁴ Joint Standing Committee on the National Disability Insurance Scheme, September 2018, https://www.nds.org.au/images/files/JSC_on_the_NDIS-Market_Readiness.pdf, accessed 28 March 2019.

This underspend seems to have resulted from inefficiencies in rollout and entry barriers for participation, not lower demand or cost overestimation.

Meanwhile, the Australian Government announced an increase in price limits for therapy, attendant care and community participation on 30 March 2019. This stems from the NDIA review into IPR recommendations. Price increases will take effect in July 2019, injecting an additional \$850 million in 2019-20 for providers of therapy, attendant care and community participation. This will firm up market stability and choice.³⁵ No extra funding was allocated to this announcement within this Budget. While this expense can be covered by the current underspend, increased pricing will have future Budget impacts, potentially requiring additional funding once enrolment reaches forecasted levels.

Hospitals

Expenditure on public hospitals is the second biggest health budget item for the Australian Government, and the largest specific purpose payment to States and Territories. Hospital funding has always been an election battle ground, and this time it is no different, with the Labor Party scoring early wins in the Longman by-election by suggesting its local hospital was worse off under the current Government.

While the 2018-19 Budget had little increase in hospital expenditure, the 2018-19 MYEFO Budget allocated \$1.25 billion over four years to establish the *Community Health and Hospitals Program*. This will allocate funding to specialist hospital services across all States and Territories, in areas such as cancer treatment, rural health and hospital infrastructure. Some funding will be spent on community health programs.

The Australian Government has actively promoted last year's Budget promise to invest \$130.2 billion in public hospitals over five years from 2020-21. This comes from the *Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform*. It was supposed to be signed-off by all Health Ministers before 2019, although Queensland and Victoria are yet to sign.³⁶ The Heads of Agreement will be used to form the National Health Agreement, due to be submitted to the Council of Australian Governments (COAG) before 2020.³⁷

While \$130.2 billion sounds impressive, funding growth reflects the growth of hospital activity based on the national efficient price, and is capped at 6.5 per cent. There is relatively little additional funding allocated to improve hospital quality or reduce public hospital waiting times, for example.

³⁵ Ministers for the Department of Social Services, Media releases, 30 March 2019, <https://ministers.dss.gov.au/media-releases/4761>, accessed 3 April 2019

³⁶ Council of Australian Governments, 2018, Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform, <https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-o>, accessed 5 March 2019

³⁷ Council of Australian Governments, 2018, COAG meeting Communiqué, 12 December 2018, <https://www.coag.gov.au/meeting-outcomes/coag-meeting-communique-12-december-2018>, accessed 5 March 2019

Budget announcements

This Budget has again highlighted the *Community Health & Hospitals Program*, which was originally outlined within the 2018-19 MYEFO Budget. There is no new funding. However, this Budget has provided some insight into specific spending within this program.

The most common announcements are associated with one-off infrastructure spends to increase physical capacities for service delivery and research. Examples include the \$100 million Comprehensive Cancer Centre at Sydney Children's Hospital, \$30 million for Brain and Spinal Wards in Adelaide, \$25.7 million for a new Ambulatory Care Centre at the Alice Springs Hospital in the Northern Territory, \$25 million for the Peel Health Campus in Western Australia, \$13.5 million for an intensive care unit in Canberra, and \$4.4 million for the North West Cancer Centre in Tasmania.

Additional funding was provided to Redland Hospital and Bowen Hospital in Queensland, Bass Coast Health in Victoria. The Budget also allocated \$52.8 for additional infrastructure for cancer treatment, including a Bloomhill Cancer Care survivor-wellness centre in Queensland, Chris O'Brien Lifehouse sarcoma surgical research centre in NSW, Cancer Treatment Centres in rural Australia to provide radiation therapy, and a new cancer centre at The Bays Hospital in Victoria.

These investments will be welcomed by communities, but may not necessarily deliver on moving the healthcare system towards true service integration. However, there is more to spend from the *Community Health & Hospitals Program*, with individual items listed making up only a small amount of the total funds committed in the 2018-19 MYEFO Budget.

Mental health

Mental health has been a policy focus since the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) was released in 2017. The Australian Government has been working towards fulfilling that plan, allocating \$192.7 million in the 2018-19 Budget, along with \$125 million over 10 years from the Medical Research Future Fund (MRFF) for research into mental health.

The Australian Government allocated another \$175.4 million over the forward estimates in the 2018-19 MYEFO Budget to mental health services. Of this, \$26.9 million was allocated to support the mental health and wellbeing of farmers in drought affected communities through telehealth, \$110.7 million to provide more GP care for the treatment and management of people with severe eating disorders, and \$1 million to develop a National Mental Health Workforce Strategy.

Another \$4.9 million was allocated within the 2018-19 MYEFO to support additional *headspace* sites in areas with high youth suicide rates, and \$31.9 million of new funding was allocated to PHNs to commission services from the *headspace* network and to support the operations of *headspace* National.

The National Monitoring Report, released by the National Mental Health Commission (NMHC) in 2018, noted some good progress towards implementation of the Fifth Plan. It also identified some headwinds faced by stakeholders.³⁸

While PHNs have been given greater responsibility for commissioning psychosocial services, their commissioning approaches are still maturing. Some have raised concerns about unintended outcomes from a competitive process, including gaps in services and damage to established relationships between providers.³⁹

The NMHC also raised concerns with the current transition arrangements for those with psychosocial disability eligible for the National Disability Insurance Scheme (NDIS). It offered several recommendations to improve the experience of consumers and carers. Mental Health Australia recommended the NDIA develop an overarching psychosocial disability strategy based on feedback it received from interviewing around 170 NDIS funding recipients.⁴⁰

Suicide is another area the Australian Government has been focused on, along with several State governments and philanthropic organisations. The National Monitoring Report noted four ongoing trials for suicide prevention across 29 sites in Australia. These trials must be properly evaluated for their cost effectiveness.

Unfortunately, the Australian suicide rate continues to increase. There were 3,128 deaths from intentional self-harm in 2017, a one third increase over the last decade for the Australian population, but a 60 per cent increase for persons aged 15-19 years.⁴¹

A potential major change for the mental health sector may stem from the Productivity Commission's inquiry into mental health. It released a terms of reference in November 2018, and an issues paper in January 2019.⁴² The scope is broad, and relatively unique compared to the many prior reports on mental healthcare, which mostly focuses on reducing stigma and discrimination, and improving prevention activities and the delivery of services.

The Inquiry will offer recommendations to the Australian Government on how to increase social and economic participation through improved mental health care. It will investigate how healthcare and other sectors of the economy, such as housing, justice, workplaces, education, and social care can change to support this goal. With such a broad scope, it may be difficult for the Productivity Commission to give due attention on the most important areas of need.

³⁸ National Mental Health Commission 2018, Monitoring mental health and suicide prevention reform. National Report 2018, <http://mentalhealthcommission.gov.au/media/245240/Monitoring%20Mental%20Health%20and%20Suicide%20Prevention%20Reform%20National%20Report%202018.pdf>, accessed 21 March 2019.

³⁹ Ibid.

⁴⁰ Mental Health Australia, 2018, National Disability Insurance Scheme: Psychosocial Disability Pathway, https://mhaustralia.org/sites/default/files/images/ndis_psychosocial_pathway_consultation_project_-_final_report_-_may_2018.pdf, accessed 21 March 2019

⁴¹ Australian Bureau of Statistics (ABS), 2018, 3303.0 Causes of Death, Australia, 2017, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02017?OpenDocument>, accessed 21 March 2019

⁴² Productivity Commission 2019, The social and economic benefits of mental health. Issues Paper, <https://www.pc.gov.au/inquiries/current/mental-health/issues/mental-health-issues.pdf>, accessed 22 March 2019

Early indications from an executive round table hosted by MUCHE in November 2018 highlighted some important themes the Productivity Commission could explore. Workshop participants suggested the mental health care sector required a more united voice to help government allocate resources and deliver mental health care services. It was noted that an office for strategic investment in mental health could provide a systematic approach for investment decisions related to mental health care initiatives. This could particularly help investment decisions across portfolios, to help reduce funding silos.

Workshop participants noted workplace health and safety legislation could be reviewed to strengthen responsibilities for organisations to ensure a mentally healthy workplace. They also noted a needs for greater involvement of people with lived experience when developing healthcare pathways and service configuration, and that relationships between healthcare professionals, informal carers and patients should be strengthened to support patient's capacity to make choices about their mental health care.

Budget announcements

The Australian Government has made mental health a key issue in this budget. It has committed \$229.9 million to improve mental health services within the community, although only \$149.4 million is presented within the Budget estimates. The main focus is \$114.5 million to trial eight mental health centres focused on delivering after-hours treatment to adults.

A perinatal mental health and wellbeing program will be developed for \$43.9 million over seven years, and the Australian Institute of Health and Welfare will receive \$15.0 million to develop a monitoring system for self-harm and suicide. This will help local areas better plan and prepare for, and respond to, suicide clusters. There is also funding to strengthen the NMHC, and multiple infrastructure development projects and programs.

An additional focus in this Budget is youth mental health. The Australian Government has responded to the alarming suicide rate among Australian youths, and to feedback it received within a National Suicide Prevention Summit held in 2018. There is \$153.4 million within the Budget estimates to expand the *headspace* network and reduce waiting times, although the Australian Government has promised an additional \$109.9 million beyond 2022-23. It has also promised \$109.7 million to extend the *Early Psychosis Youth Services* program at 14 *headspace* centres, although this expenditure has not been included in the Budget estimates.

Pharmaceuticals

The Australian Government allocated \$455.7 million over two years for new and amended listings on the Pharmaceutical Benefit Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) within the 2018-19 MYEFO Budget. Some of this cost will be reduced through rebates negotiated as part of purchase agreements.

Medicine access and affordability is a key issue within the election lead up. The Labor Party has also pledged to improve affordability within the next Community Pharmacy Agreement.⁴³ The Australian

⁴³ Catherine King MP 2019, Address to the Pharmacy Guild, https://www.shpa.org.au/sites/default/files/uploaded-content/website-content/Media_releases/king_app2019_transcript.pdf, accessed 2 April 2019

Government announced it will explore legislated options to reduce medicine listing times. This includes the potential to fund some medicines with high and unmet clinical need through the Manage Access Program arrangements, and prior to receiving Pharmaceutical Benefits Advisory Committee (PBAC) application recommendations.

While this approach would certainly be welcomed by patients, it comes with some risk. It will be difficult to establish a cost effective price without a PBAC review. It may also be politically challenging to remove funding for a medicine that helps some patients, but the effect is not large enough to be deemed cost effective. This scenario would certainly complicate any further price negotiations.

Meanwhile, the Therapeutic Goods Administration (TGA) is considering switching 15 medicines from Prescription Only Medicine to Pharmacist Only Medicine. This has the potential to reduce costs to the Australian Government through a reduction in GP visits for prescriptions. It would further reduce costs if these medicines were also taken off the PBS, however this is not guaranteed.

Budget announcements

The Australian Government has noted it will provide \$331 million over five years from 2018-19 for new and amended listings on the PBS and the RPBS, although only \$201.4 million is contained within the estimates as some funding has already been provided for by the Australian Government. This funding will support a wide range of medicines treating lung, kidney and skin cancer, and leukaemia.

While an improvement in the administration of medicine payments announced in the 2018-19 Budget has meant the headline Budget forecast for PBS expenditure drops by around 18.4 per cent, this is merely an accounting artefact. Forecasted expenditure for the PBS shows it will remain stable at just over \$10 billion per year up to 2022-23. There is no material decrease in PBS expenditure.

Pharmacy

The pharmacy sector continues to move away from traditional dispensing roles to becoming more involved in medication management and integrated care. A Medicine Safety report released by the Pharmaceutical Society of Australia (PSA) highlighted around 250,000 annual admitted episodes are associated with medication-related problems.⁴⁴ The PSA called for further Australian Government funding for pharmacists to enable the development of stronger pharmacovigilance and medicines safety systems.⁴⁵

⁴⁴ Pharmaceutical Society of Australia 2019, Medicine safety. Taking care, <https://www.psa.org.au/wp-content/uploads/2019/01/PSA-Medicine-Safety-Report.pdf>, accessed 28 March 2019

⁴⁵ Pharmaceutical Society of Australia 2019, Pharmacists in 2023. For patients, for our profession for Australia's health system, <https://www.psa.org.au/wp-content/uploads/2019/02/Pharmacists-In-2023-digital.pdf>, accessed 28 March 2019

The pre-budget submission from the Pharmacy Guild of Australia focused on removing the optional (pharmacist discretion) \$1 discount on prescriptions, to be replaced by a \$1 reduction in PBS patient co-payment.⁴⁶

While discounts were introduced in 2016 to reduce out-of-pocket costs, the Guild argues it has led to inequitable access to medicines, given the discount is applied to around 28 per cent of prescriptions dispensed by community pharmacies.⁴⁷ The *Review of Pharmacy Remuneration and Regulation* also recommended this policy be removed, but this was rejected by the Australian Government.⁴⁸

Ironically, success of the \$1 discount relies on pharmacy price competition, yet the Australian Government did not accept a recommendation from the *Review of Pharmacy Remuneration and Regulation* to ‘reform the Pharmacy Location Rules to remove barriers to community access and competition between pharmacies’.⁴⁹ Legislation to remove the Pharmacy Location Rules sunset clause was passed in 2018, effectively locking in anti-competitive regulations, and in some cases local pharmacy monopolies, for the duration of the Sixth Community Pharmacy Agreement (6CPA).⁵⁰

Budget announcements

This Budget has allocated \$245 million to pharmacies, although some of this represents a redistribution of funds from the Community Pharmacy Programs from the 5CPA and 6CPA. Only \$99.1 million was included in the Budget estimates.

Pharmacists will receive \$215 million through the Administration, Handling and Infrastructure (AHI) fee pharmacists can charge for filling a prescription, while \$15 million will be spent on additional Community Service Obligation payments to pharmacy wholesalers. Another \$15 million will help expand the Dose Administration Aids program and the MedsCheck and Diabetes MedsCheck program in community pharmacies.

The Budget also notes the commitment by the Australian Government to reduce the time taken to transact PBS claims, from 9-16 days to 2-9 days. This will be absorbed by the Budget, with no financial effect other than on underlying cash balance. This processing target is focused on improving pharmacy cash flow.⁵¹

⁴⁶ The Pharmacy Guild of Australia 2019, More affordable medicines for all Australians, <https://www.guild.org.au/news-events/news/forefront/v09n02/more-affordable-medicines-for-all-australians>, accessed 20 March 2019

⁴⁷ Department of Health, 2018, Expenditure and Prescriptions Twelve Months to 30 June 2018, <http://www.pbs.gov.au/statistics/expenditure-prescriptions/2017-2018/expenditure-and-prescriptions-twelve-months-to-30-june-2018.pdf>, accessed 29 March 2019

⁴⁸ Department of Health, 2019, Review of pharmacy remuneration and regulation, <http://www.health.gov.au/internet/main/publishing.nsf/Content/review-pharmacy-remuneration-regulation>, accessed 20 March 2019

⁴⁹ Commonwealth of Australia, 2017, Review of Pharmacy Remuneration and Regulation. Final report. [http://www.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/\\$File/revi-ew-of-pharmacy-remuneration-and-regulation-final-report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/7E5846EB2D7BA299CA257F5C007C0E21/$File/revi-ew-of-pharmacy-remuneration-and-regulation-final-report.pdf), accessed 3 May 2018.

⁵⁰ Ibid.

⁵¹ Ibid.

Unfortunately, one item missing from this Budget was the recommendation by the PBAC to replace the currently implemented 12 month repeat listings with increased dispensing volumes.⁵² This would have allowed for two months' supply, rather than one, across a range of digestive enzymes, lipid lowering medicines, ulcerative colitis and ocular lubricants. Benefits would have included reduced travel time for patients visiting pharmacies, reduced co-payments for the patient, and reduced dispensing costs for the Australian Government. However, the Pharmacy Guild of Australia took exception to the potential negative impact on pharmacists dispensing fees, and the Australian Government backed down from its original announcement. The Australian Government should try again after the election because it is a sensible policy.

Primary care and medical services

The Australian Government has been trying to mitigate the political risk of battling over primary care in the election lead up, after the Labor Party's successful 'Medicare' campaign during the 2016 election.

The 2018-19 MYEFO Budget allocated \$512 million to primary care, with \$318 million for GPs. This included new Medicare funding for GP services related to eating disorders, improving rural and remote areas, and enhanced GP services in residential aged care facilities.

Medicare listings were also expanded for new items for genetic testing for the diagnosis of Alport syndrome, obstetric Magnetic Resonance Imaging (MRI) for pregnant women to allow investigation and diagnosis when fetal central nervous system abnormality is suspected, and for the mobile provision of x-rays to patients in residential aged care facilities.

The 2018-19 MYEFO Budget extended funding for the Health Care Homes Trial for patients with chronic and complex conditions, establishing a new wound management trial to test models of care for chronic wound management, and funding for a Neurological Nurse Specialist Pilot program. It also included \$176.4 million for an additional 30 MBS eligible MRI machines.

High out-of-pocket costs for healthcare has become an important issue for patients, providers and private health insurance funds.⁵³ An Australian Institute of Health and Welfare (AIHW) report noted there is inequitable access to healthcare services, within and across socioeconomic status. In lower socioeconomic areas, the proportion of patients with out-of-pocket costs ranged from 19 per cent to 62 per cent. While Australian's spend around \$1,200 per person annually on out-of-pocket costs, for some it is much higher.⁵⁴

⁵² Department of Health 2018, August PBAC outcomes – Other matters, <http://www.pbs.gov.au/industry/listing/elements/pbac-meetings/pbac-outcomes/2018-08/Outcome-Statement-August-2018-Increased-MDQ.pdf>, accessed 28 March 2019

⁵³ Parnell, S. 23 March 2019, Specialists resist gap fee clarity, *The Australian*, <https://www.theaustralian.com.au/business/careers/specialists-resist-gap-fee-clarity/news-story/f90a7599fe3bbb1ce6662ca6cc415ac5>, accessed 29 March 2019.

⁵⁴ AIHW 2018, Patients' out-of-pocket spending on Medicare services, 2016–17, https://www.myhealthycommunities.gov.au/our-reports/get-report-file/hc50/publication/AIHW_HC_Patients_out_of_pocket_spending_Aug_2018, accessed 17 February 2019

A Ministerial Advisory Committee on Out-of-Pocket Costs reported on these issues to the Department of Health in November 2018.⁵⁵ The Australian Government committed to develop a national searchable website to provide the public with greater access to information about the price of specialist services, and an education campaign to help people better understand medical out-of-pocket costs.⁵⁶

While transparent pricing is welcomed, a website and education campaign is unlikely to be successful. After all, the Fuel Watch and Grocery Choice websites promised by the Labor Party in the 2007 election, to appease voters concerned with the cost of living, were abandoned a year later.

Healthcare providers claim the Medicare rebate indexation freeze introduced in 2013-14 Budget has forced them to charge higher co-payments. The Australian Government's phased indexation plan outlined in the 2017-18 Budget will restore indexation on all remaining Medicare items by 1 July 2020. The Labor Party committed \$213 million to restore MBS indexation sooner, if elected.⁵⁷

Budget announcements

Primary care is the Budget centrepiece for the health portfolio, receiving \$1.1 billion over five years. Significant funding is being directed in three areas, including \$187.2 million to lift the indexation freeze for all GP items, \$448.5 million for a new chronic disease care funding model and \$202.5 million for a revised *Practice Incentive Program Quality Incentive (PIPQI)*. The Australian Government will be pleased when the PIPQI starts, after implementation delays due to GP resistance.^{58,59}

Other funding for frontline services includes a new medical training pathway for rural generalists and additional training places for GPs in rural, remote and regional communities. There are changes to geographic eligibility criteria for rural bulk billing incentives as part of the arrangements agreed in the 2018-19 *A Stronger Rural Health Strategy*. Funding has been allocated to trial urgent care centres in Western Australia, while \$17.2 million has been allocated to establish a chronic disease grants program to fund priority activities recommended by National Strategic Action Plans.

This Budget also addressed long-standing patient and provider concerns with access to diagnostic imaging services.⁶⁰ It included \$308.9 million over five years to increase the number of MRI licences to

⁵⁵ Department of Health, 2019, Ministerial Advisory Committee on Out-of-Pocket Costs Terms of Reference, [http://www.health.gov.au/internet/main/publishing.nsf/Content/D36463E1BDEC3441CA25823100793966/\\$File/AMENDED%20Terms%20of%20Reference%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D36463E1BDEC3441CA25823100793966/$File/AMENDED%20Terms%20of%20Reference%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf), accessed 29 March 2019.

⁵⁶ The Hon Greg Hunt MP 02 March 2019, National strategy to tackle specialist out of pocket costs, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2019-hunto35.htm>, accessed 29 March 2019.

⁵⁷ Maiden, S. 25 March 2019, Out-of-pocket GP costs, rebate freezes in focus as Labor puts Medicare costs on agenda, *The Daily*, <https://thenewdaily.com.au/news/national/2019/03/25/medicare-freeze/>, accessed 29 March 2019.

⁵⁸ Lyons, A 02 March 2019, Overhaul of Practice Incentives Program delayed until May 2019, *newsGP*, <https://www1.racgp.org.au/newsgp/professional/overhaul-of-practice-incentives-program-delayed-un>, accessed 03 April 2019.

⁵⁹ AMA, 21 March 2019, PIP quality improvement incentive start date pushed back, <https://ama.com.au/gp-network-news/PIP-quality-improvement-incentive-start-date-pushed-back>, accessed 03 April 2019.

⁶⁰ Australian Diagnostics Imaging Association, 23 September 2018, MRI "arms race" masking the real issue facing patients,

provide Medicare subsidised access, but this measure was already announced in February 2019. It also lifts the index freeze on ultrasound and x-rays from 1 July 2020, and adds two new MBS items for diagnosis of breast cancer with MRI.

While lifting the rebate freeze for GP and imaging services should allow providers to reduce patient co-payments, the question is whether the additional funding will land in the patient's pockets, or boost provider profits?

Bulk billing rates have seemingly not been impacted by the rebate freeze. Both are at record high levels, with 86.1 per cent for GP services and 78.0 per cent for diagnostic imaging.⁶¹ Patients may have adapted to their greater out-of-pocket costs, allowing GPs to continue charging patients an additional 5 per cent each year.⁶² Alternatively, some providers may choose to limit future increases in co-payments to attract more patients. Only time will tell.

The Australian Government should be commended for supporting innovation in chronic disease care funding. This is forward thinking, and compliments the Health Care Home trials, which were extended in the 2018-19 MYEFO Budget. Chronic disease care is ill-suited to the current fee-for-service MBS system.⁶³ While an evaluation needs to determine whether these initiatives are cost effective, leadership supporting evidence based policy is a good place to start.

Private health insurance

Private health insurance members experienced another annual premium increase on 1 April. This year it was 3.25 per cent on average. While the lowest since 2001,⁶⁴ it is nearly 50 per cent higher than Australia's annual wage increase, and greater than the 2 per cent cap (for two years) promised by the Labor Party, if elected.

Those without private health insurance, or members looking to switch, will also face a simpler choice. Insurers will be required to include minimum hospital cover standards, and classify policies into Basic, Bronze, Silver or Gold. Other changes include an increased allowable excess for hospital care, from \$500 to \$750, allowable discounts (maximum of 10 per cent) for people aged 18-29 years, and travel and accommodation benefits for people required to travel long distances for hospital care.

<https://www.adia.asn.au/public/3/system/newsAttachments/ADIA%20Response%20to%20MRI%20Announcement%20Sunday%2023%20September%202018%20FINAL.pdf>, accessed 29 March 2019, accessed 19 March 2019.

⁶¹ Department of Health 2019, Annual Medicare Statistics, <http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>, accessed 3 April 2019.

⁶² The Department of Health 2018, Annual Medicare Statistics – Financial Year 1984-85 to 2017-18, <http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>, accessed 3 April 2019

⁶³ Department of Health 2019, Primary Care Reference Groups Consultation - Medicare Benefits Schedule (MBS) Review Taskforce reports, <http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-prcg-consult>, accessed 29 March 2019.

⁶⁴ This represents the second reduction in premiums over the last two years. These reductions have resulted from a reduction in minimum benefits payable for nearly all medical devices listed on the Prosthesis List, which is expected to save health care funds over \$1.1 billion between 2018 and 2021.

These are welcome changes, for sure, but the private health insurance sector faces a more serious problem. Can it remain sustainable?

The proportion of Australians with membership is down, the government rebate is slowly evaporating, and many members struggle to find value. The demand for hospital care continues unabated as our population ages, and we still battle to keep people with chronic conditions out of hospital.

The sector sought further government support in this year's budget. They argued that increased membership removes pressure on public hospital waiting lists. Private Healthcare Australia estimated a reduction in membership to 40 per cent could result in a 20-91 per cent increase in public hospital waiting times for selected common surgeries.⁶⁵

This argument has a long history. It was used when the Coalition government introduced private health insurance reforms in the late 1990s, including the Medicare Levy Surcharge, 30 per cent rebate and Lifetime Health Cover. The Health Minister Greg Hunt recently noted that the Labor Party's plan to remove the rebate on low-cost policies will lead to higher premiums and increased pressure on the public system.

The strange thing is, no empirical research has verified that increased membership leads to lower public hospital waiting times.

Some suggest increased membership from the late 1990s reforms did nothing for waiting times.⁶⁶ Of the 15 surgical procedures reported by the Australian Institute of Health and Welfare, 13 had experienced increased median waiting times by 2001-02.⁶⁷ Others have found the reverse relationship potentially exists in Australia. That is, increased membership is associated with increased waiting times.⁶⁸ Similar findings have been found in other countries.⁶⁹

Trends comparing membership to waiting times suggest public hospital patients are waiting longer than ever, despite increased membership. For example, median waiting times for public hospital elective surgery increased from 24 days in 1996-97 when membership was 32 per cent, to 40 days in 2017-18 when membership was 46 per cent.^{70,71}

⁶⁵ Private Healthcare Australia 2018, Pre-Budget Submission 2019-20 Improving the Value and Sustainability of Private Healthcare, <https://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Pre-Budget-Submission-2019-20.pdf>, accessed 19 March 2019.

⁶⁶ Hopkins S, Zweifel P, 2005, The Australian health policy changes of 1999 and 2000. An evaluation. *Applied Health Economics and Health Policy*, Vol 4(4), 229-238

⁶⁷ MUCHE analysis using publically available waiting time data provided by the Australian Institute of Health and Welfare.

⁶⁸ Duckett S J, 2005, Private care and public waiting, *Australian Health Review*, vol. 29(1):87-93.

⁶⁹ Hughs Tuohy C, Flood C.M, Stabile M., 2004, How does private finance affect public health care systems? Marshaling the evidence from OECD nations, *Journal of Health Politics, Policy and Law*, Vol. 29(3), 359-396

⁷⁰ Australian Institute of Health and Welfare (AIHW), Waiting times for elective surgery 1995-96 and 1996-97, <https://www.aihw.gov.au/reports/health-care-quality-performance/waiting-times-elective-surgery-1995-96-1996-97/contents/summary>, accessed 22 March 2019

⁷¹ Australian Institute of Health and Welfare (AIHW), Elective surgery waiting times 2017-18: Australian hospital statistics, <https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-2017-18/contents/table-of-contents>, accessed 23 March 2019

The same trend is evident when focused on elective surgeries typically covered by private health insurance. For example, the median waiting time for total knee replacement performed in public hospitals was 88 days in 1996-97, but 198 days in 2017-18. More than two thirds of all total knee replacements are performed in private hospitals.^{72,73}

Many factors can impact waiting times, including healthcare demand, the availability of operating theatres and the number of hospital beds. Private hospitals offer an alternative where public hospital infrastructure is lacking. It therefore seems counterintuitive that increased membership would not reduce waiting times. There are two potential explanations.

First, around two thirds of surgeons work in both public and private hospitals.⁷⁴ Increased membership means increased demand for private hospital care. A more lucrative private hospital can attract more surgeon time, which means less time for the public hospital, and greater pressure on their waiting lists. It also incentivises surgeons to maintain long public hospital waiting lists to support private hospital demand.

Indeed, a greater proportion of surgeon time was spent in private hospitals over the last decade.⁷⁵ The hours surgeons spent on consulting and procedures has also decreased by around 28 per cent since 2009, which means public hospitals have less access to surgeon time overall.⁷⁶

Second, many Australians with private hospital cover still choose to use public hospitals. As premiums continue to rise, more people continue to ‘downgrade’ their cover through exclusions and greater excesses. Many members are concerned with out-of-pocket costs associated with private hospital care, given they can be large and unexpected.^{77,78} All these factors mean there is less incentive for members to use private hospitals, to the detriment of public hospital waiting lists.

Private health insurance allows members to skip the waiting list queue, one reason why people become members. But it is inequitable if we believe hospital care should be based on need. Private health care should complement our public hospital system, not substitute it. Directly working with State and

⁷² Australian Institute of Health and Welfare (AIHW), Waiting times for elective surgery 1995–96 and 1996–97, <https://www.aihw.gov.au/reports/health-care-quality-performance/waiting-times-elective-surgery-1995-96-1996-97/contents/summary>, accessed 22 March 2019

⁷³ Australian Institute of Health and Welfare (AIHW), Elective surgery waiting times 2017–18: Australian hospital statistics, <https://www.aihw.gov.au/reports/hospitals/elective-surgery-waiting-times-2017-18/contents/table-of-contents>, accessed 23 March 2019

⁷⁴ RACS 2016, Surgical workforce 2016, https://www.surgeons.org/media/25115898/2017-05-26_2016-surgical-workforce-census-full-report_final.pdf, accessed 19 March 2019

⁷⁵ RACS 2016, Surgical workforce 2016, https://www.surgeons.org/media/25115898/2017-05-26_2016-surgical-workforce-census-full-report_final.pdf, accessed 19 March 2019

⁷⁶ Ibid.

⁷⁷ Ministerial Advisory Committee 2018, Report: Ministerial advisory committee on out-of-pocket costs, [http://www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/\\$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/$File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf), accessed 25 March 2019.

⁷⁸ The Australian Government has pledged to develop a website to compare specialist fees, and develop a program to better educate patients on the potential costs associated with hospital care. This was in response to the *Ministerial Advisory Committee Report on Out-of-Pocket Costs*.

Territory governments to help reduce public hospital waiting lists would be a more efficient use of taxpayer money.

The solution to ensuring private health insurance sector sustainability is arresting the increasing demand for hospital care. State and Territory governments are tackling this problem through investments in integrated care pilots and programs, along with infrastructure investment, to support care outside the hospital. While some private health insurers have also invested in integrated care, and other programs to reduce hospital demand,⁷⁹ the private health insurance sector needs to invest more. Only then may members start to see sustained low premium increases.

Budget announcements

This Budget will have minimal impact on the private health insurance sector. The Australian Government will provide \$5 million over two years to educate consumers on changes associated with the reforms introduced on 1 April 2019.

However, this may be the calm before the storm. A major shake-up of private health insurance is potentially on the horizon. The Labor Party announced it will launch a Productivity Commission review into private health insurance, if elected.

While the Labor Party noted it has ‘*no plans to make further changes to the rebate*’,⁸⁰ it may revisit those plans once the Productivity Commission completes its analysis. The last Productivity Commission review into private health insurance looked upon rebates rather dimly, noting ‘*The rebate is unlikely to cost effectively relieve pressure on the public system*’.⁸¹

Other notable changes

Health and medical research

This Budget sees the greatest single investment credit of \$7.8 billion into the Medical Research Future Fund (MRFF), solidifying the Australian Government’s commitment to health and medical research. The Budget notes the MRFF fund is on-track to reach the promised \$20 billion commitment by 2021.

The Australian Government will link \$5 billion of MRFF funding to specific initiatives outlined within a Ten-Year Investment Plan. This will consolidate our position as world leaders in research, and will be welcomed by researchers. However, it also represents a significant departure from the original intent,

⁷⁹ Examples include Medibank Private’s *CareComplete* program, HCF’s *Healthy Weight* and *My Health Guardian* programs, and GMHBAs *Health and Wellbeing* pilot for patients with chronic disease.

⁸⁰ Australian Labor Party 2018, Discussion paper. Proposed Productivity Commission inquiry into the private health sector, https://alp.org.au/media/1503/181212_privatehealthinsurance_discussionpaper.pdf, accessed 3 April 2019.

⁸¹ Industry Commission 1997, Private health insurance. Report No. 57, https://www.pc.gov.au/data/assets/pdf_file/0006/156678/57privatehealth.pdf, accessed 3 April 2019

which was to deliver \$1 billion each year for health and medical research.⁸² This is primarily due to lower rates of returns compared to those outlined in prior Budgets.^{83,84}

This raises the question whether the Fund should continue to be capitalised with additional funds to enable \$1 billion in annual disbursements, or whether the reduced disbursements is enough to support the health and medical research sector.

This Budget outlines how the Australian Government would seek to allocate future research funding to projects related to patients, researchers, missions and translation over the next 10 years. This funding is not a commitment, but a plan, and may change within a revised Australian Medical Research and Innovation Strategy, or from future recommendations made by the Australian Medical Research Advisory Board (AMRAB).

Sport

Sport funding is prominent within this Budget, allocating \$385.6 million over six years to develop and implement a national sports plan, Sport 2030. This builds on existing budget measures outlined in last year's Budget and the 2018-19 MYEFO Budget.

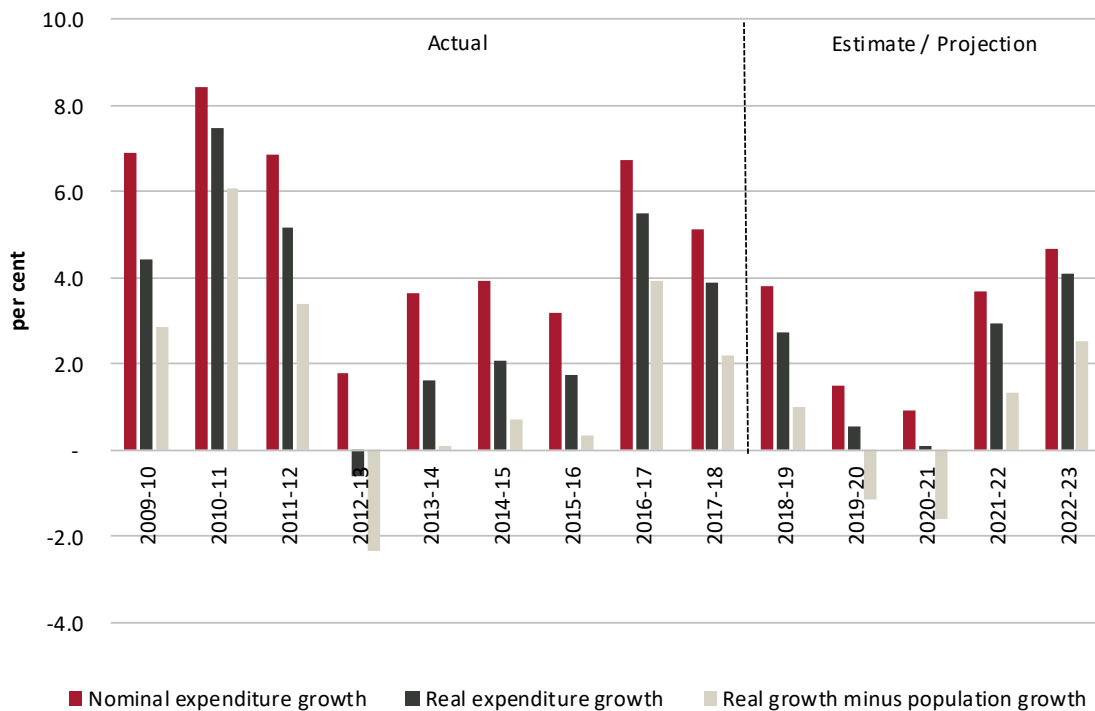
⁸² 2015/16 Budget Paper 1, Table 8.3.

⁸³ Portfolio Budget Statement 2017/18, Finance Portfolio, Table 2.2.1.2 (pp.31)

⁸⁴ Portfolio Budget Statement 2018/19, Finance Portfolio, Table 2.2.1.2 (pp.32)

The Budget in pictures

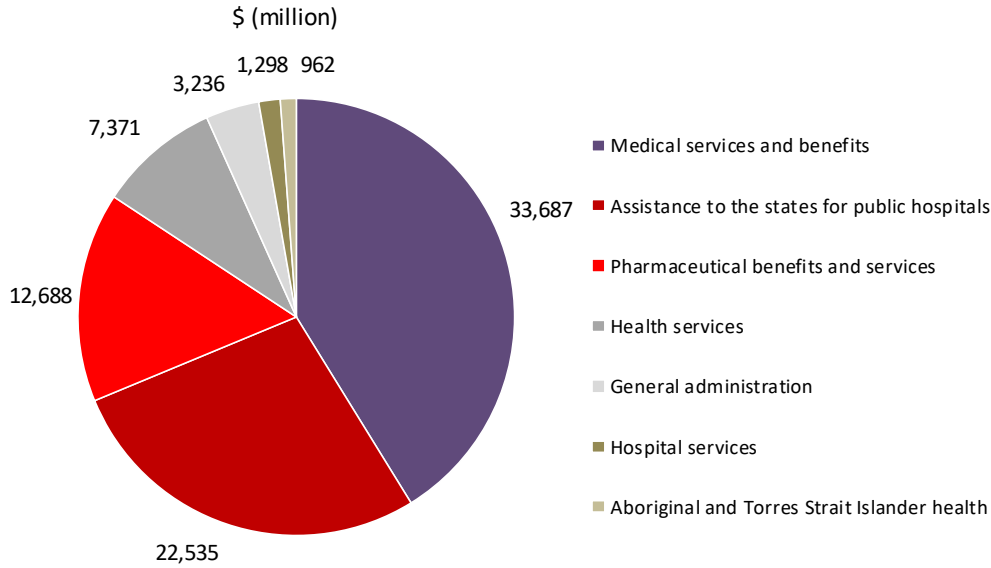
Chart 1: Annual change in Budget health expenditure



Note: 1. No adjustment was made to PBS expenses from the improved price administration arrangements announced in the 2018-19 Budget given revenue estimates were not published. This may underestimate growth rates up until 2020-21. 2. 'Real expenditure growth' was estimated using the Australian Institute of Health and Welfare (AIHW) Total Health Price Index. A linear forecast was used from 2017-18 onwards. 3. 'Real expenditure growth minus population growth' was estimated using the Australian Bureau of Statistics (ABS) Series B population estimates and projections

Source: MUCHE calculations based off Budget Paper No.1

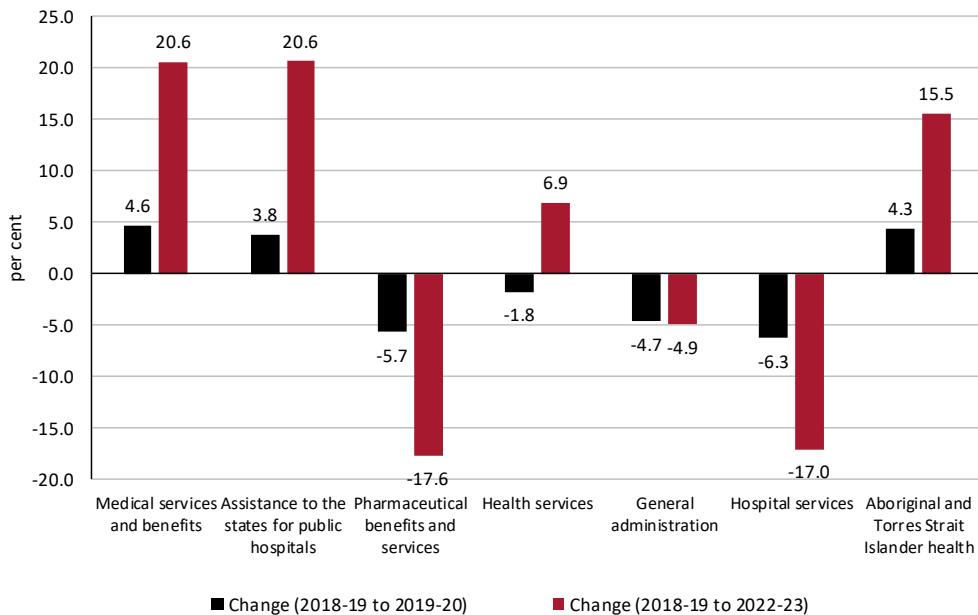
Chart 2: Composition of the Health portfolio, 2019-20



Note: No adjustment was made to PBS expenses from the improved price administration arrangements announced in the 2018-19 Budget given revenue estimates were not published.

Source: Budget Paper No.1

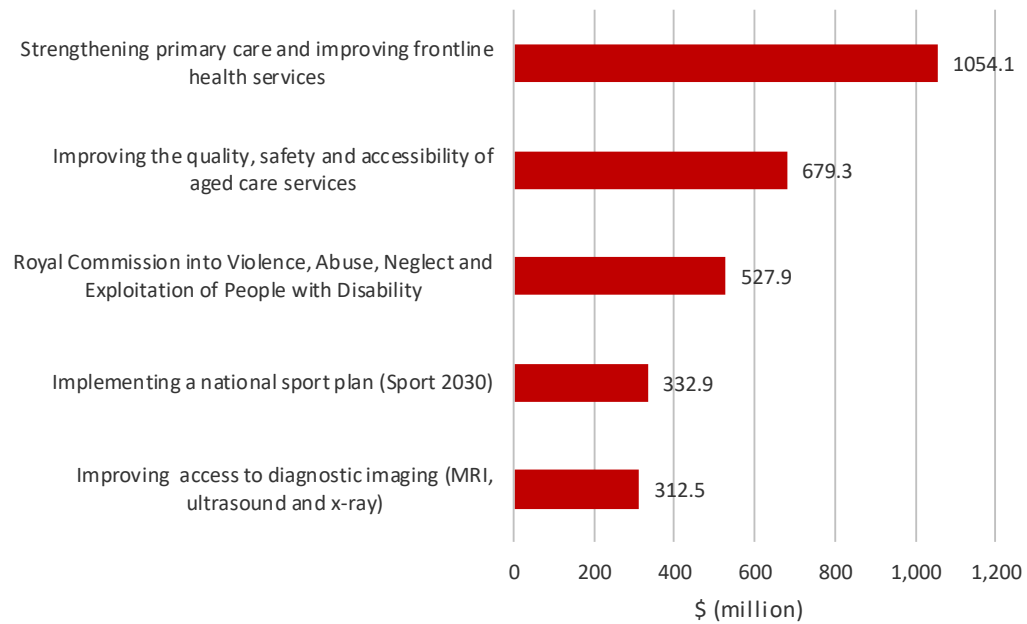
Chart 3: Estimated proportional change in expenditure



Note: No adjustment was made to PBS expenses from the improved price administration arrangements announced in the 2018-19 Budget given revenue estimates were not published. This will underestimate growth rates for Pharmaceutical Benefits and Services. According to the Health Portfolio Budget Statement, overall PBS investment is relatively stable.

Source: Budget Paper No.1

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



Source: Budget Paper No.2