

AN ANALYSIS OF THE 2008-09 HEALTH BUDGET

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I have not analysed the aged care and sport and recreation provisions of the budget. Indigenous health provisions in the budget will be analysed separately.

OVERVIEW

The 2007-08 Budget, the first from the Rudd Labor Government, delivers on the Government's election commitments and adds some additional health spending.

Total new spending on health is **\$2.917 billion / 5 years**. In addition, **\$10 billion** is promised for the new Health and Hospitals Fund.

It is anticipated that in the future an unspecified amount from the increased tax on 'alcopops' will be allocated to preventive health programs.

This spending is offset by savings of **\$2.608 billion/5 years**.

Total Commonwealth Government spending in health is **\$46.03 billion** in 2008-09 or **\$241 billion / 5 years**, averaging around 15.7 percent of total budget spending.

The budget papers predict that expenses related to health are likely to be a major contributor to the growth in Commonwealth Government spending in future decades. Total expenses for health is estimated to increase by 5.2% in real terms over the forward estimates, or on average by around 1.7% pa.

Medical services and benefits funded through Medicare and the Private Health Insurance rebate are the main contributors to rising health costs (average increase 2.2% pa), driven primarily by the number of services provided by GPs and a shift by GPs to management services which provide higher rebates. However due to the cuts in this budget, the outlays for primary care practice incentives are not predicted to increase over the forward estimates.

Despite a growing number of new high-cost drug listings on the Pharmaceutical Benefits Scheme, estimated growth is expected to increase by just 1.9% pa. over the forward estimates.

HOSPITALS AND THE AUSTRALIAN HEALTH CARE AGREEMENTS

The health budget contains **\$2 billion / 5 years** in spending for public hospitals and healthcare facilities.

The major commitments are **\$500 million** in 2007-08 to extend the current Australian Health Care Agreements (AHCAs) for 12 months (\$500 million was previously provided in the February additional estimates), and up to **\$600 million** over 2007-08 to 2010-2011 to reduce elective surgery waiting lists. This latter measure is to be provided as \$150 million for an immediate national blitz on waiting lists, \$150 million to make systemic improvements such as the construction of day surgery units to hospitals, and up to \$300 million for incentive payments for those States and Territories that meet waiting list reduction targets. However the way the funds are allocated over the forward estimates is confusing, given the Prime Minister's emphasis on the need for states and territories to implement reforms by mid 2009, as a significant part of these funds (\$370 million) is not available until after July 2009.

The budget also includes **\$389.5 million / 5 years** in grants and recurrent funding for medical technology such as MRIs, upgrading and expanding hospital and community health facilities, and medical training infrastructure. A significant amount of this funding has already been allocated in election commitments to individual hospitals and communities.

During the election campaign, the Howard Government committed to major spending in hospital facilities in Tasmania. The Government will not proceed with this initiative, included in the MYEFO 2007-08, at a saving of **\$37.3 million / 5 years**. These savings help offset the cost of the \$50 million in election commitments to Tasmania made by the Rudd Government. This commitment included two GP super clinics, a dialysis unit at Launceston and a PET scanner for the Royal Hobart Hospital.

The budget also has savings of **\$54.7 million / 5 years** to put towards grants for medical technology as a consequence of scrapping the previous Government's measure to provide funding for 11 Medicare-eligible MRI units.

The National Health and Hospitals Reform Commission is provided with **\$6.9 million** in funding for 2007-08 and 2009-10, implying that the Commission will be disbanded once its report is filed in June 2009 and the new AHCAs are in place.

Table 1. Summary of election-based and new budget 2008-09 measures for hospitals

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
AHCAs additional funding for public hospitals	\$500m	-	-	-	-	\$500m
(+ Feb add estimates commitment)	(+\$500m)	-	-	-	-	(+\$500m)
Tackling elective surgery	\$75.0m	\$155.0m	\$150.0m	\$220.0m	-	\$600m
Hospitals and community health	\$142.0.	\$71.9m	\$55.0m	\$57.3m	\$63.3m	\$389.5m
Improved access to MRI	-\$0.6m	-\$9.7m	-\$14.9	-\$14.7m	-\$14.8m	-\$54.7m
Tasmanian Health Services Infrastructure	-\$6.0m	-\$19.3m	-\$7.5m	-\$2.3m	-\$2.2m	-\$37.3m

The Budget establishes a Health and Hospitals Fund to finance health infrastructure, medical technology equipment and medical research facilities and projects. The fund will receive an initial allocation of **\$10 billion**, and both interest and capital can be used. The funds, which will not be available until 2009-10, will be distributed through the new COAG Reform Fund, which will also distribute funds provided in future budgets through the new National Partnership Payments.

The Government will not proceed with the Health and Medical Investment Fund (HMIF) proposed by the previous Government. This Fund was to have been established with proceeds from the sale of Medibank Private, which will not now proceed. This means there is a reduction in the estimated funds that were to be transferred to the HMIF, but there are still savings of **\$351.7 million** over 2009-10 to 2011-2012.

The new Australian Health Care Agreements (AHCAs)

Budget Paper No 3 (BP 3) provides information about how the new federal relations will work through COAG, and the new framework for federal financial relations.

Payments for specific purposes will be rationalized to five or six, including one Specific Purpose Payment (SPP) for health care. National Partnership Payments (NPPs) will be used to facilitate reforms, support specific projects and reward the achievement of reform-based performance benchmarks.

The SPPS will be ongoing, with periodic reviews. Each new SPP will have a statement of objectives and outcomes which will include the role and responsibilities of each jurisdiction, performance indicators and benchmarks, and policy and reform directions.

The funding arrangements for the SPPs and NPPs will be negotiated as one financial package by Treasurers, through the Ministerial Council for Commonwealth-State Financial Relations, for endorsement by COAG. BP 3 (p16) says that this is to allow portfolio ministers to focus on policy aspects of delivering more effective and efficient services.

The COAG Reform Fund will receive contributions directly from the Commonwealth Government and the three funds set up for capital investment. Where investments are to be undertaken by the States and Territories and the Commonwealth has agreed to fund these, the funding will be provided through the COAG Reform Fund in the form of NPPs.

From 1 July 2009, the new health SPP will incorporate the following existing payments:

- AHCAs funding for public hospital services (\$9.7 billion in 2008-09);
- Funding under the national public health program (\$239.9 million in 2008-09);
- Funding under the organ and tissue donation program (\$3.9 million in 2008-09);
- Funding under the youth health services program for primary health care services for homeless and at-risk youth (\$2.6 million in 2008-09).

The treatment of payments made for essential vaccines, highly specialized drugs, and organ transplantation services under the new scheme has yet to be decided.

Current and new payments to be made as NPPs include:

- Funds to the Royal Darwin Hospital as a national trauma response centre (\$13.7 million in 2008-09);
- Funds for aged care assessment teams (\$376.4 million in 2008-09);
- Funds to reduce elective surgery waiting lists;
- Funds for the establishment of a Commonwealth Dental Health Program;
- Funds to encourage qualified nurses to return to the workforce.

Table 2 Australian Health Care Agreements

Measure	2007-8	2008-09	2009-10	2010-11	2011-22
AHCAs	\$9,247.2m + \$500m	\$9,724.8m			
Public health and other grants	\$234.5m	\$246.4m			
AHCAS including public health and funding grants	\$9,981.7m	\$9,971.2m	\$10,528.6m	\$11,095.9m	\$11,696.2m
Current NPPs	\$119.3m	\$123.1m	\$126.7m	\$130.4m	\$134.2m
NPPs from election commitments	\$216.5m	\$290.5m	\$257.2m	\$331.5m	\$10.4m
Existing payments					
Vaccines	\$541.0m	\$263.7m	\$214.8m	\$165.2m	\$165.2m
HSD	\$513.4m	\$554.2m	\$589.0m	\$626.3m	\$659.1m
Other	\$6.4m	\$6.5m	\$6.4m	\$6.4m	\$6.3m

Table 3.3 BP 3 (page 38) includes the forward estimates for the next round of AHCAs.

Table 3.3: Payments to support state health services

Smillion	Estimates		Projections		
	2007-08	2008-09	2009-10	2010-11	2011-12
National healthcare agreement			10,528.6	11,095.9	11,696.2
Health care grants(a)	9,747.2	9,724.8			
National public health	228.0	239.9			
Organ and tissue donation	3.9	3.9			
Youth health services	2.6	2.6			
National Partnership payments(b)					
Aged care assessment	68.4	71.9	75.2	78.7	82.2
Royal Darwin Hospital - equipped, prepared and ready	13.4	13.7	14.0	14.2	14.5
Helping public patients in hospitals waiting for nursing home places	37.5	37.5	37.5	37.5	37.5
<i>including Election commitments</i>					
Commonwealth Dental Health Program	-	92.0	96.6	101.4	-
Elective surgery waiting list reduction plan	75.0	155.0	150.0	220.0	-
Health infrastructure grants	141.1	40.3	4.4	2.7	1.6
Supporting nurses back into the workforce - incentive payments	-	2.4	5.1	6.0	7.2
Supporting nurses back into the workforce - training payments	0.4	0.8	1.1	1.4	1.6
Existing payments(c)					
Essential vaccines	541.0	263.7	214.8	165.2	165.2
Health program grants	1.2	1.2	1.2	1.3	1.3
Highly specialised drugs(d)	513.4	554.2	589.0	626.3	659.1
Organ transplantation services	1.8	1.9	1.9	1.9	1.9
Organ transplantation services (capital)	0.2	0.2	0.2	0.2	0.2
Repatriation general hospitals	2.0	1.9	1.8	1.7	1.6
Supporting Western Sydney - positron emission tomography scanner at Westmead Hospital	1.2	1.3	1.3	1.3	1.3
Total	11,378.4	11,209.2	11,722.8	12,355.7	12,671.5

The funding for the AHCAs and NPPs is broken out by state and territory for the years 2007-08 to 2011-2012 in table B.2 (BP 3 pp 95-99).

GP SUPER CLINICS AND MEDICARE SERVICES

A major election commitment from the Government was the establishment of GP Super Clinics, aimed at improving access to prevention and chronic diseases management through primary care. A central tenet is the co-location of a range of health care services, based on local needs.

During the election **\$220 million** was promised for new or upgraded infrastructure, incentives to pay for administrative and nursing support, and teaching rooms and facilities for trainees and GP registrars. Services will be funded through current Medicare rebates and practice incentive payments.

The budget contains **\$275.2 million / 5 years** for the establishment of 31 GP Super Clinics in listed locations. At least 26 of these clinics are election commitments. The average funding provided per clinic is \$8.9 million, implying that ongoing costs will be more than budgeted at the time the election commitment was made.

There is only **\$38.7 million / 4 years** in new Medicare spending in the budget.

There is a provision costed at **\$13.1 million / 4 years**, and announced by the Howard Government during the election campaign, to allow GPs to directly refer patients for MRI scans of knees and for suspected multiple sclerosis (MS). MRI scans of knee problems and for suspected MS make up 20 per cent of MRI services.

The Child Health Checks for 4 year olds will introduce new MBS items, at a cost of **\$25.6 million / 4 years**, to enable GPs and practice nurses to undertake checks of height, fitness, eyesight and hearing at the time of their 4 year immunisation. It is expected that 250,000 checks will be done each year - at an estimated cost of \$24 / check. The BP 2 (p 208) states that in addition, funds will be provided to State and Territory Governments for health checks to be undertaken by other immunisation providers in local or community health clinics. It is assumed that this will be additional funding provided through the new AHCAs.

Savings proposals

These spending provisions are more than paid for by a raft of savings, totaling **\$1 billion** (the figure rises to **\$1.5 billion** if the Medicare CDM dental cuts are included), taken in a range of Medicare programs, not all of them identified in the Budget papers, and GP incentive payments, and by increased compliance audits.

This includes **\$120 million** in savings in pathology services, **\$227.8 million** in incentive payments to GPs, **\$16.7 million** from the Australian Primary Care Collaboratives program, and **\$503.7 million** in a raft of programs in primary care, pathology, diagnostic imaging, mental health and e-health implementation that have a history of underspends (see Table 5). The programs included in this last provision have a total funding of \$854.4 million in 2008-09 and \$3.3 million over 2008-09 to 2011-12. Savings taken represent 13 percent of the cost of these programs in 2008-09 and 15 percent of the cost over the forward estimates.

Although there is a commitment that funding levels for individual programs will be reviewed in the future should demand exceed expected take-up rates in the future, there is no commitment to investigate and then address reasons for slow or low take-up. It is likely that a major reason is lack of workforce, yet the majority of the savings (\$333.7 million) are in workforce-related programs. It is also disappointing to see cuts of \$272.6 million in mental health programs (see section on Mental Health).

Savings of **\$12.8 million/ 4 years**, set against Medicare reimbursements for IVF treatment, are achieved by allowing Medicare benefits to patients who wish to reverse their elective sterilisation. This is seen as a more cost effective alternative for people wanting to have children. The Howard Government abolished funding for these procedures in 1997. The cost of reversing a sterilisation ranges from \$5,000 to \$10,000. The cost of a single IVF cycle is \$6940, with the cost of a live birth over \$100,000, depending on the woman's age.

In addition DoHA will achieve savings of **\$147.2 million / 4 years** through increased Medicare compliance audits. There is a cost (\$76.9 million) for conducting these audits, but this accrues to the Medicare Australia budget.

Table 4 Medicare spending and savings

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
GP Super Clinics	\$33.1m	\$76.6m	\$66.3m	\$49.3m	\$49.8m	\$275.2m
Medicare spending						
GPs MRI referral						\$13.1m
Child Health Checks	-	\$7.3m	\$5.9m	\$6.1m	\$6.3m	\$25.6m
Medicare and related savings						
Adjusted funding for specific programs	-	-\$113.0m	-\$137.8m	-\$130.1m	-\$122.9m	-\$503.7m
Pathology services	-	-\$23.4m	-\$24.9m	-\$26.6m	-\$28.3m	-\$103.2m
e-health incentive	-	-\$16.1m	-\$32.3m	-\$31.8m	-\$30.6m	-\$110.7m
A/H services	-	-\$3.6m	-\$5.8m	-\$8.7m	-\$8.2m	-\$26.2m
Mental health incentive	-	-\$1.8m	-\$1.8m	-\$1.8m	-\$1.9m	-\$7.2m
Immunisation incentive	-	-\$14.6m	-\$22.6m	-\$23.1m	-\$23.6m	-\$83.7m
APCC program	-	-\$4.2m	-\$4.1m	-\$4.2m	-\$4.2m	-\$16.7m
Reversal of sterilisation	-	-\$2.3m	-\$2.8m	-\$3.5m	-\$4.2m	-\$12.8m
CDM dental item	-\$41.4m	-\$116.8m	-\$97.6m	-\$113.5m	-\$122.2m	-\$491.4m
Medicare compliance audits (DoHA)	-	-\$6.9m	-\$23.5m	-\$22.7m	-\$23.2m	-\$147.2m

Table 5 Savings made in specific programs

PROGRAMS	Savings over forward estimates
Transfer of Unused Funds from a Pathology Project for Remote Areas to Medicare	\$12.0m
Cessation of base funding to support access to MRI services	\$2.3m
Reduction in funding to support quality diagnostic imaging	\$4.5m
General Practice Infrastructure Training and Support - Primary and Coordinated Care	\$20.0m
General Practice Infrastructure Training and Support - Primary Care Financing	\$11.5m
Primary Care Collaboration and Research	\$6.3m
After Hours Primary Care and Round the Clock Medicare: Investing in After Hours GP Services	\$32.6m
eCommunities - eHealth implementation	\$10.5m
Reduced funding for the Telephone Counselling, Self-Help and Web-based Support Program (COAG mental health package)	\$2.5m
Reduced funding for the Mental Health Nurse Incentive Program (COAG mental health package)	\$188.0m
Reduced funding for NGOs under the National Mental Health Program	\$6.0m
Reduced Funding for the Support for Day to Day Living in the Community Program (COAG mental health package)	\$0.5m
Reduced Funding for Mental Health Services in Rural and Remote Areas Program (COAG mental health package)	\$15.5m
Reduced Funding for - Better Access to Psychiatrists, Psychologists and GPs through the MBS (Better Access) initiative - Education and Training component (COAG mental health package)	\$29.7m
Reduced Funding for psychiatry training outside hospitals (COAG mental health package)	\$2.0m
COAG Risk Modification	\$28.4m
Australian Better Health Initiative - encouraging active patient self-management of disease	\$29.3m
Sharing Health Care Initiative	\$6.0m
Aged Care Access GP Panels	\$13.7m
HECS reimbursement scheme	\$16.0m
Reduced Funding for the Training for Rural and Remote Procedural GPs program	\$33.5m
Reduced Funding for the prevocational General Practice Placement Program	\$30.0m
Reduced Funding for the Registrars Rural Incentives Program	\$3.0m
Total savings	\$503 m

PREVENTION

Spending on prevention under the headings “Keeping People Well – Focus on Prevention” and “Supporting Maternal and Child Health” total **\$95.0 million / 4 years**.

This includes **\$53.3 million** to tackle binge drinking, **\$15.0 million** for anti-tobacco programs (there is a further \$14.5 million for Indigenous anti-smoking initiatives) and **\$21.9 million** for obesity and healthy nutrition initiatives, but this is a puny response when the annual direct and indirect costs of obesity and obesity-related diseases, smoking and alcohol abuse total almost \$70 billion, equivalent to the total cost of the health system.

Even when the costs of child health checks and continuation and expansion of the bowel cancer screening program are included, the Commonwealth's new commitment to prevention amounts to only \$52 million a year over the next four years.

Clearly major policy changes and investments in this area must await the deliberations of the National Preventative Health Taskforce and the funding bonanza that will result from the application of higher taxes to 'alcopops'. The budget provides **\$4.5 million / 5 years** for the development of a National Preventative Health Strategy, although it is not clear what funds will be available from this for the operation of the Taskforce.

The inclusion of sport and recreation in the health and ageing budget provides an opportunity for a multifaceted approach to tackling lifestyle diseases such as obesity, diabetes and heart disease, but this has been missed. Of \$117.5 million to be spent over the next five years on sport and recreation, only \$24.5 million could be described as going to community recreational activities, and the remainder is for elite sports

Savings of **\$1.6 million / 2 years** were taken from the Healthy Active Australia initiative developed by the Howard Government and redirected to partially offset the \$2.9 million cost of the new Healthy Habits for Life initiative.

CANCER

The budget provides **\$291.8 million / 5 years** for cancer initiatives. Of this, **\$107.3 million** is for election commitments made to specific facilities or regions. The cost of radiation oncology facilities for Cairns and Lismore is offset by redirecting \$15.3 million in unspent funds from the \$90.3 million / 4 years Better Access to Radiation Oncology measure in the 2006-07 budget. Despite the need, especially in rural areas, the roll-out of radiation oncology funds has always been slow and the 2006 funding included \$10.1 million unspent from the 2002-03 budget measure Better Treatment for Cancer Patients.

\$87.4 million / 4 years is provided for the National Bowel Cancer Screening Program. These funds will enable the continued roll-out of this program and its extension to people turning 50 between 2008 and 2010.

Table 6 Funding for National Bowel Cancer Screening Program

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
National Bowel Cancer Screening Program	(\$16.4m)	\$30.8m	\$27.2m	\$29.4m	-	\$87.4m

This program was first funded in the 2005-06 Budget, when the Government provided \$43.4 million over three years (including \$4.0 million in capital funding), to phase in a

national bowel cancer screening program, commencing in August 2006. Initial screening was offered to Australians turning 55 or 65 years of age between 1 May 2006 and 30 June 2008, and those who were involved in the Pilot Program that ran from November 2002 to June 2004. This new funding is a considerable increase on the \$16.4 million provided in 2007-08, but in a divergence from a true screening program, patients must still pay the costs not reimbursed by Medicare for needed follow-up doctors' visits and colonoscopies.

The Government has said that it will address the issues around cost of and access to colonoscopies in the next set of AHCA's, but the April 2008 report from the National Health and Hospitals Reform Commission sets no targets in this regards and does not mention this issue.

The National Bowel Cancer Screening Program Monitoring Report 2007 from the AIHW (<http://www.aihw.gov.au/publications/can/nbcspmr07/nbcspmr07-c00.pdf>) shows:

- 475,198 invitations to take part in FOBT screening were sent between 7 August 2006 and 31 July 2007;
- As at 31 July 2007, there were a total of 155,839 people who had completed a FOBT analysed by pathology;
- Of those FOBTs analysed, 7.0% tested positive for blood in the sample;
- There were a total of 2,764 visits to general or other primary health practitioners as a result of a positive FOBT recorded during the period for all three target populations;
- Referral for colonoscopy was made in 91.5% of these consultations;
- There were a total of 2,283 colonoscopies following a positive FOBT result recorded for all three target populations;
- Pre-cancerous polyps, adenomas or cancer were detected in 62.8% of all positive FOBT results investigated by colonoscopy.

Included in the increased budget for cancer is an additional **\$19.0 million / 4 years** to complete the development of and operational costs for an electronic register for women vaccinated against Human Papilloma Virus. This funding will also support the operation of a call centre to assist women and parents of children participating in the program to access vaccination information. Initial funding for this register was announced in March 2007.

This budget has only two provisions that directly help patients to tackle the cancer journey. **\$31.0 million / 5 years** will provide breast prostheses to all women who have had a mastectomy as a result of breast cancer, and **\$15 million / 3 years** to CanTeen will assist with the establishment of youth cancer networks for the social and emotional support of young adults with cancer.

DENTAL HEALTH

The Budget provides **\$780.7 million / 5 years** for dental health programs. This is made up of **\$290 million / 3 years** for a Commonwealth Dental Health Program and **\$490.7**

million / 5 years for a Teen Dental Plan. The funding for this latter plan is from the scrapping of the current Medicare dental benefit available under the Chronic Disease Management (CDM) program.

Table 7 Funding for new dental programs

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Commonwealth Dental Health Program	-	\$92.0m	\$96.6m	\$101.4m	-	\$290m
Teen Dental Plan	\$5.6m	\$101.5m	\$111.1m	\$133.2m	\$139.3	\$490.7m

The Commonwealth Dental Health Program will provide funds to the states and territories to supplement existing public services and/or purchase private dental services. It is estimated that up to 1 million additional dental consultations will be funded, and that this will help the 500,000 people currently on waiting lists for public services.

The Teen Dental Plan will provide up to \$150 per year towards an annual dental preventive check for teenagers aged 12-17 in families receiving Family Tax Benefit Part A or in receipt of ABSTUDY or Youth Allowance.

Funding of \$510 million / 3 years was promised for the Teen Dental program during the election campaign, and given the concerns that \$150 / year will not go far in the provision of needed preventive care, it is disappointing that this election promise was not met in full.

The recently released report from the NHHRC has as a performance indicator (no 5.5) the wiring time for access to public dental services. The accountability is described as ‘subject to negotiation as the Commonwealth has foreshadowed changes to its support for dental health services’.

Savings from the Chronic Disease Management Medicare-funded dental items

Under the Chronic Disease Management (CDM) program, patient with a chronic medical condition and complex care needs being managed by a GP under specific Medicare care plans were eligible for referral to a dentist for treatment. The patient’s oral health must also be impacting on, or likely to impact on, their general health. Eligible patients could receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years.

New Medicare dental items (items 85011-87777) to cover services by dentists, dental specialists and dental prosthetists were introduced in November 2007 to replace dental items that were rarely used and caused patients to incur substantial out-of-pocket costs. A comprehensive range of dental services was covered, including dentures. Note that

this program was originally funded at **\$377.6 million / 4 years**, but the first five months of operation indicated the potential for increased costs.

Dental services and cost 1 November, 2007 – 31 March, 2008

Services delivered by (MBS items)	Number of services	Cost to Medicare
Dentists (85011 – 85986)	159,420	\$19.44m
Dental specialists (86012 – 86986)	1,586	\$0.28m
Dental prosthetists (87011 – 87777)	10, 431	\$21.78m
TOTAL	171,437	\$21.78m

If assume every patient got an assessment from a dentist, then 20,135 patients treated.

Analysis of services delivered 1 November, 2007 – 31 March, 2008

(not a complete list of services delivered)

Type of service	Number of services	Cost to Medicare
Diagnostic services	53,568	\$1.79m
Preventive	17,785	\$0.85m
Extraction	12,428	\$1.32m
Restorations and fillings	35,157	\$3.79m
Crowns, bridges, implants	8,644	\$6.08m
Dentures, including repairs and maintenance	31,695	\$6.23m

It is clear that the restructured version of the CDM dental program provided more services and covered more expensive services, so that more people who have severe oral health problems and chronic and complex conditions are benefiting.

However it can be argued that waiting until patients fulfill the conditions for access to these dental services is waiting too long, and inevitably means that the services provided are more about extractions and dentures than about prevention and restoration.

The Government has abolished this program, with no new patients eligible for treatment after March 2008. The savings are put towards the Commonwealth Dental Health Program.

Table 8 Savings from abolishing CDM dental program

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
CDM dental	-\$41.4m	-\$116.8m	-\$97.6m	-\$113.5m	-\$122.2m	-\$491.4m

MENTAL HEALTH

There is very little spending on mental health in this budget, reflecting the lack of focus on mental health during the election campaign.

The major commitment is **\$41.3 million / 4 years** for a National Plan for Perinatal Depression. However in the media releases accompanying the budget papers, this is described as a **\$85 million** initiative comprising \$55 million from the Commonwealth over the 5 years to 2012-13 and a contribution of \$30 million to be sought from the states and territories. Funding of \$5 million / 5 years is to be provided to *beyondblue* to support the implementation of the National Perinatal Depression Plan.

This allocation of funds is somewhat different that that outlined at Senate Estimates in February: *“The actual million commitment itself, Senator, involved a total of \$85 million, of which \$5 million was to go to beyondblue for overseeing the implementation of the plan; \$20 million was to go to the expansion of the Better Outcomes ATAPS program, access to allied psychological services; \$30 million was to go to states and territories to roll out aspects of implementation of the plan and a further \$30 million was to be sought from the states and territories through an invitation to them to invest in the plan as well.”*

This measure is described as providing for the routine screening of mothers before and after pregnancy by midwives, child and maternal health workers and GPs. Training will be provided for health professionals to improve support and follow-up for ‘at risk’ women and to establish research and data collection processes. It is not clear where or if the promised \$20 million funding for increased ATAPS services has been delivered.

An additional **\$35 million / 4 years** is provided for post-graduate and masters degree scholarships for mental health nurses (see workforce section).

\$2.4 million / 3 years will be provided from 2008-09 from within existing Departmental resources to establish a National Advisory Council on Mental Health. The Council will provide independent expert advice to the Government and assist with the coordination of Commonwealth, state and Territory mental health services. It is not clear why this measure is not funded over the full forward estimates.

A number of mental health programs took budget cuts and the fate of some others is unclear. The previous Government ended the Practice Incentive Payment (PIP) available

under Better Outcomes in Mental Health in May 2007, and this Government has claimed savings of **\$7.3 million / 4 years** from this.

A further **\$9.7 million** was saved by not delivering on the final two years of funding for the media and educational campaigns to alert the community to the links between illicit drugs and mental illness. The March 2008 report from DoHA on progress on the Commonwealth's component of the COAG National Action Plan on Mental Health indicates that to date only research and consultative work has been undertaken on this initiative, funded initially at \$21.6 million.

Savings totaling **\$503.7 million / 4 years** were made from a range of health programs on the basis that they had a lower than anticipated uptake. Mental health programs were severely hit, with cuts of **\$272.6 million / 4 years**.

It is particularly problematic to see significant cuts in mental health workforce and training programs with no apparent effort to address the reasons for low and slow uptake. The scholarship programs to train more mental health nurses and psychologists will not deliver more mental health workers for three to five years, and action to deliver more and better services cannot wait that long.

\$188 million of the \$503.7 million is due to a cutback of the Mental Health Nurses Incentive Program. This program was introduced in July 2007 with funding of \$191.6 million over five years to provide non-MBS incentive payment to general practices, private psychiatrist services and other appropriate community providers (including Divisions of General Practice) to engage or retain mental health nurses to assist in the provision of coordinated clinical care for people, in the community, with severe mental health disorders. However uptake has been slow because of a shortage of mental health nurses.

Training programs for GPs, psychiatrists and other mental health workers have also been cut, with total savings of **\$31.7 million**. This seems particularly short-sighted.

\$15.5 million of savings comes from reduced funding for mental health services in rural and remote areas, where the need for services is high. The COAG mental health package originally contained \$51.7 million / 5 years to increase access to treatment services provided psychologists, social workers and mental health nurses in rural and remote areas. At the time the policy was released the mechanism for the provision of these services was not stated.

It is not clear which of several recent provisions to fund rural and remote mental health services are being cut. The 2007-08 Budget contained an additional \$20.6 million / 4 years to provide up to 114 allied health and/or mental health nursing professionals to drought-affected communities. There was also \$10.1 million / 2 years to provide Mental Health Support for Drought Affected Communities through funding to up to 39 DGPs in these areas. This makes of total of \$82.4 million for the provision of mental health services in rural and remote areas.

In July and August 2007, the Government announced that 15 organisations (including Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service) were funded to provide mental health services at a total cost of \$21 million. There is no current measure of how many services have been provided or the type of health care professionals who delivered these services.

In September 2007, the Government announced funding of \$7.4 million to 39 DGPs in NSW, Queensland, South Australia and Victoria to employ community support workers to provide crisis counselling and outreach services for people psychologically affected by the drought.

\$28.4 million is saved from a program referred to as ‘COAG risk modification’. It is not clear what this is, but it may be the initiative for improved services for people with drug and alcohol problems and mental illness, originally funded at \$73..9 million / 5 years.

It is important to notice that these mental health programs are part of the Howard Government’s COAG mental health package, and many of the delays in their implementation can be laid to that Government’s lack of commitment to mental health. Historical under-spending patterns cannot emerge if programs are yet to be developed.

Table 9 Savings in mental health programs

PROGRAMS	Savings over forward estimates
Reduced funding for the Telephone Counselling, Self-Help and Web-based Support Program (COAG mental health package)	\$2.5m
Reduced funding for the Mental Health Nurse Incentive Program (COAG mental health package)	\$188.0m
Reduced funding for NGOs under the National Mental Health Program	\$6.0m
Reduced Funding for the Support for Day to Day Living in the Community Program (COAG mental health package)	\$0.5m
Reduced Funding for Mental Health Services in Rural and Remote Areas Program (COAG mental health package)	\$15.5m
Reduced Funding for - Better Access to Psychiatrists, Psychologists and GPs through the MBS (Better Access) initiative - Education and Training component (COAG mental health package)	\$29.7m
Reduced Funding for psychiatry training outside hospitals (COAG mental health package)	\$2.0m
COAG Risk Modification	\$28.4m
Abolition of PIP for Better Outcomes in Mental health	\$7.3m
Cancel media and educational campaigns to alert the community to the links between illicit drugs and mental illness	\$9.7m
TOTAL	\$289.6m

RURAL HEALTH

The Budget has spending of **\$31.6 million / 4 years** on rural health initiatives. These are all workforce related, except for \$1.9 million to be provided in 2008-09 for small rural infrastructure projects.

The John Flynn Scholarships and the Medical Specialist Outreach Assistance Program were previously funded as part of the Rural Health Strategy (2004-05 to 2007-08) and the Rural and Remote Health Infrastructure Program has been formed from a merger of the Rural Medical Infrastructure Fund (once part of the Regional Partnerships Program) and the Rural Private Access program (also part of the Rural Health Strategy).

Table 10 New spending in rural health programs

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Additional funding for John Flynn Placement program	-	\$1.0m	\$3.3m	\$2.0m	\$2.0m	\$8.3m
Additional funding for MSOAP	-	\$3.0m	\$3.0m	\$3.0m	\$3.0m	\$12.0m
Allied Health Rural and Remote Clinical Placement Scholarship program	-	\$0.8m	\$0.8m	\$0.8m	-	\$2.5m
Rural and Remote Health Infrastructure program	-	\$1.9m	-	-	-	\$0.9m
Specialist Obstetrician Locum Scheme	-	\$1.9m	\$2.0m	\$2.0m	\$2.0m	\$7.9m

The Rural Health Strategy

The Rural Health Strategy, previously the Regional Health Strategy, was reauthorized to 2007-08 in the 2004-05 budget, at \$830.2 million / 4 years. This represented funding at the 2003-04 level with indexing in the out years. At that time the package was also ‘broadbanded’ – so that states and territories were given some flexibility with the funding of the measures within the package.

- New GP Registrars
- Enhanced Rural Assistance to medical Undergraduate Students
- HECS Reimbursement Scheme
- Bonded Scholarships for Medical Students to Practice in Rural Areas
- Medical Training – University Departments of Rural Health
- Medical Training – Rural Medical Training Clinical Schools
- Rural Specialist Support Program (previously Medical Specialist Outreach Assistance)
- Workforce Support for Rural GPs
- Rural Primary Health Program (previously More Allied Health Services and Regional Health Services)

- Rural Primary Health Program – Primary Health Projects (previously Rural Chronic Disease Initiative)
- Enhanced Rural and Remote Pharmacy Package
- Rural Private Access Program (previously Bush Nursing, Small Community and Regional Private Hospitals)
- Aged Care – Adjustment Grants for Small Rural Facilities
- Communications Strategy

The Health Minister has committed to:

- Establishing an Office of Rural Health in DoHA, to drive reform in the rural health sector (note that such an office previously existed and was abolished around 2005).
- Over the next 12 months reforming the remoteness classification structure (RRMA) to ensure that incentives and rural health policies respond to current population figures and real need.
- Over the next 12 months examining all existing programs that support rural health professionals, to determine how to better support communities in most need of assistance.

It is assumed that funding for measures within the Rural Health Strategy is continuing while the promised reviews are undertaken. It is known that rural Divisions of General Practice have received notification that the More Allied Health Services program will continue for another 12 months.

An audit by DoHA of health workforce shortages in rural areas was completed earlier this year. It found that:

- The current supply of health professionals is not sufficient to meet current needs.
- This situation will get worse as both the population and the workforce age.
- Australia is highly reliant upon overseas trained health professionals, with 36% of doctors working in Australia trained overseas. This figure rises to 41% in rural and remote areas.
- The supply of health professionals in many rural and regional centres is low to very poor. For example: The average number of full-time general practitioners per 100,000 population varies from a peak of over 100 in the best-serviced major cities to as low as 25.3 in some very remote areas, while the average number of medical workers varies from a peak of over 600 in the best-serviced major cities to as low as 30 in some very remote areas.

PHARMACEUTICAL BENEFITS SCHEME

The budget spends **\$846 million / 5 years** (and refers to an additional spend of **\$129.8 million** which is already included in the forward estimates) on the listing of new PBS medicines, the funding of Naglazyme on the Life Saving Drugs Program and the provision of a subsidy for insulin pumps for young people with Type 1 diabetes.

Table 11 The cost of new PBS listings

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Extension to listing of Remicade						(\$25.5m)*
Extension to listing of Topamax						(\$39.1m)*
Listing of Renagel						(\$65.2m)*
Listing of Champix	\$12.6m	\$24.6m	\$20.0m	\$20.3m	\$19.6m	\$97.1m
Listing of Sensipar	-	\$36.7m	\$40.6m	\$43.2m	\$45.8m	\$166.4m
Listing of Tysabri	-	\$52.2m	\$83.4m	\$107.5m	\$127.1m	\$370.2m
Minor new listings	\$13.8m	\$34.6m	\$41.0m	\$45.1m	\$47.0m	\$181.5m

\$5.5 million / 4 years is provided for subsidies of up to \$2,500 (depending on family income) towards the cost of insulin pumps for young people under the age of 18 who have type 1 diabetes and for whom an insulin pump is deemed clinically necessary. However insulin pumps cost between \$6,500 and \$11,000. Annual disposable costs are around \$270-\$300 each month, or up to \$3,000 a year but since 2004 insulin pump consumables have been subsidised by the National Diabetes Services Scheme.

The budget makes savings of **\$113.8 million / 5 years** in PBS and related expenditure. This includes savings of **\$95.5 million / 4 years** in the DoHA budget (and additional savings of \$9.9 million in the DVA budget) from changes in the way pharmacists are reimbursed for the preparation and dispensing of chemotherapy drugs, based on the amount of active ingredient used, rather than the number of vials.

An additional **\$3.4 million / 4 years** is saved by extending the period for which a repeat prescription can be written for patients with a chronic condition from six to 12 months, and \$14.9 million over 2007-08 to 2009-10 by not proceeding with the community campaign to promote the benefits of generic medicines announced in the 2007-08 budget. The Government will encourage the use of generic medicines by a new incentive payment of \$1.50 to be paid to pharmacists for the dispensing of generic medicines from August 1, 2008. It is assumed that the costs of this measure are paid from Pharmacy Agreement funds.

The Budget also contains a measure for recovery of the costs of PBAC approvals, which will save and estimated **\$1.8 million / 3 years** over the forward estimates. This represents a reversal of Labor's previous opposition to PBAC cost recovery. It is not clear if there will now be tighter time and transparency requirements on the PBAC as a consequence, similar to those that apply to the TGA approval process which is also funded on a cost-recovery basis.

HEALTH WORKFORCE

There are several provisions in the budget to expand the health work, at a total cost to the DoHA budget of **\$130 million / 5 years**.

.The budget provides **\$12 million / 4 years** to the McGrath Foundation to recruit, train and employ up to 30 specialist breast cancer nurses. It is not clear what happens in 2011-12 when this support ceases.

Nurses who have left the workforce will be encourage back to work in hospitals and residential aged care with cash bonuses of \$6,000 and an additional \$1,000 to the facility to assist with the costs of re-training and re-skilling. The total cost of this measure, which is expected to bring up to 7,750 extra nurses into hospitals and up to 1,000 extra nurses into aged care is **\$39.4 million / 5 years**. This initiative, when first announced, was funded at \$81 million / 5 years. It is not clear why costs are 50% lower.

The budget provides **\$13 million** to establish a specialist clinical training school at the Greenslopes Private Hospital in Brisbane. This school will offer up to 60 training places a year to medical students from the University of Queensland.

\$35.0 million / 4 years is provided to expand the current provision that provides post-graduate funding for mental health nurses and psychologists. This original measure was in the Howard Government's COAG mental health package in 2006 with funding of \$103.5 million / 5 years. This was to provide training support for a total of 1,400 additional mental health nurses and 700 additional clinical psychologists by the end of 2011. The current budget states that the additional \$35.0 million will provide scholarships for 1070 mental health nurses (of which over 100 will be for nurses in rural and remotes areas) and 222 scholarships for psychologists in rural and remote areas. When compared to 2006, this package seems to be underfunded.

The DEEWR budget contains **\$99.5 million / 4 years** for an increase in university places for nursing by 90 places starting in July 2008 and a further 1170 places in 2009.

The costs of these new measures is more than offset by the savings of **\$169.9 million / 5 years** made by not proceeding with the Howard Government's proposal (announced in the MYEFO 2007-08) to create 25 nursing schools to deliver hospital-based training for enrolled nurses, primarily in private hospitals. \$148.7 million of these savings are in the DoHA budget and \$21.3 million are in the DEEWR budget.

\$333.7 million of the \$503.8 million in savings taken from 23 different health programs which have underspends are from training and workforce-related programs.

Table 12 Spending on health workforce initiatives

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Specialist breast cancer nurses	\$3.0m	\$3.0m	\$3.0m	\$3.0m	-	\$12.0m
Supporting nurses back into workforce	\$0.7m	\$5.4m	\$10.3	\$11.2m	\$11.8m	\$39.4m
Mental health nurses and psychologists training subsidy	-	\$5.0m	\$10.0m	\$10.0m	\$10.0m	\$35.0m
Rural health workforce initiatives	-	\$6.7m	\$9.1m	\$7.8m	\$7.0m	\$30.6 m
Greenslopes Private Hospital clinical school	\$11.7m	\$1.3m	-	-	-	\$13.0m
Hospital-based clinical training for ENs (DoHA budget)	-\$15.5	-\$43.6	-\$30.9	-\$29.2m	-\$29.5m	-\$148.7

PRIVATE HEALTH INSURANCE

The Government will make savings costed at **\$299.2 million / 4 years** by increasing the income thresholds at which the Medicare level surcharge kicks in from \$50,000 to \$100,000 a year for singles and from \$100,000 to \$150,000 a year for couples. The thresholds have not been indexed since the surcharge was introduced in 1997.

Table 13 Savings from changes in the Medicare levy surcharge

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Increasing the Medicare levy surcharge thresholds		-\$231.6m	-\$41.4m	-\$10.4m	-\$15.6m	-\$299.2m

The new thresholds of \$100,000 for singles and \$150,000 for families raise the financial level at which people who choose not to take out private health insurance will be hit with a stick for failing to do so, but the current carrot, the 30 per cent rebate (which extends to 35% and 40% for older Australians, remains untouched, as does Lifetime Health Cover, which health economists see as the biggest stick.

The people most likely to drop their insurance policies are the well-off, fit young singles who currently purchase the cheapest policies to avoid the surcharge, never intending to use them.

The AHIA has run a scare campaign that claims that over 900,000 people are likely to dump their PHI. The Government has said that the figure is 486,000.

The actual figure depends on what assumptions are made about the average cost of a policy (and the level of deductibles and exclusions that people have accepted for these policies), the number of people represented by each purchasing unit, the value that people see in not just purchasing a policy but in using it for private hospital care, and the persistent threat of Lifetime Health Cover.

The insurance industry's own data suggest that many people will continue to purchase PHI cover, even when this is a financial impost. The Australian Health Insurance Association says that more than 2.4 million people in households with gross annual incomes that are below \$48,000, and more than 1 million people in households with gross annual incomes below \$26,000 have private health insurance cover.

The Government has made savings of \$20.3 million / 4 years in the Medicare Australia budget by not proceeding with further development of the ECLIPSE system. This system allows private health funds or Medicare Australia to advise private patients seeking treatment in hospital to establish, prior to treatment, how much they are likely to be out of pocket on the basis of quotes from Medicare Australia and the funds.

HUMAN INFLUENZA PANDEMIC PREPAREDNESS

Funding of **\$4.7 million / 2 years** has been provided from the DoHA budget to COAG (through the Office of Prime Minister and Cabinet) to ensure a whole-of-government approach to pandemic preparedness in Australia. A further **\$0.9 million** is provided in 2007-08 for the development of legislation to formalize existing voluntary arrangement between the Commonwealth, States and Territories in relation to communicable disease outbreaks and other significant public health events.

There is funding of **\$166.5 million / 2 years** for replenishment of expiring pharmaceuticals and vaccines in the National Medical Stockpile. The budget papers state that funding for 2010-11 and beyond will be based on a consideration of the make-up of the stockpile with respect to current and future threats.

OTHER SAVINGS MEASURES IN THE BUDGET

There are savings of **\$122 million** to the DoHA budget as a consequence of changes to the way in which the income test for the Commonwealth Seniors Health Card is applied and the institution of a fraud and compliance program to ensure that only people who are entitled to use these cards retain access

The final two years of an advertising campaign for the Continence Management Strategy will not proceed, with savings of **\$3.0 million** and savings of **\$4.0 million** are taken from the National Psychostimulant Initiative which was set up to inform Australian about the

use, harm and long-term effects of psychostimulant use and to deliver workforce training and treatment activities

Table 14 Other Budget savings measures in the Health portfolio

Measure	2007-8	2008-09	2009-10	2010-11	2011-22	Total
Comm Seniors health Card changes to income test	-	-	-\$20.5	-\$20.2	-\$21.6	-\$62.3m
Comm Seniors Health card – compliance reviews	-	-\$3.7m	-\$16.0m	-\$18.3m	-\$21.7m	-\$59.7m
Advertising for Continence Management Strategy	-	-\$1.5m	-\$1.5m	-	-	-\$3.0m
National Psychostimulant Initiative	-	-\$2.0m	-\$2.0m	-	-	-\$4.0m

OTHER BUDGET ISSUES

E-health

Funding already in the forward estimates provides **\$60.63 million** for e-health in 2008-09, up 50% from the budget allocation in 2007-08. However the e-health area has consistently had significant budget blow-outs. In 2006-07, actual spending of \$78.97 million exceeded estimated spending by \$22 million, and in 2007-08 actual spending of \$64.68 million exceeded estimated spending by \$24.6 million.

It is not immediately clear how much of this funding goes to the troubled National e-Health Transition Authority (NeHTA). In 2006 then Chief Executive Ian Reineke said that NeHTA had been allocated funding of \$160 million and had received initial funding of \$28 million over four years to mid-2008. The Commonwealth contribution to this was presumably 50%.

NeHTA is under considerable pressure to deliver on many of its e-health objectives in the next 12 months. The development of a unique healthcare identifier is scheduled for completion by mid-2009, but the contract between NeHTA and Medicare Australia to do this was only signed in January.

A recent review undertaken by the Boston Consulting Group (BCG) identified a range of obstacles to Australia's e-health agenda including critical staff shortages. The review said NeHTA is currently operating up to 50 per cent under budget due to recruiting delays, and as a result NeHTA has had to look offshore to fill the resource gap. The review also called for closer consultation with stakeholders. Health industry professionals and the IT industry described NeHTA's engagement style as "dogmatic".

The Portfolio Budget Statement, Outcome 10 says: *“In 2008-09, the Australian Government, through the Department, will work with the states and territories, professional groups and consumers, to address the aspects of e-Health requiring national leadership and coordination. This includes the development of a national e-Health strategy. The Department will specifically oversee the development of national standards to enable compatibility of e-Health systems across the national health network and ensure these standards align with national e-Health policy. The Department is working to ensure health systems are interoperable, and can safely and securely exchange electronic health information between health professionals with patients’ permission. The Government will consult with medical groups, the software industry, other professions and the community to ensure the needs of all are taken into account and the benefits of e-Health are communicated.”* This seems to suggest that national coordination of e-health initiatives will be pulled back from NeHTA and run by the Government.

The budget makes savings of **\$110.7 million / 4 years** in the GP incentive payment for e-health, and a single new incentive payment will be introduced in August 2009 to encourage GPs to develop the capacity to exchange information and promote the use of electronic decision support systems. The new payment will be at the rate of \$6.50 / patient with payments capped at \$50,000 per practice per year. This represents 7,692 patients; the annual patient load of a full-time GP is usually estimated at around 7,500.

Further savings of **\$10.5 million** are made by abolishing the e-health component of eCommunities.

Quality and safety

In March 2008 the Australian Health Ministers’ Advisory Council approved the 3 year work plan for the Australian Commission on Safety and Quality in Health Care to lead and coordinate national improvements in safety and quality in health care across all health care settings. The budget has funds of **\$15.9 million** for 2008-09 for these activities, which includes \$4.9 million already at hand, presumably unspent from the \$17.8 million budget provided in 2007-08.

Biomedical research

While there are funds in the budget for research infrastructure, the only new research funding is **\$15 million / 3 years** for additional independent clinical trials of drugs and research into cancer treatment.

The NHMRC will have an administered appropriation of **\$621.7 million** in 2008-09. This includes non research funding of \$3.8 million for the National Institute of Clinical Studies. This is an increase of \$123 million from 2007-08.

Hearing loss

The Government's election commitment to a Hearing Loss Prevention Program received no funds in this budget. The Portfolio Budget Statement for Outcome 7 states that:

“The Australian Government will increase prevention efforts by establishing a Hearing Loss Prevention Program to conduct targeted research and implement prevention programs. The program will have a particular focus on Indigenous Australians, young people and those in the workplace. Throughout 2008-09, to ensure there is an appropriate evidence-base for prevention activities, the Department will initially focus on commissioning research that addresses critical gaps in knowledge. A key challenge in implementing this initiative is identifying the areas of greatest need within target groups. Once these needs have been identified by consultation with experts, the Department will use this information to procure relevant research and prevention activities.”