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Commonwealth Government Health Budget Bulletin November 2008: Addendum

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This is an addendum to the full MYEFO update of the Health Budget Bulletin - November 2008 which was released to our subscribers on 19 November 2008. It is not to be used in any way without our express permission.

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The Health Budget Bulletin is prepared by the **Macroeconomics** *health team headed by Dr Lesley Russell (pictured below). The bulletins are published at least twice a year (approximately two weeks after the release of the Budget and the Mid Year Economic and Fiscal Outlook) along with supplementary features which are supplied as issues arise in the health portfolio. This addendum to the November 2008 Bulletin focuses on analysing the fiscal and policy impacts of the latest COAG Health agreement reached on 28 November 2008.*

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ADDENDUM TO MYEFO ANALYSIS 2008-09

Tracking COAG Health Funding

On 28 November 2008 the Commonwealth and State and Territory Governments finalised arrangements for the reformed Special Purpose Payments (SPP) framework including payments for health. The Communique from that COAG meeting can be found at **http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm**.

The announcements made on health care funding were more generous than I predicted in my MYEFO analysis. The states received a total **of $64.4 billion / 5 years** for the new AHCAs (now called the Healthcare SPP), which include funds for public health programs, including the delivery (but not the purchase) of vaccines. This funding includes an increase in indexation amounting to **$4.8 billion / 5 years** or 7.3 per annum, despite the fact that most forecasters consider a decline in producer prices a real possibility over the next 18 months.

Table 1 Changes in funding for Australian Health Care Agreements in MYEFO

Measure	2007-08*	2008-09	2009-10	2010-11	2011-22
Health SPPs ($m) from MYEFO #Apparently includes NPPs.		11,263	10,893*	11,552	11,837
Health payments in AHCAs ($m) from Budget.	11,378	11,209	11,773	12,356	12,671

* decline is due to reclassification of HSD ($597 million in 2008-09) to Commonwealth own expense from 1 July 2009.

it's not clear if these numbers differ from the Budget numbers solely because of increases in the cost of the HSD component. Based on MYEFO figures, this cost in 2008-09 is now $42.8m more than predicted in the Budget.

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The States and Territories also received **$2.798 billion** in additional payments for specific activities including health workforce training and preventive health. COAG also agreed to spending of **$1.578 billion** to improve Indigenous health and **$218 million** for e-health initiatives through NeHTA. In order to help track this new funding and how it relates to previous budget proposals, Tables 1 to 3 from our MYEFO analysis are updated here.

Table 2 Payments to support state health services, from MYEFO

Measure	2007-08*	2008-09	2009-10	2010-11	2011-22
AHCAs	$9,247.2m + $500m	$9,724.8m			
Public health and other grants	$234.5m	$239.9m			
AHCAS including public health and funding grants (National Healthcare SPP)	**$9,981.7m**	**$9,971.2m**	**$10,559**	**$11,139m**	**$11,742m**
Current NPPs	$119.3m	$52.4m	$69.0m^	$74.4m^	$77.6m^
NPPs from election commitments	$216.5m	$291.8m	$257.2m	$331.5m	$10.4m
Existing payments Vaccines HSD Other (organ transplants etc)	 $541.0m $513.4m $6.4m	 $350.1m $597.3m $6.8m	 $3.8m - $4.0m	 $3.8m - $3.9m	 $3.8m - $3.9m

^ this now includes $14 million in payments for Indigenous early childhood development

* from Budget papers – added for comparison.

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Table 3 Commonwealth spending on healthcare (from the COAG Communique)

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
Additional indexation Healthcare SPP ($m)	500.0	674.5	913.5	1,190.9	1,500.1	4,779.0
Hospital reform and workforce NPP*	536.5	166.1	294.9	379.8	375.7	1,753.0
Preventive health NPP	-	17.6	67.05	145.2	218.2	448.1
e-Health (NeHTA) NPP	-	28.7	39.2	41.0	-	108.9
Investment in EDs NPP	750	-	-	-	-	750
Total Healthcare NPPs ($m)	**1,286.5**	**212.4**	**401.2**	**566.0**	**593.9**	**3,059.9**

** this presumably represents spending on training and subacute beds, although there is a disparity between the total spending here and that outlined separately for these two initiatives. The additional $153 million provided here may represent some spending carried over from election commitments (eg transitional care beds).*

Analysis of new funds for health care

The 2003-08 AHCAs provided a total of **$42 billion / 5 years**.

On the basis of MYEFO (with assumptions made for spending in 2012-13), it was originally planned to give the States and Territories around **$60 billion**. In fact, they received **$64.4 billion / 5 years,** an increase of **$4.8 billion,** due to the increase in indexation from 5.3 per cent to 7.3 per cent.

Other funds from the Commonwealth:

- **$750 million** for Emergency Department (ED) services (in 2008-09);
- **1.1 billion** for health care training[1];
- **$500 million** for 1600 subacute beds;
- **$448 million** for preventive health measures [2];

[1] Plus a commitment from the States and Territories to spend $540 million

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- **806 million** to improve Indigenous health[3];
- **$109 million** to NeHTA 2009-10 to 2011-12.

Funding for Emergency Departments

The **$750 million** provided in 2008-09 is expected to fund the equivalent of **1.9 million** ED presentations and recognises that EDs are treating an increasing number of patients who could otherwise be treated in the primary care sector. It is assumed that implementation of proposed reforms in primary care and an increased roll-out of GP SuperClinics will help address this issue. The breakdown of this funding by state and territory is:

New South Wales	$248.6 million
Queensland	$146.7 million
Victoria	$181.3 million
Western Australia	$75.3 million
South Australia	$61.7 million
Tasmania	$16.6 million
Australian Capitol Territory	$10.0 million
Northern Territory	$9.8 million

The 2008-09 Budget provided $600 million over 2007-08 to 2010-11 to reduce elective surgery waiting lists. This measure is to be provided as **$150 million** for an immediate national blitz on waiting lists (this money has gone out), **$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. The COAG Communique does not spell out how the **$300 million** in incentive payments will be distributed.

[2] Over 4 years, starting 2009-10 and **$872 million / 6 years**.

[3] Over 4 years (plus $772 million from States and Territories).

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Funding for health workforce training

This is part of a total commitment of $1.6 billion for health workforce training (see footnote 1). The Commonwealth has committed to:

- **$500 million** for undergraduate clinical training, including increasing the clinical training subsidy to 30 per cent for all health undergraduate places;
- an increase of 605 postgraduate training places, including **$86 million** for 212 GP training places and 73 specialist training places in the private sector;
- funding of **$28 million** to train 18,000 nurse supervisors, 5,000 allied health and VET supervisors and 7,000 medical supervisors;
- **$175.6 million / 4 years** in capital infrastructure to expand teaching and training, especially at major regional hospitals; and
- **$264 million** for other initiatives to include the establishment of a National Workforce Agency.

Sub-acute beds

It is assumed that these are the same as transition care beds, although the costs appear higher. The Communique states that this $500 million (to be provided in 2008-09) will fund the equivalent of 1,600 sub-acute beds. It is possible that this is not all new money. The 2008-09 Budget provided **$293.2 million / 4 years** for an additional 2000 transition care beds. A report released in the first week in December from the Minister for Ageing, Justine Elliot, says that, to date, only 228 of these beds have been allocated.

Preventive health

The preventive health funding is **$448.1 million / 4 years** and $**872.1 million / 6 years**, commencing in 2009-10 and rolling out quite slowly in the initial years. The Communique outlines a number of elements that this funding could be spent on, but presumably details await the final report from the National Preventative Health Taskforce.

The Communique states that governments have specifically committed to:

- increase the proportion of adults and children with healthy body weight, reduce rates of obesity and avert new cases of diabetes in adults each year;
- increase the proportion of children and adults meeting national guidelines for physical activity and healthy eating; and

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- reduce the proportion of adults smoking daily.

Interestingly, no indicator for harmful drinking is included, even though the Government introduced a series of measures in 2008 intended to curb binge drinking. However, a series of long-term targets are included in the November 30 2008 media release issued by the Prime Minister Kevin Rudd and the Minister for Health Nicola Roxon, headed "Keeping people well and taking pressure off our Hospitals":

- reducing the hazardous consumption of alcohol;
- increasing the proportion of children and adults at a healthy body weight by 3 percentage points within 10 years; and
- reducing the daily smoking rate from 16.6 per cent to 10 per cent within 10 years.

Other long-term targets drawn from the discussion paper "Australia: the healthiest country by 2020" released by the National Preventative Health Taskforce in October 2008 for

2020 include:

- halting and reversing the rise in overweight and obesity;
- reducing the prevalence of daily smoking to 9 per cent or less; and
- reducing the prevalence of harmful drinking for all Australians by 30 percent.

It is not clear why the targets for 2018 and 2020 are so different. Nor is it apparent why COAG can set targets for healthy body weight when the NPHT can't and is unwilling to accept a target for the harmful consumption of alcohol.

It is also not clear how the new funding arrangements with the States and Territories for public health activities such as breast cancer screening and HIV/AIDS, previously funded under the PHOFAs, allow for program expansion and the associated funding increases.

Accountability and better performance reporting

The Commonwealth and the States and Territories have also agreed to a range of objectives and outcomes for the health and hospital system, and the Commonwealth and the States have also agreed to report against a number of performance measures to address these outcomes. The Minister's office has released a list of 68 performance indicators for government reporting under a new national performance scorecard scheme.

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These indicators are largely based on the performance indicator set developed by the Australian Institute of Health and Welfare, rather than the 41 performance benchmarks put forward by the National Health and Hospitals Reform Commission in their April 2008 report "Beyond the Blame Game: accountability and performance benchmarks for the next Australian Health Care Agreements".

However there are some interesting differences and omissions:

Take for example discharge planning, the hand-over of care when patients leave hospital.

- The AIHW also has three PIs in this area (#29 is about the proportion of discharge summaries transmitted electronically within 1 day of discharge; #30 is about discharge plans for complex care needs within 5 days of discharge; #32 is about post-discharge community care for mental health patients).
- The NHHRC has three PIs relating to this (4.4 and 4.5 are about patient referral to primary care and/or public mental health service providers following discharge; 11.2 is about the proportion of discharge summaries that are provided electronically).

The COAG PIs contain no indicators relating to this issue, despite the fact that it is recognised as a problematic area where communication often goes awry and patients and their GPs are left without adequate information. This may be related to the fact that there are no indicators in the COAG agreement set related to e-health performance.

The COAG Reform Council will report progress against these performance measures annually, commencing in 2009-10.

The Commonwealth and the States and Territories have also agreed to provide a basis for more efficient use of taxpayer funding of hospitals, and for increased transparency in the use of those funds through the introduction of Activity Based Funding. This will allow for comparisons of efficiency across public hospitals.

e-health

COAG has committed an additional **$218 million** to the NeHTA (50:50 cost shared between the Commonwealth and the States and Territories) for the period July 2009 - June 2012.

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The last meeting of Australian Health Ministers Council held on 5 December 2008, announced that ministers had reached agreement on a national plan to share patients' e-health records. This additional funding comes at the same time a report commissioned from Boz and Co by the NHHRC slammed the "scatter-gun" spending of almost **$1.3 billion** on state-based e-health schemes.

Indigenous health

COAG has made a commitment of almost $**1.6 billion** to "closing the gap" in Indigenous health. This is made up of **$806 million** from the Commonwealth and **$772 million** from the States and Territories.

The Communique states that the Indigenous Health funding will lead to:

- reduced smoking rates among Aboriginal and Torres Strait Islander peoples;
- reduced burden of diseases for Aboriginal and Torres Strait Islander communities;
- increased uptake of Medicare Benefits Schedule-funded primary care services to Indigenous people with half of the adult population (15-65 years) receiving two adult health checks over the next four years;
- significantly improved coordination of care across the care continuum; and
- over time, a reduction in the average length of hospital stay and reduction in re-admissions.

The expectation is that over a five-year period, around 55 per cent of the adult Indigenous population (around 155,000 people) will receive a health check with about 600,000 chronic disease services delivered. More than 90,000 Indigenous people with a chronic disease will be provided with a self-management program, and around 74,500 Indigenous people will receive financial assistance to improve access to Pharmaceutical Benefits Scheme medicines.

The Commonwealth funds will be allocated as follows:

- **$470 million** to improve chronic disease management;
- **$171 million** to increase the capacity of the primary care workforce to care for Indigenous Australians with chronic diseases; and
- **$161 million** to tackle key risk factors for chronic diseases in the Indigenous community, like smoking.

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The State and Territory funding will provide additional resources for tackling smoking, expanding allied health and other state government funded services, and introducing strategies to improve care provided to Indigenous people in public hospitals. This year COAG has agreed to initiatives for Indigenous Australians of $4.6 billion across early childhood development, health, housing, economic development and remote service delivery.

Reforming funding and service delivery between governments

Perhaps the most historic element of the new Health agreements is not the funding itself but the change to the payment structure. As the Communique states:

> *"COAG agreed to consider in 2009 an ambitious program of reforms to roles and responsibilities for funding and delivery of services to the community. The goals of such reforms will be to deliver more integrated and responsive services for individuals and families, to clarify accountabilities between governments and to improve performance of service systems. COAG requested officials to bring back specific proposals in relation to community mental health, disability services and aged care in the first half of 2009 as part of this program."*

The new payment structure transfers all funding and transfers responsibilities to the Treasuries, while line agencies must focus on policy reviews and development. Only time will tell whether these changes result in more focused and efficient management of Commonwealth-State financial arrangements and promote improved service delivery.

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