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# Commonwealth Government Health Budget & Reform Commission Bulletin July 2009

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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 (coinciding with 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 Bulletin does not analyse the aged care and sport and recreation provisions of the Budget. Indigenous health provisions in the Budget are analysed in a separate bulletin.*



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## Table of Contents

<b>IN THIS BULLETIN.....</b>	<b>9</b>
<b>1 NHHRC REPORT – TIME FOR ACTION.....</b>	<b>12</b>
1.1 Introduction.....	12
1.2 Opportunity knocks – is anyone listening?.....	12
1.3 Lessons to Learn from US reform.....	13
1.4 The buck stops here... ..	14
<b>2 HEALTH CARE BUDGET PROVISIONS .....</b>	<b>15</b>
2.1 Background.....	15
2.2 COAG Commitments.....	15
<b>3 WORKFORCE .....</b>	<b>16</b>
3.1 Improving maternity services packages .....	18
3.2 Medicare Benefits Schedule – nurse practitioner workforce – expansion.....	20
3.3 Divisions of General Practice program – new funding formula.....	20
3.4 Prevocational training for doctors in general practice .....	21
3.5 General practice training – consolidating regional training providers – further efficiency .....	22
3.6 General practice training – extension of time for rural placements.....	23
3.7 Practice Incentive Payments – quality and administrative improvements – further efficiency .....	23
3.8 Nursing education and recruitment – further efficiency.....	24
3.9 Workforce program – realising efficiency savings from consolidation .....	24
3.10 Support for specialists to re-enter the workforce – cessation.....	25



3.11	Public Health Education and Research Program – discontinuation .....	25
<b>4</b>	<b>INFRASTRUCTURE .....</b>	<b>27</b>
4.1	Health and Hospitals Fund – hospital infrastructure and other projects .....	28
4.2	Health and Hospitals Fund – translational research and workforce training .....	34
4.3	Health infrastructure projects in Tasmania .....	35
4.4	Health and Hospitals Fund – national cancer statement.....	36
4.5	Health and hospital reform – establishment of the National Institute for Virology .....	36
<b>5</b>	<b>RURAL HEALTH .....</b>	<b>37</b>
5.1	Rural Health Workforce Strategy .....	39
5.2	Rural Health Workforce – maintaining rural multidisciplinary care .....	40
<b>6</b>	<b>ACCESS TO MEDICINES .....</b>	<b>42</b>
6.1	Breast cancer program – continuation of funding for the Herceptin program.....	43
6.2	Pharmaceuticals Benefits Scheme – enhancements to the National Prescribing Service .....	44
6.3	National Return and Disposal of Unwanted Medicines program – additional funding .....	45
6.4	Pharmaceutical Benefits Scheme – chemotherapy drugs – delayed implementation of more efficient program.....	45
6.5	Pharmaceutical Benefits Scheme – extending the therapeutic group premium policy .....	46
6.6	Pharmaceutical Benefits Scheme – extending the PBS reference pricing policies to all non-exempt pharmaceutical items .....	46
6.7	Pharmaceutical Benefits Scheme – increased uptake of PBS Online .....	47
6.8	Pharmaceutical Benefits Scheme – interim increase in the handling fees under Section 100 Remote Aboriginal Health Service Program .....	48



6.9	Epidermolysis bullosa – national dressing scheme .....	48
<b>7</b>	<b>INDIGENOUS HEALTH .....</b>	<b>49</b>
7.1	COAG commitments – National Partnership on Closing the Gap in Indigenous Health Outcomes .....	52
7.2	Closing the Gap – NTER – Indigenous health and related services.....	53
7.3	Closing the Gap – expanding link-up services for the Stolen Generation.....	54
7.4	Closing the Gap – Indigenous dental services in rural and regional areas .....	55
7.5	Closing the Gap – Improving eye and ear health services for Indigenous Australians.....	56
7.6	Closing the Gap – quality assurance for the Aboriginal and Torres Strait Islander Medical Services pathology program.....	57
7.7	Indigenous access to health care services – further efficiency .....	58
7.8	Shared Responsibility and Regional Partnership Agreements.....	59
7.9	Reduction of the business management training initiative – further efficiency.....	59
<b>8</b>	<b>MEDICARE COSTS .....</b>	<b>61</b>
8.1	Medicare Benefits Schedule – capping Extended Medicare Safety Net benefits for items with excessive fees.....	63
8.2	Medicare Benefits Schedule – capping Extended Medicare Safety Net benefits for items with excessive fees – obstetrics services .....	64
8.3	Medicare Benefits Schedule – ensuring the appropriate use of clinical procedures and adjusting to modern technologies.....	65
8.4	Medicare Benefits Schedule – new and revised listings .....	65
8.5	Medicare Benefits Schedule – reversal of proposal to fund magnetic resonance imaging scans of the knee or brain – further efficiency .....	66
8.6	Medicare Benefits Schedule – a quality framework for reviewing services.....	66



<b>9</b>	<b>CANCER SERVICES .....</b>	<b>67</b>
9.1	Cancer Australia – improved lung cancer data and treatment guidelines.....	69
9.2	World Class Cancer Care – Building Cancer Support Networks program – continuing funding.....	69
9.3	World Class Cancer Care – Building Cancer Support Networks program – continuing funding.....	70
9.4	World Class Cancer Care – cancer data to improve cancer survival.....	70
9.5	Radiation Oncology – national radiotherapy single machine trial – discontinuation.....	70
<b>10</b>	<b>PATHOLOGY AND DIAGNOSTIC IMAGING .....</b>	<b>72</b>
10.1	Medicare Benefits Schedule – diagnostic and pathology services.....	74
10.2	Medicare Benefits Schedule – access to PET services provided at Westmead and Royal North Shore Hospitals and Austin Health Services.....	77
10.3	Magnetic Resonance Imaging – transitional funding for Gippsland and South Eastern NSW Mobile unit.....	78
10.4	Magnetic Resonance Imaging unit in north-west Tasmania – redirection of funding .....	78
<b>11</b>	<b>PREVENTATIVE HEALTH.....</b>	<b>79</b>
11.1	COAG Communiqué February 2006.....	79
11.2	Australian Better Health Initiative – further efficiency .....	80
11.3	Australian Better Health Initiative – cease promotional activities for 45-year old health check .....	81
11.4	Australian Better Health Initiative – promoting health lifestyles – further efficiency.....	82
11.5	Grants for physical activity projects in the community – discontinuation .....	83
11.6	Investment in Preventative Health (Environmental Health) program – further efficiency .....	83



11.7	Primary care – Sharing Health Care Initiative – further efficiency .....	84
<b>12</b>	<b>PRIVATE HEALTH INSURANCE .....</b>	<b>86</b>
12.1	Private health insurance – fair and sustainable support for the future .....	87
12.2	Private health insurance – transparent premium setting .....	88
12.3	Medibank Private – change in status .....	88
12.4	Regulatory changes .....	89
<b>13</b>	<b>MENTAL HEALTH .....</b>	<b>90</b>
13.1	Leadership in mental health reform – continuation and further efficiency .....	90
13.2	Medicare Benefits Schedule – Better Access Initiative – continuing professional development .....	91
13.3	Medicare Benefits Schedule – Better Access Initiative – improved targeting for the most in need and better quality of services .....	91
13.4	Mental health – continuation of existing services in rural and remote areas .....	92
13.5	Mental health – continuation of Mental Health Support for Drought-Affected Communities program .....	92
<b>14</b>	<b>E-HEALTH .....</b>	<b>94</b>
14.1	e-Health – electronic clinical information and communication for north-west Tasmania .....	94
14.2	e-Health program – further efficiency .....	95
<b>15</b>	<b>OTHER HEALTH MEASURES .....</b>	<b>96</b>
15.1	Hospital Accountability and Performance Program – continuation .....	96
15.2	Hearing services – introduction of hearing threshold .....	97
15.3	National Illicit Drug Strategy – a more strategic approach .....	97
15.4	Stoma Appliance Scheme – implementing a new program approach .....	97



15.5	Support for diabetes – remove duplication in research effort.....	98
15.6	Torres Strait health protection .....	99
<b>16</b>	<b>AGED CARE.....</b>	<b>100</b>
16.1	Aged care viability supplements – increase .....	100
16.2	National Palliative Care Strategy – continuation of funding .....	101
16.3	Prudential regulation of aged care providers – not to proceed with cost recovery ....	102
16.4	Assistive technology in community care – discontinuation.....	102
16.5	Continence Aids Payment Scheme – more choice for users .....	103
16.6	Fairer income testing in residential aged care – ending the 28-day income test exemption .....	104
<b>17</b>	<b>OTHER PORTFOLIOS.....</b>	<b>105</b>
17.1	Department of Finance and Regulation.....	105
17.2	Australian Taxation Office .....	105
17.3	Department of Education, Employment and Workplace Relations .....	105
17.4	Department of Human Services.....	106
17.5	Department of Innovation, Industry, Science and Research .....	106
17.6	Treasury .....	107
17.7	Department of Veterans' Affairs.....	107



## In this Bulletin...

This Budget was always going to be cast in the shadow of the global financial crisis but the real shadow came from what was at Budget time the impending report of the National Health and Hospitals Reform Commission (NHHRC) released finally this week.

On the upside, the NHHRC report provides the Rudd Government with a reform blueprint it can own and use to steer the reform debate. On the downside, haven't we heard it all before, and when will action finally be taken to address the problems and inefficiencies and poor outcomes that have been catalogued for more than a decade? It looks like we will have to endure another listening tour and another election before concrete policy will be put in place to address these age-old issues.

The tone for this Health Budget, on the other hand, was set very much by the short to medium term exigencies of the global financial crisis. This always meant that the 2009-10 Budget was going to be more about targeted new spending and lots of budget cuts in current programs.

But such times can offer a unique opportunity to refocus and recast old policies and spending to achieve better value and better outcomes – and the drive to do this has never been greater.

The Rudd Government has yet to deliver on the substantial reforms promised to tackle the prevention and better management of chronic diseases, to provide the outreach, team work and coordination that is needed to ensure physical and mental health and wellbeing, and to address the inequalities and inequities that are inherent in the current system.

However this year an examination of the Health Budget shows that this opportunity has been missed. The bean counters clearly won out over the policy wonks, and to the extent that new policy is made, it seems that this was done by Finance and Treasury, not Health.

This is demonstrated most obviously in the proposal to means test the private health insurance rebate, which is arguably the biggest policy change in the Budget. While this measure was aimed at reigning in expenditure, which now is almost \$4 billion annually, increasing the Medicare levy surcharge to help persuade higher income earners to continue to purchase private health cover takes steps (deliberately or inadvertently) towards new policy about the role of the private system in health care. In effect, this proposal presages the Government's response to the financing reform recommendations that are included in the report from the NHHRC.



And there are more reports on health reform from advisory bodies due within the next few months. However there are no measures in the Budget to provide the resources that will be needed to facilitate analysis and implementation of the recommendations from the reports from the NHHRC, the National Preventative Health Taskforce, and the National Primary Health Care Strategy External Reference Group.

The Budget does have some welcome new spending, most notably on infrastructure for health services and research (albeit without the recurrent costs that will also be needed), the provision of new maternity services led by midwives, and to allow nurse practitioners access to Medicare items and prescribing rights.

There is \$232 million for initiatives to help close the gap in Indigenous health, although the majority of these funds will go to the Northern Territory. Despite the huge unmet need, Indigenous health programs are not immune from budget cuts, losing \$25 million.

The total spending in health over the five years 2008-09 to 2012-13 is \$4.7 billion. This includes spending on Indigenous health but does not include aged care or sport and recreation. New spending, \$3.0 billion of which is from the Health and Hospitals Fund for infrastructure, is off-set by savings totalling \$3.3 billion.

Analysing the 2009-10 Health Budget and tracking the funding commitments is a particularly difficult exercise this year. The Budget Papers and Portfolio Budget Statements provide a lot of information, but nowhere is there a statement about the total amount of new spending or the total savings made from current programs. Funding commitments are bolstered by constant references to funding already provided through the Council of Australian Governments (COAG) and to funding commitments that extend well beyond the forward estimates.

Last year the raft of budget cuts were gathered together under the rubric of 'responsible economic management'. This year the euphemisms are about 'modernising Medicare', 'improved targeting' or 'further efficiencies'.

Substantial new spending was never a realistic possibility for this Budget, and in many ways, the Health Budget is better than might have been predicted on the basis of new funding commitments.

However the failure of this Budget to link the need make savings to health policy reforms – for example, not to just redress the blow-outs in the cost of the Medicare safety net and the



Better Access mental health program but to improve the functioning of these programs and the health of patients – means that inevitably it must be judged harshly.

At budget time next year, with an election looming and the pile of health reform report growing, the Rudd Government may lament this wasted opportunity.



## 1 NHHRC Report – time for action

### 1.1 Introduction

What does the final report from the National Health and Hospitals Reform Commission (NHHRC) tell us that we didn't already know? What does the report recommend that has not already been discussed? The Government waited for this report for 18 months, only to tell Australia that key decisions on health care reform will not be made until next year.

We have known for years that more needs to be done in preventive health and improving access to primary care, e-health records are necessary to prevent errors and duplication, dental services are unaffordable for many Australians, tackling medical errors saves lives and money, and different funding responsibilities will improve the integration of acute and community care services.

### 1.2 Opportunity knocks – is anyone listening?

Now we have one more report on these issues. Taking the positive approach, it's useful to have an up-to-date analysis in a report that the new government can own, and hopefully this will serve as a common rallying point for moving forward. However, on the negative side of the ledger, a signal has already been sent by the government that health reform is not on the fast track, and by design, this report has managed to avoid a key issue in health reform – the role of private health insurance and government support for that role. It also barely tackles a second key issue – the rapid growth in patients' out-of-pocket costs - which affects affordable and equitable access to care.

In comparison to the US, Australia can tackle the reforms needed to give the nation the health care system it needs for the 21st century with some considerable tools already at hand:

- Australia has universal health cover and a national health care system (Medicare) that facilitates the management of costs and services.
- Most Australians have a regular practitioner who can serve as the coordinator of their health care services – the 'medical home' that has been shown to be essential for integrated care, access to screening services, and addressing health inequalities. The Divisions of General Practice can also serve as the basis for 'accountable care organisations', which take responsibility for the delivery and quality of patients' health care services. In the US, health care reform legislation



must build these primary care structures from a very small base, with a major shortage of primary care health workers.

- Australia has integrated cost-benefit analysis into its procedures for assessing what pharmaceutical benefits should be available and to some extent, what medical benefits should be covered. In the US, the term 'cost effectiveness' cannot be used without raising the spectre of the government intervening between the doctor and the patient.
- Australia has done lots of pilot studies, some of which have demonstrated very clearly approaches that will improve health care services. For example, several studies conducted in Australia in 1998 and 1999 showed that multidisciplinary, home-based interventions using nurses decreased the frequency of unplanned readmissions and out-of-hospital deaths in older patients with various chronic illnesses and was particularly cost-effective among high-risk patients with heart failure. This useful information has languished in the archives of the journals in which it was published – it's time to dig it out and use it.

### 1.3 Lessons to Learn from US reform

The US has a different arsenal of innovative tools to help drive health reform, and Australia could adopt some of these now, without any further delays:

- The US has better (and independent) data collection, analysis and public reporting systems. These include statewide systems that report medical problems in hospitals, and a national system of registration for doctors that must be checked at the time of employment. The new health care reform legislation will require mandatory reporting by doctors of relationships with pharmaceutical and device manufacturers and financial interests in hospitals, and by hospitals and ambulatory surgical centres on health care associated infections. The House bill establishes a national medical device registry to facilitate post-marketing analysis of safety and effectiveness, and a new position of Assistant Secretary for Health Information.
- The US has committed to substantial investments in public health, with funding support for the establishment of a public health workforce corps, training programs, research and infrastructure, seeing this as a required foundation for better preventive and primary care.



- Health care funders and providers are already well down the road towards recognition that fee-for-service rewards activity and not outcomes. The best examples of quality care in the US are in places like Rochester, Minnesota, Grand Junction, Colorado, Seattle, Washington, or Durham, North Carolina - all of which have world-class hospitals and costs that fall below the national average. In these communities doctors are financially rewarded for totality of the care they deliver and the health outcomes that result. And perhaps more importantly, this is the accepted and prevailing culture among health care workers and their patients.
- Studies have shown that the care for patients in the highest-cost regions of the US tends to be very fragmented, with considerably more diagnostic tests, hospital admissions, operations, and specialist visits, but less low-cost preventive services and primary care, and equal or worse survival, functional ability, and satisfaction with care. That is also a lesson that applies in Australia, albeit in slightly different ways.

#### 1.4 The buck stops here...

The Prime Minister Kevin Rudd and Minister for Health, Nicola Roxon now have a choice – to move forward and use the NHHRC report and its findings to strengthen their hands against those who would oppose their actions, or to prevaricate and hide behind the options the report puts forward. Initiatives of the type outlined above and many of the important recommendations from the NHHRC report do not require a major restructure of the relationships between the commonwealth and state and territory governments, and they should not be held hostage to COAG agreements.

Health care reform is not easy. Just ask President Obama. But doing nothing is not an option, and tomorrow is not too early to start on implementation.



## 2 Health Care Budget Provisions

### 2.1 Background

The total spending in health over the five years 2008-09 to 2012-13 is **\$4.7 billion**. This includes spending on Indigenous health but does not include aged care or sport and recreation. New spending, **\$3.0 billion** of which is from the Health and Hospitals Fund for infrastructure, is off-set by savings totalling **\$3.3 billion**.

There is **\$232 million** to initiatives to help close the gap in Indigenous health, although the majority of these funds will go to the Northern Territory. Despite the huge unmet need, Indigenous health programs are not immune from budget cuts, losing **\$25 million**.

It should not go unnoticed that included in the Health Budget spending is **\$85 million / 4 years** to Medicare Australia, of which **\$51.4 million** is for management and administration costs and **\$33.6 million** is for related capital costs.

### 2.2 COAG Commitments

Central to the COAG reforms agreed to in 2008 were five new Specific Purpose Payments (SPPs), including a National Healthcare National Partnership (NP) with funding of **\$60.5 billion / 5 years** (this was increased to **\$64.4 billion** in November 2008). The new SPPs will be central to achieving delivery improvements and reforms.

New NP payments will be used by the Australian Government to fund specific projects and to facilitate and / or reward States that deliver on nationally significant reforms.

There are currently four NPs in health:

- Hospitals and Health Workforce Reform (**\$1.7 billion / 5 years**);
- Preventative Health (**\$448.1 billion / 4 years**);
- Taking Pressure off Public Hospitals (**\$750 million in 2008-09**);
- Indigenous Health (**\$1.6 billion / 4 years**).

Some documents also include the e-health NP with federal funding of **\$108.9 million / 3 years**.

These NPs were effective 1 January 2009.



### 3 Workforce

According to the 2009–10 Budget Papers, the Government has developed an agenda for reform which will make the health system '*more responsive, coherent and efficient*' by using the skills of all health workers better.

However despite this claim, the Budget is a mixed bag as far as workforce is concerned. While there are some workforce innovations in the Budget, many of the measures announced are about rearranging or continuing with current programs. Overall this Budget spends **\$396.7 million / 4 years** on workforce provisions, but at the same time makes savings of **\$75.4 million**.

There is funding for two innovative initiatives - expanding the role of nurse practitioners in the delivery of health care by providing them with access to the MBS and PBS, and expanding Medicare and indemnity support for midwives - along with continued funding at quite modest levels for the rural health workforce, and additional funds for prevocational training for GPs and for the Divisions of General Practice.

There is also some infrastructure funding that will support clinical education and training, primarily for new medical and dental schools.

There is what purports to be a new Rural Workforce Strategy but for the most part this is a continuation of renamed and, in some cases consolidated programs, with little or no increase in funding. The new geographical classifications system that will replace the current Rural, Remote and Metropolitan Areas (RRMA) classification and the boost in rural relocation payments for GPs will undoubtedly help some towns and regions that are currently struggling to recruit GPs, but any scheme that involves decisions made on the basis of boundaries will inevitably have winners and losers. The weakness of the new rural workforce strategy is that it is focused almost entirely on GPs.

It is disappointing to see the Public Health Education and Research Program (PHERP) summarily discontinued, apparently without any consideration of the recent review of public health research conducted by Professor Don Nutbeam, which remains, to the frustration of Nutbeam and many others, unreleased. Commissioning reviews and then ignoring them is no way to make evidence-based policy.

There is nothing to tackle continuing workforce problems in areas such as aged care nursing, mental health nursing, public dental services and specialist services outside



metropolitan areas, and indeed some programs in these areas have had budget cuts, without any effort to see if they could be improved or replaced with better programs.

**Table 1 Summary of workforce initiatives**

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
<b>Workforce – spending provisions</b>						
Prevocational training for GPs	-	\$8.9m	\$10.4m	\$10.5m	\$11.4m	\$41.2m
Expansion of MBS schedule to NPs	-	\$11.5m	\$13.2m	\$17.4m	\$17.6m	\$59.7m
New funding formula for DGP	-	\$1.9m	\$3.1m	\$2.6m	-	\$7.5m
Improving maternity services	-	\$14.2m	\$25.4m	\$30.5m	\$50.4m	\$120.5m
Rural health workforce strategy	-	\$26.7m	\$32.7m	\$35.0m	\$40.0m	\$134.4m
Rural multidisciplinary training	-	\$2.7m	\$2.7m	\$2.8m	\$2.8m	\$10.9m
Pathology and diagnostic imaging	-					\$22.5m
<i>Total spending</i>	-	<i>\$65.9m</i>	<i>\$87.5m</i>	<i>\$98.8m</i>	<i>\$122.2m</i>	<i>\$396.7m</i>
<b>Workforce – savings provisions</b>						
Nursing education and recruitment	-	-\$0.6m	-\$0.6m	-\$0.6m	-\$0.6m	-\$2.3m
Practice incentive payments	-	\$2.1m	\$0.6m	-\$13.7m	-\$14.8m	-\$25.8m
Support for specialists to re-enter workforce	-	-\$0.6m	-\$0.6m	-\$0.7m	-\$0.7m	-\$2.6m
GPET	-	-\$0.2m	-\$0.8m	-\$0.8m	-\$0.8m	-\$2.6m
GP training – rural placements	-	-	-\$0.2m	-\$0.3m	-\$0.3m	-\$0.8m
Consolidating regional training providers	-	-\$1.5m	-\$3.0m	-\$3.0m	-\$3.0m	-\$10.3m
Workforce program efficiency savings	-	-\$0.4m	-\$0.4m	-\$0.4m	-\$0.4m	-\$1.5m
Discontinuation of PHERP	-	-	-\$6.6m	-\$11.3m	-\$11.5m	-\$29.5m
<i>Total cuts</i>	-	<i>-\$1.3m</i>	<i>-\$11.6m</i>	<i>-\$30.7m</i>	<i>-\$32.1m</i>	<i>-\$75.4m</i>



### 3.1 Improving maternity services packages

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$8.8m	\$24.7m	\$29.7m	\$49.5m	\$112.7m
Medicare Australia	-	\$2.4m +\$3.1m*	\$0.7m	\$0.8m	\$0.9m	\$7.9m
<i>Total</i>	-	\$14.3m	\$25.4m	\$30.5m	\$50.5m	\$120.5m

\* Related capital costs

This innovative initiative responds in a timely fashion to the recommendations of the recent report on maternity services from the Commonwealth Chief Nursing and Midwifery Officer. The Government has committed \$120.5 million / 4 years for the introduction of Medicare-supported midwifery services and other measures to provide women with greater choice of care during pregnancy, birthing and post-partum.

The Budget Papers and accompanying media release provide some outline of the measures that will be included in this package, but much detail is lacking and presumably remains to be worked out. Full implementation will not begin until November 2010.

The package includes:

- Access to MBS and PBS benefits for services provided by eligible midwives working in collaboration with doctors.
- A Government-supported professional indemnity insurance scheme for eligible midwives.
- An expansion of the Medical Specialist Outreach Assistance Program (MSOAP) to provide integrated teams that will include midwives, obstetricians, GPs, paediatricians, Allied Health Workers (AHWs) to under-serviced areas.
- Extra scholarships for GPs and midwives to expand the maternity workforce, especially in rural and remote areas.
- Professional development programs for midwives and to encourage GPs to undertake additional training in obstetrics and anaesthesiology.
- A new 24/7 telephone helpline and information services to provide information and support before and after birth.
- The development of a quality and safety framework, professional guidelines and advanced midwifery credentialing.



There is also a commitment to agreement with the States and Territories on a National Maternity Services Plan.

The main thrust of this initiative is that midwives will now be able to work as private practitioners (something previously limited in large part by the difficulty in obtaining professional indemnity cover), have their services subsidised by the MBS and prescribe medications under the PBS.

There are limitations imposed in that the Budget Papers refer to 'eligible' midwives (presumably those with agreed post-graduate qualifications and experience) and the services must be carried out in 'collaborative arrangements' with hospitals, healthcare settings and doctors. It's not clear how easy it will be for midwives to meet these criteria and how cooperative doctors, in particular, will be. It's also not clear how many midwives currently forced to work in salaried positions in hospitals and birthing centres will be attracted away from this sector into private work: this could impact adversely on publicly funded maternity services.

The expansion of MSOAP requires that there is spare capacity for maternity care health professionals to do this work and that they are willing to work together in the proposed integrated teams.

It is interesting to speculate whether the proposed 24/7 hotline represents a reworking of the controversial and under-utilised Pregnancy Counselling Hotline.

These provisions alone will not be sufficient to address the current problems in the availability (and affordability) of maternity services, many of which relate to over-stretched public hospital facilities. The development of a quality and safety framework will help here, along with national agreed guidelines for risk management (See [http://www.menzieshealthpolicy.edu.au/MCHP\\_V3/site/other%20tops/Position%20paper%20%20Reforming%20maternity%20service%20in%20Australia.pdf](http://www.menzieshealthpolicy.edu.au/MCHP_V3/site/other%20tops/Position%20paper%20%20Reforming%20maternity%20service%20in%20Australia.pdf)).



### 3.2 Medicare Benefits Schedule – nurse practitioner workforce – expansion

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$1.5m	\$10.8m	\$16.8m	\$16.9m	\$46.0m
Medicare Australia	-	\$8.9m +\$1.0m*	\$2.1m +\$0.3m*	\$0.6m	\$0.6m	\$13.5m
<i>Total</i>	-	\$11.5m	\$13.2m	\$17.4m	\$17.5m	\$59.7m

The provision will help provide for the development of a model for the more effective use of nurse practitioners in the health workforce by expanding their role and allowing them access to the MBS and the PBS from November 2010. This should help with workforce issues in rural and remote areas.

This measure has been criticised by the Royal Australian College of General Practitioners which has argued that, unlike funding for practice nurses, the funding provided to support the expansion of the role of specialist nurse practitioners does not meet the workforce needs of GPs, presumably because nurse practitioners work in independent practice and are not supervised by medical practitioners. This type of criticism highlights how difficult it is to implement new workforce programs with new roles for the various professions.

Measures like this also give some indication of the high cost of administration of Medicare and the PBS by Medicare Australia. In this case Medicare Australia gets 27 per cent of the program funding.

### 3.3 Divisions of General Practice program – new funding formula

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$1.9m	\$3.1m	\$2.6m	-	\$7.6m
Current funding*	\$79.5m	\$81.2m	\$82.7m	-	-	

\* from 2007-08 budget

This additional funding will go, via a new funding formula based on the new classification system for remoteness areas, to those DGPs where there has been significant population growth. Longer term funding arrangements are to be considered prior to the expiry of the current new funding agreements on 30 June 2012.



It appears that no provision has been made for the funding of Divisions from January to June 2012.

### 3.4 Prevocational training for doctors in general practice

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	\$8.9m	\$10.4m	\$10.5m	\$11.4m	\$41.2m

This funding will provide 160 additional places / 4 years in the Prevocational General Practice Placement Program (PGPPP), bringing the total number of annual places in 2012-2013 to 410.

This program provides voluntary general practice placements for junior doctors undertaking hospital training but not yet enrolled in a speciality as a way of encouraging them to become GPs. Interns and international medical graduates are also able to participate in this program, which currently provides up to 280 placements annually. The program is currently managed by the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners.

A separate provision in the Budget makes savings of \$2.6 million / 4 years in this program by transferring its administration to General Practice Education and Training (GPET).

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.2m	-\$0.8m	-\$0.8m	-\$0.8m	-\$2.6m

A national internal evaluation of the PGPPP was undertaken in 2007. The evaluation covered outer urban, regional, rural and remote placements undertaken by junior doctors in the PGPPP from January 2005 to June 2007. During this time there were 244 placements, 75 per cent in rural and remote areas.

These data, admittedly now several years old, suggest that this program is not currently operating at maximum capacity. It is not clear how moving this to GPET will save funds.



### 3.5 General practice training – consolidating regional training providers – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$1.5m	-\$3.0m	-\$3.0m	-\$3.0m	-\$10.4m

The Australian General Practice Training Program (AGPT) is managed by General Practice Education and Training Limited (GPET), set up in 2001, on behalf of the Australian Government. The vocational endpoints of training are Fellowship of the Australian College of Rural and Remote Medicine and Fellowship of the Royal Australian College of General Practitioners, either of which is required for vocational recognition under the *Health Insurance Act*.

GPET has a regionalised system of general practice education and training, currently delivered through 20 regional training providers (RTPs) across Australia, which promotes horizontal and vertical integration of general practice education and training. The RTPs are distributed as follows:

- NSW – 9
- Northern Territory – 1
- Queensland – 3
- South Australia – 3
- Tasmania – 1
- Western Australia – 1
- Victoria 2

It is not clear if any of these can be consolidated without inconvenience and increased travel requirements for GPs in training.



### 3.6 General practice training – extension of time for rural placements

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$0.2m	-\$0.3m	-\$0.3m	-\$0.8m

This measure will extend the time of a rural placement for trainee GP specialists from six to 12 months. The rationale given is that this will ensure greater medical continuity in the community. The savings are made by a (presumed) reduction in the number of relocation subsidies paid under the program. It is not clear if a 12 month rural placement now becomes mandatory or is optional.

### 3.7 Practice Incentive Payments – quality and administrative improvements – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$4.9m	-\$1.3m	-\$14.1m	-\$15.2m	-\$35.5m
Medicare Australia	-	\$2.3m +\$4.7m*	\$0.7m +\$1.2m*	\$0.4m	\$0.3m	\$9.6m
<i>Total</i>	-	-\$2.1m	\$0.6m	-\$13.7m	-\$14.9m	-\$25.8m

\* related capital costs

These changes are described as improving quality and safety and simplifying administrative changes, although establishing how these aims will be achieved is not easy from the information provided in the Budget Papers.

For example, the simplification of administration is achieved only at a cost of \$9.6 million to Medicare Australia.

The provision that will require non-accredited practices to adhere to proper vaccine storage and handling processes is important for quality and safety, but only achieves savings if a reasonable proportion of the 750 practices no longer qualify for the GP Immunisation Incentive.

It is not clear how these new requirements for the payment of practice incentives will impact on GPs' red tape, paper work and cash flows.



### 3.8 Nursing education and recruitment – further efficiency

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.6m	-\$0.6m	-\$0.6m	-\$0.6m	-\$2.3m

Savings are made by consolidation of five existing programs:

- Bringing Nurses Back into the Workforce;
- Rural Nurse Initiative (Nurse Scholarship program);
- Retraining Scholarships for More Practice Nurses and Allied Workers in Metropolitan Areas;
- Additional Practice Nurses for Rural Australia: and
- The Mental Health Postgraduate Scholarship Scheme.

It would be an interesting exercise to see if this consolidation does indeed result in \$2.3 million in savings as a consequence of administrative efficiencies.

### 3.9 Workforce program – realising efficiency savings from consolidation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.4m	-\$0.4m	-\$0.4m	-\$0.4m	-\$1.5m

This is yet another Budget provision that aims to make savings by consolidation of programs. In this specific case, savings might actually result, but it is unlikely we will ever know the outcome.

Eighteen elements of the current workforce program will be consolidated into three sub-programs:

- Health Workforce Innovation and Reform;
- Medical Training and Supply; and
- Nursing and Allied Health Training and Supply.

These programs have an average funding of \$401.4million / year across the forward estimates.



### 3.10 Support for specialists to re-enter the workforce – cessation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-\$0.6m	-\$0.6m	-\$0.7m	-\$0.7m	\$2.6m

The Specialist Re-entry Program was established in 2003 as part of the Fairer Medicare package to provide support to assist medical practitioners to re-enter the workforce following career interruptions. Re-entering medical practitioners participating in this program are eligible for three months refresher support including a supported clinical placement (where this occurs in a private practice, services attract the Medicare rebate).

The Budget Papers state that the uptake of this program has been low (it has not been possible to find publicly available information about the uptake) and the program is no longer considered a cost-effective means of encouraging the re-entry of specialists into clinical practice.

### 3.11 Public Health Education and Research Program – discontinuation

	2008-09	2009-10	2010-11	2011-12	2012-13	Total
DoHA	-	-	-\$6.6m	-\$11.3m	-\$11.5m	-\$29.5m

The Public Health Education and Research Program (PHERP) aims to strengthen national capacity to educate and train Australia's public health workforce. PHERP assists tertiary institutions across Australia to offer a range of postgraduate public health education programs, including research training. The program has been reviewed several times, in 1999, 2005 and 2008.

The Budget Papers state that *'the most recent review of the program concluded that successive government investments have increased the public health workforce capacity to address population health issues.'*

Evidence to Senate Estimates indicates that cutting PHERP was purely a cost-saving measure that did not reflect the performance of the program or any review of research and education needs.

In response to the fact that the 2008 NHMRC Review of Public Health Funding in Australia (Nutbeam Review) has yet to be released, Professor Nutbeam took the unusual step of writing a public letter to the Minister (see

<http://blogs.crikey.com.au/croakey/2009/05/28/roxon-to-face-anger-over-blocked-public-health-report/> ). In that letter he said *'This Program [PHERP] was regularly*



*referred to in our consultations and in the Report as one of the factors that has supported success in public health research in Australia. We appear to be going backwards not forwards in response to the success of public health research in Australia.'*

**The rural health workforce provisions are analysed in Section 3: Rural Health.**

**The pathology and diagnostic imaging workforce provisions are analysed in Section 8: Pathology and Diagnostic Imaging.**