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Commonwealth Government Health Budget Bulletin June 2008

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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 have been analysed separately and will be released soon in a special supplement to this Bulletin.



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In this Bulletin..

The Rudd Government has two stated goals in health policy: to end the cost shifting and the blame game between the Commonwealth and the states and territories, and an increased focus on prevention and primary care in order to address the predicted impact of a growing burden of preventable chronic illness on acute care costs and resources. Good health policy is seen as part of good economic policy. The aim is to see measurable improvements in a range of health, economic and budget indicators over time. While it is too early to judge how successful the new Government has been in meeting these outcomes, it is possible to assess their actions and funding commitments to this point against the stated policy. .

The 2008-09 Budget has demonstrated the new Government's commitment to taking a leadership role in a partnership with the states and territories to address needed reforms in the provision of acute care services through public hospitals. Unfortunately, accompanying budget cuts mean less funding for mental health and primary care and there is little progress in the development of a national strategic approach to prevention and reforms in the funding and delivery of primary care.

While allowance should be made for consultative and review processes currently in train and the current restrictive budgetary climate, lack of action in these important areas calls into question the Government's commitments to make mental health and prevention central aspects of health care, the ability to sustain planned reforms in the acute care sector, and support for equity in the delivery of health care services.

New spending on prevention initiatives averages \$54 million a year and is a drop in the bucket against the annual direct and indirect costs of obesity and obesity-related diseases, smoking and alcohol abuse which total \$70 billion. Funding for mental health services has actually been cut, a move that appears in contradiction to the new Government's stated preference for dealing with the drivers of poverty and social and economic dislocation in the community.

In this Bulletin we provide some overall Budget context and analysis (including spending trends) and then focus on examining the impact of the Budget measures on health policy and programs.



Budget 2008-09: Overview & Commentary

The new Rudd Government has recognised the importance of good health to individual Australians and to underpinning participation and productivity in the economy and in society. It understands that a health system orientated towards prevention and primary care delivers better health outcomes for a lower cost than one which focuses on treating people only when they are ill. *“Keeping people well, in addition to treating and managing those who are ill, must become an express dual purpose of Australia’s health system. This objective needs to underpin both the Australian Health Care Agreements and Medicare.”*¹

The jury will be out for some time yet on how successfully the Government has been in translating these election commitments into policy and action.

Success will be judged in the following terms:

1. Whether a genuine brave attempt has been made to reform the health system based on the stated principles of the Government’s health policy.
2. Whether better health outcomes are being achieved for patients in terms of reducing the incidence/managing chronic diseases and better services are being provided to patients.
3. Whether improved economic and budget outcomes are being assisted through improved participation and productivity along and lower costs for government.
4. Whether cuts made in the health budget as part of ‘responsible economic management’ are being redirected to areas that deliver higher returns including those targeting primary care and prevention.

Future editions of the Bulletin will look to assess progress in these terms.

Highlight of the 2008-09 Health Budget is the obvious commitment, expressed in the funding provided, to a leadership role in the partnership with the states and territories to address the needed reforms in the provision of acute care services through public hospitals.

¹ Rudd & Roxon (2007). Fresh Ideas, Fresh Economy: Preventative health care for our families and our future economy, ALP policy document, June 2007.



Lowlights of the 2008-09 Health Budget is the lack of funding for mental health and preventive care and lack of progress in the development of public health and primary care policy. However, allowance must be made for the need to take note of the recommendations yet to come from a raft of commissions, advisory committees and taskforces, along with the self-imposed political imperative of responsible economic management.

1.1 Policy contained in the Budget

The largest new health spending initiative contained in the 2008-09 Budget relates to the period over the next 12 months, while funding and performance agreements for the new **Australian Health Care Agreements** are negotiated. The states and territories get an immediate boost of \$1 billion in additional funds for public hospitals, plus \$150 million to conduct an immediate national blitz to clear the backlog of people who have been waiting for elective surgery and \$142 million for improvements and upgrades in health care facilities and more advanced medical technologies such as magnetic resonance imaging (MRI) and positron emission tomography (PET) machines.

Over the four years 2008-09 to 2011-12, in addition to the funding provided through the Health Care Agreements, there will be a further \$247.5 million for health infrastructure and new technologies and \$150 million for hospital improvements such as new day care facilities that will help the states and territories continue to meet elective surgery waiting list reduction targets. There is \$300 million available for incentive payments to those states and territories which meet these targets.

Most importantly, the interest and the principal from the **Health and Hospitals Fund**, which has an initial allocation of \$10 billion, will finance health infrastructure and medical research so that these priorities do not need to compete with patient services for funding.

The **National Health and Hospitals Reform Commission** (NHHRC) has been established by the Government to *“provide advice on performance benchmarks and practical reforms in the Australian health system which could be implemented in both the short and long term.”* However the benefits of the reforms which the NHHRC will generate and this new funding will support will only fully eventuate when the Government also implements promised reforms in prevention and primary care.

There are major lessons to be learnt here from the United Kingdom, which has witnessed unprecedented levels of government investment in the National Health Service (an



increase of nearly 50 percent, more than £43 billion, since 2002). As a result of increased resources, the health of the population has improved, targets for increased numbers of procedures have been exceeded, and elective admissions and outpatient attendances have increased. The system has been able to cope with large increases in emergency presentations and care, and waiting times for inpatient and outpatient treatment have improved considerably.

However the expected productivity gains have been elusive and decreased costs for hospital services have not been realised, despite some evidence suggesting that the failure to reduce costs may be partially offset by improved quality. Savings have not been made because the proposed e-health program, recognised as key to productivity improvements and health gains, is well behind schedule and because the recommended framework of public health objectives for tackling the prevalence of important determinants of health status – things like smoking, obesity, physical activity and diet – was not taken forward.

Sir Derek Wanless, in his September 2007 report, Our Future Health Secured, predicted that if health policy remains focused on short-term imperatives, health care costs will continue to rise.

One disappointing aspect is to see some lost opportunities in this Budget to progress the agenda **on prevention and primary care reform**. While major policy changes and investments in this area must await the deliberations of the National Preventative Health Taskforce, the funding bonanza that will result from the application of higher taxes to alcopops, and the development of the National Primary Health Care Strategy, there is sufficient evidence and support to advance the agenda much more than has been done to date.

Budget and earlier announcements provide \$53.3 million to tackle binge drinking, \$29.5 million for anti-tobacco programs 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 total public spending on health care. 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 amount to only \$54 million a year over the next four years.**



Tackling the lifestyle diseases that take such a toll on our health and our health care system requires a multi-faceted approach that must extend well beyond the health portfolio. The inclusion of **sport and recreation** in the health and ageing budget provides an opportunity in this regard that has been missed this year. Of \$117.5 million to be spent over the next five years, only \$22.2 million could be described as going to community recreational activities, and the remainder is for elite sports.

In **primary care**, the growing concern is that a Medicare system that only pays General Practitioners (GPs) for services delivered if and when the patient visits their practice **will not deliver in terms of better prevention, early intervention and management of chronic illnesses**. The incentive payments that were introduced a decade ago to encourage GPs to do more in these areas have not had a huge take-up, and this Budget sensibly cuts these incentives – but does nothing about replacing them with incentives that will work.

The fact that the new **GP Super Clinics** will continue to use this fee-for-service reimbursement to GPs for their services and those of the nurses and allied health professionals they employ has the potential to undermine the ability of super clinics to deliver better preventive health care and chronic illness management.

The adage that the devil is in the detail is never more true than at budget time. This year the details of the health budget reveal that the big loser is **mental health**. Despite the huge burdens of cost and disability that mental illness imposes on society, despite a raft of reports that cogently argue for doing and spending more, and despite election commitments to make mental health a priority, the budget details reveal **spending cuts of \$290 million in mental health programs over the next four years**.

There are some new commitments in mental health. A total of \$76.3 million will be spent on a national plan for peri-natal depression and more post-graduate and masters degree scholarships for mental health professionals, and \$2.4 million will be provided from within existing Department of Health and Ageing (DoHA) resources to establish a National Advisory Council on Mental Health.

But this new spending is more than offset by the cuts in mental health programs. The rationale provided for these cuts is that the programs have historically been under-spent, and that if demand does increase in the future, then more funds will become available.



Most of the affected programs are part of the Howard Government's COAG mental health package funded in the 2006-07 Budget, so there is no long history to support the argument about the reduction in funds reflecting the historical spending pattern. Lack of leadership and strategic policy from the previous Government meant that these programs never really got up and running.

However there is no commitment from the Rudd Government to examine the value of these programs, to understand why uptake rates have been less than predicted, and to invest the budget savings in innovative approaches to the delivery of mental health services. All new programs are currently constrained by severe workforce shortages, and access to services is particularly limited for people who live outside metropolitan areas.

1.2 Summing up: Our assessment of the first Rudd Health Budget

The Rudd Government's first budget sends a mixed message on health policy reforms, but overall should be viewed as a positive start based on six months in government.

Changing the focus of the health care system and the way in which services to keep people healthy and treat their illnesses are delivered cannot happen overnight, and needs a cohesive strategy which involves all stakeholders. So we should not expect miracles in this first budget in the first six months of government.

But we should expect a consistent focus on these new imperatives that will deliver the required new strategies, action plans and funding as soon as possible. The target timeline should be the 2009-10 Budget.

The next health Budget should benefit from the overall structural reform of the health system generated through current review processes which, if successful, will introduce agreed performance benchmarks to ensure improved patient outcomes and address current gaps and overlaps in the provision of needed health care resources. These reforms may incur upfront costs but will have longer term savings attached. While there is public support for increased spending in health care, and this is essential in certain key areas, ultimately, the only way affordable and sustainable reforms will be achieved across the health budget is through the more effective use of existing resources.



The full version of this health budget analysis is available from Macroeconomics.com.au by subscription.