Australian Council of Social Service

Federal Budget 2010
Analysis and Commentary on Health Portfolio, May 2010[1]

Overview

The 2010 Federal Budget has begun to do what ACOSS has long been advocating - a health system that coordinates and integrates health promotion and primary care within a clearly multi-disciplinary model. However, important pieces of the puzzle are missing, not least in the areas of oral health and mental health. The reform measures announced at COAG and supplemented in this Budget are still insufficient for a comprehensive and fully integrated healthcare system. Only some of the elements are present and they are not yet in the correct proportions to fit together in a final and complete picture. While there are grounds for hope, we are still waiting for the details of a more concrete plan to achieve effective reforms over time.

This document addresses announcements for the health portfolio in the 2010 Federal Budget, including some previously agreed to by the Council of Australian Governments, that are directly relevant to ACOSS priorities of improving access to health services and improving health outcomes for low income Australians.

ACOSS Health Budget Priorities

In our Priority Statement for the 2010 Federal Budget, ACOSS made four recommendations to address the missing elements of integrated primary care and oral health in our health system.

1. Fund comprehensive, community-based primary health care.
2. Remove the 30% private health insurance rebate for ancillary cover.
3. Abolish the Medicare Chronic Disease Dental Scheme and Teen Dental Program; and
4. Following from 3. above, introduce universal access to oral health care.

We focused on primary health and oral health as elements vital for improving access to health care and health outcomes amongst low income Australians. Recognising the enormity of the reforms proposed under the government's three-pronged reform agenda of health and hospitals, primary care and preventive care, ACOSS also made specific proposals about revenue measures within the health portfolio that could offset some of the expenditure necessary to reform our health system.

The Government has adopted these revenue proposals in part or full, but they have not been supported in parliament. They are measures that seek to address some of the most inefficient and unfair elements of spending in the health portfolio and they stand on their own merits in terms of fairness, as well as generating much-needed revenue for additional health spending.

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The allocations to health are amongst some of the most significant in this Budget. They are also complex; distributed over a range of different measures and over different timescales; and include previously announced as well as new measures. The following analysis of health revenue and expenditure measures seeks to clarify some of these complexities, focusing on the items most relevance to ACOSS priorities.

National Health and Hospitals Network (NHHN) expenditure measures	2010-11 ($m)	2011-12 ($m)	Total over 4 yrs ($m)
E-Health	**185.6**	**281.2**	**466.7**
Personally controlled electronic health records (*new*)	185.6	281.2	466.7
Hospitals	**879.1**	**676.4**	**3545.5**
Activity based funding (*new*)	67.7	38.1	163.4
Flexible funding for emergency departments, elective surgery and sub-acute care	25.2	25.2	200.4
Four-hour national access target for emergency departments — facilitation and reward funding	150.5	100.5	501.9
Four-hour national access targets for emergency departments — capital funding	50.4	50.4	251.4
Improving access to elective surgery — capital funding	50.4	25.4	150.7
Improving access to elective surgery — facilitation and reward funding	300.6	118.6	652.3
New sub-acute hospital beds	234.3	318.2	1625.4
GP and primary care	**76.4**	**259.3**	**1221.2**
Coordinated diabetes care	5.7	13.3	449.2
Medicare Locals and access to after-hours primary care (*new*)	14.0	66.6	416.8
Improved primary care infrastructure (*new*)	56.7	179.4	355.2
Workforce	**74.8**	**201.9**	**1173.5**
Building nursing careers (*new*)	1.6	4.8	21.0
Expanding clinical placement scholarships for allied health students	1.6	1.6	6.5
Exploring regulation of the personal care workforce (*new*)	1.1	1.5	3.5
More general practice training rotations for junior doctors	26.4	34.1	149.6
More places on the GP Training Program	3.3	30.8	344.9
Nurse practitioners (*new*)	6.3	3.4	18.7
Research into aged care staffing levels	0.3	0.3	0.5
Rural locum scheme for allied health professionals	1.4	1.3	5.3
Rural locum scheme for nurses (*new*)	7.9	6.9	28.8
Support for practice nurses (*new*)	3.8	70.7	390.3
Training and education incentive payments (*new*)	11.3	14.3	59.9
Training specialist doctors	14.0	28.8	144.5

Aged care	**199.5**	**153.2**	**532.8**
Expand access to multi-purpose services	50.7	35.5	122.0
Expansion of zero real interest loans	72.1	72.1	145.0
Improving access to General Practice and primary health care	14.1	14.3	98.6
Improving the viability of community care providers	2.3	2.5	10.1
Increasing business efficiency	0.6	2.1	7.0
One-stop shops	23.3	2.6	36.8
Protecting savings	6.3	5.1	21.8
Reform of roles and responsibilities — HACC and related programs	19.0	5.4	38.3
Strengthening arrangements for complaints	10.1	12.6	50.6
Supporting Long Stay Older Patients*	1.0	1.0	2.7
Mental health	**19.6**	**39.0**	**123.2**
Additional mental health nurses	5.3	7.7	13.0
Expanding the Early Psychosis Prevention and Intervention Centre model	6.5	6.3	25.5
Flexible care packages for patients with severe mental illnesses*	-3.0	5.1	5.9
More youth friendly services	10.8	19.9	78.8
Prevention	**1.3**	**1.0**	**2.6**
Plain packaging of tobacco products	1.3	1.0	2.6
National standards and performance	**45.1**	**64.7**	**266.0**
Australian Commission on Safety and Quality in Health Care (*new*)	0.7	8.2	35.2
Independent Hospital Pricing Authority (*new*)	3.8	31.8	91.8
Information and awareness (*new*)	18.3	1.1	29.5
National Performance Authority (*new*)	22.3	23.6	109.5
Additional health expenditure measures	**2010-11 ($m)**	**2011-12 ($m)**	**Total funding ($m)**
National Binge Drinking Strategy - expansion (*new*)	**9.5**	**11.8**	**50.0**
MBS Revision of access for specialist consultation items (*new*)	**2.5**	**4.0**	**16.9**
National Male Health Policy (*new*)	**-**	**-**	**16.7**

Key health revenue measures	**($m in 2010-11)**	**($m in 2011-12)**	**Total ($m)**
Fifth Community Pharmacy Agreement	**-125.1**	**-109.3**	**-483.5**
Medical Benefits Schedule (MBS) - Restructure of items	**-4.3**	**-4.0**	**-15.5**
PBS - Medicine pricing reform	**-30.7**	**-191.2**	**-1296.7**
Tobacco - excise increase	**1130**	**1170**	**-5000.0**
Medical expenses tax offset – threshold increase	**0.0**	**95.0**	**-350.0**

Impacts of key new measures and commentary

1. Medicare Locals

A nation-wide network of Primary Health Care Organisations will be responsible for improving care coordination and service integration. They will be based on the existing Divisions of General Practice and will receive $180m in contractual funding re-directed from the Divisions in addition to $290m in budgetary allocation. There will be approximately one Medicare Local to every two Local Hospital Networks

Commentary *Funding is very small considering the potential scope of work; and proportionately even smaller compared to hospital funding. It is still unclear how health promotion and prevention will be undertaken and additional infrastructure is essential if primary healthcare is to link up services from general practices, private allied health and government provided community health care (which can be accessed more readily by consumers). The alignment and relationship between the Medicare Locals (ML) and the Local Hospital Networks (LHN) will also be critical if the MLs are to effectively coordinate and integrate services with the LHNs. Missing from these changes is specification of a population-level planning framework and an equitable distribution mechanism to ensure that the system better meets the needs of those currently missing out on access to primary healthcare services, including consumers in rural and remote areas; culturally and linguistically diverse communities; indigenous communities; urban homeless people; and people from other socially excluded parts of the population.*

2. After Hours GP services

A new 24-hour national telephone-based service coordinated by Medicare Locals will provide people with after-hours medical advice, diagnosis and referral at a cost of $126m. It will be an add-on to the nurse triage, information and advice services currently provided by the National Health Call Centre Network (‘*healthdirect Australia*’).

3. GP Super clinics

An additional 23 GP Super Clinics (building on the 36 GP Super Clinics announced in the 2008-09 Budget) will be established to provide access to a range of health professionals in one location. Around 425 existing GP clinics will be upgraded to Super Clinic-type facilities with grants of up to $500,000 to provide space for allied health services, group education, counselling, and community health promotion.

Commentary *Responses to this measure have been somewhat mixed. On the one hand, the ongoing centrality of doctors means this initiative continues the focus on a medical model of health - albeit from the perspective of general practitioners - rather than one engaging with the social determinants of health. It further entrenches the fee for service culture and does not promote primary prevention.*

Some of the expenditure for GPs is actually to employ nurses and upgrade infrastructure for them. These are useful measures but are really quite inadequate compared with the scale of investment that is required to shift our health care system from an acute illness system to a 'wellness' system. This problem is heightened by the absence of measures to address integration between services; and the lack of extra money for areas of great and pressing need including mental health, dental health and Indigenous health.

On the other hand it has the potential to improve health outcomes if properly monitored. Additional infrastructure is essential, as are mechanisms to ensure both equitable distribution of services and the development of services appropriate to the needs of excluded populations. Making such services more available after hours at bulkbilled rates or with minor co-payments will assist in reducing inappropriate resort to hospital emergency departments for relatively minor injuries and illnesses

4. Electronic Health Record

Introduction of personally controlled electronic health records by 2012/13 to improve health care delivery, safety and efficiency. Records will consist of a health summary view, and an index summary of specific healthcare events. E-health records will be a voluntary opt-in system and individuals must give their consent to establish a record. Implementation will initially focus on target groups including those with complex and chronic conditions, older people, Indigenous people, and mothers and newborn babies.

Commentary *E-health will take up a significant proportion of the $2billion allocated to primary care. Consumer representatives have been supportive of the move towards e-health in Australia. However the cost of this development is significant and its allocation in the 2010 Budget essentially represents capital expenditure to establish the necessary systems and infrastructure. While the benefits in improved primary care and illness prevention can be foreseen, they are still some way off. This means that a significant proportion of the primary care allocation will not yield benefits for health care consumers in the immediate future.*

5. Workforce

$522.7m additional funding for workforce initiatives includes $390.3m to provide financial support to nurses to expand their role in primary care as GP practice nurses and $128.4m career development.

Commentary *Most of these initiatives were announced in relation to COAG and are to be welcomed. The inclusion of money to educate nursing staff in areas of great need such as aged care and rural and regional health is important. But there is still a need to address the underlying reason that nurses do not choose to work in these areas already, including poor wages; inadequate funding; and the heavy reliance on unskilled staff which creates enormous pressures for professional staff. The lack of support, particularly in rural and regional areas, means additional training may not be enough to retain staff here.*

Additional clinicians will be welcomed but there is still insufficient recognition that significant benefits can be gained by redefining existing roles within the health workforce. Options include introducing new contributors like physician assistants; and reinforcing the benefits of clinicians such as nurse practitioners who, although presently unsupported within the health sector, are allied health clinicians who can work as members of integrated clinical teams in the community and in primary healthcare settings as well as in hospitals.

6. Closing the gap in indigenous health outcomes

Initiatives funded cover community safety, employment, education and early childhood programs, housing, communication and broadcasting, and legal assistance. In addition there is support for flexible and integrated remote area service delivery to indigenous communities.

Commentary *In contrast to the model for primary care, most of these initiatives address social determinants of health but will not necessarily improve access to health care and health outcomes. In particular there is a glaring absence of additional funding to address closing the significant gap in life expectancy between Indigenous and non-Indigenous people.*

Empowering indigenous communities to set their own priorities for achieving better health and allowing them to direct resources to them would be a good way to ensure that better health outcomes were achieved.

7. Rural health

Commentary *While there is extension to some allocations for rural services, such as mental health care, there are still significant gaps in the access people in rural and remote areas will have to central elements of Australia's health system. In particular, the Rural Health Alliance has noted a disappointing lack of action on the dental health workforce, maternity services and on patients' accommodation and travel.*

8. Mental health

Commentary *There is some money for mental health nurses in the budget and there is a possibility of some increased access through care packages. Of much greater concern is the removal of social workers and occupational therapists from the Medicare rebate scheme, effective July 2010. This means that Medicare rebates will cease for new clients accessing social workers and occupational therapists under the Better Access to Mental Health Services Program. Australians with mental health issues who access these services will no longer be able to claim back the Medicare rebate currently available, which will frequently mean they are unable to afford the service.*

Since 2006, the Better Access to Mental Health Services has enabled social workers and occupational therapists with specialised mental health skills and experience to offer services to clients referred from GPs. These clients have serious mental health conditions, such as depression, anxiety or post-traumatic stress disorders. The Australian Association of Social Workers estimates that 1500 doors to early intervention mental health services will be closed for vulnerable Australians with mental health issues, when social workers and Occupational Therapists are no longer funded to provide these services.

Conclusion: Oral health the biggest hole in the Budget

The glaring gap in the health budget is the total failure to address the unmet oral health needs of a significant proportion of the population who cannot access private dental services because of the cost and are excluded from the very limited public dental programs. ACOSS and the COSS network have long advocated on this issue and it is a problem that was identified directly by the NHHRC.

But it has been repeatedly ignored by Commonwealth governments past and present. In a post-budget briefing, the Health Minister acknowledged that the scale and cost of the Denticare scheme proposed by the NHHRC was simply too expensive for the Government to contemplate.

Instead, the Rudd government intends to attempt once again to close the Medicare Chronic Disease Dental Scheme and to make funding available for the introduction of the Commonwealth Dental Health Program and the Medicare Teen Dental Plan. However, without the support of the Senate, the Government has been unable to do so to date.

Through Medicare, the Rudd Government has budgeted $68m for 2010-11. This includes the Medicare Teen Dental Plan (1.3m vouchers each year) and the Medicare Chronic Disease Dental Scheme. There is also a planned expansion of the Rural Placements Program for dentists and funding for pilot projects identified as suitable for mobile indigenous dental pilot projects.

Population oral health must be seen as an essential element of a universal health system and its ongoing exclusion means that the gaps in oral health outcomes for low income Australians can only increase. Not withstanding that the Government has rejected the recommendation for Denticare, this budget was also an opportunity to begin to address the looming crisis in the dental workforce by initiating a dental residents internship program to structure dental graduates into the public dental system.

As far as access to affordable dental services, there was not much in this budget for the many Australians who could not eat their dinner properly on budget night.