

The MUCHE Health Report 2020

ANALYSIS OF THE 2020-2021 FEDERAL BUDGET



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About MUCHE

Macquarie University is one of Australia's leading research universities, with an enviable reputation for excellence. While still relatively young, success of the past 50 years has positioned our distinctive approach to deliver ground-breaking research with world-changing impact.

Recently, we have invested heavily in infrastructure, with over \$1 billion spent on facilities and buildings. We have also significantly expanded our teaching and research capacity in health, for example, with the development of a new Faculty of Medicine and Health Sciences, and relocation of the Australian Institute of Health Innovation from the University of NSW.

The University's objectives are to accelerate world-leading research; to prepare world-ready higher degree research candidates; to actively engage externally as a world-recognised research collaborator and partner of choice. We believe collaborating with industries, governments, communities, professions and academic colleagues around the world is paramount to our success.

Macquarie University's Centre for the Health Economy (MUCHE) is a strategic initiative to undertake innovative research on health and aged care. Our vision is to create a world where decision makers and the public are empowered with trusted and influential research. Our mission is to be Australia's most influential health economics research centre in academic and public policy debate.

We undertake research funded by competitive academic grants and by government and non-government organisations. We actively promote our research using a clear communication strategy to inform public debate, assist decision-making, and help formulate strategy and policy.

We investigate the Health Economy at the macro level, focused on the interdependency of these systems with each other and the broader economy. We investigate factors beyond the health and aged care sectors that impact the health and wellbeing of populations.

Our point of difference lies in our approach to research. While MUCHE primarily consists of specialist health economists, researching the Health Economy requires many skills sets and experience. Solving complex problems within health and aged care now requires teams with multi-disciplinary skills working closely together.

We actively collaborate with Macquarie University academics within the Macquarie Business School, Faculty of Medicine, Health and Human Sciences, and Faculty of Science and Engineering. We collaborate with Macquarie University research hubs and centres. These include partners within the Australian Hearing Hub, the Australian Institute of Health Innovation, H:EAR, and the Centre for Emotional Health. Our collaborations extend to world leading universities in Europe and Asia.

We take pride in combining our professional approach to partner engagement, with our academic approach to methodology, to deliver innovative and translational research.



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Executive summary

This Health Budget is almost wholly preoccupied with responding to the COVID-19 pandemic. It builds upon the substantial expenditure outlined in the Economic and Fiscal Update and reflects a Health Budget haemorrhaging money.

Nominal growth rates in health expenditure are 8 per cent for 2019-20 and 7.8 per cent for 2020-21, which are the highest seen since 2010-11. Health expenditure is estimated to decline in 2021-22 given most of the COVID-19 related expenditure is forecasted to stop. This reflects the Budget assumption that a COVID-19 vaccination program is fully in place by late 2021.

Large amounts of spending responding to the COVID-19 pandemic makes sense, given it remains our greatest immediate health threat. Fortunately, a vaccine seems likely and could be available to our most vulnerable by January 2021.

The National Partnership Agreement (NPA) received another \$1.1 billion. This funding increases the total to \$4.8 billion since the COVID-19 pandemic began. The NPA will see COVID-19 treatment costs shared with state and territory governments using a 50-50 split, and provides state and territory governments access to private hospitals for public patients.

This Budget also allocated \$1.7 billion to purchase two COVID-19 vaccines. That builds on the \$3.2 billion allocated in the Economic and Fiscal Update to purchase personal protective equipment.

Some crucial changes required to improve the mental health and aged care sectors are missing from this Budget. This will result in opportunity cost for care recipients from long term reform not otherwise pursued by the Australian Government.

While more funding was allocated to increase Better Access mental health care episodes, Productivity Commission recommendations on mental health care reform have been kicked down the road, hopefully to the next Budget, but that is not guaranteed.

The Australian Government knows long term mental healthcare reform is desperately needed. The National Mental Health Commission makes that explicit every year. The sector is characterised by fragmentation, poor coordination, inadequate mental health care workforce, service gaps, and ineffective services.

In response to the COVID-19 pandemic, the Australian Government temporarily increased access to psychological telehealth services, but the effectiveness of telehealth remains unclear. Other mental health services delivered online, such as MindSpot, have better evidence.

Mental health care reform should start now to ensure people struggling with their mental health from bushfires, the COVID-19 pandemic, unemployment, and financial distress can receive appropriate care.

A Budget centrepiece is \$1.6 billion allocated to release another 23,000 Home Care packages over four years. This is welcomed and was recommended by the Royal Commission into Aged Care Quality and Safety.

However, around 60,000 people are currently waiting for a Home Care package. Another 44,000 receive an interim Home Care package while they wait for their approved package. That means many people will still miss out. More funding is required.

This Budget has allocated additional lump sum payments to residential aged care providers to address costs during the COVID-19 pandemic. Additional funding was allocated to improve infection control. Residential aged care workers will receive an additional bonus to encourage them to stay in the sector.

Significant funding for residential aged care providers to employ more staff to improve quality is missing from this Budget. Additional funding was proposed by the Royal Commission after it recognised under resourcing within residential aged care and a strong relationship between costs and quality.

While the Australian Government may be waiting for the Royal Commission's final report, reforms will take several years to implement. Current residents may miss out on improved quality care given their average length of stay is 2.5 years. Increasing residential aged care employment could have helped with Australia's unemployment problem.

Also missing from this Budget was funding to increase allied and mental health service visits in residential aged care, as recommended by the Royal Commission.

The Australian Government is projected to pay \$26.9 billion on the private health insurance rebate over the next four years.

It has tinkered around the edges of private health insurance within this Budget, allowing younger Australians to stay on a family policy until they turn 31 years old. This will help retain younger members and promote lifetime membership, but it will not reduce the pressure to increase prices.

Large scale reform seems unavoidable to stop the slow financial deterioration of private health insurers. Increasing hospital benefits per member is the primary driver. The sector must reduce private hospital demand from its members by investing more into wellbeing and integrated care programs.

Our response to the COVID-19 pandemic has been deft. Australia has experienced fewer infections and deaths per capita than nearly every other developed country. Many lives have been saved (so far) because of increased coordination and goodwill within healthcare and other portfolios.

The Australian Government must now focus on the future. Overhauling the mental health care system and the aged care system will be challenging and expensive, but necessary. The need to undertake these at the same time will add complexity. A growing and ageing population means significant increases in health funding will be required for years to come.

Australia is an affluent country with small net debt as a proportion of GDP compared to other developed countries. Bond yields are at historical lows, which translates into lower interest payments. While our net debt will increase, public debt interest will remain relatively subdued.

Increased government spending on health and aged care is therefore a choice for the Australian Government. Despite the increased cost associated with COVID-19, now is the time to pursue reform, not in the future.

1. Aged care

The aged care sector has had a tough year. The Royal Commission into Aged Care Quality and Safety handed down its interim report in October 2019, lambasting providers and implicating the Australian Government. It found an aged care system with systemic poor quality, overuse of psychotropic medications and physical constraints, social isolation, and neglect.¹

Then came COVID-19, a virus that preys on older vulnerable persons and spreads through confined spaces like a fire tornado. While the first wave saw the Australian residential aged care sector avoid the large scale deaths experienced in US and European aged care homes, the second wave in Victoria showed there was no room for complacency.

There have been 2,049 cases across people living in Australian Government subsidised residential aged care homes with 657 deaths. Victoria has accounted for 97 per cent of cases and 95 per cent of deaths.² In Victoria, 113 facilities have reported at least two infections, compared to four in NSW and one in Tasmania.³ This represents 4 per cent of all facilities with two or more infections.

The Victorian experience has exposed additional cracks in residential aged care. There has been some confusion over whether providers, the Australian Government, or states and territories are ultimately responsible for resident health outcomes.⁴ Others suggest there may be a significant shortfall of lump sum accommodation payments towards the end of 2020, exposing some providers to serious cash flow and liquidity problems.⁵

The Australian Government has tried to keep one step ahead. It developed an aged care response plan to COVID-19 in March and provided additional funding to aged care providers. Funding has targeted aged care workforce retention, infection control, contact tracing, and gaining access to private hospital wards to treat infected residents.⁶ According to the Minister for Health, the Australian Government had

¹ Royal Commission into Aged Care Quality and Safety 2019, Interim report: Neglect, Commonwealth of Australia, Canberra.

² Department of Health, 2020, Covid-19 cases in aged care services – residential care, Australian Government, <https://www.health.gov.au/resources/covid-19-cases-in-aged-care-services-residential-care>, accessed 29 September 2020.

³ Department of Health, 2020, COVID-19 outbreaks in Australian residential aged care facilities, Australian Government, https://www.health.gov.au/sites/default/files/documents/2020/09/covid-19-outbreaks-in-australian-residential-aged-care-facilities-25-september-2020_0.pdf, accessed 29 September 2020

⁴ Royal Commission into Aged Care Quality and Safety, 2020, Aged care and Covid-19: a special report, Commonwealth of Australia, Canberra

⁵ Ansell Strategic, 2020, RAD exposure analysis. Overview and forecasting report, Prepared for the Department of Finance, <https://agedcare.royalcommission.gov.au/system/files/2020-09/ANS.0001.0003.0001.pdf>, accessed 30 September 2020

⁶ The Hon Greg Hunt MP, 2020, Support for aged care residents and aged care workers across Victoria, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/support-for-aged-care-residents-and-aged-care-workers-across-victoria>, accessed 29 September 2020

allocated \$1.5 billion to aged care since the pandemic began,⁷ although the Economic and Fiscal Update suggests only \$1.3 billion was new funding, with \$547 million unrelated to COVID-19.⁸ Victorian providers have also received personal protective equipment (PPE) from the National Medical Stockpile and significant surge workforce assistance from the Australian Government.⁹

Victoria continues to wrangle its COVID-19 outbreak under control and the Royal Commission into Aged Care Quality and Safety continues to develop recommendations for wholesale structural reform.¹⁰ Still, the Australian Government has ample opportunity to improve the lives of older Australians within this Budget.

A natural starting place is to increase access to home care. The Australian Government had already announced an additional \$71.4 million for the Commonwealth Home Support Programme to support people living at home longer.¹¹ It had also announced an additional \$325.7 million would be spent on 6,105 home care packages in 2020-21.¹²

Increased funding to residential aged care providers is also required. The positive relationship between cost and care quality found by the University of Queensland and international studies that show a positive relationship between price and quality,^{13,14} suggest increased revenue to providers can increase quality, so long as providers spend that revenue on care. The Royal Commission into Aged Care Quality and Safety has already proposed funding be allocated to providers to hire more staff, while also requiring them to report their expenditure.¹⁵

Significant Budget announcements

A Budget centrepiece is the \$1.6 billion allocated to release another 23,000 Home Care packages over four years. This builds on the Australian Government's significant investment over the last two years to

⁷ The Hon Greg Hunt MP, 2020, Additional Funding to Reinforce Australia's Aged Care Sector, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/additional-funding-to-reinforce-australias-aged-care-sector>, accessed 29 September 2020

⁸ The Treasury, 2020, Economic and Fiscal Update. July 2020, Australian Government, Canberra

⁹ Department of Health, 2020, COVID-19 outbreaks in Australian residential aged care facilities, Australian Government, https://www.health.gov.au/sites/default/files/documents/2020/09/covid-19-outbreaks-in-australian-residential-aged-care-facilities-25-september-2020_o.pdf, accessed 29 September 2020

¹⁰ The Royal Commission into Aged Care Quality and Safety final report is due on 26 February 2021.

¹¹ The Hon Greg Hunt MP, 2020, Additional Funding to Reinforce Australia's Aged Care Sector, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/additional-funding-to-reinforce-australias-aged-care-sector>, accessed 29 September 2020

¹² The Treasury, 2020, Economic and Fiscal Update, Australian Government, Canberra

¹³ Herr A, Hottenrott H, 2016, Higher prices, higher quality? Evidence from German nursing homes, Health Policy, Vol. 120, pp. 179-89.

¹⁴ Konetzka T, Norton EC, Stearns SC, 2006, Medicare payment changes and nursing home quality: Effects on long stay residents, International Journal of Health Care Finance and Economics, Vol. 6, No. 3, pp 173-89.

¹⁵ Royal Commission into Aged Care Quality and Safety, 2020, Revised funding, financing and prudential regulation hearing propositions – 13 September 2020, Commonwealth of Australia, Canberra

increase Home care packages. An increase in Home Care packages will be welcomed and was recommended by the Royal Commission into Aged Care Quality and Safety within its interim report.

However, demand will continue to outstrip its supply. There were 59,071 people seeking a Home Care package at their approved level at the end of March 2020, who were not offered access to a lower level package. Another 44,528 people had been offered an interim Home Care package while they waited for a Home Care package at their approved level.¹⁶

The Australian Government has allocated \$91.6 million allocated to support implementing the Australian National Aged Care Classification (AN-ACC) funding model. This builds on \$166.9 million allocated over two years within the Economic and Fiscal Update. It will include a shadow assessment for one year, where all residents will be assessed by an independent assessor using the AN-ACC tool.

The Business Improvement Fund, established this year to improve aged care providers' financial operations, received \$35.6 million over two years, building on the \$48.7 million allocated in the Economic and Fiscal Update. This will help residential aged care providers experiencing financial difficulty to either undertake business improvement activities, sell or transfer a facility to another provider, or close a facility without leaving residents stranded.

A total of \$52.8 million was allocated in this Budget and the Economic and Fiscal Update to implement a serious incident response scheme for aged care.

The Australian Government has allocated another \$743.6 million to aged care providers to support efforts against the COVID-19 pandemic, although many of these expenditure items have been previously announced.

Of this, \$245.0 million will be allocated as a supplement in 2020-21 to help residential aged care providers and home care providers meet COVID-19 related costs. An additional \$92.4 million was allocated to residential aged care providers to support workers in hotspots remaining at a single facility.

Another \$205.1 million has been allocated over two years from 2020-21 as a third instalment of the workforce retention bonus to keep residential aged care staff in the sector. \$103.4 million was allocated for 2020-21 to improve infection control in residential aged care. This will include mandated trained infection control officers.

The Australian Government has provided significant support to aged care providers in response to the COVID-19 pandemic. However, significant funding for residential aged care providers to employ more staff to improve quality, which was problematic before COVID-19, is missing from this Budget.

While the Australian Government may argue that it should wait until the Royal Commission into Aged Care Quality and Safety delivers its final report in February 2021, reforms will take years to implement. The 240,000 permanent residents currently receiving residential aged care will miss out given their

¹⁶ Department of Health, 2020, Home Care Packages Program, Data Report, 3rd Quarter 2019-20, Australian Government, https://gen-agedcaredata.gov.au/www/aihwgen/media/Home_care_report/Home-Care-Data-Report-3rd-qtr-2019-20-PDF.pdf, accessed 29 September 2020

average length of stay is 2.5 years.^{17,18} Increasing residential aged care employment could have helped with Australia's unemployment problem.

The Legislated Review of Aged Care recommended that the Australian Government ask consumers to pay more for their care in 2017.¹⁹ The Australian Government did not implement this. The Treasury has stated that increased contributions from aged care recipients can improve aged care.²⁰ This implicitly requires that money from care recipients complements the Australian Government spending pool rather than substituting spending. Otherwise, increased contributions will amount to naught for aged care quality.

It may be politically challenging to increase aged care funding in an environment of tight revenues and large debts. This is particularly the case within the health portfolio, where mental health care reforms will also be competing for valuable funds. However, the challenge must be met. Residential aged care residents have received poor quality care for too long. The Australian Government should signal its willingness to commit politically and fiscally to ensuring quality improves in residential aged care.

¹⁷ Productivity Commission, 2020, Report on Government Services, Aged Care Services, Australian Government, Canberra

¹⁸ Australian Institute of Health and Welfare (AIHW), 2020, Explore people leaving aged care, Submission to the Royal Commission into Aged Care Quality and Safety, Australian Government, Canberra

¹⁹ Department of Health, 2017, Legislated review of aged care 2017, Australian Government, Canberra

²⁰ The Treasury, 2020, Treasury's response to Notice to Give Information or a Statement in Writing No. NTG-0797, Australian Government, Canberra

2. Hospitals

Public hospital expenditure is the second biggest health portfolio budget item for the Australian Government, and the largest specific purpose payment for state and territory governments. It is fertile ground for blame gaming given the Australian Government contributes to approximately 39 per cent of public hospital funding,²¹ while states and territories manage their public hospitals.

Public hospital funding agreements typically take aeons to negotiate. It was therefore an historic moment when the Australian Government agreed with states and territories to allocate \$3.7 billion to the National Partnership Agreement (NPA) on COVID-19 Response.

The NPA promised a 50-50 split with state and territory governments of the costs of diagnosis and treatment of COVID-19 related patients, along with funding for respiratory clinics and drive through testing services.²² It included an upfront \$100 million given to states and territories on their sign-up to the deal.

The Economic and Fiscal Update also ushered in the 2020-25 National Health Reform Agreement Addendum signed in May. It noted the Australian Government would provide \$131.4 billion over six years from 2019-20.

While this sounds impressive, it represents the status quo. Apart from one-off and spot investments in capital infrastructure, objective assessments of the underlying costs of providing care for the population are agreed within routine funding increases. There was only an additional \$38.4 million within the Economic and Fiscal Update compared to prior estimates.

More interesting components of the National Health Reform Agreement Addendum were six agreed health care reforms. These include: nationally cohesive health technology assessment; paying for value and outcomes; joint planning and funding at a local level; empowering people through health literacy; increased investment in prevention and wellbeing; and enhanced health data.²³

While state and territory governments must detail implementation plans for each, there is no requirement to implement these plans. Governance for these reforms is also unclear now that a new National Federation Reform Council has replaced the Council of Australian Governments.

Another game changer for hospital care in response to the COVID-19 pandemic was an unprecedented agreement made between the Australian, state and territory governments with 657 private hospital facilities (acute care, psychiatric and day hospitals) to guarantee access to their resources when needed. This includes providing hospital care for public patients, using intensive care units, and accommodation

²¹ Australian Institute of Health and Welfare (AIHW), 2020, Australia's hospitals at a glance 2018-19, Australian Government, Canberra

²² The Treasury, 2020, Economic and Fiscal Update, Australian Government, Canberra

²³ Australian Government, 2020, Addendum to National Health Reform Agreement 2020-25, Australian Government, Canberra

for quarantine and isolation cases.²⁴ The Australian Competition and Consumer Commission (ACCC) provided authorisation to state and territory governments to coordinate with private hospitals, given these activities could have breached competition law without it.²⁵

Most interesting are the possibilities for combined public and private hospital interoperability in the future. The COVID-19 response has essentially seen the private hospital sector “... act as not-for-profit organisations for the duration of the arrangement, and also to open their books for audits”.²⁶

Given state and territory governments struggled to reduce public patient elective surgery waiting times before the COVID-19 pandemic, the ubiquitous use of private hospitals to treat public patients in the future now seems more achievable. Precedent now exists, whereby private hospitals have agreed to prioritise public hospital patients. NSW has entered into an agreement with Ramsay Health Care to have an opportunity to purchase services for public patients after viability supplements cease.²⁷

Each state and territory has negotiated individual contracts with private hospital providers. This has made available private hospital beds for aged care recipients with COVID-19 in Victoria,²⁸ and underwritten private hospital operational costs in NSW through ‘viability payments’.²⁹ The Australian Government estimated the agreement with private hospitals would cost taxpayers \$1.3 billion, but also noted the funding was uncapped.³⁰

The Independent Hospitals Pricing Authority (IHPA) is also working to understand the cost implications of COVID-19 for future Hospital Services Payments, alongside other public health initiatives. This will include funding directly related to hospital care for COVID-19 and those related to the spill-over effects on other services, such as elective surgery.³¹

The current and future amount of the hospital agreements between the Australian Government, states and territories, and private hospitals is uncertain, reliant not only on the month-by-month modelling of

²⁴ Parliament House, 2020, COVID-19: Major partnership with private hospitals, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2020/April/Agreement_with_private_hospitals, accessed 5 October 2020

²⁵ Australian Competition and Consumer Commission (ACCC) 2020, Private and public hospitals can continue cooperating on COVID-19, <https://www.accc.gov.au/media-release/private-and-public-hospitals-can-continue-cooperating-on-covid-19>, accessed 6 October 2020

²⁶ Sweet M, 2020, Pandemic drives an historic integration of public and private hospitals, <https://croakey.org/pandemic-drives-an-historic-integration-of-public-and-private-hospitals/>, accessed 6 October 2020

²⁷ LaFrenz C, 2020, Ramsay Health Care pens COVID-19 beds deal with NSW Health, <https://www.afr.com/companies/healthcare-and-fitness/ramsay-health-care-pens-covid-19-beds-deal-with-nsw-health-20200515-p54t9z>, accessed 6 October 2020

²⁸ Aged care residents sent to private hospitals as elective surgery halted <https://www.smh.com.au/national/aged-care-residents-sent-to-private-hospitals-as-elective-surgery-halted-20200728-p55g8v.html>

²⁹ LaFrenz C, 2020, Ramsay Health Care pens COVID-19 beds deal with NSW Health, <https://www.afr.com/companies/healthcare-and-fitness/ramsay-health-care-pens-covid-19-beds-deal-with-nsw-health-20200515-p54t9z>, accessed 6 October 2020

³⁰ Parliament House, 2020, COVID-19: Major partnership with private hospitals, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2020/April/Agreement_with_private_hospitals, accessed 5 October 2020

³¹ Australian Government, 2020, National Partnership on COVID-19 response, Australian Government, Canberra

activity costs, but also the costs of having private hospital services on stand-by. This can vary from month to month.

Significant Budget announcements

A further \$1.1 billion was allocated for the NPA in this Budget to support public hospitals through the COVID-19 response. This adds to the \$3.7 billion allocated in the Economic and Fiscal Update, bringing the total to \$4.8 billion since the COVID-19 pandemic began. Of this, \$3.1 billion was allocated for states and territories, and \$1.7 billion was allocated for the private hospital viability guarantee.

The cost of the NPA had cost around \$3.5 billion as of 30 September 2020. A substantial proportion of this cost is for equipment, including ventilators (\$339.7 million) and personal protective equipment (\$997 million). However, the single largest expenditure item is the \$1.0 billion expended on minimum viability payments for private hospitals.³²

Details on what these viability costs comprise are likely detailed within contracts between the states and territory governments and individual private hospital providers. Costs of one provider may be commercial-in-confidence given it may reveal cost structures to competing private hospital providers. However, it would be prudent to ensure some visibility on the breakdown of costs to ensure the taxpayer has received value for money.

³² Department of Health, 2020, Budget 2020-21 Stakeholder Information Pack <https://www.health.gov.au/sites/default/files/documents/2020/10/budget-2020-21-stakeholder-pack.pdf>, accessed 7 October 2020.

3. Mental health

The mental health care sector was in dire need of reform and investment before COVID-19 came along, consequent to system-wide government inattention. Suicide rates had increased since 2006, particularly among young Australians. This stimulated a reallocation of funds by the Australian Government to mental health services, such as *headspace*, and increased research funds through the Medical Research Future Fund (MRFF) to wrestle suicide rates down.

Despite the Fifth National Mental Health and Suicide Prevention Plan being endorsed by Australian governments in 2017, the mental health care sector is characterised by service fragmentation, uncoordinated investment decisions, inequitable and under resourced services, too little focus on prevention and early intervention, care that is not evidence based, and stigma and discrimination for people living with mental ill health.³³

There is no shortage of recommendations to improve the mental health care system for the Australian Government. The most recent National Monitoring Report (NMR) made 30 recommendations aimed at addressing population data gaps, better identifying service gaps and improving the mental health care workforce, collecting better data on consumer preferences, and independently monitoring mental health policy outcomes.³⁴

The NMR also recommended strengthening primary healthcare networks (PHNs) and the National Disability Insurance Scheme (NDIS), while better coordinating suicide prevention plans across states and territories. A major theme throughout the recommendations was a better measurement of outcomes associated with care and policy implementation.

An interim report from the Royal Commission into Victoria's Mental Health System made similar recommendations. It recommended establishing a Victorian Collaborative Centre for Mental Health and Wellbeing for improved research and training, and to promote collaboration across the sector.

The Royal Commission also recommended increasing acute inpatient public mental health beds, expanding suicide prevention and follow-up care, improving Aboriginal social and emotional wellbeing, more involvement of lived experience in system design and care delivery, improved and expanded workforce, and a new approach to mental health investment decisions.³⁵

The Productivity Commission also released its interim report on mental health and has since handed the final report to the Australian Government. Recommendations with the interim report included staged process for system reform, including reforms to jurisdictional governance and funding models, with service elements including better use of telehealth, particularly online treatment options and consultations by videoconference.

³³ Productivity Commission, 2020, Mental Health. Draft Report. Volume 1, Australian Government, Canberra

³⁴ National Mental Health Commission (NMHC), 2019, National Report 2019, Australian Government, Canberra

³⁵ Royal Commission into Victoria's Mental Health System, 2019, Interim Report, Parl Paper No. 87, State of Victoria, Melbourne

The Productivity Commission also recommended an increased carer workforce, more income support for people with mental ill health and their carers, better housing options, better care coordination across the spectrum of mental health community care, more acute and primary care services, and early intervention for children and young adults.

The summer bushfires and the COVID-19 pandemic has raised mental health awareness and put mental health care front and centre of the political debate. This has increased mental healthcare reform complexity and urgency.

The Australian Government responded to calls for more mental health care resources in May through its \$48.1 million National Mental Health and Wellbeing Pandemic response plan. The Plan was to improve data collection and monitoring of mental ill health within the community, expanding services to vulnerable people, and a large communications campaign.³⁶

The Australian Government had already introduced temporary MBS telehealth items in March for consultations with psychologists, occupational therapists, and social workers.³⁷ It announced in August that it would provide an additional 10 Medicare subsidised psychological therapy sessions for people subjected to further restrictions in areas impacted by a second wave of COVID-19.³⁸

The Australian Government also announced in August another \$12 million to increase telephone and digital and telephone counselling services,³⁹ and in September announced \$31.9 million to support Victorians, mostly through 15 new mental health clinics commissioned by PHNs.⁴⁰

The Australian Government announced an additional \$24 million to headspace in June.⁴¹ This builds on the \$263.1 million allocated to *headspace* in the 2019-20 Budget. The Productivity Commission has recommended that any funding to *headspace* should be made conditional on meeting referral targets.⁴² There is a question mark over the effectiveness of *headspace*, with small gains in mental health found in

³⁶ The Hon Greg Hunt MP, 2020, COVID-19: \$48.1 Million for National Mental Health and Wellbeing Pandemic Response Plan, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/covid-19-481-million-for-national-mental-health-and-wellbeing-pandemic-response-plan>, accessed 30 September 2020

³⁷ Department of Health, 2020, COVID-19 temporary MBS telehealth services, Mental health services, [http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/\\$File/COVID-19%20Temporary%20MBS%20telehealth%20Services%20-%20Mental%20Health%2008052020.pdf](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/0C514FB8C9FBBEC7CA25852E00223AFE/$File/COVID-19%20Temporary%20MBS%20telehealth%20Services%20-%20Mental%20Health%2008052020.pdf), accessed 30 September 2020

³⁸ The Hon Greg Hunt MP, 2020, Additional COVID-19 Mental Health Support, Media release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/additional-covid-19-mental-health-support>, accessed 30 September 2020

³⁹ The Hon Greg Hunt MP, Further mental health support for Victorians during COVID-19 pandemic, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/further-mental-health-support-for-victorians-during-covid-19-pandemic>, accessed 30 September 2020

⁴⁰ The Hon Greg Hunt MP, Government launches new COVID-19 mental health clinics in Victoria, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/government-launches-new-covid-19-mental-health-clinics-in-victoria>, accessed 30 September 2020

⁴¹ The Hon Greg Hunt MP, 2020, \$24 million funding boost for additional mental health care at headspace, Media release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/24-million-funding-boost-for-additional-mental-health-care-at-headspace>, accessed 30 September 2020.

⁴² Productivity Commission, 2020, Mental Health. Draft Report. Volume 1, Australian Government, Canberra

the most recent evaluation.⁴³ There had been no assessment of cost relative to mental health outcomes associated with *headspace* care, although this type of evaluation was recently commissioned by the Australian Government and remains ongoing.

There is a call to arms from providers, clinicians, and academics for still more resources to deal with what they now suggest is a mental ill health deluge, characterised by anxiety and depression, along with increased domestic violence and more suicide.

Treating mental ill health benefits the individual and society. Broader positive externalities include improved productivity, reduced reliance on informal care, and reduced use of resources outside the healthcare system (e.g., housing). The Productivity Commission and the Royal Commission into Victoria's Mental Health System have already put a robust economic case forward for significant reform.

There are two primary sources of increased mental ill health from COVID-19. There is the mental ill health response directly related to COVID-19, including the impacts from being infected, holed up in long periods of lockdown, and from the stress associated with treating those with COVID-19 such as frontline healthcare workers.

While any COVID-19 vaccine next year may alleviate some mental ill health as society returns to normal, there are still potential impacts from the economic recession. This will reverberate throughout Australian society, with high unemployment, reduced incomes, and financial distress likely characterising the economic landscape for years to come.

Australia therefore faces a large and prolonged increase in mental ill health, and the recent increased use of mental health services would suggest this is occurring. While recessions do impact mental health, and the community is still reeling from the bushfire disasters from last summer, there is some uncertainty about the quantum of severity and prevalence of mental ill health and health inequalities.

People who have previously managed their mental health and wellbeing well may now need additional support and interventions. Telehealth consultation services can be increased, but there is little evidence on whether they are effective or represent value for money.

Research has shown that internet based mental health intervention platforms, such as MindSpot, produce health outcomes just as good as face to face interventions. Other new models are starting to emerge and will compete for Australian Government funding. COVID-19 provides an opportunity to test these models to deliver mental health care in a more cost effective way.

Significant Budget announcements

This Budget has allocated \$47.3 million for additional mental health and crisis support for Victoria, although most of this funding was already announced.

The Australian Government also announced that it would fund 10 additional psychological therapy sessions each calendar year nationally under the Better Access initiative. This is estimated to cost \$100.8 million over three years and represents an extension on what was previously announced.

⁴³ Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi, Y., Nguyen, H., Wingrove, C. and Katz, I. (2015). Is headspace making a difference to young people's lives? Final Report of the independent evaluation of the headspace program. (SPRC Report 08/2015). Sydney: Social Policy Research Centre, UNSW Australia.

This Budget has also allocated \$45.7 million to help young Australians with mental ill health participate in the workforce.

While an increase in mental health care funding is welcomed, Productivity Commission recommendations on mental health care reform have been kicked down the road, hopefully to the next Budget,⁴⁴ but that is not guaranteed. The Australian Government knows long term mental health care reform is desperately needed.

It is more important now than ever that the Australian Government allocates funding to mental health care using a coordinated strategy across portfolios. Historically, funding has often been allocated in reaction to a perceived crisis or to placate lobbying demands. Governments worldwide must avoid cheap, low quality mental health care interventions when looking to increase access in response to the COVID-19 pandemic and recession.⁴⁵

Real time monitoring of mental ill health is essential. So too is proper evaluation of mental health care services for effectiveness and value. New funding should come with conditions that require the recipient to collect data and seek an independent evaluation. Governments need to ensure that providers are accountable based on measured outcomes valued by care recipients.⁴⁶

⁴⁴ The Hon Scott Morrison MP, 2020, Q&A. National Press Club, <https://www.pm.gov.au/media/qa-national-press-club-0>, accessed 8 October 2020

⁴⁵ Moreno C, et al, 2020, How mental health care should change as a consequence of the COVID-19 pandemic, The Lancet Psychiatry, Vol. 7, Issue 9.

⁴⁶ Ibid.

4. Pharmaceuticals and vaccines

The question on everyone's mind is 'Will there be a COVID-19 vaccine, and when can I get it'? The World Health Organisation reports there are about 193 candidate vaccines currently being evaluated.⁴⁷ Most vaccines are in pre-clinical trials being tested on animals, however 11 are in Phase 3 clinical trials testing for efficacy.⁴⁸

The Australian Government entered into agreements with the University of Oxford/AstraZeneca and the University of Queensland/CSL in September to produce more than 84.8 million vaccine doses at a cost of \$1.7 billion.⁴⁹

The world held its collective breath when the Oxford/AstraZeneca vaccine clinical trial was voluntarily paused in September due to a reported adverse event.⁵⁰ While the trials have been deemed safe to resume in the UK, Brazil, South Africa, India, and Japan, the US trial is yet to resume.⁵¹

Vaccines for Australians will be manufactured in Melbourne if all goes to plan. Early access to 3.8 million doses of the University of Oxford/AstraZeneca vaccine for the most vulnerable Australians is expected by the Australian Government in January or February 2021, although people may require two doses.⁵² Full roll out of the vaccine to the rest of Australians is not expected to be completed until towards the end of 2021.

Understandably the Australian Government is insuring itself against the two vaccines falling over at the last hurdle. It signed up to the international COVAX group for \$123.2 million to gain access to a broad

⁴⁷ World Health Organisation, 2020 Draft landscape of COVID-19 candidate vaccines <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines>, accessed 7 October 2020.

⁴⁸ Corum J, Wee S-L, Zimmer C, 2020, Coronavirus vaccine tracker, <https://www.nytimes.com/interactive/2020/science/coronavirus-vaccine-tracker.html>, accessed 6 October 2020

⁴⁹ The Hon Scott Morrison MP, The Hon Greg Hunt MP, The Hon Karen Andrews MP, 2020, Australia Secures Onshore Manufacturing Agreements For Two Covid-19 Vaccines, Media Release, <https://www.pm.gov.au/media/australia-secures-onshore-manufacturing-agreements-two-covid-19-vaccines>, accessed 7 October 2020.

⁵⁰ Reuters/ABC, 2020, Oxford says patient illness which forced pause to AstraZeneca coronavirus clinical trial 'unlikely' related to vaccine, <https://www.abc.net.au/news/2020-09-17/astrazeneca-says-oxford-covid-19-illness-unrelated-to-vaccine/12672530>, accessed 7 October 2020.

⁵¹ AstraZeneca 2020, COVID-19 vaccine AZD1222 clinical trial resumed in Japan, follows restart of trials in the UK, Brazil, South Africa and India, <https://www.astrazeneca.com/media-centre/press-releases/2020/covid-19-vaccine-azd1222-clinical-trial-resumed-in-japan-follows-restart-of-trials-in-the-uk-brazil-south-africa-and-india.html>, accessed 7 October 2020

⁵² AstraZeneca, 2020, Phase III Double-blind, Placebo-controlled Study of AZD1222 for the Prevention of COVID-19 in Adults, <https://clinicaltrials.gov/ct2/show/NCT04516746?term=NCT04516746&draw=2&rank=1>, accessed 7 October 2020

portfolio of COVID-19 vaccine candidates.⁵³ It also announced \$12 million to support Australian research into five other vaccine candidates through the Medical Research Future Fund (MRFF).⁵⁴

A COVID-19 vaccine may not be the panacea everyone wants.⁵⁵ Around 67 per cent of the population must be immune to achieve herd immunity and reduce the incidence of infection.⁵⁶ Whether this is achievable depends on vaccine efficacy and uptake.

Research from the University of Sydney and IPSOS indicates that only 85-88 per cent of Australians surveyed will get vaccinated.^{57,58} Not all Australians can be vaccinated due to medical conditions, and further trials also need to be conducted before the vaccine can be administered to children. Finally, the successful vaccine may only reduce the severity of the disease, rather than protect against infection, and patients may require another dose every year to boost their immune system response.

While the Australian Government responds to the COVID-19 pandemic, patients continue to suffer from various medical conditions. Expenditure on the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits scheme (RPBS) has slowed in recent years due to the price disclosure scheme and statutory price reductions. Annual expenditure on the PBS/RPBS grew by 8.9 per cent in real terms between 1997-98 and 2007-08,⁵⁹ then fell to 2.3 per cent per annum between 2007-08 and 2017-18.⁶⁰

The Australian Government receives advice from the Pharmaceutical Benefits Advisory Committee on which medicines and vaccines it should fund. The PBAC process is reasonably efficient in terms of the time between submission and PBAC recommendation (17 weeks).⁶¹ However, the number of submissions and the time from PBAC recommendation to PBS listing is a contention point with

⁵³ The Hon Greg Hunt MP, 2020, Australia Now Eligible to Purchase COVID-19 Vaccine Doses Through COVAX, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australia-now-eligible-to-purchase-covid-19-vaccine-doses-through-covax>, accessed 7 October 2020.

⁵⁴ The Hon Greg Hunt MP, 2020, Further Investment In Three New Australian COVID-19 Vaccine Research Projects, Media Release, <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/further-investment-in-three-new-australian-covid-19-vaccine-research-projects>, accessed 7 October 2020.

⁵⁵ Parkinson B, 2020, Will a vaccine really solve our COVID-19 woes?, Macquarie University, <https://lighthouse.mq.edu.au/article/please-explain/august-2020/Will-a-vaccine-really-solve-our-COVID-19-woes>, accessed 7 October 2020.

⁵⁶ Randolph H, Barreiro L, 2020, Herd Immunity: Understanding COVID-19. *Immunity*; 52(5): 737-741

⁵⁷ Dodd R, Cvejic E, Bonner C, Pickles K, McCaffery K, Willingness to vaccinate against COVID-19 in Australia, [https://www.thelancet.com/pdfs/journals/laninf/PIIS1473-3099\(20\)30559-4.pdf](https://www.thelancet.com/pdfs/journals/laninf/PIIS1473-3099(20)30559-4.pdf), accessed 7 October 2020.

⁵⁸ IPSOS, 2020, 9 in 10 Australians say they would get vaccinated for COVID -19, <https://www.ipsos.com/en-au/9-10-australians-say-they-would-get-vaccinated-covid-19>, accessed 7 October 2020.

⁵⁹ Australian Institute of Health and Welfare 2009. Health expenditure Australia 2007-08. Health and welfare expenditure series no. 37. Cat. no. HWE 46. Canberra: AIHW.

⁶⁰ Australian Institute of Health and Welfare 2019. Health expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW.

⁶¹ Department of Health, 2020, Procedure guidance for listing medicines on the Pharmaceutical Benefits Scheme Australian Government, Canberra, <https://www.pbs.gov.au/info/industry/listing/listing-steps>, accessed 7 October 2020.

pharmaceutical companies.⁶² On average, there is a further 31 weeks between PBAC recommendation and PBS listing.⁶³ This is mainly due to delays caused by price negotiation.

Significant Budget announcements

This Budget relies on a critical assumption that a COVID-19 vaccine becomes available, and any localised outbreak is contained. It assumes that a population-wide Australian COVID-19 vaccination program will be fully in place by 2021.⁶⁴

This Budget has allocated \$1.7 billion to purchase two COVID-19 vaccines, although this was already announced in September. So was the \$123.2 million allocated to access additional vaccines through the COVAX group and the \$24.7 million for the supply and storage of vital consumables, such as needles and syringes, to ensure vaccines can be administered once available.

It is interesting to consider what is missing from this Budget. This Budget only contains funding to purchase a COVID-19 vaccine for the next two years. It implicitly assumes that a booster dose is not required each year. This is likely due to the uncertainty surrounding the effectiveness of a vaccine.

There is no question that the Australian Government would not find the additional funds if required, given the huge impact of the COVID-19 pandemic on the economy and the potential impact an outbreak can have on health.

However, this Budget does not explicitly allocate funding to cover the administration of the vaccine. This typically costs \$17.75 when administered by a GP, but cheaper if administered by a nurse. This equates to around \$444 million if 25 million COVID-19 vaccine doses were administered by GPs, and nearly \$900 million if two vaccine doses were required to stimulate an effective immune response.

This Budget has announced an additional \$375.5 million towards a range of new and amended listing on the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme. This includes high cost medicines for several different cancers. There is some uncertainty on the true cost of these medicines given revenue from rebates negotiated as part of listing agreements are not published.

This Budget has also announced that the Australian Government will introduce a New Medicines Funding Guarantee Fund, ensuring funding is available for new listings on the PBS and RPBS. While the Australian Government has always guaranteed listings of PBAC recommended medicines, it had previously needed to find funding offsets from either the pharmaceutical program (e.g., through reducing prices) or from elsewhere in the health portfolio.

The New Medicines Funding Guarantee Fund may reduce the time between a PBAC recommendation and PBS listing. It will also provide a strong signal to pharmaceutical companies both locally and globally, that the Australian Government is willing to invest in the medicine supply chain.

⁶² McCauley D, 2020, PBS drug listings being delayed by bureaucracy, medicines lobby says, Sydney Morning Herald <https://www.smh.com.au/politics/federal/pbs-drug-listings-being-delayed-by-bureaucracy-medicines-lobby-says-20191014-p530fs.html>, accessed 7 October 2020.

⁶³ Lybrand S, Wonder M, 2020, Analysis of PBAC submissions and outcomes for medicines (2010-2018). *Int J Technol Assess Health Care*, 36(3):224-31.

⁶⁴ Commonwealth of Australia, 2020, Budget Measures Budget Paper No. 1, Statement 2: Economic Outlook 2020-21, Canberra, <https://budget.gov.au/2020-21/content/documents.htm>, Page 2-6.

This Budget also includes additional funding of vaccines through the National Immunisation Program (\$49 million), including a meningococcal B vaccine for Aboriginal and Torres Strait Islander infants and children and adults with medical conditions who are at increased risk of invasive meningococcal disease.

5. Pharmacy

In an era of economic uncertainty, the Seventh Community Pharmacy Agreement (7CPA) signed by the Australian Government, Pharmacy Guild, and the Pharmaceutical Society of Australia, provided a degree of certainty and stability to approximately 6,000 community pharmacies and pharmaceutical wholesalers.

The Australian Government has committed to investing \$18.3 billion in remuneration for dispensing PBS subsidised medicines, professional pharmacy programs, and community pharmacy management services over the five years of the agreement life.^{65,66} One change from the Sixth Community Pharmacy Agreement compared to the 7CPA is a greater contribution from patients, increasing from \$3.4 billion to \$9.5 billion.

There remains a question over whether the 7CPA represents value for money. The Australian Government has failed to include key changes into pharmacy agreements that help consumers, reflecting the powerful lobby position of the Pharmacy Guild of Australia. Reform to pharmacy location rules to remove barriers to community access and competition were scrapped in 2018.⁶⁷ The optional \$1 copayment discretionary discount was not included in the 7CPA, thereby limiting price competition.

A key recommendation to increase convenience for people with chronic conditions to access medicines was also excluded in the 7CPA. The Pharmaceutical Benefits Advisory Committee (PBAC) had recommended that people accessing any of 143 medicines for chronic conditions be allowed 60 days extended dispensing script.⁶⁸

A run on medicines in the early days of the COVID-19 pandemic led the Therapeutic Goods Administration (TGA) to require and recommend pharmacists to limit the supply of dispensing

⁶⁵ The Hon Greg Hunt MP, 2020, More essential support for Australian patients through community pharmacy, Media Release. <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/more-essential-support-for-australian-patients-through-community-pharmacy>, accessed 30 September 2020

⁶⁶ Department of Health, 7th Community Pharmacy Agreement, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/New-7th-Community-Pharmacy-Agreement>, accessed 30 September 2020

⁶⁷ Department of Health, 2019, Review of pharmacy remuneration and regulation, <http://www.health.gov.au/internet/main/publishing.nsf/Content/review-pharmacy-remuneration-regulation>, accessed 7 October 2020

⁶⁸ Department of Health, August 2018 PBAC outcomes. Other matters, <https://www.pbs.gov.au/industry/listing/elements/pbac-meetings/pbac-outcomes/2018-08/Outcome-Statement-August-2018-Increased-MDQ.pdf>, accessed 30 September 2020

medications to one month.⁶⁹ The Pharmacy Guild of Australia latched onto that, arguing the 60 days extended dispensing policy therefore be excluded in the 7CPA.⁷⁰

While the Pharmacy Guild of Australia also argued that extended dispensing would reduce patient medication adherence and increase medicines waste, the extended dispensing would have reduced foot traffic through pharmacies and dispensing volume. This may have been their most significant concern.

The COVID-19 pandemic has impacted pharmacies in other ways. In March, the Australian Government introduced an interim Home Medicines Service to pay fees to pharmacies to deliver Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) prescriptions.

This was offered to people isolating themselves due to COVID-19 and vulnerable people,⁷¹ projected to cost the Australian Government \$25 million.⁷² The Australian Government also fast tracked electronic prescribing, allowing written prescriptions to be sent to the patient's pharmacy of choice as a photo or PDF via email, text message, or fax.⁷³

The 7PCA also supported pharmacy vaccination services by considering adopting a consistent and harmonised approach for training pharmacists and granting their access to the National Immunisation Program (NIP). Pharmacy vaccination services have been in place for several years, but the legislation and training guidelines vary across jurisdictions.⁷⁴

If the COVID-19 vaccine trials prove successful, the Australian Government will provide around 25 million vaccine doses to Australians for free, and double that if a booster shot is required.⁷⁵ There is no indication of how these will be dispensed, but there is a potential role for pharmacists to put their hand up to meet the expected surge in vaccine demand.

⁶⁹ Therapeutics Goods Administration (TGA) 2020, Limits on dispensing and sales of prescription and over-the-counter medicines, <https://www.tga.gov.au/media-release/limits-dispensing-and-sales-prescription-and-over-counter-medicines>, accessed 5 October 2020

⁷⁰ Paola S, 2020, 60 day dispensing, dollar discount gone in the Agreement, Australian Journal of Pharmacy, <https://ajp.com.au/news/60-day-dispensing-dollar-discount-gone-in-the-agreement/>, accessed 5 October 2020

⁷¹ Department of Health, 2020, Home Medicines Service – Information for consumers, <https://www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-home-medicines-services-information-for-consumers.pdf>, accessed 5 October 2020

⁷² The Treasury, 2020, Economic and Fiscal Update, Australian Government, Canberra

⁷³ Department of Health, 2020, Fact Sheet – National Health Plan A Guide for Prescribers, <https://www.health.gov.au/sites/default/files/documents/2020/09/covid-19-national-health-plan-prescriptions-via-telehealth-a-guide-for-prescribers.pdf>, accessed 5 October 2020

⁷⁴ Department of Health, 7th Community Pharmacy Agreement, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/New-7th-Community-Pharmacy-Agreement>, accessed 30 September 2020

⁷⁵ Prime Minister, Minister for Health, Minister for Industry Science and Technology, 2020, Australia secures onshore manufacturing agreements for two COVID-19 vaccines, Media Release. <https://www.pm.gov.au/media/australia-secures-onshore-manufacturing-agreements-two-covid-19-vaccines>, accessed 30 September 2020

Significant Budget announcements

There were no significant Budget announcements expected to impact pharmacy.

6. Primary care

When a vaccine arrives, and the dust settles, the COVID-19 pandemic may have imposed the most significant structural change on the primary care sector than all other health and aged care sectors. This will stem from a massive shift from face to face consultations to universal telehealth, implicitly bringing the digital health reform agenda forward by about a decade.

While many primary care measures introduced in response to the COVID-19 pandemic are temporary, telehealth barriers have been smashed, and patients are enjoying their newly found convenience.

GPs have been the focus of attention by the Australian Government. They received a large funding increase within the Economic and Fiscal Update in response to the COVID-19 pandemic. This included \$619.1 million for a temporary increase in the value of GP bulk billing incentives and \$54.8 million in increased Practice Incentive Payments to support GPs.

The Australian Government also introduced temporary MBS items to increase access to out-of-hospital services via telehealth in March. They covered GP and other medical practitioner (OMP) services, mental health services, specialist services, obstetric and midwifery services, allied health services, and dental practitioners.

GPs and OMPs were required to bulk bill their telehealth patients, but received a doubling of all Medicare bulk-billing incentive fees for pensioners, under-16s and concession card holders. Both ceased on 1 October 2020, which means GPs are now free to charge copayments for telehealth consultations. This will likely increase the price paid for telehealth, with GPs likely to recoup the reduction in bulk billing incentive fees through increased telehealth copayments.

Before the COVID-19 pandemic, only people living in rural and remote areas were eligible for subsidised telehealth services, and the delivery was restricted to video conference. The COVID-19 pandemic has accelerated the switch to telehealth at warp speed. MBS telehealth consultations increased from 183,689 in 2019,⁷⁶ to 4.7 million consultations in June 2020, accounting for 28.1 per cent of all consultations.⁷⁷

Telehealth adoption has been uneven across health practitioners. It ranges from the lowest of 5 per cent of allied health consultations to more than one third of mental health care consultations.⁷⁸ There is also

⁷⁶ Boyages S, 2020, COVID-19 consequence: telehealth will go mainstream, <https://insightplus.mja.com.au/2020/15/covid-19-consequence-telehealth-will-go-mainstream/>, accessed 6 October 2020

⁷⁷ Snoswell, C.L., Caffery, L.J., Hobson, G., Taylor, M.L., Haydon, H.M., Thomas, E., Smith, A.C. Centre for Online Health, The University of Queensland. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia, <https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia> Last update : 13 August 2020. accessed 30 September 2020

⁷⁸ Ibid.

some heterogeneity in delivery, with 91.5 per cent being delivered by telephone compared to 8.5 per cent through video conference.⁷⁹

There is a mixed sentiment about the new normal from health practitioners. While many believe telehealth improves the access and equity in health care, some have raised concerns about clinical outcomes and treatment adherence.⁸⁰ This highlights the need for an extensive and detailed evaluation of telehealth services' effectiveness and value.

The temporary MBS telehealth items are due to expire on 31 March 2021. Rather than sticking to that, the Australian Government should undertake a robust evaluation of telehealth outcomes and cost effectiveness, by measuring patient outcomes, experience, and satisfaction. This will provide evidence on whether further telehealth integration into the future healthcare delivery system is appropriate.

The digital health revolution is also on the horizon. Building on the existing National Digital Health Strategy,⁸¹ the Australian Government must keep developing additional policies to facilitate patient and physician use of digital health technology, including training and education, addressing patient privacy and designating a remuneration system to encourage practices to embed digital health into their delivery system.

Significant Budget announcements

The Australian Government's focus on responding to the COVID-19 pandemic continued with an additional \$711.7 million to extend temporary Medicare Benefits Schedule (MBS) pathology items for COVID-19 detection and diagnosis to March 2021. This measure will facilitate Australians' access to bulk billed testing, particularly for aged care and interstate freight workers.

The other significant primary care initiative was the \$170.8 million allocated to extend further the operation of up to 150 GP led respiratory clinics for assessing, diagnosis, and management of COVID-19. This measure will continue to take the pressure off GPs, hospitals, and emergency departments, and provides a degree of reassurance to the public in case of a surge in the infection rate.

This Budget has also allocated \$111.6 million for telehealth services. This will guarantee continued access to Medicare-subsidised telehealth for GPs, allied health, mental health, and specialist services for a further six months.

⁷⁹ Ibid.

⁸⁰ Results of Royal Australasian College of Physicians (RACP) Members' Survey of new MBS Telehealth attendance items introduced for COVID-19, June 2020. https://www.racp.edu.au/docs/default-source/policy-and-advocacy/policy-and-advocacy/racp-members-survey-new-mbs-telehealth-attendance-items-introduced-for-covid-19.pdf?sfvrsn=31d1ef1a_7, accessed 30 September 2020

⁸¹ Australian Digital Health Agency (ADHA), 2018, Safe, seamless and secure: evolving health and care to meet the needs of modern Australia. Australia's National Digital Health Strategy (2018-2022), https://conversation.digitalhealth.gov.au/sites/default/files/adha-strategy-doc-2ndaug_o_1.pdf, accessed 6 October 2020

7. Private health insurance

Private health insurance was said to be in a “death spiral” at the beginning of the year. While there was some tinkering with the uniform classification of policies last year, the downward trend in the proportion of the population with hospital cover has continued. Only 43.6 per cent of the population were covered in June 2020, compared to 46 per cent in June 2017.⁸²

These statistics hide some crucial details. Membership has declined by 121,000 in the last three years, which represents a 1.1 per cent reduction. However, the membership is getting older, thereby increasing total risk. Members aged less than 60 years has decreased by 322,000, while members aged above 60 years has increased by 201,000.⁸³

The good news is that the annual reduction in membership since 2017 has reduced. This suggests that private health insurance is not in a death spiral, but is facing strong headwinds. Private health insurance sustainability relies on either rebalancing the increased risk profile of those insured or better managing costs (claims volume and healthcare prices) associated with older members.

Private health insurers are struggling on both counts. Allowable discounts (maximum of 10 per cent) for people aged 18-29 years introduced in 2019 have not arrested the exit of young members. Part of the problem is that private health insurers are only paying discounts to 428,000 members,⁸⁴ or just over one third of those eligible. It seems private health insurers are unwilling to drop their prices to improve their risk pool, particularly for those members eligible for the largest discounts.

A loss of income and high unemployment from COVID-19 will likely impact younger members the most. This has already started to occur. The largest net decrease in membership between March and June 2020 was for people aged between 20-24. Those aged 25-29 were the group with the third largest net decrease.⁸⁵

The struggle with managing costs is observed in benefits paid. Benefits per episode has barely changed for hospital treatment between March 2019 and March 2020. For example, benefits per episode for acute care increased by 0.7 per cent, while the benefits per episode decreased for medical and prosthesis.

However, hospital benefits per person increased by 3.7 per cent.⁸⁶ This shows that increased episodes per member contribute to increased private health insurance expenditure. This stems from the

⁸² APRA, 2020, Private health insurance membership and coverage statistics, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>, accessed 6 October 2020

⁸³ Ibid.

⁸⁴ Department of Health, 2020, Private health insurance reform data, Australian Government, Canberra

⁸⁵ APRA, 2020, Private health insurance statistics highlights June 2020, <https://www.apra.gov.au/quarterly-private-health-insurance-statistics>, accessed 6 October 2020

⁸⁶ Australian Prudential Regulatory Authority (APRA), 2020, APRA, 2020, Private health insurance statistics highlights March 2020, <https://www.apra.gov.au/sites/default/files/2020-05/Quarterly%20private%20health%20insurance%20statistics%20March%202020.pdf>, accessed 6 October 2020

membership pool ageing and more hospital care being used by older members, a trend that has occurred over the last 20 years.

The private health insurance sector has seen net margins reduce from 5.0 per cent to 4.0 per cent between March 2019 and March 2020. Profits after tax were \$973 million for 12 months to March 2020, while equity rose by \$405 million.⁸⁷ Financial performance has continued to deteriorate since the COVID-19 pandemic started, with the net margin being 2.8 per cent in June 2020.⁸⁸ However, some of this reduction may be due to inherent variability in APRA's quarterly statistics.

Private health insurers deferred price increases for six months in response to the COVID-19 pandemic. This is fair given non-urgent elective surgeries were stopped as the Australian Government sought to shore up valuable private hospital resources. However, the Rebate Adjustment Factor was set at one, which means the private health insurance rebate remains the same until April 2021.⁸⁹

Private Healthcare Australia continues to push for more funding support from the Australian Government, particularly for people younger than 40 years.⁹⁰ It argues that increased membership will take the pressure off the public hospital waiting list. There is no evidence to support this claim.

There is some evidence to suggest private health insurance increase public hospital waiting lists, by increasing overall demand for hospital care, and shifting public hospital resources into the private hospital system.⁹¹ A detailed explanation of why increased membership is unlikely to reduce public hospital waiting times in Australia was presented in the 2019 MUCHE Health Report.⁹²

Significant Budget announcements

The Australian Government is projected to pay \$26.9 billion on the private health insurance rebate over the next four years. This is a significant amount of funding, considering there has never been a study to quantify the value the Australian taxpayer receives for this expenditure.

The Australian Government has tinkered around the edges of private health insurance within this Budget, allowing younger Australians to stay on a family policy until they turn 31 years old.⁹³ It hopes to

⁸⁷ Ibid.

⁸⁸ Australian Prudential Regulatory Authority (APRA), 2020, APRA, 2020, Private health insurance statistics highlights June 2020, <https://www.apra.gov.au/sites/default/files/2020-08/Quarterly%20Private%20health%20insurance%20statistics%20June%202020.pdf>, accessed 6 October 2020

⁸⁹ Department of Health, 2020, Private health insurance – Rebate adjustment factor Effective 1 April 2020, <https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-phicircular2020-24>, accessed 7 October 2020

⁹⁰ Private Healthcare Australia, Budget Submission 2020-21 Revised Version <https://www.privatehealthcareaustralia.org.au/pha-pre-budget-submission-2020-21-revised-version/>

⁹¹ Cambie Surgeries Corporation v. British Columbia (Attorney General), 2020 BCSC 1310, Paragraph 2342, <https://www.bccourts.ca/jdb-txt/sc/20/13/2020BCSC1310.htm#SCJTITLEBookMark3342>, accessed 6 October 2020

⁹² Cutler H, Epp J, Aghdaee M, Partington A, 2019, The MUCHE Health Report 2019, https://www.mq.edu.au/_data/assets/pdf_file/0007/761380/Final-MUCHE-2019-Budget-Report.pdf, accessed 6 October 2020

⁹³ Currently, those who are aged 24 years old would have previously needed to take out their own cover, independently or with a partner. From April 2021, this decision will not be required of people until they are 31 years of age.

align the decision for young people to hold private health insurance with the beginning of Lifetime Health Cover.⁹⁴ This will help retain younger members and promote lifetime membership, but it will not reduce the pressure to increase prices.

The Australian Government will also commission two actuarial studies. These will investigate Lifetime Health Cover and the risk equalisation scheme to ensure they are providing appropriate incentives.

The Australian Government has allocated \$19.5 million over four years from 2020-21 to improve access and affordability of private health insurance. Most of this funding is earmarked for the Medical Cost Finder website, costing \$17.1 million.⁹⁵

The Australian Government intends to increase transparency in elective surgery out-of-pocket costs and help patients and referring clinicians to choose care based on price. However, it will be impossible for patients to determine value for money, given participation in the Medical Cost Finder website is voluntary for clinicians, and there is no comparable quality information.

The Australian Government is looking to shift some care from private hospitals into homes and the community, announcing it will consult with the sector on expanding home and community based mental health and rehabilitation care.

This is a welcome direction. However, large scale reform seems unavoidable to stop the slow deterioration of private health insurers and to ensure the taxpayer gets value for money from the private health insurance rebate. Most insurers have shirked on their responsibility to invest significant amounts into wellbeing and integrated care programs to keep people out of hospital.

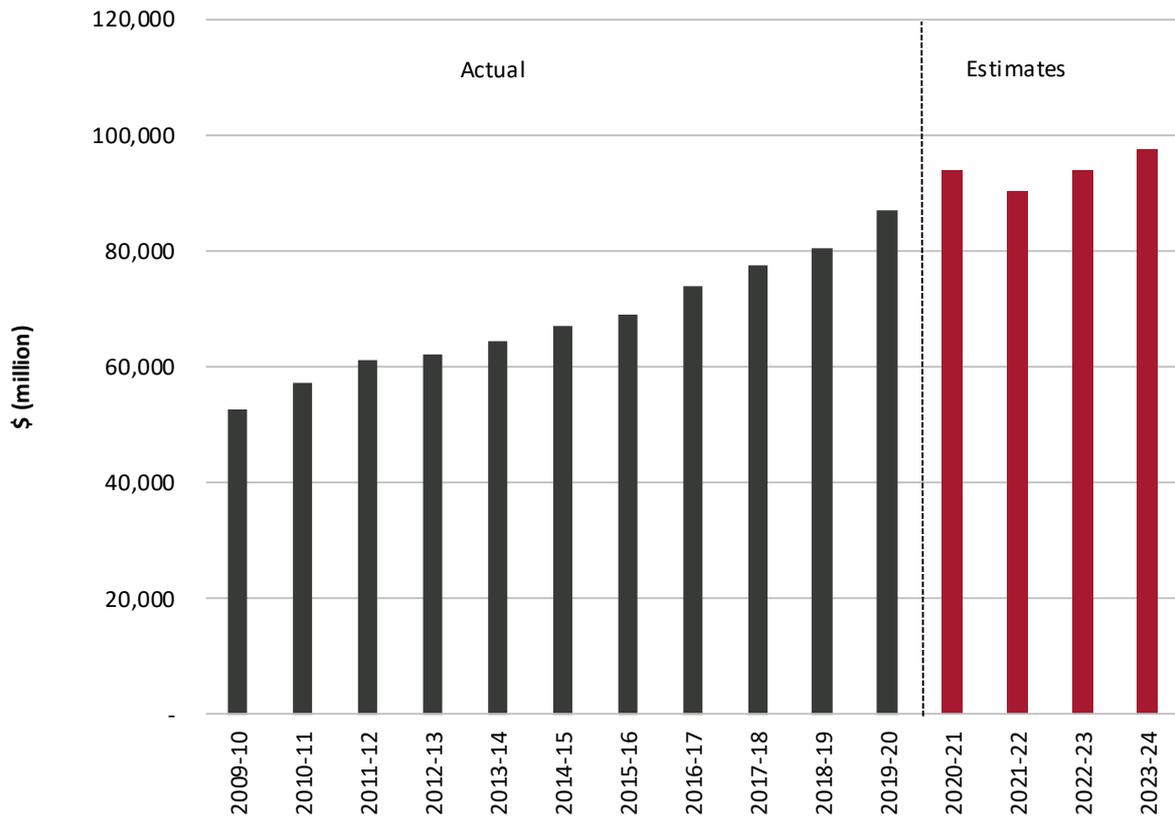
Better aligning incentives within the risk equalisation pool may incentivise insurers to invest more into wellbeing and integrated care programs to keep people out of hospital. However, this is already happening with Medibank Private leading the way. More insurers must follow suit.

⁹⁴ Department of Health, 2020, 2020-21 Portfolio Budget Statement, Australian Government, Canberra
<https://www.health.gov.au/resources/publications/budget-2020-21-health-portfolio-budget-statements>

⁹⁵ Department of Health, 2020, Budget 2020-21 Stakeholder Information Pack, Australian Government, Canberra
<https://www.health.gov.au/sites/default/files/documents/2020/10/budget-2020-21-stakeholder-pack.pdf>

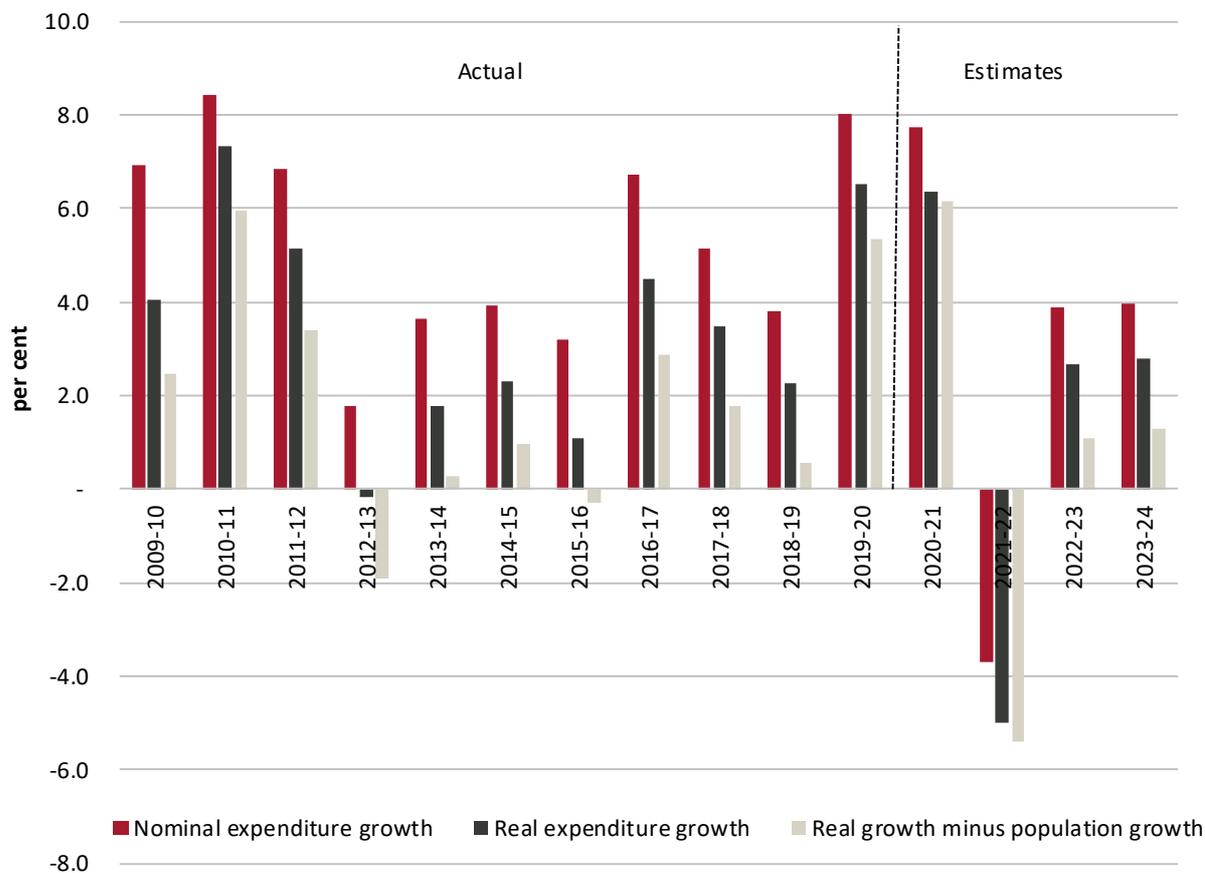
The Budget in pictures

Chart 1: Health expenses



Source: Budget Paper No.1 for 2019-20 to 2023-24. All other health expenses were taken from Budget Paper No.1 released in previous Budget years.

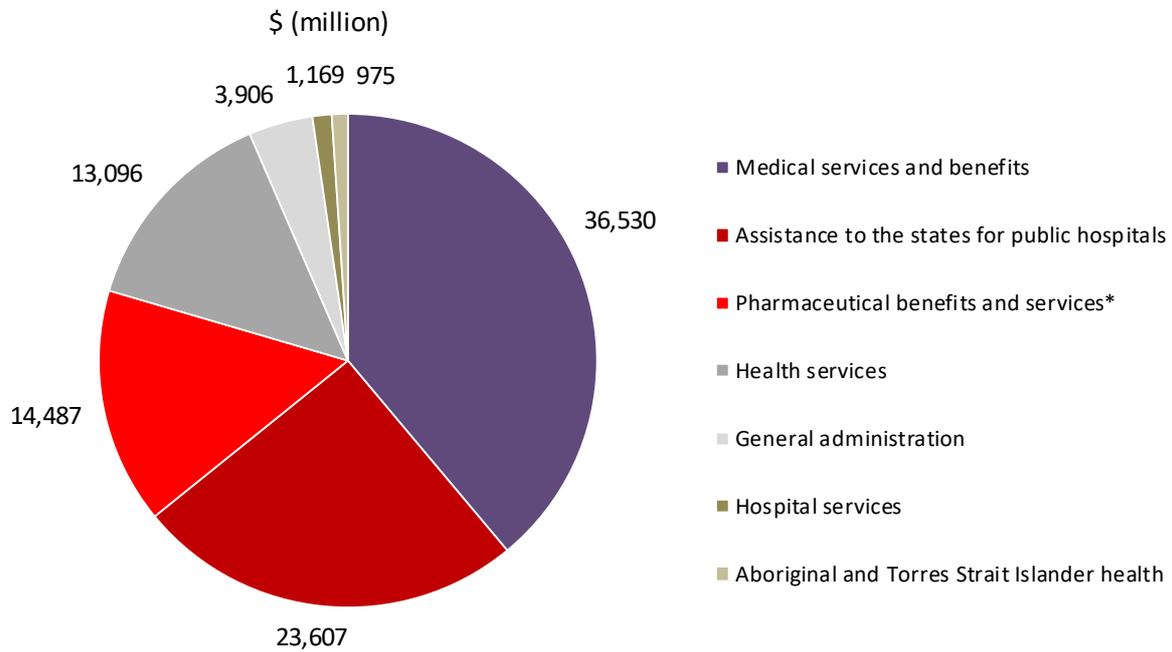
Chart 2: Annual change in health expenses



Note: 1. ‘Real expenditure growth’ was estimated using the Australian Institute of Health and Welfare (AIHW) annual rates of health inflation found in Table 2.6 of Australia’s Health Expenditure 2017-18 report. A linear forecast was used for years 2018-19 to 2023-24. 2. ‘Real expenditure growth minus population growth’ was estimated using the Australian Bureau of Statistics (ABS) Series B population estimates and projections. Population growth rates were adjusted down for 2019-20, 2020-21, and 2021-22 to align with population projections presented in Budget Paper No.1.

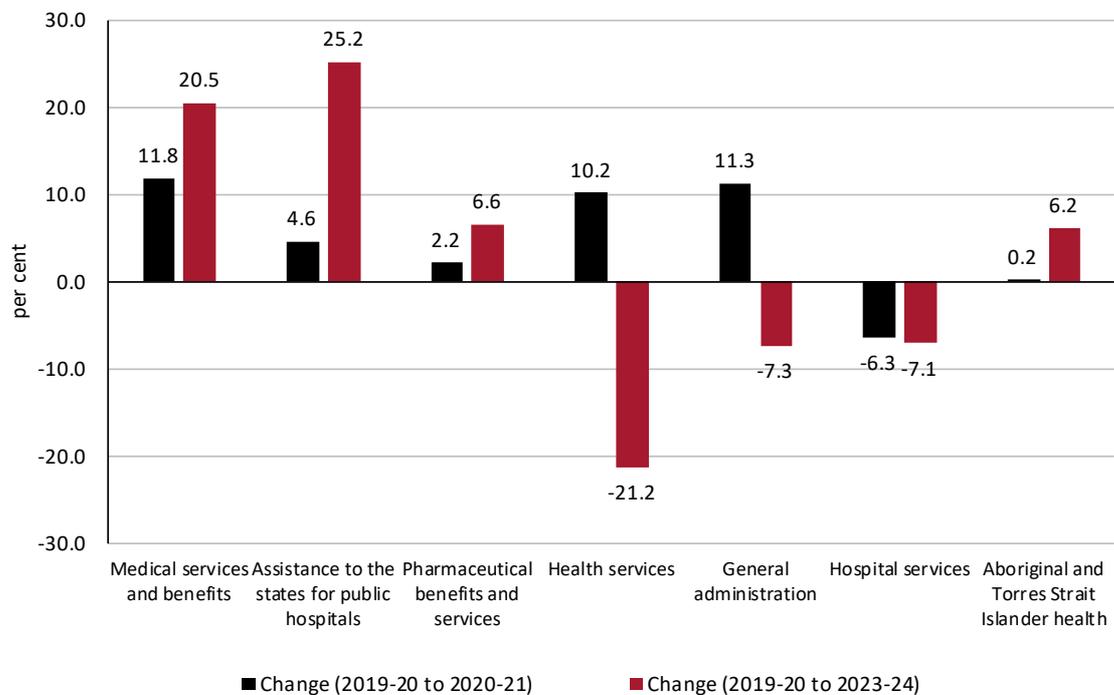
Source: MUCHE calculations based off Budget Paper No.1

Chart 3: Composition of health expenses, 2020-21



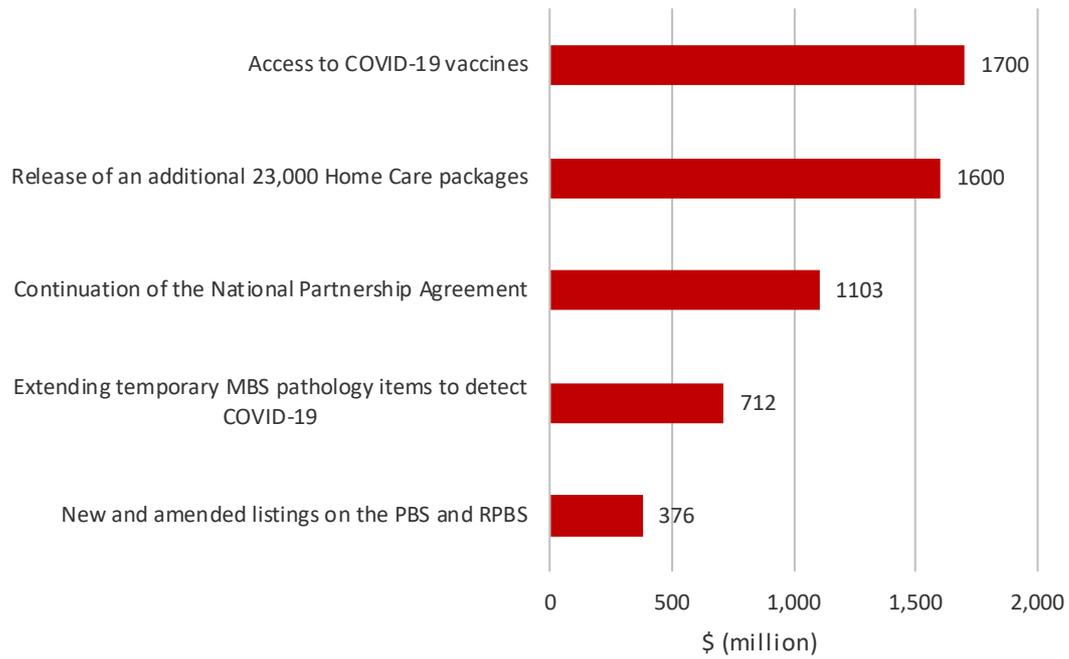
Source: Budget Paper No.1

Chart 4: Estimated proportional change in expenditure



Source: Budget Paper No.1

Chart 5: Top five payment increases since the Economic and Fiscal Update



Source: Budget Paper No.2