

Health and the 2008-09 Federal Budget

Report by Access Economics Pty Limited for the
Australian Medical Association

Health and the 2008-09 Federal Budget

"It's clearly a budget. It's got a lot of numbers in it."

George W Bush, Reported by Reuters, 5 May 2000

EXECUTIVE SUMMARY

- In terms of the overall Budget strategy, the Government has exceeded expectations with expenditure restraint and an estimated surplus in 2008-09 exceeding \$20b. It remains open to question whether this will be enough to help stem inflation and stave off further politically painful interest rate rises. Although there are signs that domestic demand is growing more slowly, Treasury has warned that national income will be boosted by the largest improvement in the terms of trade seen for a generation.
- Health and aged care are treated relatively kindly in this budget. The Government studiously delivered its election promises. New spending of \$5.7b offsets savings of \$3.3b (net \$2.5b), a far cry from the slash and burn savings in the first Howard/Costello budget (1996). Overall Commonwealth Government health spending is estimated to grow by about 4.6% per annum in nominal terms over 2007-08 to 2011-12. At current health sector inflation and labour cost growth, this is close to zero % per annum real growth. More spending is backed up in the decision pipeline (the current AHCA has been extended by one year — the new agreements to apply from 2009-10 will certainly cost the Commonwealth some large dollars).
- The sharp increases in the thresholds for the Medicare levy rebate sends a very confused message. The Government has adopted a policy that harms the insurers and the private hospitals while adding further burdens to an over-stressed public hospital system and the long term fiscal position. State and Territory Governments could legitimately ask for monetary compensation for the extra costs they will face down the track. There is a potential sting in the tail for consumers.
- General Practice is subjected to spending cuts that are estimated to be more than the cost of the Super Clinics. Rural and regional health gets very limited attention. Public hospitals get just enough to struggle by for another year, with the medium term outlook still resolving. Mental health is still waiting for a seat at the table.
- The main restraint on the health system is not a shortage of money but rather a shortage of skilled health professionals. The budget addresses some needs (primarily nurses) but fails to see many others.
- That said, there are bright spots also in the previously announced election platform. Indigenous health is starting to get the sort of attention it should have been given 20 years ago. It is a good start, but more to do. The cancer initiatives get a tick. And the Government is starting to build a framework for health prevention, hopefully not on the back of potentially more inefficient or inequitable taxes. Hope springs ...

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THE BUDGET IN OVERVIEW

THE YEAR ENDING (2007-08)

The estimated underlying cash balance in 2007-08 is a surplus approaching \$17b. Given the Howard government's heavy spending, outlays rose as a share of GDP. The resources boom boosted revenues, which also rose as a share of GDP.

With fiscal settings expansionary and capacity constraints (skilled labour and infrastructure) starting to bite, the Reserve Bank arguably had no option but to try to rein in spending by increasing interest rates. Even so, price and wage inflation reared, both now over 4% p.a.

THE YEAR AHEAD (2008-09)

It is not possible to understand the 2008-09 Budget without fully understanding what happened in 2007-08. That was the year in which the previous government essentially lost the plot. In our May 2007 report on the 2007-08 health budget, we noted our concerns with the overall Budget strategy in the following terms:

"This Budget suggests an underlying complacency as though the good times will just roll on (so it is safe to spend up in an election year). In doing so, the Budget takes some risks with inflation and interest rates given the capacity restraints in the economy, the lack of productivity growth and a slow pace of structural reform."

With the benefit of hindsight, we can see that most economists underestimated the risks ex-Treasurer Costello was taking with the economy. Historically, Australian governments have been relatively poor managers of the "good times". The Howard/Costello government failed on two counts. It mismanaged the economic cycle and it mismanaged structural change.

The cyclical mismanagement of the economy manifested itself in a lack of discipline on spending and on tax cuts when discipline was sorely needed. Hence Access Economics' 2007 portrayal of the then Treasurer with his foot flat on the accelerator and Reserve Bank Governor with a foot hard on the brakes—so no wonder the economy was smoking.

The previous government also dropped the ball on structural reform. The GST improved the structure of the tax system, but other tax reforms were unhelpful (such as halving CGT rates). Real spending on education was cut unwisely early in the last government's term, contributing to the subsequent skills shortage. There was little recognition of the steps that were needed to strengthen the supply side of the economy.

No wonder, then, that the incoming Rudd government faced a difficult task in framing this budget. In the lead up to the budget, they took some care to talk up the problems so as to dampen some demands. This enabled them to trump market expectations with a degree of expenditure restraint and an estimated surplus of over \$20b. They do deserve credit for their efforts. Have they done enough? Our assessment is that the budget measures may not be enough to stave off further interest rates rises (which would be hugely unpopular with the electorate). This is addressed in the next section.

STRUGGLING WITH PROSPERITY

There are several keys to understanding the dilemma the Government faced in framing the 2008-09 budget:

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- ❑ First, the Government felt that it had no option but to deliver on its election promises. This it has done (in large part), even though inflation trends suggested a substantial rethink of the tax cuts was indicated.
- ❑ Second, cyclical management of the economy is always difficult when monetary policy and fiscal policy settings have been working against each other. That was the scenario in 1991 (the recession we didn't have to have). There is a risk of a sharp loss of confidence by consumers and businesses alike that can apply much stronger brakes to the economy than policy settings intend. That said, a runaway train is hard to stop.
- ❑ Third, the boost to the economy from a sharply improving terms of trade – the latest surge in coal and iron ore prices – is quite enormous. Historically, Australia has suffered a long term trend decline in its terms of trade. While financial markets are fussing about the potential impact of recession in the US, in the real economy business managers are fretting about how to move enormous quantities of coal, iron ore and gas through the railways and the pipelines to the ports and the ships. Financial markets have feared a recession in the US, but the Chinese and Indian economies have been resilient and are increasingly important to us. Were they to stumble, we'd feel it keenly.

There are some self-stabilisers in the economy. In response to a sharply improving terms of trade, the \$A has appreciated against the \$US, now approaching parity (whereas \$A1 was worth only 50 cents US as recently as 2001). Further appreciation would reduce the risks to the economy (but make both exporters and those who compete with imports unhappy). A rising currency reduces the \$A value of export incomes and reduces the \$A cost of imports. It simultaneously moderates the income boost from exports and moderates inflation.

The things we cannot fix quickly are the capacity constraints in labour markets and in infrastructure. There are long lead times for both training more people and infrastructure investment.

This Government sees education as an investment in the future. That augurs well for the longer term capacity of the economy.

Some economic indicators point to an easing in demand, or, if not an easing *per se* then a slower rate of growth. Consumer demand may have to fall back further to “make room” for the voracious demands of the resources sector. It is not an easy trick to pull.

HEALTH CARE IS NOT A “NATURAL” COUNTER-CYCLICAL

The demand for health care rises inexorably, with scant regard to the state of the cycle in the economy. Health is a “superior good”. As real incomes rise over time, people tend to spend more of their income on health. New health technologies attract demand and can be very costly. The ageing of the population also contributes to the demand for health care, although not as much as the income and technology drivers of health care.

Short term boosts to health spending have often failed to achieve their aims because the necessary supply-side initiatives are missing. Health spending by government is more effective (and involves less wastage) when the hand on the tiller is steady and resolute. While governments have typically funded about 70% of national health spending, the likely scenario of the future is that the government share will fall. Effective private financing options become all the more important. The impact from the ageing of the population is building up year by year. Traditional private health insurance products may not be sufficient to meet the challenges down the track.

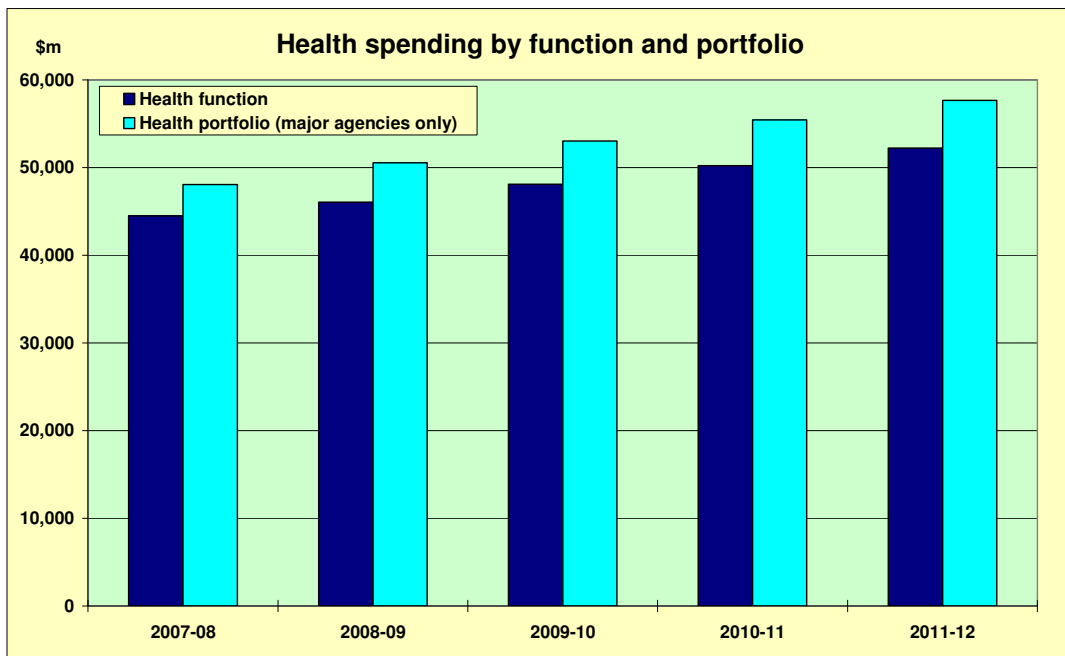
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From time to time, it is necessary to dampen aggregate demand. Few elements of health care are truly discretionary. Savings initiatives frequently boil down to shifting cost off budget (meaning patients pay more). But since the demand for health care is not price elastic, something else in household budgets has to give. That suggests the focus for health spending should be medium and longer term sustainability.

THE HEALTH BUDGET

SPENDING TRENDS

The budget papers classify spending two main ways: by function and by agency. These do not align fully. The Department of Health and Ageing is responsible for the bulk of Commonwealth health spending, but the Department of Veterans Affairs is also a health spender. The Department of Health and Ageing is also responsible for significant aged care programs. Only small amounts are classified to the health function. The bulk is in the social security and welfare function. The agency data is available for Departments and their major sub-agencies.



Spending on the health function is estimated to grow by 4.1% p.a. on average in nominal terms from \$44.46b in 2007-08 to \$52.19b in 2011-12. Spending on the health portfolio (including the major sub-agencies) is estimated to grow by 4.7% p.a. on average in nominal terms, from \$48.05b in 2007-08 to \$57.66b in 2011-12.

Measured either way (by function or portfolio), health spending is falling as a percentage of total spending. However, this budget breaks new ground in Budget honesty, correctly accounting for the GST. It includes the GST as a Commonwealth tax (which it is) and the on-payment of GST revenues to the States and Territories as expenditure (which it is). This item of spending is fast growing, with a boom in retail spending generating gains of 9.7% p.a. in nominal terms on average over the past 5 years. Health spending measured either way is growing as a proportion of outlays other than GST payments.

SPENDING IN THE PIPELINE

The health spending included in this budget is by no means all we can expect to see in the years covered by the forward estimates (2009-10 to 2011-12). The Commonwealth and State governments have agreed to extend the current AHCA by one year (at an immediate cost to the Commonwealth of some \$1b) while they negotiate for a new agreement. The extra Commonwealth spending that will be needed to make the public hospital system viable is very substantial, almost certainly well in excess of \$5b in the normal 5-year term of an AHCA.

The Commonwealth has decided to apply some of the budget surplus to a new Health and Hospitals Fund (in place of the Health and Medical Infrastructure Fund envisaged by the Howard government). The savings measures include the offset from the abandonment of the HMIF, but the Government has yet to decide how to spend the interest earned in the HHF so has not included any estimates in the Budget.

MEDICARE LEVY SURCHARGE THRESHOLDS

The figures in the Budget papers for expenditure on the PHI rebate and the expected savings as a result of the increases in the Medicare Levy surcharge thresholds throw up some strange anomalies. The measure is estimated by the Government to produce savings in PHI rebate expenditure of \$960m over 4 years, comprising \$232m in 2008-09, \$237m in 2009-10, \$246m in 2010-11 and \$256m in 2011-12. Partly offsetting that is a cost to revenue of \$660m (given fewer people will pay the surcharge), comprising \$195m in 2009-10, \$235m in 2010-11 and \$230m in 2011-12. The estimated net saving is \$299m over four years.

The estimated net saving in 2008-09 is highly implausible

The Federal Treasurer has revealed that the budget estimates are based on Federal Treasury modelling which indicates that some 485,000 people will drop their PHI cover. In order to achieve first year savings of \$232m, there has to be a sudden and large exodus of PHI members before 1 July 2008. We do not expect that to happen:

- ❑ The Medicare levy surcharge is only one of the factors affecting the decisions around PHI membership. The parlous state of the public hospitals and the adverse publicity surrounding them may make people reluctant to drop their cover. The Lifetime Health Cover arrangements expose people to a higher PHI premium in the future (up to 70% higher) if they drop their cover and rejoin later in life. These factors might induce some to keep their cover. At the same time, the mortgage belt is under considerable stress given interest rate pressures and excessive household borrowing. Some others will see PHI as a “luxury” that can give way to more pressing needs.
- ❑ A first year estimated saving of \$232m implies a loss of PHI contributions of some \$720m in 2008-09 (assuming an average rebate rate of 32%). If the “average” contributor dropped out from 1 July, we estimate PHI coverage would have to fall by some 534,000 people (a 5.9% fall in coverage) to realise the projected rebate saving for 2008-09.¹

¹ If the average contributor did not drop out until 1 January 2009, then twice as many have to pull out to generate the 2008-09 saving (in which case, the savings would be much higher again in 2009-10 and later years). However, the pattern of PHI savings identified by Treasury - \$232m in 2008-09 and \$237m suggests it sees a similar reduction in PHI membership in both these years.

- ❑ Treasury's reported estimate of 485,000 people would imply that the people who drop out are purchasing PHI products that are **more expensive** than the average. We anticipate the converse. That is, the people who might be expected to drop their cover in the first instance would be younger high income earners who have purchased cheaper PHI products (front-end deductible and/or exclusionary policies) because that is cheaper than paying the surcharge. These are the PHI "Clayton's members", the people whose reason for joining a fund is focussed much more on tax saving than on sharing their risk or receiving benefits.
- ❑ The spread of PHI premiums is now very wide. A top level product can cost three times as much as the most basic product. Were the contributors who drop their cover in the first year paying, on average, two thirds of the average premium, then 800,000 of them would have to drop their cover by 1 July 2008 in order for the Government to realise the estimated first year saving of \$232m. We do not expect that will happen. **Instead, we expect the first year savings to fall well short of the \$232m.**

The pattern of savings over the four years is highly implausible

The forward estimates for the years 2009-10 to 2011-12 suggest that, following a large drop in coverage prior to 1 July 2008, there will be little further response to the measures in the out-years. The projected rebate savings grow very slowly: \$237m in 2009-10, \$246m in 2010-11 and \$256m in 2011-12 while the projected loss of surcharge revenue also grows modestly, primarily reflecting the fact that an increasing number of taxpayers would otherwise have been dragooned in to paying the surcharge.

The estimates of rebate savings are "doctored". Based on the usual Treasury/Finance approach to costing policy changes (which excludes behavioural impacts), the figuring excludes the provision for increases in rebates as a result of premium increases (which have been running at around 5% per annum). That provision for that element of rebate expenditure is hidden in the contingency reserve. The reason for non-disclosure is that the Government does not want the private funds to know what premium increases it expects lest this weaken the Government's position when dealing with applications for approval of premium increases. The doctoring of the forward estimates makes it quite clear that rebate savings estimates assume a large drop in coverage with flat-lining thereafter.

In the past when PHI subsidies have been pared by governments, the impact has been like a rolling snowball. The initial loss of low-claiming, younger members inevitably means premium rises for those retaining their cover in the first instance. These premium increases shake out more members, and more premium rises result. The funds then struggle to reduce their management expenses and the management expense ratio rises, adding to the premium woes and the continuing decline in membership. Over time, a higher proportion of those dropping cover are older, higher claiming members.

There is little the Government will be able to do to stem the premium inflation it has triggered save for reversing the measure. The Government can disallow premium increases in theory, but has few degrees of freedom in reality if the exercise of that power puts the funds in breach of the prudential regulations.

This report does not provide forecasts of the numbers who will drop their cover in response to the measure. Not enough is known about the price elasticity of demand for private health insurance. In broad terms, we expect that the rebate savings will be small in 2008-09, well below the budget estimate of \$232m, but much larger by the end of the forward estimates period (2011-12).

Impact on public hospitals

If, as we anticipate, the first people to react to the measure are the younger “Clayton’s members”, then there will be little initial impact on public hospitals. That will come later on as the snowball gets larger and forces older, sicker people to drop their PHI cover. Given that the financial burdens on State and Territory Governments will rise over time, it is legitimate for them to ask for monetary compensation for the extra public hospital costs they will face in the medium term (but likely not in 2008-09).

Impact on the viability of private funds

Again, if as we anticipate the first people to react to the measure are the younger “Clayton’s members”, the main impact of the measure will be on the financial viability of the private health funds and not on the public hospitals. If the Government were able to achieve the budget estimate of \$232m in savings in 2008-09, this would imply loss of contributions revenue to the funds of over \$700m. The corresponding reduction in benefit expenditure could, however, be as little as \$200m. That would leave the funds short \$500m, implying a premium increase of 5% over and above any premium increase needed to cover costs. Such an outcome would shake out many more members. As stated above, we do not think the \$232m saving is plausible. Therefore, the impact of the measure on fund premiums will be quite modest in the first years but will build up over time.

Lurching from poor public policy to poor public policy

The Howard/Costello Government did not adjust the thresholds for the Medicare Levy surcharge after its introduction in 1997. Consequently, over time, instead of targeting very high income earners for not having PHI, it ended up targeting people earning anything over average weekly earnings. Some adjustment to the threshold eg, to \$70,000 for singles and \$140,000 for couples/families (and a sensible indexation framework thereafter) would have restored the system to previous real levels, if this was the goal.

The Medicare Levy surcharge thresholds set in this budget represent poor public policy. The increases are too sharp and too risky. Singles on incomes approaching \$100,000 p.a. are not people on modest incomes. It is extraordinarily difficult to justify tax breaks for them (and increased taxpayer spending on them when they do go to hospital), particularly in light of new means testing of other welfare expenditures. Couples on a lower total income will be denied the Commonwealth Seniors Health Card under expanded income tests announced in the budget. Single pensioners struggling on a pittance would have been more deserving beneficiaries of Government largesse.

A very confused message

The sharp increases in the thresholds for the Medicare levy rebate leaves the Government sending very confused messages to the private health sector. While the Government claims to understand and appreciate the importance of the private health sector, it has adopted a policy that will harm the private insurers in the first instance. Down the track, that will also harm the private hospitals, and whatever harms the private hospitals also harms the public hospitals which are already struggling with burdens that overwhelm their resources. Both sectors have to pull their weight or the whole system fails. In the light of the Intergenerational Reports, Governments cannot and will not carry the full burden of financing health care in years to come. A fully functioning private health insurance system is a necessity, not an optional extra.

Needs will increase. Health spending is not budgeted to grow relative to GDP. So services will have to be rationed and fewer people will be able to fall back on private provisioning. This is a recipe for worsening health inequities and outcomes.

INDIGENOUS HEALTH

The Rudd Government deserves full credit for trying to come to grips with the unconscionable neglect of Indigenous health over many years. As they get further into it, they will find that the funds committed to date are not enough to achieve the closure of the gap in life expectancy within a generation. However, there is good will and a readiness to engage the problems and the communities in a constructive way. The particular program initiatives include several that appear highly relevant. The tobacco initiative is especially pertinent given the number of Indigenous Australians who die from tobacco-induced illnesses. Expanding the Indigenous health workforce is a critical step to making the delivery of health care in Indigenous communities more effective.

The new funding committed in this Budget falls short of the amount we believe is needed to make a difference. In the past, politicians have used a faulty framework to measure their efforts on Indigenous health. Some have argued that we spend more per capita on Indigenous people than on non-Indigenous, but that is as meaningless as saying that we spend more health dollars on people with cancer than we spent on people who do not have cancer. The per capita spending on Indigenous people has been far too low given their poor health status. Poor health infrastructure (water, sewerage, housing) and limited access to education all contribute to their health problems. Hope now springs ...

RURAL AND REGIONAL HEALTH

It would seem that rural health has been put into the too-hard basket for now. The recent rural health workforce audit showed a dire need to build the medical workforce in rural areas. The Government has implemented its election policies, but these were tinkering at the edges and rural people were certainly hoping for more from the Government. There will be disappointment that the budget lacks the big ticket spending on major workforce programs or rural hospital infrastructure.

However, it would be a mistake to underestimate the difficulty. For well over a decade, governments have thrown money at rural health spending programs. These appear, at best, to have slowed the gulf in access and outcomes but not closed it. There is still a mortality gap for rural and remote Australians, though not as great as for Indigenous Australians.

PUBLIC HOSPITALS

The need for more appropriate resources for public hospitals is painfully clear to all. It is, however, perfectly reasonable to allow the Rudd Government some time to come to grips with what's required. There is merit in buying a year's grace before entering into new agreements with the State and Territory governments. There may even be the possibility in that time of developing genuinely sustainable reforms that develop private sector capacity rather than just spending down past public sector savings.

There is enormous inertia holding back real change in the Federal health financing imbroglio. We can only hope that some real progress is made in COAG early on, before the good will evaporates, as it surely will. We await next year's health budget with great interest.

GENERAL PRACTICE

The 2008-09 health budget contains a very large number of new spending and savings measures, some 150 in all. There are some 50 measures involving spending of between \$0.1m and \$10m or savings of between \$0.1m and \$10m. Yet there is one \$500m saving item spanning seven different program areas with no further breakdown available at time of writing this report. This measure spans both GP and specialist services. Likewise, an estimated saving of \$70m from Medicare Australia audits covers both GPs and specialists. The poor quality information provided does make it difficult to assess the impact of the budget on GPs. Our best estimate is that some \$445m has been cut out of service provision.

On the other side of the ledger, \$275m is to be spent on GP Super Clinic facilities (not on services per se).

While the Government is talking up its focus on health prevention, it is winding back spending on GP services which is the front line for preventive health care.

As to the sub-elements:

- ❑ The provision for GP MRI referral is good news, and the decision to allow 12 month scripts for people with chronic disease is a minor but welcome change.
- ❑ The GP Super Clinics were an election commitment (albeit with some more funding). It is far too early to be assessing the potential effectiveness of the program. Fancy facilities may not be enough to attract workforce into areas of real need. The aim should be to add to, rather than replace, extant local health infrastructure.
- ❑ It is very disappointing to see the excision of the highly successful immunisation incentives program.
- ❑ Grants for after hours services have been rationalised so that funding will no longer be available to help establish new facilities. The Budget papers imply that the money will go into the GP Super Clinics instead.
- ❑ The funding for the pre-vocational GP training program — designed to give young doctors an early taste of general practice and encourage them to consider it as a long term career option — is being cut. While the program struggled to meet recruitment targets early on, the numbers of doctors participating has been growing and it was expected to reach its full potential. Less than 30% of Australian graduates choose GP training for a career, a poor outcome exacerbated by cutting programs of this nature.
- ❑ There is no extra funding for GP training. The Government has expressed the wish to deliver better primary health care services — if it wants to do that it needs to ramp up the number of GP training places. A large proportion of the GP workforce is close to retirement and we are not training enough GPs to replace them as well as keep up with growing demand on GP services. Given the Government's focus on prevention, a plan to increase GP training places would have been welcome. Despite AMWAC recommendations that we need around 1,000 new GPs every year, we still only set aside 600 training places each year.

The Government missed some real opportunities. For example, it could have increased funding for practice nurses working for and on behalf of GPs. Practice nurses help take the pressure off GPs and allow them to see an increased number of patients.

OTHER MEDICAL WORKFORCE ISSUES

Australia is doubling its output of medical graduates to address workforce shortages (a new Clinical school at Greenslopes Private Hospital is announced in the Budget). Medical training does not finish at medical school. More resources are needed to support training for interns as well as specialist trainees. For a government strongly committed to investment in education, the lack of response on this issue is worrying.

HEALTH AND HOSPITALS FUND

The Rudd Government has cancelled the previous Government's plan for a Health and Medical Infrastructure Fund (HMIF). The HMIF was announced by then-Treasurer Peter Costello in August 2007. It was to receive an initial investment of \$2.5 billion from the surplus with a subsequent top-up from the proceeds of the sale of Medibank Private.

The Rudd government plans instead to establish a \$10b Health and Hospitals Fund (HHF) and it will not sell Medibank Private. It will establish two other surplus-fed "nation building" funds as well, a Building Australia fund (BAF) and an Education Investment Fund (EIF).

No funds will be spent from HHF before 2009-10. It is envisaged that both the capital and the earnings of these three funds will be available over time to finance appropriate projects.

The HHF will be available for:

"capital investment in health facilities, including renewal and refurbishment of hospitals, medical technology equipment and major medical research facilities and projects."
(Source: Budget Statement No. 1 page 1.20)

Renewal and expansion of health infrastructure is an essential prerequisite for a high quality health system. The "trick", however, is to make complementary investments in health education and training so that we do not end up with splendid new facilities sitting idle for want of the skilled health professionals needed to work with the new infrastructure. The Queensland Premier can provide a few examples of this occurring already.

This potentially good measure could be made better if HHF and EIF could also be applied to investments in human infrastructure (and not just fixed capital). It could be made better again if the most needy health areas (eg Indigenous health) were explicitly within the purview.

It could fail, however, if State and Territory Governments seize upon it as a means to drop the ball on their health capital funding commitments. It does look like a sitting duck for cost-shifting.

MISSED OPPORTUNITIES

There remain many other opportunities to improve the effectiveness of health spending. The AMA has previously drawn attention to the silos that separate drug and alcohol services from mental health services. Yet a very high proportion of patients with drug and alcohol problems also have mental health conditions. A holistic, patient-centred approach would end this divide.

THUMBS UP, THUMBS DOWN

The overall commitment to health	👍
Something to tide over the public hospitals (for a year)	👍
Indigenous health (kick start)	👍
Cancer initiatives	👍
Dental initiatives	👍
More focus on health prevention (but stumbling on immunisation)	👍
Aged care transitional care (helps the aged & public hospitals)	👍
PBS spending initiatives	👍
Some of the workforce initiatives	👍
Health and Hospitals Fund	👍
Resisting the temptation to slash health research	👍
General Practice (despite Super Clinics)	👎
Rural & regional health	👎
Failure to get moving on post-graduate medical training	👎
Financing through inefficient, inequitable RDT taxation measures	👎
Missed opportunities to encourage greater private sector capacity	👎👎
Medicare Levy surcharge thresholds	👎👎

HEALTH MEASURES OVERVIEW

The 2008-09 health budget contains a very large number of new spending and savings measures (over 150). The detailed measures table can be accessed at the web site of the Department of Health and Ageing in html format or a downloadable pdf file. See <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2008-glance.htm>

The table over the page seeks to summarise the measures. The categorization is problematical. Some splits (eg, between GPs and other) have had to be estimated given the paucity of data provided. In other cases, particular items could have been classified several different ways. The cancer category includes screening for bowel cancer. This fits cancer as a disease category. It could equally have been classified as health prevention. Budget measures categories are typically not mutually exclusive. There is no consistent framework from year to year. The categories reflect the political imperatives of the day.

The measures table allows us to see:

- ❑ The overall picture (new spending \$5.7b, savings \$3.3b, net spending \$2.45b);
- ❑ The “winners” — hospitals up \$1.5b net, pharmaceuticals (including the stockpile) up \$900m net, aged care up \$660m net with solid commitments to dental health and cancer;
- ❑ The “losers” — medical services generally and private health services.

When looking at the measures table, keep in mind that there is still more spending backed up in the decision pipeline (especially AHCA and the Health and Hospitals Fund). While the latter is to be created by setting aside money from the budget surplus, it matters not from which bucket the money is spent.

It is also important to keep in mind that Budget measures always overstate the extent of new spending. The “measure” is the difference between two mythical figures: last year’s forward estimate and the new forward or budget estimate. Forward estimates of spending typically are underestimates. That allows governments to give the impression that spending is all under control going into the future, while gaining kudos for “new” spending. It is analogous to the Government using tax bracket creep to increase the real rate of taxation and then, magnanimously, granting “tax cuts” and/or bribing voters (with the voters’ own money) via new spending deals. Budgeting is not so much a science as an alchemy using smoke and mirrors.

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Summary of spending and savings measures in the 2008-09 Health Budget (\$m)

New measures (\$m)	2007-08	2008-09	2009-10	2010-11	2011-12	5-yr total	2007-08 to 2011-12		
	\$m	\$m	\$m	\$m	\$m	\$m	Spend	Save	Net
Measures affecting GPs (est.)	33.1	-3.4	-56.8	-73.8	-69.9	-170.1	275.2	-445.8	-170.6
Other medical Medicare (est.)	-0.6	-121.9	-142.4	-139.0	-137.3	-541.4	19.9	-561.2	-541.3
Private health insurance	0.0	-231.6	-41.4	-10.5	-15.5	-299.0	660.0	-959.0	-299.0
Public hospitals	713.2	212.8	198.7	276.7	63.4	1,464.9	1,502.2	-37.3	1,464.9
Indigenous health	1.4	33.5	39.7	52.3	53.5	180.1	180.1	0.0	180.1
Pharmaceuticals	16.3	285.9	195.1	186.1	207.7	891.0	1,014.7	-123.6	891.1
Aged care	0.0	96.4	123.2	184.6	257.3	661.5	702.8	-41.3	661.5
Health prevention (sport)	11.0	21.0	1.3	4.6	6.6	44.5	117.5	-73.1	44.4
Health prevention nei	4.8	12.4	23.1	29.1	29.1	98.6	112.3	-13.7	98.6
Cancer	7.9	76.1	114.0	63.6	9.4	270.9	291.8	-20.9	270.9
Dental health	-35.8	76.7	110.1	121.1	17.1	289.3	780.7	-491.5	289.2
Health workforce	-15.7	-36.7	-14.8	-12.7	-13.3	-93.0	76.9	-170.0	-93.1
Sundry measures	0.0	1.4	-102.4	-121.0	-124.1	-346.1	5.6	-351.7	-346.1
Total new spending							5,739.7		
Total savings measures								-3,289.1	
Net spending	735.6	422.6	447.4	561.1	284.0	2,451.2			2,450.6

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