Chapter 4
2015-16 Budget

Introduction

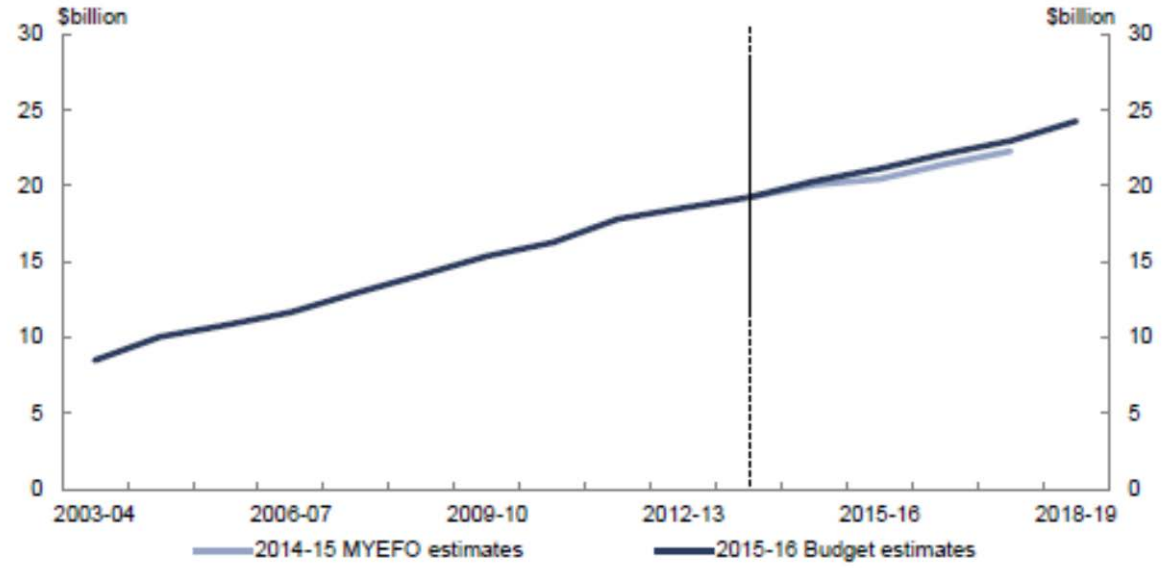
4.1 On 12 May 2015 the Government handed down its 2015-16 Budget. This chapter outlines those Budget measures which affect primary healthcare and general practice, and examines the initial commentary made by stakeholder groups.

4.2 The main 2015 Budget measures affecting primary healthcare are:

- Review of Medicare Benefits Schedule
- Rationalisation and streamlining of Flexible Funds
- E-Health: Introduction of the myHealth Record
- Re-introduction of Practice Incentives Programme (PIP) after hours care
- Removal of the Medicare Healthy Kids Check

4.3 The Medicare changes announced in the 2014 Budget and the 2014 MYEFO – consisting of the $7 co-payment and the shorter consultation times respectively – are excluded from the 2015 Budget.[1] The result is a gap in savings of around $3 billion over the forward estimates. This is represented in the 2015 Budget and 2014 MYEFO charts analysis completed by the Parliamentary Budget Office (see Figure 2).

Figure 2—Change from 2014-15 MYEFO to 2015-16 Budget[2]



1 Budget 2014-15, Budget Paper No. 2, 'Medicare Benefits Schedule – changes to GP rebates – reversal', p. 102.

2 Parliamentary Budget Office, *2015-16 Budget and forward estimates – charts*, 28 May 2015, p. 18.

4.4 The $7 co-payment and short consultation times policies and commentary around them can be found in Chapter 3.

4.5 Out of the measures introduced in the 2014 Budget, only three major health measures were continued into the 2015 Budget: the allocation of savings to the Medical Research Future Fund,[3] the continued indexation freeze, and the $5 co-payment on PBS items.[4]

Medical Research Future Fund

4.6 Despite its initial introduction in the 2014 Budget, the Medical Research Future Fund legislation was only introduced into the House of Representatives on 27 May 2015.[5] When questioned about the Medical Research Future Fund Bill 2015 during June 2015 Budget Estimates hearings, officials from the Department of Health told Senators that a number of concepts relating to the fund remain to be clarified.[6]

Indexation freeze

4.7 Another measure continued from the 2014 Budget is the indexation freeze. The Health Minister has stated that indexation freeze will remain in place even while the MBS review proceeds. In a statement on 22 April 2015, the Minister said:

> "As an article of good faith, I am open to a future review of the current indexation pause as work progresses to identify waste and inefficiencies in the system."[7]

4.8 The continuation of the indexation freeze has drawn strong criticism. The AMA have argued that the freeze will have the same effect as a co-payment as it will put a strain on general practice and force doctors to pass on additional costs to consumers:

> Even if indexation comes back in on 1 July 2018, the effects of the freeze will be felt forevermore because of the compounding effect. This will increase out-of-pocket costs for private medical care and force more people to seek care in the public sector. But the likelihood of them receiving timely care and treatment will be diminished by the squeeze on funding flowing from the Commonwealth.[8]

---

3 Budget 2014-15, Budget Paper No. 2 p. 132.

4 Budget 2014-15, Budget Paper No. 2 p. 140.

5 *Votes and Proceedings No. 117*, House of Representatives, 27 May 2015, p. 1317.

6 Mr Martin Bowles PSM, Secretary, Department of Health; Mr Mark Cormack, Deputy Secretary, Department of Health; and Ms Janet Anderson, First Assistant Secretary, Acute Care Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, pp 26–27.

7 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

8 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 1.

4.9 The RACGP too have expressed significant concerns, telling the committee that ultimately additional costs for healthcare will cause most difficulties for the vulnerable:

> The RACGP has calculated that the freeze of general practice patient rebate consultation items will result in a total reduction of funding of $558.6 million up until 2019 for general practice consultation items alone. General practices cannot absorb the reduced funding and will be forced to either pass costs on to the patients, including those in society who are most vulnerable, or close down. Freezes on patient rebates are not sustainable for an already stretched sector.[9]

4.10 GPs told the committee that the indexation freeze would impact on the viability of their practices. For instance Dr Emil Djakic, a GP from Ulverstone, Tasmania, explained that the freeze would harm his business and the community in which it is based:

> The introduction of a price point and a co-payment and the change in our MBS rebate rates and a freeze over a period of time is going to significantly put pressure on that [low socio-economic] part of the community… Access, [to primary healthcare] I think, is under threat and my business views that as a concern.[10]

4.11 Dr James Wilson, another Tasmanian GP, expressed a similar view to Dr Djakic. He observed that the indexation freeze would dissuade medical students from choosing a career in general practice. Further, Dr Wilson felt that the government's indexation freeze policy would threaten GPs continuing to bulk-bill:

> As to the cuts, the freeze, and that, I am not quite sure that came from a medical think-tank, and it also basically says to someone who is young and up-and-coming: 'Either get out of or do not go into general practice, and don't bulk-bill.'… I think that the Australian system – and it is not perfect – is, in general, a wonderful thing. As to tearing away at the basis of that, like [Dr Djakic] was talking about, in general practice – which is a recognised value-for-money proposition – those changes do not sit well with me as a GP.[11]

Medicare Benefits Schedule review

4.12 As discussed in Chapter 3, after the Minister for Health announced that she would conduct wide ranging consultations with all stakeholders about possible healthcare reforms.

---

9 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 8.

10 Dr Emil Djakic, Ulverstone GP, *Committee Hansard*, 17 April 2015, p. 26.

11 Dr James Wilson, Tasmanian GP, *Committee Hansard*, 17 April 2015, p. 27.

4.13 On 22 April 2015, the Minister announced that the outcome of her consultations was a review of the MBS.[12] The 2015 Budget provides $34.3 million over two years from 2015-16 for the Medical Services Advisory Committee's activities, including an expanded MBS review overseen by a clinician led Medicare Benefits Schedule Review Taskforce.[13]

4.14 Also included in the $34.3 million measure is the formalisation of government consultation with stakeholders on primary care. The consultation will be led by a Primary Health Care Advisory Group with 'will include primary health care professionals, health economists and health academics.'[14]

4.15 The Minister has identified three priority areas for the review:

> 1. The Government is establishing a Medicare Benefits Schedule (MBS) Review Taskforce led by Professor Bruce Robinson, Dean of the Sydney Medical School, University of Sydney. Currently, the MBS has more than 5,500 services listed, not all of which reflect contemporary best clinical practice. The MBS Review Taskforce will consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients.
> 2. The Government is establishing a Primary Health Care Advisory Group led by former Australian Medical Association President, Dr Steve Hambleton. The Advisory Group will investigate options to provide: better care for people with complex and chronic illness; innovative care and funding models; better recognition and treatment of mental health conditions; and greater connection between primary health care and hospital care.
> 3. The Government will also work with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks. The vast majority of medical practitioners provide quality health care, but a small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients.[15]

4.16 While the review is to be an ongoing process, each taskforce will report back with its key priority areas for action in late 2015.[16]

---

12 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

13 Budget 2015-16, Budget Paper No. 2, p. 104.

14 Budget 2015-16, Budget Paper No. 2, p. 104.

15 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

16 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government to deliver a healthier Medicare', Media Release, 22 April 2015.

4.17 During Budget Estimates, Mr Bowles, Secretary of the Department of Health, explained that the Primary Health Care Advisory Group would have a broad focus, looking at:

> …opportunities to reform primary healthcare to support better management of patients, particularly in the chronics and complex space. We are trying to make sure that Medicare and primary health care in those broader issues are sustainable into the future. We want to have a look particularly at the complex and chronic care conditions and at whether there are other ways of looking at those. Ultimately, that will look not only at models of care; it will look at the issues between the hospital sector and primary care and it will also look probably at some of the funding mechanisms that currently go to how we pay for services, particularly in that chronic disease space.
>
> You will see in the media sometimes that it is looking at blended funding models. It could be fee-for-service for certain things or it could be a payment for a certain set of activities. But if you have a look at some of the chronic disease categories like diabetes, some of the things you need there are care facilitation, allied health resources and all sorts of different things, not only doctor related issues. So this is about trying to have a bit of a fundamental rethink of how we might do that.[17]

4.18 Mr Bowles expected that the Primary Health Care Advisory Group would report back on its identified priorities by the end of 2015:

> Dr Steve Hambleton has been appointed the chair of that group and the rest of the group will be announced shortly. He has already started to talk with a range of people. The department is obviously underpinning a lot of the work in this space. We are supporting him in trying to look at how we might do things in this space. The idea would be that we come back to government later this year, probably closer to Christmas, around some options. That does not mean that we will have definitive answers to everything by Christmas, because, as you would appreciate, reforming Medicare and primary health care involves quite a complex set of issues. But, by Christmas, I think Dr Hambleton and others will have a pretty good idea of what is feasible and what may not be feasible.[18]

4.19 Asked about the relationship between the Primary Health Care Advisory Group and the Reform of Federation process currently underway, Mr Bowles acknowledged that there would be some overlap in the processes, but he could not outline the exact way in which one process might inform another:

> The green paper is likely to be out before then [Christmas time, when the Primary Health Care Advisory Group will report], but the white paper comes out at some stage early next year. Clearly, there will be overlap in

17 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

18 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

> some of these issues. It is fair to say that the reform of the Federation white paper, the health component, will have something to say about primary health care, and particularly chronic disease management…
>
> …Reforming the Federation white paper will go to the states and territories and the Commonwealth—the relationship, obviously, because that is what the Federation is. This [the Primary Health Care Advisory Group] will feed in to some of the thinking on it, but there will be a whole range of broader thinking as well.[19]

Commentary

4.20 The MBS review has been cautiously welcomed by stakeholders. For example Ms Alison Verhoeven, CEO of the AHHA told the committee that the AHHA welcomed the review:

> By taking a critical view on the validity of some of the treatments and processes currently in place, increased efficiency rather than blunt fiscal measures will drive sustainability. We hope that the government will commit to making public the findings of the review, and we recommend that mechanisms for regular ongoing reviews of the system be put into place to ensure that the MBS continues to operate in the most sustainable and cost-effective way possible.[20]

4.21 Noting the Minister's comments about her being open to remove the indexation freeze in the future as part of "good faith discussions", the RACGP told the committee that:

> The MBS review needs to examine the value and appropriateness of Medicare rebates, focusing on meeting patients' needs. While the health minister has indicated that the potential lift of the freeze may form part of the MBS review, the RACGP believes that they should be separate discussions.[21]

4.22 The AMA has welcomed the MBS review but remains sceptical of the outcomes and urged the Minister to hold to the stated object of the review and not have the review become a Budget savings exercise:

> The MBS review is one where we are encouraged by the statements that she is making—that it is to be clinician led with the prime goal of improving care and to have the MBS review reflect modern medical practice. But we are also extremely wary that this could be used as a device to simply to cut funding out of MBS wherever possible. We remain intensely alert to that possibility. We have always said that, as leaders of the profession of health care, we are open to good evidence and innovation in models of care, but

19 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 50.

20 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, 19.

21 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 8.

> we are always looking to preserve the best of what we have built to this point and to improve the models of care. We think that Minister Ley is speaking in that regard, but again it is the outcomes that matter. We are always prepared to act in good faith. The question is: over time, will the deeds and policy positions of the government match that?[22]

Flexible Funds

4.23 The Flexible Funds were created in 2011 as a means of consolidating 159 health and ageing programs into a more efficient funding structure. Eighteen broader funds were created within the Health portfolio at this time. In 2013 following Machinery of Government changes, the following funds were transferred to the Department of Social Services:[23]

- Aged Care Workforce Fund; and
- Aged Care Service Improvement and Healthy Ageing Grants Fund.

4.24 The 16 Flexible Funds which remain under the Health portfolio are:

1. Chronic Disease Prevention and Service Improvement Fund
2. Communicable Disease Prevention and Service Improvement Grants Fund
3. Substance Misuse Prevention and Service Improvement Grants Fund
4. Substance Misuse Service Delivery Grants Fund
5. Health Social Surveys Fund
6. Single Point of Contact for Health Information, Advice and Counselling Fund
7. Regionally tailored primary care initiatives through Medicare Locals Fund
8. Practice Incentives for General Practices Fund
9. Rural Health Outreach Fund
10. Aboriginal and Torres Strait Islander Chronic Disease Fund
11. Health System Capacity Development Fund
12. Health Surveillance Fund
13. Quality Use of Diagnostics, Therapeutics and Pathology Fund
14. Health Workforce Fund
15. Indemnity Insurance Fund

---

22 Dr Stephen Parnis, Vice President, AMA, *Committee Hansard*, 9 June 2015, p. 4.

23 Department of Health, department website, 'Flexible Funds – Funding the nation's health priorities', www.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfunds.htm.

16. Health Protection Fund[24]

4.25 The measure in the 2015-16 Budget states that savings of $962.8 million will be achieved over five years by 'rationalising and streamlining' funding across a number of programs, including Flexible Funds.[25]

4.26 However, Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, advised the Senate Community Affairs Legislation Committee at Budget Estimates that by a decision of government two funds had been excluded from the Budget measure:

- Aboriginal and Torres Strait Islander Chronic Disease Fund; and
- Indemnity Insurance Fund[26]

4.27 The 2015-16 Budget measure is in addition to a measure announced in the 2014-15 Budget to freeze the indexation on the Flexible Funds from 2015-16. This earlier measure resulted in "savings" of $197.1 million.[27]

4.28 At Budget Estimates, the Secretary of the Department of Health, Mr Martin Bowles, advised the Senate Community Affairs Legislation Committee that the 2015 Budget measure would take $596.2 million from the Flexible Funds, in addition to the $197.1 million from the 2014 Budget.[28]

4.29 It became clear during the Budget Estimates hearings that the government and the department have not considered the detail of how the Flexible Funds are to be "rationalised" and "streamlined". Mr Bowles told the Senate Community Affairs Legislation Committee that:

> We will do some detailed analysis over the next couple of months. There will be a range of different factors that we will take into account and we will have conversations with government about that as well.[29]

Commentary

4.30 The Department of Health's lack of detail about which Flexible Funds will be cut, to what extent and by when, have caused major confusion and concern amongst

---

24 Department of Health, department website, 'Flexible Funds – Funding the nation's health priorities', www.health.gov.au/internet/main/publishing.nsf/Content/budget2011-flexfunds.htm.

25 Budget 2015-16, Budget Paper No 2, p. 110.

26 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 10.

27 Budget 2014-15, Budget Paper No. 2, p. 131.

28 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 9.

29 Mr Martin Bowles PSM, Secretary, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 11.

both stakeholders and the organisations dependent on this important source of funding.

4.31 The RACGP Vice President, Dr Morton Rawlin, told the committee that in the current circumstances it is impossible to estimate what programs might be cut. Dr Rawlins was concerned that evidence-based programs might be in danger:

> Our main concern is that we are really unclear as to what programs are being cut, what are not being cut, what the extent of visit percentage cut across the board of all programs is or whether a particular program is defunded. Without that level of evidence definition it is very hard to make an evidence based prediction. There may be, within those programs, some which—without funding evidence based programs—will disappear and that would be very negative. But there are others that may not be evidence based and it is not such an issue. We need to have more detail of where those cuts might affect, who they might affect and how they would impact on general practice and the health system, more generally. It is hard to say.[30]

4.32 Ms Helen Tyrrell, CEO of Hepatitis Australia, told the committee that her organisation's core work is funded under the Communicable Disease Prevention and Service Improvement Grants Fund. For Hepatitis Australia, the funding from the Flexible Fund is essential to its ongoing viability. Ms Tyrrell explained that she had raised the issue with the Minister:

> In this context, I asked the minister at the post-budget briefing at Parliament House what value she placed on the role of peak national organisations like Hepatitis Australia. Her response showed an understanding of our role and our commitment to the partnership approach. But, to be honest, it is of little comfort until I secure ongoing funding.[31]

4.33 Ms Tyrrell advised that without funding certainty, her organisation (and others like) it was subject to inefficiencies which undermined its core work:

> Since the Abbott government came into office, I have had two six-month extensions and now one 12-month extension to our core funding contract—and that takes us through to June next year. The inefficiencies that this has created severely undermine our ability to conduct the work that the government wishes us to conduct to address viral hepatitis in Australia.[32]

4.34 Ms Cathy Dyer, the Director of Corporate Services at the Maari Ma Health Aboriginal Corporation, provided a similar perspective on the disruptive nature of short-term government contracts. Her evidence also suggests that the duration of government contracts to non-government organisations are becoming shorter and shorter:

---

30 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 12.

31 Ms Helen Tyrrell, CEO, Hepatitis Australia, *Committee Hansard*, 9 June 2015, p. 14.

32 Ms Helen Tyrrell, CEO, Hepatitis Australia, *Committee Hansard*, 9 June 2015, p. 14.

> As soon as you have attracted someone to the region, we always cross our fingers and hope that they will stay long-term…but, when that does not happen, you lose them to the region. If at the 12th hour or three months down the track or six months down the track a government department does find the funding to continue your program, you have lost that person, the relationships they have built up with their clients is gone and a new person needs to be found. That period of time of recruitment is long. They move to the region, they have to become familiar, they have to build relationships again, and you are 12 months further down the track. It is just the reiteration of the cyclical nature of funding that has plagued Aboriginal health forever. All this [uncertainty of federal funding] does is play into it again. So we do the best we can to maintain some level of stability, but government funding does not assist us. It really does not assist us in building relationships or in maintaining a good rapport with the clients that we are trying to assist. When government funding goes three years, 12 months, six months, three months, you lose people.[33]

4.35 Evidence given by Ms Amanda Mitchell, the Acting Deputy Chief Executive Officer of the Aboriginal Health Council of South Australia Inc, appeared to confirm a trend in government contracting for short-term contracts:

> We have had a very successful program with our tackling smoking and healthy lifestyle team. We found out a couple of weeks ago that it will be going to select tender later on this year, via invitation, and our program will continue for the next six months. In the last 18 months of the funding there has been a freeze on employment, so we have to have the same people in the team. For the last six months it has been extended by three months and then a further three months.[34]

4.36 Ms Alison Verhoeven, CEO AHHA, explained that the Flexible Funds support a large number of frontline healthcare and preventive health services:

> The flexible funds are used to support a whole range of programs and organisations that deliver services to people across the Australian community, including prevention type services and also chronic disease management, drug and alcohol treatment, mental health services and the like. Because they are largely delivered into the primary care sector, one of the important contributions that they make is reducing some of what might be preventable hospitalisations. That is very important not only for the health of the community but also for the sustainability of funding in the health system overall.[35]

---

33 Ms Cathy Dyer, Director, Corporate Services, Maari Ma Health Aboriginal Corporation, *Committee Hansard*, 10 June 2015, p. 13.

34 Ms Amanda Mitchell, Acting Deputy Chief Executive Officer, Aboriginal Health Council of South Australia Inc, *Committee Hansard*, 11 June 2015, p. 12.

35 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 22.

4.37 Ms Verhoeven warned that cuts to the Flexible Funds and the organisations which rely on them will have real life harmful consequences:

> Ad hoc cuts in flexible funds will damage individuals, will damage organisations and potentially will increase the burden on the hospitals. Because we simply do not know where those cuts are going to be made—we did see in Senate estimates last week some headline figures, but they do not really provide us with great clarity about exactly where those cuts are going to occur—it is very difficult to understand what the impact will be on the overall health budget situation. What we can say, though, is that this is a part of the health sector which is underfunded at the moment anyway—in prevention and chronic disease management—and cuts will hurt.[36]

4.38 Ms Melanie Walker, Acting CEO of the Public Health Association of Australia (PHAA), told the committee that the confusion around how much would be cut from the Flexible Funds had been exacerbated by comments made by the Secretary of the Department of Health, Mr Bowles, during the 2015 Budget lock up:

> We subsequently found out in this budget that another $500 million or so, as announced in the health budget lock-up, was going to come out of the health flexible funds over the next four years. Just last week we found that that was actually another $596.2 million, as the secretary had rounded down in his briefing on budget night. That now means that $197.1 million [due to non-indexation] plus the $596.2 million takes it to the big end of $800 million worth of cuts across the health flexible funds to be applied over the next four financial years.[37]

4.39 Ms Walker outlined the extent of the uncertainty facing organisations receiving funding through Flexible Funds—with some funded for six months and others for 12 months:

> Obviously taking $800 million out of those funds over a period of four years has the capacity to decimate the efforts of the non-government sector in Australia, in our opinion. So we are very, very concerned about the implications of those cuts. Some of the currently funded organisations have received six-month extensions to their current funding agreements that are due to end on 30 June—as in this month—so that will take them up to Christmas. Others of the funds have received a 12-month extension, which will take them to June next year. But, as we understand it, all bets are off after that.[38]

4.40 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health's advice regarding the six and 12 month extensions of funding, provided at Budget Estimates was that:

---

36 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 22.

37 Ms Melanie Walker, Acting CEO PHAA, *Committee Hansard*, 9 June 2015, p. 39.

38 Ms Melanie Walker, Acting CEO PHAA, *Committee Hansard*, 9 June 2015, p. 39.

> What is happening at the moment is that these organisations have been notified about extensions for six or 12 months. The reason for that extension is that we are looking to reconfigure the funds, as the secretary has indicated. As part of reconfiguring the funds, we will have to come up with new guidelines and new processes where people apply for funding. Once those processes are completed, everybody will have to reapply. Clearly, when you are looking across 14 flexible funds, you do not want to do them all at once. So we have some that we can do within the six-month period; others will take longer, and that is the 12-month period. That is what we are working through at the moment.[39]

4.41 Upon further questioning, Department officials provided evidence on the way in which funds had been chosen for six or 12 month extensions:

> Dr Bartlett: It was a fairly arbitrary decision.
>
> Senator DI NATALE: Did you draw the names out of a hat? What does 'arbitrary' mean?
>
> Dr Bartlett: No. 'Arbitrary' means that you look at it and decide on relative complexity of process to work through and then length of time that we think it will take us to do it.
>
> Senator DI NATALE: What was the process that you used to do that?
>
> Dr Bartlett: A group of us talked about it, talked to the minister's office about it and got agreement about how we would stage this.
>
> Senator McLUCAS: Was it by fund?
>
> Dr Bartlett: It was by fund.
>
> Senator McLUCAS: Organisations funded by certain funds got six months and others that were funded through other flexible funds got 12?
>
> Dr Bartlett: It was done on a fund basis.[40]

4.42 Ms Walker also observed that some of the Flexible Funds that are planned to be cut relate to drug and alcohol dependency:

> It is a little ironic that two of those funds [the Substance Misuse Prevention and Service Improvement Grants Fund; and the Substance Misuse Service Delivery Grants Fund] are specifically in the area of alcohol and other drug treatment and prevention, given that we currently have the National Ice Taskforce working its way around the country looking at issues in terms of addressing the so-called ice epidemic. Whether it is an epidemic or not is up for some debate, but there is definitely a problem there. One would think

---

39 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 13.

40 Dr Richard Bartlett, First Assistant Secretary, Portfolio Investment Division, Department of Health, Senate Community Affairs Legislation Committee, *Budget Estimates Hansard*, 1 June 2015, p. 13.

> that, at this juncture, removing a big chunk of funding from alcohol and other drug related services would not necessarily be a sensible thing to do in terms of increasing capacity to address those problems, particularly in rural and remote Australia.[41]

4.43 Ms Walker advised the committee that it was her understanding that the drug and alcohol treatment services fund recipients had received a 12 month extension but that 'all bets are off after that'. She noted that with the drug and alcohol dependency services already subject to lengthy waiting lists and difficulty attracting staff, the cuts are ill timed to say the least:

> In terms of the capacity of the sector, I think it is well documented that there are lengthy waiting lists for most funded drug and alcohol treatment services in Australia and there have been for quite some time. It is a serious impediment to families and communities seeking assistance with these problems. Whether we are talking about the use of methamphetamine or alcohol related problems, or indeed any form of drug problems, drug and alcohol treatment services are the front line in providing assistance to families, individuals and communities who are addressing these problems. And when the waiting lists are quite lengthy already, any reduction in funding to these services would only create an additional barrier to people seeking help. At the moment we have seen $20 million go to an advertising campaign to raise awareness in communities around the potential impacts of ice and what that can look like at the pointy end. It seems a little misguided to be spending that money on raising awareness if, when that awareness is raised, there is nowhere to go for help. So, I guess that is our concern around cuts to the treatment sector.[42]

4.44 A concern highlighted by Ms Walker was that the uncertainty around the cuts to the Flexible Funds is making forward planning impossible for organisations, particularly those providing frontline services:

> It is really unclear, and that is what is so disconcerting for the sector at the moment. Everyone is okay today, but no-one really knows about tomorrow. And whether tomorrow is the end of the year or the end of the financial year, it creates a climate of uncertainty in which it is very difficult to do any service planning, particularly for front-line service delivery agencies such as those in the drug and alcohol treatment sector.[43]

4.45 Ms Walker told the committee that for frontline drug and alcohol dependency programs forward planning was vital—without it these services cannot admit people to receive treatment:

> Drug and alcohol rehabilitation is quite a lengthy process, so people stay in rehabilitation for some months. It is not going to be long before it becomes

41 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 39.

42 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, pp 40–41.

43 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 42.

> an issue for admissions. How are these services going to know whether they can accept more people into the programs if they are not sure how long their funding is going to go for and whether their funding is going to continue long enough for the person to complete their treatment?[44]

E-Health

4.46 The 2015 Budget describes the myHealth Record as 'a new direction for electronic health [e-health] records in Australia'.[45] The myHealth Record replaces the previously implemented Personally Controlled Electronic Health Records (PCEHR).

4.47 The change to myHealth Record from the PCEHR outlined in the 2015 Budget is a result of the findings of a review into the PCEHR commissioned on 3 November 2013 by the then Health Minister the Hon Peter Dutton MP.[46] The review handed down its report in December 2013,[47] and the report was made public on 19 May 2014.[48]

4.48 The 2015 Budget provides $485.1 million over four years to 'continue the operation of the eHealth system, make key system and governance improvements and implement trials of opt-out arrangements.'[49] The improvements include renaming the eHealth system, transitioning governance arrangements from the National E-Health Transition Authority to a new Australian Commission for eHealth. Trials of the new system, including an opt-out model will be held in 2016 and new legislation will be introduced to facilitate the changes.[50] This legislation is currently part of a consultation process being conducted by the Department of Health.[51]

4.49 The 2015 Budget notes that 'funding of $699.2 million for the redevelopment of the PCEHR was provisioned for in the contingency reserve at the 2014-15 Budget.'[52] The $485.1 million allocated in the 2015 Budget represents a saving of

---

44 Ms Melanie Walker, Acting CEO, PHAA, *Committee Hansard*, 9 June 2015, p. 42.

45 Budget 2015-16, Budget Paper No. 2, pp 104-5.

46 Panel Report, *Review of the Personally Controlled Electronic Health Records*, December 2013, p. 5.

47 Panel Report, *Review of the Personally Controlled Electronic Health Records*, December 2013, p. 5.

48 Department of Health, department website, *Personally Controlled Electronic Health Record (PCEHR) System*, www.health.gov.au/internet/main/publishing.nsf/Content/ehealth-record.

49 Budget 2015-16, Budget Paper No. 2, pp 104–5.

50 Budget 2015-16, Budget Paper No. 2, pp 104–5.

51 Department of Health, department website, *Welcome to ehealth.gov.au*, http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/content/home.

52 Budget 2015-16, Budget Paper No. 2, pp 104–5.

$214.1 million, which will be 'redirected by the Government to fund other Health policy priorities or will be reinvested into the Medical Research Future Fund.'[53]

Commentary

4.50 There has been cautious stakeholder support for the government's changes to e-health records. For example, the RDAA commented:

> The previously announced trial of an opt-out eHealth system, to be renamed the My Health system. We welcome this in-principle, and the Government's recognition of the need to support doctors and practices should an opt-out system be adopted.[54]

4.51 Ms Verhoeven, CEO of the AHHA, told the committee that:

> The AHHA cautiously welcomes the investment in e-health through the funding of the My Health Record program. We argue that the provision of timely access to patient's health records is an essential step in improving health outcomes in Australia and coordinating care. But given the uptake of the Personally Controlled Electronic Health Record was limited, we do think that piecemeal budget responses are not an adequate response.
>
> We encourage the government to implement the recommendations of the AHHA submission to the PCEHR review, such as focusing on enhancing information exchange and the interoperability between systems rather than developing additional data repositories; identifying barriers to participation; providing incentives to engage clinicians; and achieving a suitable balance between the need for information and privacy. These are all challenges that must be addressed. Going forward, new approaches to e-health need to be clear, decisive and capable of delivering more significant results than the staggering steps we have seen in the past.[55]

After-hours Care

4.52 Funding for the Medicare Locals had included the Practice Incentives Programme (PIP) After Hours Payment, with the role of the Medicare Locals being to ensure that after hours care was provided in their areas and GP practices received payment for the service.[56]

4.53 In 2013, the then Health Minister the Hon Peter Dutton MP commissioned a review of the Medicare Locals by Professor John Horvath.[57] The review found that

---

53 Budget 2015-16, Budget Paper No. 2, pp 104–5.

54 RDAA, 'Mixed-bag Budget for rural health sector: Rural doctors search for fine details in Health Budget', Media Release, 12 May 2015.

55 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.

56 National Health Reform Process and Delivery Publication, Government Publication, September 2011, p. 18.

57 The committee examined the Review of Medicare Locals in its first interim report. For further reading, see: Senate Select Committee on Health, *First Interim Report*, 2 December 2014, Chapter 4.

stakeholders were largely unsatisfied about the Medicare Locals' administration of the after-hours care programme.[58] As a result of this finding, Professor Horvath recommended that a separate review be conducted to focus on the Medicare Locals' administration of the after-hours care programme.[59]

4.54 The *Review of After Hours Primary Health Care* report, which was conducted by Professor Claire Jackson, was announced on 19 August 2014. In announcing the review, Minister Dutton explained that Professor Jackson would begin the review immediately and hand down her findings to the Government by 31 October 2014.[60] Professor Jackson's report was made public on 15 May 2015.[61]

4.55 Professor Jackson's review recommended, amongst other things that:

> **Recommendation 1**
>
> The Commonwealth resumes responsibility for after hours funding of general practice from Medicare Locals from 1 July 2015.
>
> **Recommendation 2**
>
> A revised Practice Incentives Programme (PIP) After Hours incentive is accessible for accredited general practices from this date.[62]

4.56 The PIP After Hours Payment outlined in the 2015 Budget implements the first two recommendations of the *Review of After Hours Primary Health Care* report. The Budget measure notes that the PIP payments will be available from 1 July 2015. Funding for the PIP will be 'met by redirecting funding from the After Hours GP Helpline and the Medicare Locals After Hours Programme.'[63]

Commentary

4.57 The PIP After Hours Payment was the least criticised component of the 2015 Budget, with the return of the policy that had been scrapped in the 2014 Budget supported by stakeholders:

- The AMA commented in a media release: 'the AMA has been calling for the return of the PIP funding for some time. The new PIP payment structure will

58 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, p. 7.

59 Professor John Horvath AO, *Review of Medicare Locals – Report to the Minister for Health and the Minister for Sport*, 4 March 2014, recommendation 8, p. v.

60 The Hon Peter Dutton MP, Minister for Health, 'Review of After-Hours Service Delivery', Media Release, 19 August 2014.

61 Ms Marie McInerney, 'Not all “Captain Chaos” but much confusion, concern on post-Budget health issues', *Croakey blog*, 19 May 2015, http://blogs.crikey.com.au/croakey/2015/05/19/not-all-captain-chaos-but-much-confusion-concern-on-post-budget-health-issues/.

62 Professor Claire Jackson, *Review of after hours primary health care – report to the Minister for Health and the Minister for Sport*, 31 October 2014, p. ix.

63 Budget 2015-16, Budget Paper No. 2, pp 109–110.

encourage and support general practices to provide After Hours coverage for their patients, which will in turn ensure continuity of care.[64]

- The RDAA also commented positively: 'The return of the management of after-hours incentive payments to the Practice Incentive Payments program in 2015-16 — we welcome this in general terms, as it should return funding and contract certainty for rural practices in relation to the provision of after-hours services.'[65]
- Similarly, the RACGP President Dr Jones said 'the RACGP genuinely supports the Government's move to return the delivery of after-hours care to GPs via the Practice Incentives Program (PIP) After Hours Payment from July 1 2015. Having GPs coordinate after-hours care is a win for patients who will be able to access the care they need from their regular general practice when they need it – even if it isn't during normal operating hours.'[66]

Removal of the Medicare Healthy Kids Check

4.58 A final budget health measure affecting primary healthcare is the cancellation of funds for the Medicare Healthy Kids Check. The 2015 Budget states that the current health assessments for children provided under the MBS are duplicated by the child health assessments currently provided by states and territories.[67]

4.59 The 2015 Budget notes that this measure will create savings of $144.6 million over four years. The savings will be 'redirected by the Government to fund other Health policy priorities or will be reinvested into the Medical Research Future Fund.'[68]

4.60 The Medicare Healthy Kids Check which began in July 2008:

> …checks physical health, general wellbeing and development in children over the age of three and under the age of five years, to ensure they are healthy, fit and ready for school.[69]

4.61 The 2011 Budget had committed an additional $11 million over five years (to 2015-16) for an expansion of the Medicare Healthy Kids Check to include:

> …development and social and emotional wellbeing, and lower the target age for the Medicare Healthy Kids Check from four to three and a half years.[70]

---

64 AMA, 'New arrangements will improve after hours GP services', Media Release, 22 May 2015.

65 RDAA, 'Mixed-bag Budget for rural health sector: Rural doctors search for fine details in Health Budget', Media Release, 12 May 2015.

66 RACGP, 'Budget delivers mixed bag for general practice', Media Release, 12 May 2015.

67 Budget 2015-16, Budget Paper No. 2, p. 103.

68 Budget 2015-16, Budget Paper No. 2, p. 103.

69 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

4.62 The expanded Medicare Health Kids Check commenced in early 2013 with a pilot through eight Medicare Locals under the direction of the Australian Medicare Local Alliance. Included in the pilot was an orientation package for GPs and other health professionals which was aimed at ensuring that those delivering the check had access to the appropriate tools and resources. The pilot was completed in December 2013.

4.63 The Medicare Healthy Kids Check continued to be available in all general practices, however the expanded check was available only in those practices which were included in the pilot areas.[71]

4.64 On 16 December 2013, Minister Dutton announced the Review of Medicare Locals by Professor John Horvath.[72] The Medicare Locals Review, and the implementation of its recommendation to transition Medicare Locals to Primary Health Networks, has meant that the expanded Medicare Healthy Kids Check has remained under the consideration of government.

4.65 In cancelling the Medicare Healthy Kids Check in the 2015 Budget, the Hon Sussan Ley MP, Minister for Health argued that

- similar child health assessments are available under state and territory government funded programs;
- the spending on the Healthy Kids Checks is unsustainable; and
- that the Healthy Kids Checks have been criticised in the past for not being of benefit to children.[73]

Commentary

4.66 Despite the Health Minister's argument in her media release on 19 May 2015 that the Medicare Healthy Kids Check is duplicated by states and territories, there has been criticism of the government's decision to cut funding.

4.67 Most notable has been the strong criticism from the RACGP and Speech Pathology Australia. RACGP President Dr Jones has advocated for GPs to be central in early monitoring of the overall health of children because a GP can take into account family conditions and observable changes in a child's development.[74] Dr Jones argued that:

---

70 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

71 Department of Health, department website, 'Expanded Medicare Healthy Kids Check', www.health.gov.au/internet/main/publishing.nsf/Content/healthy-kidschk.

72 The Hon Peter Dutton MP, Minister for Health, 'Medicare Locals Review', Media Release, 16 December 2013.

73 The Hon Sussan Ley MP, Minister for Health, 'GPs still funded to deliver important kids checks', Media Release, 19 May 2015.

74 RACGP, 'Budget threatens health of Aussie kids', Media Release, 18 May 2015.

> Restricting this service to state based programs will limit access and further fragment care by forcing families to seek care outside their regular general practice… It is disappointing the Federal Government made this decision without discussion or consultation with the profession because we could have provided advice on how to improve the Healthy Kids Check.[75]

4.68 Dr Morton Rawlin, Vice President of the RACGP, enlarged on RACGP public statements at the committee's hearing on 9 June 2015. Dr Rawlin told the committee that there were two reasons for the importance of the Medicare Health Kids Check. The first was the priority the check gave to preventative health:

> …in many ways, it [the Health Kids Check] is actually a signal that preventative health is important. Up until several of these item numbers appeared—and the Healthy Kids Check was probably the main one—preventative health was really done, if you like, under the carpet. It was not recognised within Medicare, item numbers and things like that.[76]

4.69 The second point Dr Rawlin raised related to the government's argument that the federally funded Medicare Healthy Kids Check duplicate the children's assessments provided by states and territories. Dr Rawlin noted that:

> One problem that we have is that the system is both state and federal, where maternal and child health services generally are state funded in most states and, as such, the services are very variable across the states and certainly across a state they are also very variable. We do know that now the distribution of general practice is actually not unreasonable. It does reach virtually all of our population.[77]

4.70 Dr Rawlin also told the committee that the RACGP was pleased that at least the Aboriginal and Torres Strait Islander Healthy Kids Check had been retained.[78]

4.71 Speech Pathology Australia also voiced concerns about the cutting of the Medicare Health Kids Check. It argued that the check is an important referral pathway to speech pathology assessment for young children who are identified as having a delayed communication development.[79] Noting that the government had a process of MBS review in train, Speech Pathology Australia observed that:

> It is of significant concern that the Government has chosen to cease this Medicare item ahead of the actual review of Medicare announced recently. Speech Pathology Australia is evaluating the possible impact on referral

---

75 RACGP, 'Budget threatens health of Aussie kids', Media Release, 18 May 2015.

76 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

77 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

78 Dr Morton Rawlin, Vice President, RACGP, *Committee Hansard*, 9 June 2015, p. 11.

79 Speech Pathology Australia, 'The Budget 2015-2016: What's in it for Speech Pathologists?', Media Release, May 2015.

> pathways for children and options for increased advocacy around these issues.[80]

4.72 Professor Nigel Stocks, the Head of the Discipline of General Practice at the University of Adelaide, contended that the government's cancellation of the Health Kids Check program may not result in an overall savings to Medicare:

> …it is not clear to me as a medical practitioner how much the programs are uniform across Australia for maternal-child health checks run by state systems. Certainly, children would miss out, potentially, in those circumstances. I would like to emphasise that these health checks are often undertaken as part of team work within a general practice. It is not just the GP who is involved; it often is the practice nurse. This is actually a good way of developing primary health care within Australia, and having a team approach to health care. That is particularly pertinent for childhood health checks.
>
> If people expect that general practitioners will take up the slack from not being able to do the health check with an MBS item, it will be difficult, because the nurse will not necessarily be involved, because there will be no direct remuneration for that time against all the other things that the nurses are potentially doing. Therefore, the time allowed for that check will be necessarily decreased. If the time were increased there would still be a cost, because you might go from, say, a level B, when you are doing some immunisations, to a level C or even to a level D, and that is going to cost extra money. So the cost savings may or may not be apparent if you are just switching from a formal health check to a time based formula.[81]

4.73 In a recent opinion piece for Medical Observer, Associate Professor Owler criticised the government's claims that the Medicare Healthy Kids Checks duplicated state child health assessments. He argued that rather than the suddenly cancelling the Healthy Kids Checks in the 2015-16 Budget, the government should have considered the checks as part of the MBS review:

> There have also been cuts of nearly $150 million taken out of general practice from changes to the child health checks, apparently because of 'duplication'. It is very unclear where the so-called duplication occurs. Such a change would have been better dealt with as part of the MBS review, rather than as a hastily conceived budget saving measure.[82]

---

80 Speech Pathology Australia, 'The Budget 2015-2016: What's in it for Speech Pathologists?', Media Release, May 2015.

81 Professor Nigel Stocks, Head, Discipline of General Practice, University of Adelaide, *Committee Hansard*, 11 June 2015, p. 31.

82 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

Committee observations

4.74 Associate Professor Owler has written that 'one of the greatest compliments you could pay the 2015 health budget is that it is not the 2014 health budget'.[83] He observes that while the 2015-16 Budget contains few 'bad policies', it continues the detrimental measures of the indexation freeze and the cuts to public hospitals. Worse still, other measures such as the cuts to the Flexible Funds are shrouded in secrecy, and information on just what the cuts will involve is scarce.[84]

4.75 As discussed in this chapter, the main 2015 Budget measures affecting primary healthcare are:

- Review of Medicare Benefits Schedule
- Rationalisation and streamlining of the Flexible Funds
- E-Health: Introduction of the myHealth Record
- Re-introduction of Practice Incentives Programme (PIP) after hours care
- Removal of the Medicare Healthy Kids Check

4.76 The introduction of the myHealth Record (a re-vamped PCEHR) and the re-introduction of the PIP afterhours care funding have received a generally warm reception with stakeholders. These measures represent either decisions long delayed (action on the PCEHR review handed to the government in October 2014) or a reversal of much criticised decisions from the 2014-15 Budget (the removal of PIP funding pending a review).

4.77 Other measures have drawn criticism due to the paucity of detailed information. The MBS review has been welcomed, but only tentatively. In particular, as noted at paragraph 4.19, the AMA has reserved judgement on the review, pending evidence that the government is indeed acting in good faith and not using the review as a means of cutting primary healthcare to achieve budget "savings".

4.78 The "rationalisation and streamlining" of the Flexible Funds has drawn much criticism, in particular for the uncertainty the lack of information is creating amongst groups who rely on these funds for ongoing resourcing. That the government and the Department of Health have yet to decide how the "rationalisation and streamlining" process will occur is a reason for great alarm. With many frontline service organisations reliant on the Flexible Funds, the ongoing uncertainty is highly likely to result in real life consequences for patients and health consumers, as well as those employed by frontline service providers.

---

83 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

84 Associate Professor Brian Owler, President, AMA, 'Shroud of secrecy amid lasting pain', *Medical Observer*, 9 June 2015.

4.79 Key among criticisms of the decision to scrap the Medicare Healthy Kids Check is that no consultation was conducted before the measure was announced in the 2015-16 Budget.

4.80 The committee notes that its previous report highlighted the need for the government to make substantial improvement in evidence-based policy making, transparency, and consultation. Given the lack of detail in the 2015 Budget, indications that the government did not consult, and the early reactions of stakeholders, it is reasonable to suppose that the government has not improved in those areas in which it previously failed.

4.81 The committee agrees with the view put by Ms Verhoeven, CEO of AHHA, and strongly suggests the government have regard to the same advice:

> Overall, it is the AHHA's view that the health portfolio continues to have a burning need for strategic vision, for genuine consultation with all stakeholders, and not just a chosen few, and a true partnership with the states and territories and regional health bodes, rather than a penalising approach, in order to deliver what we all want: a healthy productive Australia with healthy contributing citizens.[85]

85 Ms Alison Verhoeven, CEO, AHHA, *Committee Hansard*, 9 June 2015, p. 20.