

## QUEENSLAND GOVERNMENT SUBMISSION

### Select Committee on Health

#### **Inquiry into health policy, administration and expenditure.**

The Queensland Government welcomes the opportunity to make a submission to the Select Committee on Health and notes this Inquiry is looking into and reporting on health policy, administration and expenditure.

#### *Queensland's Public Healthcare System*

Consistent with the principles and objectives of the National Health Reform Agreement (NHRA) agreed to by the Commonwealth and States and Territories, the Queensland Government has implemented significant reforms and key structural changes across its public hospital and healthcare system. A key feature of these reforms has been devolving centralised control and decision-making to independent Hospital and Health Services (HHSs), which have greater autonomy and greater ability to respond to the health needs of the local community. Enhanced performance, accountability and transparency across Queensland's public healthcare system has been driven through this increased autonomy, along with specific key performance indicators and targets.

The Queensland public healthcare system, collectively known as 'Queensland Health', comprises the Department of Health, sixteen HHSs and the Queensland Ambulance Service (QAS). The Department of Health is responsible for managing the public health system, including purchasing services from the HHSs which are responsible for delivering public healthcare services. The Queensland Government also makes use of private and non-government organisations (NGOs) to deliver publicly funded health services.

The Queensland Government is implementing its plan to achieve a contemporary and sustainable healthcare system through its *Blueprint for better healthcare in Queensland* (the Blueprint) released in February 2013. The Blueprint outlines a statewide healthcare system with new capacity, cooperation, transparent reporting systems and financial accountability, through structural and cultural reform. The Blueprint has four principal themes:

1. Health services focused on patients and people;
2. Empowering the community and our health workforce;
3. Providing Queenslanders with value in health services; and
4. Investing, innovating and planning for the future.

In 2014-15, Queensland Health's operating budget will be \$13.622 billion, an increase of \$942 million from its 2013-14 adjusted operating budget position of \$12.680 billion. A total of \$11.006 billion (or 80.8 per cent of the total budget) will be allocated through service agreements to provide public healthcare services from HHSs and other organisations including Mater Health Services and St Vincent's Health Australia.

As at 30 June 2014, Queensland Health had an estimated 70,400 full-time equivalent staff. Of these, approximately 85 per cent were working across approximately 182 facilities, including 20 specialist hospitals, primary healthcare centres, residential aged care and mental health services, operated by HHSs.

The remaining 15 percent were working in the Department of Health, which includes the QAS and two Commercialised Business Units. The Queensland Government is committed to reducing red tape and bureaucracy, including directing the greatest possible proportion of resources to frontline services. The proportion of doctors and nurses relative to total Queensland Health staff has increased from 48.68 per cent in June 2012 to 50.19 per cent in June 2014.

#### *Health investment and federal financial relations*

The sheer scale of investment in healthcare services in Australia, estimated to be \$140.2 billion in 2011-12 and accounting for about 9.5 per cent of Australia's gross domestic product (Report on Government Services 2014), highlights the critical importance of ensuring funding, policy and service delivery settings are optimised.

Nationally, Commonwealth Government funding accounted for \$59.5 billion or 42.4 per cent in 2011-12. The significant impacts of the Commonwealth Government's policy decisions around the funding of health and education services are self-evident in the Commonwealth's estimate of savings of \$80 billion over the period to 2024-25 from reductions in funding to the States and Territories.

Improvements to healthcare and outcomes for Queenslanders are compromised by the budgetary and service planning uncertainty associated with reversals of Commonwealth commitments, which has been a feature of successive Commonwealth Governments.

Furthermore, cooperation in federal fiscal relations has been compromised since the Council of Australian Governments (COAG) agreed to the Intergovernmental Agreement on Federal Financial Relations (IGA FFR) in 2008. Over time, Commonwealth Governments have moved to convert Specific Purpose Payment (SPP) funding into prescriptive funding across health, disabilities and education, impeding State and Territory flexibility. The cumulative impacts of these actions support the case for a reduction in the degree of vertical fiscal imbalance (VFI) by strengthening the States' and Territories' capacity to raise revenue.

Queensland notes that the need for reform to roles and responsibilities and fiscal relations between the levels of government, has been recognised by COAG. Work is currently progressing on these issues through a White Paper on the Reform of the Federation, and a White Paper on the Reform of Australia's Tax System. Indeed, the Terms of Reference (ToR) of the Select Committee on Health are somewhat pre-emptive of the outcomes of work on the White Paper on the Reform of the Federation, planned to be delivered by the end of 2015.

In particular, the White Paper's ToR signal possible changes to the Commonwealth Government's position in relation to, among other matters: principles and criteria to be applied when allocating roles and responsibilities; accountability for performance in delivering outcomes; and fiscal sustainability at both levels of government. The White Paper's ToR also signal it will deal with the practical application of these principles in the allocation of roles and responsibilities in the areas of health. They also address the inadequacy of own source revenue raising by State and Territory Governments compared to their spending responsibilities.

More generally, the ongoing White Paper process must address the appropriate roles and responsibilities of both levels of government to ensure an equitable distribution, reflective of risk and responsibility while offering the most efficient delivery mechanism.

Without pre-empting work on the White Paper, the Queensland Government offers comments on each of the following areas under examination by the Select Committee on Health.

**a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting.**

Reductions in Commonwealth health funding to States and Territories is not unique to the current Commonwealth Government. In 2012, the then Commonwealth Government announced health funding cuts amounting to \$381 million to Queensland over four years. Of this, \$103 million was retrospectively applied, directly impacting on services already being delivered.

In an environment where Commonwealth Governments can unilaterally terminate funding agreements or change the parameters for funding calculations, the capacity of the Queensland Government to adopt a long-term outlook for operational and capital planning and investment and service reform through its public hospital and health service system, is severely compromised.

In its 2014-15 budget, the Commonwealth Government abandoned several funding commitments made in the NHRA. This decision undermines the intent of the NHRA and other intergovernmental agreements to ensure the sustainability of the Australian health system. It abrogates the stated commitment to transparent and certain funding and governance arrangements, and the improvement of health outcomes for all Australians.

NHRA funding structures were founded on the concept of sharing demand and other risks between the States and Territories and the Commonwealth. The revised funding approach abandons this approach, so that State and Territory Governments are now exposed to future demand and other risks. It is a funding model that provides an outcome that is less than optimal when compared with either the NHRA or its predecessor the National Healthcare Agreement SPP, which included three elements in its approach to growth funding:

- age and sex weighted population change (recognising the composition of the population, not just its absolute size, is an important determinant of costs);
- health price indexation (recognising health costs typically increase faster than the Consumer Price Index); and
- health technology factor (recognising additional funding would be required specifically to maintain pace with developing health technologies).

This approach better recognised, in the context of VFI, the Commonwealth Government's responsibilities to the Australian people and the resource requirements of States and Territories in maintaining a modern health service.

The 2014-15 Commonwealth Budget Papers show the revised growth rate for Commonwealth public hospital funding in 2017-18 will be approximately 4.3 percent per annum - a more than 50 percent reduction from previously forecast growth rates under the NHRA (about 10 percent per annum).

There is a need for an agreed funding model that recognises resource requirements and adequately accounts for growth in healthcare and healthcare costs. The Queensland Government supports the development of an agreed funding model that incentivises technical efficiency (driving value for money) and allocative efficiency (ensuring equity).

The National Partnership Agreement on Improving Public Hospital Services (NPA on IPHS) ceased on 30 June 2014. Funding under this NPA was used to expand Queensland's emergency department (ED), elective surgery and sub-acute public hospital services. Coupled with administrative reform at the State level, this NPA enabled progress towards the National Elective Surgery Target and National Emergency Access Target.

The NHRA provided an in-principle commitment for the Commonwealth Government to adjust its State and Territory health baseline funding to reflect the ongoing cost of providing these additional NPA IPHS services. References to this commitment and necessary financial provisions to support it are absent from the 2014-2015 Commonwealth Budget.

As stated above, unilateral decisions made by successive Commonwealth Governments affect the ability of the Queensland Government to plan future public hospital and health services. The funding consequences inevitably have a negative impact on the volume of public hospital and other health services that can be delivered in Queensland in the coming years. The capacity of the Queensland Government to absorb this clear cost shift is severely limited by current revenue raising arrangements and capacity.

**b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare.**

The proposed introduction of patient contributions for general practitioner, pathology and diagnostic services may mean Queenslanders visit general practitioners less frequently or not at all and instead present at public hospital EDs for advice and treatment. Most substantially impacted will be those who use the health system more frequently, such as the elderly, low income earners and people with chronic illnesses. Patients could delay seeking treatment for conditions which in turn may lead to worsening health outcomes. Complications from delayed medical advice may result in admission to hospital, which is also more costly to the community as a whole.

Greater numbers of low acuity presentations at public EDs also impacts on the existing capacity to treat more urgent cases in a timely manner. If patients attend EDs in preference to a general practitioner, the cost of meeting this increase in demand falls to the Queensland Government under current funding arrangements and responsibilities. This represents a clear cost shift from the Commonwealth to the State.

The Queensland Government has no plans to introduce co-payments for outpatients and admissions in Queensland, as was considered by the previous Queensland Government in 2006. The current Queensland Government believes in and remains committed to universal, free public hospital access. Any plans to bring in co-payments will be actively repudiated by the Queensland Government.

The decision to pause indexation on some Medicare Benefits Schedule fees may also contribute to patients incurring higher out of pocket expenses for private medical services. Their choice to pursue private or public hospital and health services will be affected, ultimately placing increased demands on public resources. Similarly, suspending rebate thresholds for private health insurance could increase demand for public hospital and health services while decreasing the amount of own source revenue available to the Queensland Health system.

**c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention.**

Health prevention, promotion and early intervention programs can result in better health outcomes for individuals and lower overall costs to the health system from treating fewer acute and chronic conditions.

The NPA on Preventive Health (NPAPH) was to be implemented over seven years from 2012 to support substantial lifestyle changes that improve health and reduce the risk of chronic disease.

Commonwealth funding of the NPAPH unexpectedly ceased on 30 June 2014. This decision risks not only the potential health gains and improvements of better prevention, promotion and early intervention, but also Queensland Government arrangements for the delivery of these programs, often by NGOs.

Decisions like these place States and Territories in a dilemma about honouring arrangements and ensuring ongoing service delivery. The Queensland Government will continue to support NPAPH programs implemented through to 2016-17, including those delivered by NGOs.

Sudden policy shifts, involving little or no consultation with affected States and Territories, make it difficult to plan and implement effective long-term preventive health measures. It also creates uncertainty about where policy responsibility for preventive health ultimately rests.

**d. the interaction between elements of the health system, including between aged care and health care.**

The separation of funding and policy responsibilities between the Commonwealth and the States and Territories for various elements of the health system, including public hospitals, primary healthcare, aged care, and oral health services, is highly complex and often lacks clarity. This affects the effectiveness and efficiency of health service delivery, not only in Queensland, but public and private health services across Australia.

Importantly, the capacity for patients and their families to experience seamless and integrated services is compromised by overlapping and blurring of responsibilities at the policy and funding level. Worse still, there is potential for many patients whose conditions cut across different sectors, for example, chronic disease, or an elderly patient requiring aged care services, to receive less than optimal care and suffer adverse health outcomes as they are forced to navigate through a plethora of duplicative programs or fall into the gaps where services aren't offered.

The NHRA aimed to define responsibilities more clearly, although the 2013 Queensland Commission of Audit (CoA) noted the significant degree of overlap between the responsibilities of the Commonwealth and State and Territory Governments and the potential for detrimental effects on productivity and efficiency, through duplication of functions, cost shifting and lack of transparency. The Queensland CoA recommended that in the absence of broader changes to Federal arrangements, there should be agreement between the different levels of government on a clear delineation of responsibilities for the performance of specific functions, and the common performance and compliance arrangements, where shared responsibilities remain, to reduce costs of overlapping and inconsistent government requirements.

The recent decisions in the 2014-15 Commonwealth Budget have created further uncertainty around roles and responsibilities and the status of the NHRA, the organisation of the Australian healthcare system and, particularly, a sustainable funding model. Resolving the confused Australian health funding and policy situation is a matter of urgency for both better patient care and health outcomes, as well as the long-term financial sustainability of the health system.

As well as the need for clarity of roles and responsibilities, the Commonwealth Government should fully perform its role commensurate with its policy and funding responsibilities for aged care, general practice and primary healthcare services.

In Queensland, successive Commonwealth Governments have historically and continue to fall short of meeting its responsibilities with aged care, particularly in regional and rural areas. Hospitals in some areas are being used by people who have completed their acute and sub-acute phase of care, and are in need of aged care services. These people remain in hospital as there are no aged care services available or because they need time to organise their financial affairs in order to pay for their aged care needs. For example, across the Cairns HHS region, about 60-70 beds are accommodating long stay older patients. These are people who remain in hospital but no longer have a clinical need to be in hospital and are in need of residential aged care.

At the same time, the Commonwealth's Far North Aged Care Planning region, which includes Cairns, has only 1,602 operational residential aged care places. This is equivalent to only 76.7 residential aged care places per 1,000 people aged 70 years and older and well below the Commonwealth's own planning benchmark of 88 places per 1,000 people aged 70 years and older. The consequence of the low level of residential aged care provision in Cairns is a high number of long stay older patients and a reduced availability of hospital beds for people, of any age, requiring acute inpatient care.

Hospital beds require and receive a much higher level of acute care and are therefore far more costly to the public purse than aged care beds. Commonwealth cost-shifting in these circumstances exaggerates the overall impact on both the Commonwealth and State health resources. It is in the interests of both the Commonwealth and the State to ensure the Commonwealth increases access to aged care in affected communities.

In addition, the Queensland Government continues to operate residential aged care facilities as a provider of last resort: in areas of market failure; and for people who have complex care needs where the NGO sector is unable to respond. In 2012-13 the total cost of Queensland Health operated residential aged care facilities was \$191 million. Of this, Commonwealth Government funding and resident charges contributed \$92.1 million with the balance of \$98.9 million being funded by the Queensland Government.

Adequate funding should be provided to State and Territory Governments when the role of provider of last resort defaults to them. If the Commonwealth Government is unable to ensure services are in place, it should fund the State the full cost of the service, noting that as a provider of last resort, the Queensland Government will not leave patients in abeyance and without access to important health care services.

**e. improvements in the provision of health services, including Indigenous health and rural health.**

Improving access for rural and remote Queenslanders and closing the gap between the health outcomes of Aboriginal and Torres Strait Islander and other Queenslanders are key priorities for the Queensland Government.

Queensland is Australia's second largest state, covering 1,722,000 square kilometres. In rural and remote Queensland, the challenge of providing health services is complicated and magnified by geographical distance and the need to address unique community characteristics. Some rural communities are experiencing rapid growth associated with resource and mining development. In contrast, some communities have an ageing population, low population density, limited and ageing infrastructure, and higher costs associated with healthcare delivery.

The Queensland Government's commitment to improving access to health services for people in rural and remote communities and Aboriginal and Torres Strait Islander Queenslanders is demonstrated by a range of initiatives.

This includes a doubling of the mileage and commercial accommodation subsidies through Queensland's Patient Travel Subsidy Scheme, which provides assistance to patients, and in some cases their carers, to enable them to access specialist medical services that are not available locally. The Queensland Government provided increased funding of \$97.7 million over four years from 2012-13 for this initiative, with an additional \$8.6 million over three years from 2013-14. Since the implementation of the Government's election commitment from 1 January 2013, more than 73,000 rural and remote Queenslanders have been assisted to travel to access specialist medical services.

In addition, the Queensland Government's investment in the Rural Telehealth Program is being realised with non-admitted telehealth occasions of service increasing by 38 per cent across the State when compared with the same period the previous year (July 2012 to March 2013).

Through *Diamond Jubilee Partnerships Ltd.* (a subsidiary of the *Queen Elizabeth Diamond Jubilee Trust Australia*), Queensland Health has also provided \$5 million in funding to treat and prevent avoidable blindness among Aboriginal and Torres Strait Islander people. A comprehensive screening program to identify at-risk clients and screen for diabetic eye disease is provided through the IDEAS Van — Indigenous Diabetes Eyes and Screening. The IDEAS Van commenced a tour of nine regional hubs across Queensland in February 2014 to provide education, equipment and specialist support to 27 Aboriginal Medical Services to treat Aboriginal and Torres Strait Islander people.

While the Queensland Government is making concerted efforts to improve the provision of services across rural and remote Queensland and for Aboriginal and Torres Strait Islander Queenslanders, requisite effort from the Commonwealth Government is also necessary.

Ambiguous and poorly specified Commonwealth programs in the primary, Aboriginal and Torres Strait Islander and community health sectors result in both gaps and duplication in health service provision, especially in rural and remote communities. Specific examples include:

- Medicare Locals being inadequately directed or incentivised to address gaps in primary care services in small rural and remote communities for which they are responsible under the NHRA and inadequate interventions in the event of poor performance;
- Failure on the part of the Commonwealth Government to adequately consider and recognise established State-funded services when planning interventions in areas such as Cape York. In these areas, there are many examples of Commonwealth-funded primary care services (delivered by organisations such as the Royal Flying Doctor Service and Apunipima Cape York Health Council) duplicating those provided by the HHSs. This duplication and lack of coordination leads to inefficiencies, inhibits effective service planning and monitoring, can result in incomplete medical records and, potentially, may result in adverse health outcomes; and
- The desire of the Commonwealth Government to have a presence in local healthcare delivery beyond its primary role as an insurer (via the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme) leads them to fund projects and programs which may be poorly aligned with what States and Territories are providing.

More effective mechanisms need to be put in place to ensure that services are provided where necessary, including rationalisation of the multiplicity of service providers and programs currently being funded by the Commonwealth which either duplicate or interface poorly with State funded and delivered programs.

**f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services.**

An effective and efficient public hospital and health system is reliant upon a strong primary healthcare and general practice service system. As previously stated, under the NHRA, the Commonwealth Government is responsible for the system management, funding and policy development of general practice and primary health care.

The Commonwealth Government exercises this responsibility primarily by subsidising private general practice services through the Medicare Benefits Scheme (MBS). However, in many locations, particularly rural and remote locations, there are no or insufficient private general practitioners and allied health workers, resulting in the Queensland Government frequently becoming a provider of last resort.

In some instances, the Queensland Government is able to claim benefits through the MBS for services provided in EDs and outpatient clinics at small rural and remote facilities. However, these arrangements are only available in a limited range of circumstances — that is, if a site is eligible to claim MBS subsidies from the Commonwealth through the COAG 19(2) exemption. This results in a number of Queensland Government facilities and staff providing primary healthcare without being able to claim from the Commonwealth Government. At the Malanda Outpatient Clinic, for example, a third of its activity from 2012-2014 was for primary healthcare services. In the absence of

arrangements to claim Commonwealth revenue, this cost is fully met by the Queensland Government.

In other cases, the Queensland Government ends up providing (and, by default, funding) allied health services intended to be captured by Commonwealth programs, due to an insufficient allied health workforce being available in the community.

The cost of healthcare service delivery in rural and remote locations is also significantly higher than in metropolitan and regional locations. Where primary healthcare services provided in rural and remote locations by the State are not covered by subsidies through the MBS, it is appropriate the Queensland Government directly bills the Commonwealth Government for these. This should be based on the full cost of providing these services.

Even in metropolitan and regional locations, there are market failures resulting from limited numbers of general practitioners, the absence of after-hours services and high out-of-pocket expenses where there is no bulk billing. This places a significant burden on EDs at public hospitals. In 2012-13, it was reported that nearly 384,000 Queenslanders attended public EDs with general practice-type presentations at an estimated cost of more than \$100 million.

As part of its 2014-15 budget, the Commonwealth Government announced it will refocus primary health care funding by replacing Medicare Locals with Primary Health Networks (PHNs) from 1 July 2015.

Aligning PHNs with Queensland's HHS boundaries and ensuring PHNs have a clear role and function, underpinned by more meaningful performance expectations, is important in facilitating a shift away from high cost hospital services to more appropriate primary healthcare services. This is critical if the healthcare system is to effectively treat the growing burden of chronic disease. The Queensland Government sees clear merit in HHSs being permitted to fulfil the role and functions of PHNs in areas where there are few private primary healthcare services.

The decision by the Commonwealth Government to defer the start of the NPA for Adult Dental Services is disappointing. The success of the current NPA on Treating More Public Dental Patients in reducing public dental waiting lists and waiting times across Queensland illustrates the importance of Commonwealth funding contributions to States and Territories for public oral health services.

#### **g. health workforce planning.**

Queensland has the most decentralised population of any Australian State or Territory. Attracting medical, nursing and allied health staff to rural/remote health services is challenging and the Queensland Government welcomes the Commonwealth Government's decision to fund 500 additional nursing and allied health scholarships to target workforce shortages in rural and remote areas.

The Queensland Government also acknowledges the rationalisation strategy and streamlining of government agencies including Health Workforce Australia functions into the Commonwealth Department of Health.

Based on population need, Queensland will continue to experience workforce shortages in medical practitioners, nurses and in some medical specialist roles. This is likely to be

more pronounced in regional, rural and remote communities where attraction, recruitment and retention of the health workforce is already a challenge.

Currently in Queensland, there is a dependence on international recruitment and the use of locums or agency services to fill relief and vacancies. While reliance on locally trained clinicians is a long-term goal, the ongoing recruitment of internationally trained clinicians will be required to meet service gaps in the foreseeable future.

The Queensland Government will continue to work in partnership with the Commonwealth Department of Health to drive health workforce reforms. The Queensland Government considers there may be merit in exploring possible joint Commonwealth-State initiatives to de-regulate aspects of the health labour market which potentially impede innovation and efficiency improvements.

The Queensland Government's vision for Queensland's healthcare system is a skilled and empowered workforce that meets the needs of Queenslanders in delivering high quality, cost-effective healthcare. The *Future workforce strategy for better healthcare in Queensland 2013–2018* is a five year plan with key initiatives and deliverables aimed at:

1. Creating a workplace culture and leadership environment which places a high value on scarce health resources, valuing our employees, and putting patients first;
2. Orienting health services to better meet local health needs, which requires significant change to many of the established cultures and practice that impact on performance and a strong culture of customer service;
3. Empowering healthcare staff to lead system reform and improve service delivery;
4. Growing total health capacity and increasing health services across a system of public, private and not-for-profit providers;
5. Partnering with HHS, private, not-for-profit sectors and other levels of government on workforce planning and other strategies to develop the future capability of the health workforce;
6. Improving the financial performance of our healthcare system to match and surpass the national average by mid-2014;
7. Breaking down traditional professional barriers and being open to new ways of working and models of care; and
8. A flexible, easy to understand employment and industrial relations system that facilitates local decision-making.

**h. any related matters.**

The Queensland Government strongly supports improving the efficiency of health service administration and management by reducing waste and unnecessary regulation and redirecting the savings to the delivery of health services.

As an example, there has been a proliferation in the number of low value Project Agreements (PAs) in recent years which involve disproportionate and onerous reporting responsibilities for the Queensland Government. Over the years 2014-15 to 2017-18, the Queensland Government is to receive Commonwealth funding under 17 NPAs and PAs (refer to **Table 1**, below, for further details). Many of these are for long-standing, project or condition-specific initiatives that are renegotiated as frequently as annually in many instances.

To continually draft, renew, negotiate and finalise many low value agreements is inconsistent with the Commonwealth's rationalisation agenda and the Queensland Government Principles for Intergovernmental Activities.

In addition, a limitation of the existing federal financial framework is the absence of an effective process for dealing with expiring NPAs. To date, there has often been no commitment by respective Commonwealth Governments to provide ongoing funding following an NPA's expiry, even when an NPA has raised community expectations for continued services.

This leaves States and Territories with the difficult decision at the end of the NPA — either to reduce services or find additional own source funding. The Queensland Government encourages the Commonwealth Government to give consideration to introducing a more efficient, sustainable funding mechanism for these types of agreements (such as rolling into base funding) as soon as possible.

The Queensland Government reiterates its concern about the significant degree of overlap between the responsibilities of the Commonwealth and State and Territory Governments and the potential for detrimental effects on productivity and efficiency, through duplication of functions, cost shifting and lack of transparency.

In addition, porous borders, particularly in the State's north, for which the Commonwealth Government is responsible, result in a significant impost on Queensland's public healthcare system. This impost includes the treatment of Papua New Guinea nationals, which is not adequately recognised by Commonwealth funding provided to Queensland under the Project Agreement for the Management of Torres Strait/Papua New Guinea Cross Border Health Issues.

**Table 1: Summary of Expected NPA and PA revenue over Forward Estimates**

		Budget Year	Forward Estimates			4 Year Total
	2013-14 (\$m)	2014-15 (\$m)	2015-16 (\$m)	2016-17 (\$m)	2017-18 (\$m)	(\$m)
Improving Public Hospital Services	127.7	0.0	0.0	0.0	0.0	0.0
Total Health Infrastructure	69.5	102.2	15.4	4.0	2.0	123.6
Health and Hospital Fund - Hospital Infrastructure (Townsville Expansion)	35.6	15.0	-	-	-	15.0
Health and Hospital Fund - National Cancer System	12.2	34.4	0.4	-	-	34.8
Health and Hospital Fund - Regional Priority Rounds	21.7	52.8	15.0	4.0	2.0	73.8
Total Health Services	9.3	10.4	11.0	11.8	1.2	34.3
Expansion of BreastScreen Australia Program	0.8	2.4	2.7	3.2	-	8.3
Torres Strait - Health Care Grant	4.5	4.5	4.6	4.7	-	13.7
National Bowel Cancer	0.5	0.5	0.7	0.9	1.2	3.3
National Perinatal Depression	2.2	1.6	1.6	1.6	-	4.8
Oz Food Net	0.2	0.3	0.3	0.3	-	0.8
Mosquito Control and Communications Officer	0.9	1.0	1.0	1.0	-	2.9
Vaccine Preventable Disease Surveillance	0.2	0.2	0.2	0.2	-	0.5
Indigenous Health	9.2	9.4	0.9	0.9	-	11.2
Improving Ear Health Services	0.2					-
Torres Strait - Saibai Island Health Clinic	0.5	0.5	-	-	-	0.5
Indigenous Early Childhood	7.6	8.0	-	-	-	8.0
Rheumatic Heart Fever	0.9	0.9	0.9	0.9	-	2.7
Other NPAs	128.5	90.6	105.3	113.0	131.4	440.3
Improving Mental Health Access and Quality of Services	15.3	15.6	10.4	-	-	26.1
Supporting Long Stay Older Patients	13.5	-	-	-	-	-
Dental Waiting list Program (formerly Commonwealth Dental Health Plan)	30.4	23.4	-	-	-	23.4
Adult Public Dental Services	-	-	40.1	59.2	78.3	177.7
Essential Vaccines	56.2	51.6	54.7	53.8	53.1	213.2
Preventative Health	13.2	-	-	-	-	-
Total NPP	344.1	212.6	132.5	129.7	134.6	609.4