Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 13 & 15 February 2013

Question: E13-154

OUTCOME 0: Whole of Portfolio

Topic: National Health Priority Areas

Type of Question: Written Question on Notice

Senator: Di Natale

Question:

a) What funding has been allocated to address prevention and control of the National Health Priority Areas in 2012-13 and across the forward estimates?
b) Can the Department update the table (set out below) that was provided during Estimates hearings in October 2010 and include all National Health Priority Areas?
c) What funding has been allocated for PBS, MBS, hospital payments and research for each National Health Priority Area?
d) What policy mechanism is used to determine funding levels for programs that specifically target prevention and control of each National Health Priority Area (ie above and beyond MBS, PBS, hospital payments and research)?
e) What progress has been made on Indigenous smoking rates and what programs and funding have been allocated beyond June 2013?
f) Is it difficult to get a complete picture of Indigenous health funding under the Close the Gap initiative?
g) What is the current funding allocation to address rheumatic heart disease?
h) What results have been achieved to date for the national rheumatic heart disease initiative? Can a table be provided which shows which programs expire when?
i) Which states are currently funded by the Commonwealth to support rheumatic heard disease activities? Is it the case that funding is not available for South Australia and New South Wales to participate? If not, why not?
j) When does the Healthy Communities Initiative expire? What processes are underway to consider renewing and strengthening this program? What results have been achieved to date?

Funding allocated to improve the health outcomes of	**2011-12 $m**	**2012-13 $m**	**2013-14 $m**	**2014-15 $m**
Cardiovascular disease	3.33	3.30	3.37	3.14
Diabetes	210.68	210.52	227.79	236.71
Cancer	724.02	353.03	262.85	255.47
Total	938.03	566.85	494.01	495.59

Answer:

a) & b) Most Commonwealth expenditure addressing the National Health Priority Areas is channelled as treatment subsidies via the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS), as transfer payments to the states and territories for hospitals, preventive and community health, and as subsidies for private health insurance via the Private Health Insurance rebate. A lesser proportion of funding is channelled through grant programs.

As most of the funding for the National Health Priorities is embedded in the MBS, PBS, private health insurance rebate and transfers to the states, this funding is not able to be mapped in the Forward Estimates. Some broad aggregates of funding attributable to the National Health Priorities in 2012-13 are:

- $1.2 billion for mental health programs;
- $405.0 million for cancer programs; $224.4 million for preventive health programs;
- $228.2 million for diabetes; and
- $318.0 million for the National Partnership Agreement in Closing the Gap in Indigenous Health.

These aggregates are exclusive of MBS and PBS funding, and the relevant value of the private health insurance rebate, with the exception of the diabetes figure, which includes a small PBS component. In addition, these aggregates are not mutually exclusive. For example, bowel cancer screening is included in both cancer programs and preventive health programs.

c) Expenditure on the MBS

Data on MBS expenditure against individual NHPAs is not available for a number of reasons. For example, patients who present to a general practitioner (GP) may be seen under a general consultancy item (e.g. Item 23). This means that MBS cost cannot be associated with an individual NHPA, even though the patient may be seen for a NHPA condition. For 2011-12, total GP expenditure (including practice nurses) was $5.58 billion, excluding practice nurses it was $5.54 billion.

A similar problem also occurs with identifying NHPA costs related to pathology and diagnostic imaging, which accounted for around $4.76 billion of total MBS expenditure for 2011-12. The majority of pathology testing would be for general disease screening.

Expenditure on the PBS

There are no PBS expenditure data for Injury Prevention and Control and Obesity. The expenditure data for the remaining NHPAs in the 2011-12 financial year are listed below:[1]

[1] Source: unpublished Department of Health and Ageing PBS Data.

2011-12 PBS expenditure data for National Health Priority Areas	
Cardiovascular health	$2,301,869,545
Cancer control	$1,073,641,415
Asthma	$312,214,673
Diabetes mellitus	$436,675,449
Mental health	$792,441,292
Arthritis and musculoskeletal conditions	$252,385,528
Obesity	$N/A
Injury prevention and control	$N/A
Total	**$5,169,227,902**

Research priorities

In 2011–12, through the Priority-driven Collaborative Cancer Research Scheme (PdCCRS), Cancer Australia continued to partner with key non-government organisations to coordinate the funding of cancer research at a national level. Thirty grants totalling $9.35 million were awarded through the PdCCRS, with the research addressing the agency's specified research priorities including the prevention of cancer; early detection of cancer; application of new treatments and technologies; and the coordination, integration and delivery of treatment and care using a multi-disciplinary approach. The grants also fund research in gynaecological cancer, lymphomas, and cancers of the lung, colon, rectum and pancreas.

In addition, NHMRC funds a range of activities, aligned with their Strategic Plan, which contribute to the broader knowledge base around human health and medical research. These activities include development, equipment and project grants, fellowships and scholarships. During 2011–12, NHMRC invested over $750 million to build Australia's research capacity and support both researchers and facilities.

The following table captures a breakdown of expenditure in National Health Priority Areas for 2011.[2]

National Health Priority Areas	**Expenditure ($m)**
Cancer	$179.8
Cardiovascular Disease	$108.3
Diabetes	$72.6
Mental Health	$61.0
Injury	$38.3
Obesity	$37.6
Arthritis	$26.0
Dementia	$25.7
Asthma	$16.9

2 NHMRC Annual Report 2011-12

d) Decisions on funding priorities and levels are determined by Government through the usual Budget processes. These decisions can be informed by evidence based research, expert advice, and input from a range of stakeholders including consumers and clinicians.

e) According to the latest information available on smoking rates for Indigenous people provided by the Australian Institute of Health and Welfare 2011, Indigenous smoking rates fell by over nine per cent between 1994 and 2008. See table at Attachment A for further information.

f) Information on health funding under the Closing the Gap initiative is gathered in a number of ways. The Department is able to track expenditure through grant and incentive programs under its closing the gap initiatives (e.g. grants under the Aboriginal and Torres Strait Islander Chronic Disease Fund).

The Department can also track uptake of Indigenous-specific items under the MBS (e.g. Aboriginal and Torres Strait Islander Health Assessments items) and expenditure on the PBS Co-payment measure. However, Aboriginal and Torres Strait Islander peoples may access other MBS items which do not record their Indigenous status. Tracking flow-on costs from the closing the gap initiatives for the increased utilisation of the MBS and the PBS (e.g. chronic disease or allied health follow-up services) is not possible.

The Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is the Indigenous Chronic Disease Package (ICDP). On 1 July 2011, the majority of the ICDP was consolidated within the Aboriginal and Torres Strait Islander Chronic Disease Fund (the Fund). The Fund provides ongoing funding to address key priorities in chronic disease prevention and management for Aboriginal and Torres Strait Islander peoples and will deliver $832 million over the first four years of its operation (from 1 July 2011 to 30 June 2015).

The Practice Incentives Program - Indigenous Health Incentive funded under the ICDP has been consolidated into the Practice Incentives for General Practices Fund. The *'Higher Utilisation costs for the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme'* measure and special appropriation component of the PBS Co-payment measure funded under ICDP are not consolidated in the Fund as these are not grant programs.

g) Medicines used to prevent and treat rheumatic heart disease tend to be PBS-listed medicines and as a result the amount of funding provided changes according to demand. It is not possible to accurately determine the amount of funding associated with medicines which are prescribed for the prevention or treatment of rheumatic heart disease specifically. This is because these medicines are also widely used to treat other conditions.

A total of $10.395 million (GST exclusive) over four years to 30 June 2016 has been allocated to continue state-based register and control programs in Queensland, Western Australia and the Northern Territory. A further $2.433 million (GST exclusive) has been allocated to Menzies School of Health Research over three years to 30 June 3015 to continue support and coordination of efforts through the National Coordination Unit.

Funding of $2.43 million over the forward estimates has been provided under the Aboriginal and Torres Strait Islander Chronic Disease Fund for the Rheumatic Fever Strategy (National Coordination Unit). The National Coordination Unit is managed by Rheumatic Heart Disease Australia to work with the three jurisdictions funded under the Rheumatic Fever Strategy: Queensland, Western Australia and the Northern Territory.

h) Funding for each of the components of the Rheumatic Fever Strategy is now in its second term. Through their register and control programs, jurisdictions continue their efforts to improve diagnosis of acute rheumatic fever and rheumatic heart disease and access to necessary antibiotics. The Department funds the National Coordination Unit, based at the Menzies School of Health and Research in Darwin, which supports jurisdictions in improving monitoring and treatment through the development of education and training resources as well as facilitating enhanced capacity for data collection and reporting.

Rheumatic Fever Strategy	**Funding Mechanism**	**Funding Period**	**Expiry Date**
State-based register and control programs in NT, WA and QLD	Rheumatic Fever Strategy Multilateral Project Agreement	2012-13 to 2015-16	30 June 2016
National Coordination Unit	Funding Agreement	2012-13 to 2014-15	30 June 2015

i) Consistent with the Australian Government's 2007 election commitment, this 2008 Budget measure only included funding for state-based register and control programs in Queensland, Western Australia and the Northern Territory.

A proposal from the South Australian Government for funding to support a rheumatic heart disease register in that state is currently under consideration. No similar approach for funding has been made by NSW.

All jurisdictions, including those not directly funded through the Rheumatic Fever Strategy, have the opportunity to contribute to, and benefit from, the activities of the National Coordination Unit. This includes professional and best practice advice on the diagnosis, notification, referral and management of acute rheumatic fever and rheumatic heart disease.

j) The Healthy Communities Initiative ceases on 30 June 2014. The Department has contracted KPMG to evaluate the initiative and expects the evaluation to be completed by November 2013. The Department intends to undertake further analysis of the initiative between November 2013 and June 2014 to identify any additional learnings that may develop during the final months of the initiative. As the evaluation is currently on-going, it is too early to confirm the results achieved from this initiative.

Attachment A: Indigenous Smoking Rates

The table provides the latest information available on smoking rates for Indigenous people. It was published in: Australian Institute of Health and Welfare 2011. *Aboriginal and Torres Strait Islander Health Performance Framework 2010*. Cat. no. IHW 53. AIHW, Canberra.

Table 2.15.8–Proportion of smokers[(a)], by sex, age, remoteness area and state/territory, 1994, 2002 and 2008, Indigenous persons aged 15 years and over

	Indigenous		
	1994	2002	2008
Sex			
Males[(b)(c)]	55.3	53.1	48.8
Females[(c)]	48.5	49.5	44.9
Persons[(b)(c)]	51.8	51.2	46.8
Remoteness Area			
Major cities[(b)]	51.9	47.7	41.6
Inner regional[(b)(c)]	52.7	52.0	45.4
Outer regional	49.9	51.2	48.7
Total non-remote[(b)(c)]	*51.4*	*50.0*	*44.7*
Remote	54.3	52.7	49.9
Very remote	51.9	55.6	54.7
Total remote	*52.6*	*54.7*	*52.9*
State/Territory			
NSW	52.6	52.9	48.2
Vic[(b)(c)]	58.6	53.9	47.6
Qld[(b)(c)]	50.4	50.5	44.0
WA[(b)]	50.7	47.9	44.2
SA[(b)]	57.7	48.1	48.0
Tas	48.9	44.0	44.5
ACT	43.1[(d)]	44.7	36.2
NT	49.9	55.5	52.7
Total[(b)(c)]	**51.8**	**51.2**	**46.8**

(a) Comprises current daily smokers and persons who smoked less than daily.

(b) Difference between 1994 and 2008 is statistically significant.

(c) Difference between 2002 and 2008 is statistically significant.

(d) Estimate has a relative standard error between 25% and 50% and should be used with caution.

Source: ABS and AIHW analysis of the 2008, 2002 NATSISS, and 1994 NATSISS.