OUTCOME 02

ACCESS TO MEDICARE

Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.

OUTCOME 2: ACCESS TO MEDICARE

PART 1: OUTCOME PERFORMANCE REPORT

Outcome 2 was managed in 2004-05 within the Department by the Medical and Pharmaceutical Service Division, the Acute Care Division, Primary Care Division, and the Department's State and Territory Offices. Contribution was also made by the Professional Services Review, which produces its own annual report.

The major components of Outcome 2 are the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), and the Australian Health Care Agreements with the States and Territories.

Major Achievements

- Improved transparency and timeliness of PBS processes to meet commitments under the Australia-United States Free Trade Agreement.
- Implementation and management of the Extended Medicare Safety-Net.
- Additional 21 Magnetic Resonance Imaging machines were approved for Medicare eligibility, bringing the total number of units across Australia to 86.
- Introduction of two new medical indemnity schemes – the Premium Support Scheme and the Run-off Cover Scheme focussing on the affordability and security of medical indemnity cover for doctors.
- A new Allied Health and Dental Care Initiative was introduced on 1 July 2004.

Challenges

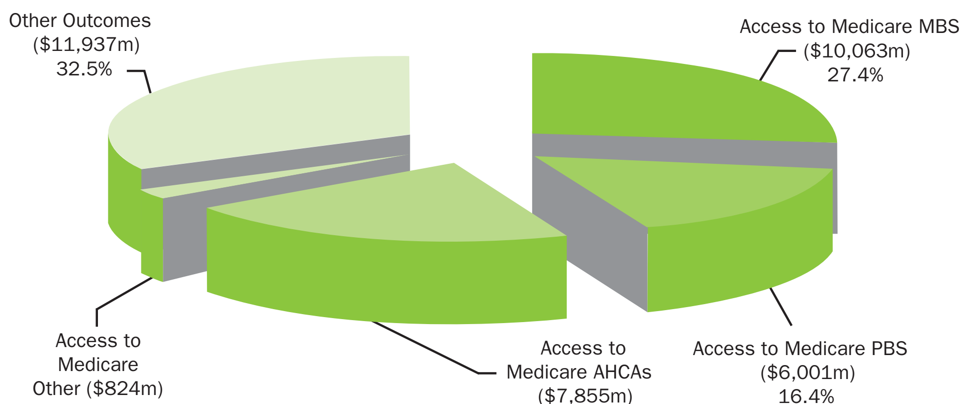
- Finalised the review of the lipid lowering drugs.
- Improving the Practice Incentives Program and Enhanced Primary Care Medicare items to reduce red tape and increase uptake of care planning Services.
- Consulting, costing and implementing the 12.5 per cent generic brand medicine, price reduction measure.

KEY STRATEGIC DIRECTIONS FOR 2004-05

Long Term Financial Stability in Health Programs

In 2004-05, the Department implemented the Government election commitment to reduce the costs of the PBS. Under this decision, the price for new generic brand medicines already listed on the PBS will be reduced by 12.5 per cent. This price reduction will also flow to other medicines under reference pricing. The first price reductions from this decision came into effect on 1 August 2005.

Figure 2.1: Outcome 2 expressed as a percentage of total Health and Ageing Portfolio expenses ($36,681m) 2004-05



NOTES: Departmental expenses includes revenue from other sources. 'Access to Medicare Other' includes Outcome 2 departmental expenses. 'Other Outcomes' includes capital ($5.7m). *Source: The Department of Health and Ageing.*

Also assisting the future sustainability of the PBS, legislation passed by the Parliament to increase the PBS patient co-payments was implemented on 1 January 2005. Apart from indexation, patient contributions have not increased since 1996-97 and have not kept pace with the rising costs of the PBS. The increase in co-payments restored the balance between Government and patient payments.

Improved Access to Services

On 1 July 2004, the Department introduced 11 allied health items and three dental care items onto the MBS, to provide rebates for access to private care. The rebates are payable for people with chronic conditions and complex care needs being managed as part of an Enhanced Primary Care multi-disciplinary care plan. These new allied health items include services such as physiotherapy and podiatry, when identified on an individual patient care plan.

In January 2005, the Department introduced additional items to improve access to general practitioner (GP) services. These items include a rebate equivalent to 100 per cent of the Medicare Schedule fee for GP services, higher rebates for after hours GP services, a new item for pap smears provided by practice nurses on behalf of doctors in rural and remote areas and inclusion of after hours services in the bulk billing incentives for rural and remote areas.

The Department introduced new, and amended existing items on 1 November 2004 and on 1 May 2005 in several specialties to better reflect clinical practice needs. These changes include:

- the referred patient assessment and management plan item which allows referral of patients by consultant psychiatrists for management in a general practice setting. This enables psychiatrists to see patients with complex needs quicker. Uptake of telepsychiatry items in rural areas, though not as high as initially expected, is gradually improving;
- a new item to cover the testing of low vision patients by optometrists which has improved access to primary care, particularly for elderly patients in rural areas who cannot visit urban low vision clinics; and
- a new item for the planning and management of the antenatal stage of a pregnancy which assists women using private obstetric services. 76,825 women benefited from this item during 2004-05.

In 2004-05, the Department approved the consumables necessary for new generation insulin pumps. These pumps were subsidised through the National Diabetes Services Scheme from 1 September 2004. This initiative will benefit 4,000 Australians with diabetes, including children and pregnant women. The new consumables are superior to earlier versions, with a lower incidence of blockage, kinkage and the resultant risk of diabetic ketoacidosis.

During 2004-05, the Department introduced 23 new medicines onto the PBS, to treat diseases such as high cholesterol, rheumatoid arthritis, parkinsons disease and lung cancer.

The Pharmaceutical Benefits Advisory Committee (PBAC) completed its review of the use and cost-effectiveness of PBS subsidised lipid lowering therapy in July 2004. Lipid lowering drugs are prescribed for patients with, or at risk of developing, coronary heart disease. The PBAC recommendations and the implications for qualifying criteria for PBS subsidised therapy are yet to be considered in a whole-of-government context.

2004-05 was the final year of the Third Community Pharmacy Agreement. The Agreement provided funding for the Enhanced Rural and Remote Pharmacy Package to improve access to quality pharmacy services for people in rural and remote areas. The package provided financial incentives for existing rural and remote pharmacies to remain open, and to encourage new pharmacies to establish in rural and remote areas.

In 2004-05, over 700 rural communities, including more than 70 remote communities serviced by Aboriginal Health Services (AHS), have benefited from these measures. During 2004-05, 34 rural pharmacies commenced or continued operation through attracting new pharmacists, and 78 AHSs received professional pharmacy support for their medication management, storage and supply activities. Also in 2004-05 the Department commenced negotiations for the Fourth Community Pharmacy Agreement. Through this Agreement the Department is aiming to ensure on-going, timely and affordable access to medicines for all Australians.

Integrated Health Care Programs

Increasing attention is being given to multi-disciplinary care in managing health problems. The Department's effort in supporting this

2

OUTCOME

multi-disciplinary approach to health care has already resulted in improved integration of health services and health outcomes for patients. Uptake of better clinical practice items such as MBS case conferencing, though not as high as initially expected is also improving. Case conferences for consultant physicians make it easier for professional groups to work together to improve health outcomes for patients.

Effective management of medications is essential to obtain the health benefits and to avoid adverse effects from medication misuse. This is particularly important for elderly people and those who take multiple medications. The Third Community Pharmacy Agreement funded the pharmacy component of two separate medication management initiatives over five years. A sister program for GPs encourages referral of high need patients for Medication Management Reviews.

During 2004-05, the Department continued to support the Home Medication Management Review program. This program provides funding for accredited pharmacists to visit patients in their homes in order to review their medications and assess how they are being used. The program aims to reduce the risk of medication misadventure and optimise the benefits from proper use of medicines. Unwanted or out of date medicines are disposed of responsibly as part of these reviews by pharmacists. From program implementation until June 2005, doctors and accredited pharmacists have completed 75,855 medication reviews, of these 28,312 were completed in 2004-05.

The Residential Medication Management Review program provides funding for accredited pharmacists to conduct medication management reviews in nursing homes. Nearly 90 per cent of residents in Australian Government funded nursing homes are receiving this pharmacy service. During 2004-05, the Department initiated a project to revise these arrangements and promote greater collaboration between doctors and pharmacists. A new Medicare item was introduced in November 2004 to encourage doctors to visit nursing home residents and to work closely with the pharmacists conducting these reviews.

Implementation of New Medical Indemnity Arrangements

The Department consulted widely with medical indemnity insurers and the Australian Medical Association, to develop legislation for two new medical indemnity schemes, the Premium Support Scheme (PSS) and the Run-off Cover Scheme (ROCS). These commenced on 1 July 2004.

The PSS replaced the Medical Indemnity Subsidy Scheme and provides benefits to a significantly wider group of doctors. Under the PSS, with effect from 1 January 2004, the Government contributes 80 per cent of the amount by which eligible doctors' gross medical indemnity costs exceed 7.5 per cent of their gross private medical income. ROCS covers the cost of medical indemnity claims notified from 1 July 2004 against eligible doctors who have left the private medical workforce or have retired from all medical practice.

The Department has continued to work with medical indemnity insurers, the Australian Medical Association and the Health Insurance Commission on the operational and administrative aspects of the new arrangements. This culminated in the passing of the *Medical Indemnity Legislation Amendment Act 2005* on 21 March 2005, which refined and improved the operational and administrative aspects of some medical indemnity schemes.

During 2004-05 the Department provided assistance to the independent review of competitive neutrality in the medical indemnity insurance market. The Government responded to this review by introducing the Medical Indemnity Legislation Amendment (Competitive Neutrality) Bill 2005 and the Medical Indemnity (Competitive Advantage Payment) Bill 2005 on 16 June 2005. Under this legislation, medical indemnity insurance groups that benefited from the Incurred But Not Reported (IBNR) indemnity scheme will make a series of payments to the Government to address the competitive advantage arising from that support. In addition, doctors who had a liability under the United Medical Protection Support Payment arrangements will now pay less.

Improved Transparency of the Pharmaceutical Benefits Scheme Listing Process

In implementing the review of the post-Pharmaceutical Benefits Advisory Committee (PBAC) processes and the pharmaceutical provisions of the Australia-United States Free Trade Agreement (AUSFTA), the Department is delivering substantial improvements in the process and transparency of the PBS. This will benefit patients, clinicians and the pharmaceutical industry by improving

their understanding of decisions about the listing of new medicines on the PBS.

The Minister for Health and Ageing appointed a joint PBAC-Medicines Australia working group to advise him on the implementation of the pharmaceutical provisions of the AUSFTA. Following a period of public consultation and consideration of the advice provided, the Minister released a statement in February 2005, setting out how Australia will implement its pharmaceutical commitments under the AUSFTA. In March 2005, an independent review process was established for applicants where the PBAC has declined to recommend the listing of a drug on the PBS. No requests for review were received during 2004-05.

The statement also detailed an approach which will now apply to the transparency of information. From July 2005, information about recommendations made by the PBAC will be available in the form of a public summary document. This information will include clinical, economic and utilisation data and will enable stakeholders to understand both the submission put to the PBAC and the PBAC's recommendation in relation to that submission. Public Summary Documents are available on the Department's website.[1]

To strengthen relations between the Department and the pharmaceutical industry and provide a greater level of interaction and understanding, an Industry Liaison Officer pilot program has been initiated by the Department. Under this trial initiative, 18 pharmaceutical manufacturers have been assigned a designated liaison officer within the Department to assist in managing the PBS relations with that company. In addition, implementation of the recommendation from the post-PBAC review to no longer require Therapeutic Goods Administration laboratory testing as a requirement for PBS listing, will ensure a more efficient listing process.

Improved Access and Affordability of Medical Services for Patients through the Medicare System

In 2004-05, the Department implemented several initiatives to improve the way in which chronic and complex care needs are managed through the Medicare Benefits Schedule. These developments include:

- a new initiative extending Medicare rebates to certain allied health and dental care services for patients with chronic conditions and complex care needs was introduced on 1 July 2004. For the first time, the services of Aboriginal health workers, audiologists, chiropractors, chiropodists, diabetes educators, dieticians, mental health workers, occupational therapists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists are eligible for a rebate under Medicare. Patients whose care is being managed under a multidisciplinary care plan are eligible for a rebate for up to five allied health, and three dental care services, where their dental condition is worsening their chronic condition; and
- new items that extend health assessments and medication reviews to aged care residents were also introduced on 1 July 2004 and 1 November 2004 respectively. They enable GPs to undertake Comprehensive Medical Assessments and Residential Medication Management Reviews for residents of aged care homes. Together with funding for Aged Care GP Panels, these new items have improved access to primary medical care for residents of aged care homes.

In response to the Red Tape Taskforce Review, the Department worked with the medical profession during 2004-05 to design ways to reduce the red tape burden on general practice. One of the key outcomes of this joint partnership was the introduction of new EPC Chronic Disease Management Medicare items. These new items commenced on 1 July 2005 and aim to increase access to health care planning for those with chronic conditions while retaining a focus on patients with multidisciplinary care needs. The new items are easier for GPs to use, provide greater flexibility, include more scope for practice nurses to assist in care planning and retain access to Medicare Allied Health and Dental Services for those with chronic and complex care needs.

During 2004-05, the Department implemented measures designed to improve the access and affordability of general practice services through Medicare, for example:

- from 1 September 2004, the Government extended eligibility for the higher bulk billing incentive payment to areas of low doctor to population ratio and with lower than average

2 OUTCOME

[1] Accessible online at <www.health.gov.au/pbs>.

bulk billing rates. This complemented existing bulk billing incentives which have played a significant part in increasing bulk billing rates for children under 16 years and Commonwealth concession card holders; and

- from 1 January 2005, the Government increased the Medicare rebate for GP out-of-hospital consultations from 85 per cent to 100 per cent of the Medicare schedule fee, providing an increased payment to doctors who bulk bill and an increased rebate to patients not bulk billed. As part of the Round the Clock Medicare initiative, the Government increased Medicare rebates by $10 for GP consultations provided during after-hours periods. The Government also introduced measures to provide access to higher Medicare rebates and the higher bulk billing incentive payment for doctors providing after-hours services in certain circumstances.

During 2004-05, the Home Medicine Review program that is administered by the Department was reviewed. The evaluation found that the program continues to address important community needs, and is widely regarded as an effective way of promoting better use of medicines.

A new MBS item was introduced on 1 January 2005 for pap smears taken by a practice nurse on behalf of a GP. The Medicare rebate is available to women in rural and remote areas. This rebate adds to the MBS items for practice nurse immunisation and wound management services introduced in February 2004. Practice nurses improve access to medical services by freeing up GPs to concentrate on other, more complex clinical matters.

Provision of Free Public Hospital Services through the Australian Health Care Agreements

During 2004-05, the Department continued to administer the 2003-08 Australian Health Care Agreements (AHCAs). In signing the agreements, State and Territory governments committed to providing equitable access to free public hospital services on the basis of clinical need for all eligible patients, as well as matching the Australian Government's annual cumulative rates of growth in hospital funding. All States and Territories qualified for the full amount of funding in 2004-05.

The Department worked collaboratively with the States and Territories during 2004-05 to develop a new standardised system for reporting recurrent health expenditure. The new system was agreed between the Australian Government and each State and Territory before 30 June 2005 as required by clause 36 of the 2003-08 AHCAs. Over time, this system will allow State and Territory investment in public hospital services to be directly compared between jurisdictions, and comparative time-series within particular jurisdictions to be generated.

In June 2005, the Department published *The State of our Public Hospitals* report.[2] The report provides a picture of our public hospitals in 2003-04 and shows how services have changed since 1998-99. As well as promoting greater State and Territory accountability for the funds they receive through the AHCAs, the report aims to:

- stimulate improvement in service performance and health outcomes;
- facilitate best practice service delivery; and
- increase community understanding of the performance of the public hospital sector, including areas of variation between States and Territories.

Increased Rehabilitation and Stepdown Care Services through the Pathways Home Program

In 2004-05, the Department worked to implement the national Pathways Home program, worth $253 million over five years, to assist States and Territories to increase their efforts in the provision of 'step-down' and rehabilitation care services. During 2004-05, $86.5 million was spent on projects to provide the community with greater access to care during the difficult period of transition from the hospital to the home. For example, $500,000 has been spent in South Australia to purchase transitional rehabilitation equipment such as lifters, walker frames and equipment aides to assist people to return home after a hospital episode.

Health Reform Agenda

In 2004-05, the Department collaborated with State and Territory health departments to identify and address areas for health system reform. Health Ministers have continued their commitment to the health reform agenda through a broad program of work designed

2 Accessible online at <www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-sooph-index.htm>.

to reform current practices in the health system. The goal is to improve the health and wellbeing of all Australians by providing optimal health care and health outcomes regardless of jurisdictional boundaries.

Specifically, the Department worked closely with State and Territory governments to improve the quality of pharmaceutical care at the time of admission, and on discharge, from a public hospital, in order to reduce the chance of adverse drug reactions and re-admission into hospital and assist in the continuity of care. The Department has also collaborated with State and Territory governments on cancer care reform and issues surrounding mental health as well as working on child health and wellbeing issues with the Community and Disability Services Ministers Conference. The Department and the peak bodies representing the pathology industry concluded negotiations for the third Pathology Agreement. This agreement was signed on 20 September 2004 and provides a partnership for government and the pathology industry to manage Medicare Benefits expenditure on pathology services.

One highlight of 2004-05 was the Improving Indigenous Health Remote Area Renal Services Project. This project aims to enhance the quality of life of people living with renal disease, their families and carers and where possible, prevent or delay the onset of renal disease.

Australia's health system was a key agenda item for discussion at the June 2005 Council of Australian Governments (COAG) meeting. COAG agreed that while Australia has one of the best health systems in the world, there is room for improvement, particularly in areas where governments' responsibilities intersect. COAG identified a number of areas where improvements could be achieved. The Department of the Prime Minister and Cabinet is responsible for managing this work and they are working closely with the Department. COAG has asked for a report in December 2005.

Separate to the Health Reform Agenda, the Department provided input to the Health Taskforce that was announced by the Prime Minister on 22 October 2004. The Taskforce was established to advise the Australian Government on options to improve the delivery of Australian health services and reported to the Prime Minister in early 2005.

Additional Medicare Eligible Magnetic Resonance Imaging units

In 2004-05, the Australian Government decided to improve access to Magnetic Resonance Imaging (MRI) services in rural and metropolitan areas. To facilitate this, the Department undertook a process to select providers in rural and metropolitan areas with an undersupply of Medicare funded MRI services and hospitals with a relevant caseload and high number of private in-patient separations. Through this process another 21 applicants were selected to provide services.

Some regional areas will have close access to Medicare funded MRI services for the first time. A number of hospitals which have demonstrated a particular clinical need will also have access to Medicare eligible MRI services. Of the 21 successful applicants, 10 were operational and claiming Medicare benefits as at 30 June 2005. The remainder will become operational by February 2006. Each new provider has agreed to provide services at no out-of-pocket cost for pensioners and concession cardholders. Of the 21 providers, 15 will provide services at no out-of-pocket cost to any patient.

PERFORMANCE INDICATORS (EFFECTIVENESS INDICATORS)

The Department of Health and Ageing is responsible, and accountable, for contributing to the achievement of nine outcomes. Effectiveness indicators are used to measure the progress the Department is making in achieving our outcomes.

Listed below are the effectiveness indicators for Outcome 2 followed by a brief description of the Department's performance in meeting these targets.

Indicator 1. Client support for Medicare	
Target: High levels of client support.	*Information source/reporting frequency:* Structured feedback through the HIC customer surveys.

As the service delivery agency for payment of entitlements under the MBS and PBS, the Health Insurance Commission (HIC) undertakes annual customer satisfaction research into its service delivery. The 2005 survey indicates a high level of support and attitudes toward the administration and delivery of services. Conducted with health practitioners, their practice managers, health consumers and pharmacists.

The medical practitioner and practice manager satisfaction with HIC's services has increased since 2004. Medical practitioner levels increased from 79 per cent to 85 per cent, while practice managers' satisfaction level remained constant at 90 per cent. Consumer and pharmacist satisfaction with the HIC's delivery of services continued to be stable with no significant difference for the past seven years, achieving 90 per cent and 85 per cent satisfaction respectively.

Indicator 2. Aboriginal and Torres Strait Islander access to Medicare	
Target:	*Information source/reporting frequency:*
Increasing Aboriginal and Torres Strait Islander access to Medicare in accordance with need.	Medicare benefits claimed by Aboriginal and Torres Strait Islander Medical Services. Enrolment and claims data through the voluntary Indigenous identifier.

To address the problems of access to the MBS by Aboriginal and Torres Strait Islander peoples, special arrangements were put in place in 1996 under sub-section 19(2) of the *Health Insurance Act 1973* to allow Medicare benefits to be paid for services provided by medical practitioners working at Aboriginal Community Controlled Health Services (ACCHSs). Regular surveys are conducted by the HIC to gather information on the number of medical practitioners employed by ACCHSs. Based on information supplied by the ACCHSs and claims processed for 2003-04, it is estimated that approximately 466,000 services were provided at a cost to Medicare of $15.4 million.

In addition, State funded clinics in Queensland and the Northern Territory received Medicare payments of approximately $2.3 million, covering 64,000 services.

Since November 2002, Aboriginal and Torres Strait Islander peoples have been able to identify as Aboriginal or Torres Strait Islander on the Medicare database by means of a voluntary Indigenous identifier. At the end of June 2005, over 84,000 people were identified as Aboriginal or Torres Strait Islander.

Approximately 41,800 Aboriginal and Torres Strait Islander people were identified during 2004-05 this represents significant growth of 80 per cent since July 2004.

Indicator 3. Percentage of Medicare services that are direct billed with no gap charged	
Target:	*Information source/reporting frequency:*
To monitor billing patterns through provision of regular reports.	Quarterly Medicare Statistics.

The number of MBS services bulk-billed increased by 8.6 per cent during 2004-05. In 2004-05, 165,964 million services were provided at no cost to the patients across all types of medical services. The percentage of all services bulk-billed in 2004-05 increased by 2.7 percentage points to 70.2 per cent.

Indicator 4. Medicare Benefits Schedule outlays per capita in rural and remote areas compared with other areas	
Target:	*Information source/reporting frequency:*
More equal distribution between localities.	Annual HIC data.

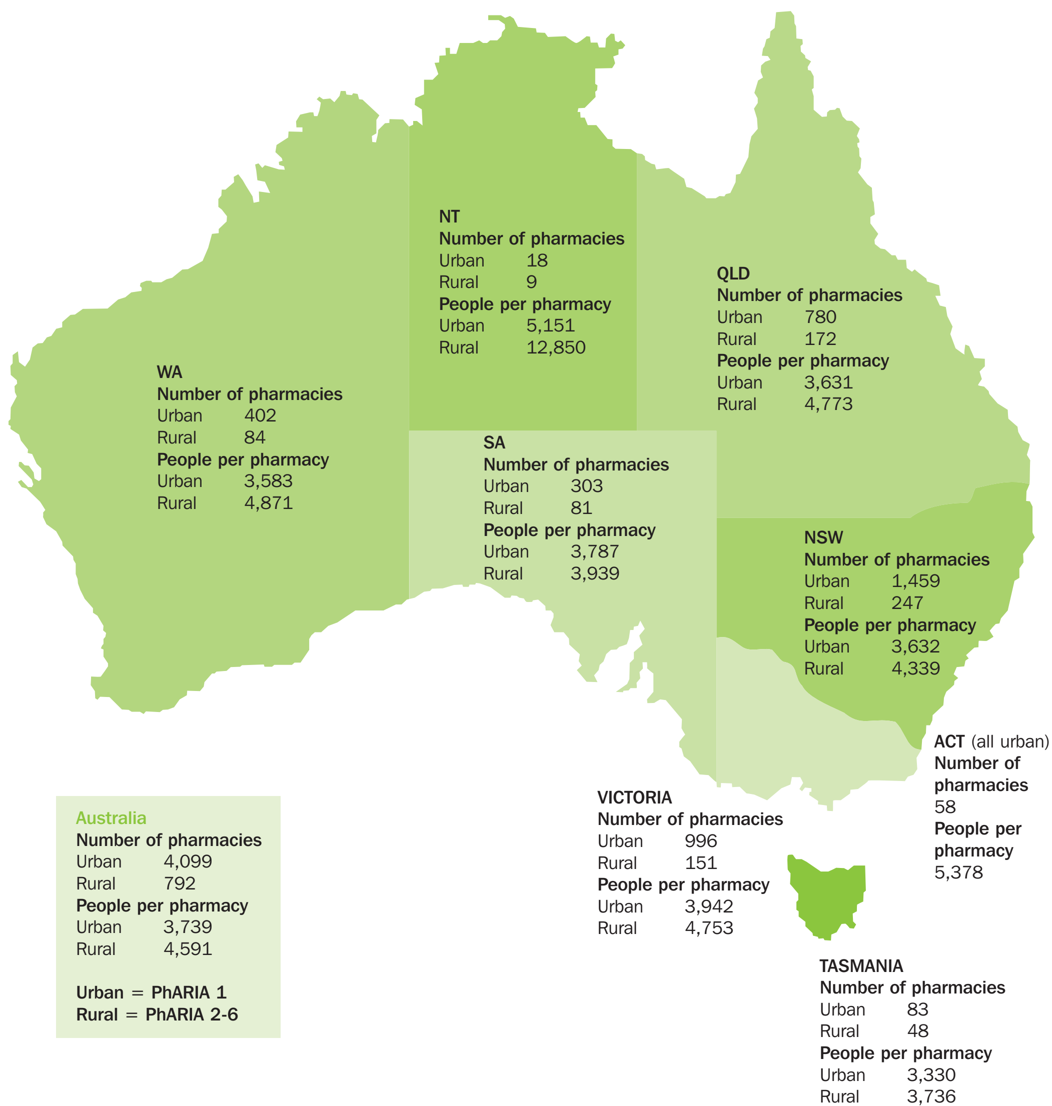
MBS outlays per capita continue to be lower in rural and remote areas, although the relationship to the national average has improved in recent years. In 1999-2000, MBS expenditure per person was $463.90[3] in capital cities, $444.12 in other metro centres, $350.52 in rural and remote areas, and $429.99 at the Australia level. In 2004-05, MBS expenditure per person was $512.48 in capital cities, $497.91 in other metro centres, $428.82 in rural and remote areas, and $487.62 at the national level.

[3] 1999-2000 MBS expenditure prices have been indexed to 2004-05 prices ($).

Indicator 5. Number of persons per approved pharmacy in Australia and the number of persons per pharmacy in urban areas compared with those pharmacies in rural and remote areas	
Target:	*Information source/reporting frequency:*
The ratio is similar for urban and rural and remote areas.	Annual HIC data.

The distribution of pharmacies across urban, rural and remote areas underlies access to the PBS. In 2004-05, there were on average 3,739 people per pharmacy in urban areas compared to 4,591 people per pharmacy in rural and remote areas.

Figure 2.2: Distribution of Australian Pharmacies by Urban and Rural Areas 2005



Source: HIC data at 30 June 2005 and Census 2001 data.

Indicator 6. Aboriginal and Torres Strait Islander access to Pharmaceutical Benefits Scheme medicines	
Target:	*Information source/reporting frequency:*
Increasing Aboriginal and Torres Strait Islander access to the Pharmaceutical Benefits Scheme in remote area Aboriginal Medical Services in accordance with need.	Annual HIC data.

To address barriers in accessing the PBS by Aboriginal and Torres Strait Islander peoples in remote areas, special supply arrangements operate under the provisions of Section 100 of the *National Health Act 1953*. These arrangements provide clients of eligible remote area Aboriginal Health Services with PBS medicines at the time of medical consultation, without the need for a formal prescription form, and without charge. Clients of more than 170 health services across remote Australia now benefit from improved access to PBS medicines through these arrangements. Total expenditure for 2004-05 was $22.0 million representing an increase of 24 per cent over 2003-04 outlays.

Indicator 7. Percentage of cost of Pharmaceutical Benefits Scheme prescriptions covered by the Government	
Target:	*Information source/reporting frequency:*
To monitor changes in underlying drivers through the provision of regular reports.	Annual HIC data.

The percentage of the cost of PBS prescriptions covered by the Australian Government decreased from 84.2 per cent in 2003-04 to 83.6 per cent in 2004-05.

Indicator 8. Pharmaceutical Benefits Scheme outlays per capita in rural and remote areas compared with other areas	
Target:	*Information source/reporting frequency:*
More equal distribution between localities.	Annual HIC data.

Over the past five years the expenditure by the Australian Government on PBS per person has increased in rural and remote areas more than other areas. PBS subsidies per capita for 2000-01 were $222.03,[4] $246.44 and $218.07 in capital city, other metro centres and rural and remote areas respectively. The corresponding figures for 2004-05 were $255.58, $283.96 and $264.10.

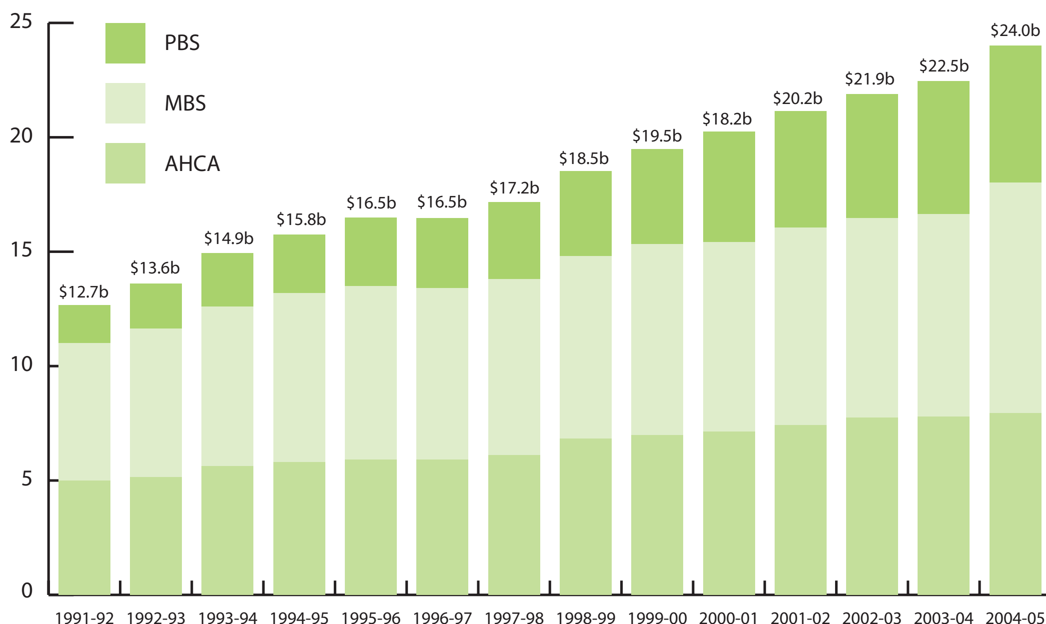
4 2000-01 PBS expenditure prices have been indexed to 2004-05 prices ($).

Indicator 9. Overall growth rates in Medicare outlays, including Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and AHCA growth rates	
Target:	*Information source/reporting frequency:*
To monitor growth rates in Medicare outlays through the provision of regular reports.	Budget papers.

In 2004-05, approximately $24.7 billion was spent on Outcome 2. This equates to approximately two-thirds of the total expenditure of the Health and Ageing Portfolio. In cash terms, the Australian Government's expenditure on the three main components of Medicare in 2004-05 was $24.0 billion, a real increase of 7 per cent on the previous year.

Outlays and growth rates for MBS, PBS and AHCAs are managed within the context of an agreement. These agreements allow for growth to occur at an agreed rate within the funding allocated.

Figure 2.3: Australian Government real outlays on PBS, MBS and AHCAs (constant 2004-05 dollars); 1991-92 to 2004-05



Source: The Department of Health and Ageing and the Health Insurance Commission data

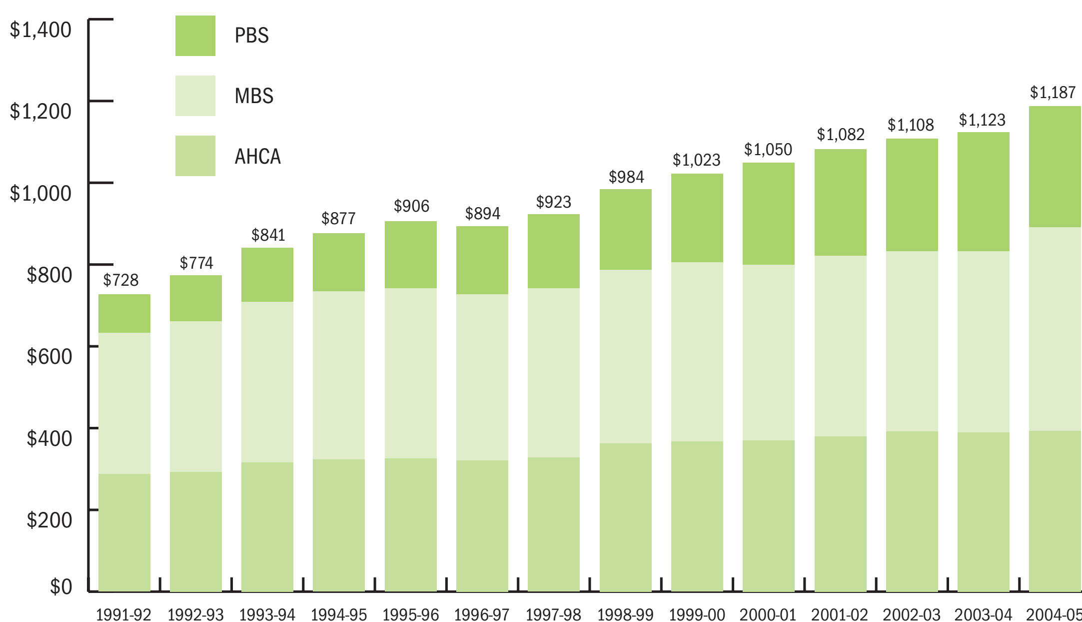
Notes

1. Outlays deflated using the non-farm Gross Domestic Product (GDP) implicit price deflator.
2. MBS refers to the Medicare Benefits Scheme.
3. PBS refers to the Pharmaceutical Benefits Scheme.
4. AHCAs refers to the Australian Health Care Agreements. Included are 2003-2008 AHCAs, 1998-2003 AHCAs, 1993-1998 Medicare Agreements and the 1988-1993 Medicare Agreements. Each Agreement contains a slightly different suite of programs. The 1998-2003 AHCAs includes funding to the states/territories under the National Health Development Fund. The 2003-2008 AHCAs includes funding to the states/territories under the Pathways Home program.
5. Outlays are on a cash basis from 1991-92 to 1998-99 and on an accrual basis from 1999-2000 to 2004-05.
6. The Department's outcome and outputs structure commenced in 1999-2000 and the AHCA funding represented since then includes both outcome 2 and outcome 4 allocations. Outcome 4 contributes less than 2 per cent annually of total funding under the AHCAs.

Indicator 10. Australian Government expenses per capita on Medicare, both total and by Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and under the AHCAs	
Target:	*Information source/reporting frequency:*
To monitor per capita expenses through the provision of regular reports.	Budget papers.

For the three components of Medicare, real growth in per capita expenditure was 5.7 per cent, rising from $1,123 per capita in 2003-04 to $1,187 in 2004-05. The per capita expenditure has increased by 35 per cent in real terms over the past ten years.

Figure 2.4: Australian Government real per capita outlays on PBS, MBS and AHCAs (constant 2004-05 dollars); 1991-92 to 2004-05



Source: The Department of Health and Ageing and the Health Insurance Commission data

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3. PBS refers to the Pharmaceutical Benefits Scheme.
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6. The Department's outcome and outputs structure commenced in 1999-2000 and the AHCA funding represented since then includes both outcome 2 and outcome 4 allocations. Outcome 4 contributes less than 2 per cent annually of total funding under the AHCAs.

Indicator 11. Trends in workforce changes due to medical indemnity costs	
Target: Workforce levels for high-risk specialty groups such as surgeons, obstetricians and procedural general practitioners do not decline due to medical indemnity costs.	*Information source/reporting frequency:* Budget papers. • Medicare data on workforce figures; • utilisation of MBS items by high risk specialty groups; • utilisation of MBS specialty item numbers by general practitioners; • Premium Support Scheme, High Cost Claims Scheme and Incurred But Not Reported Indemnity Scheme expenditure data; and • premiums for high-risk specialties after premium support.

According to MBS utilisation of specialty numbers, there was no significant reduction in procedural general practitioners, obstetricians and neurosurgeons in 2004-05 compared with 2003-04. In addition, the Department is provided with medical indemnity premium data, which is then used by the Australian Government to track the effectiveness of the Government's medical indemnity framework and to improve the operation of medical indemnity schemes in the future. Premium data for 2004-05 will also be used for a report to be released by the Australian Competition and Consumer Commission.

PART 2: PERFORMANCE INFORMATION

Performance Information for Administered Items

Administered Item 1. Access through Medicare to cost effective medical services, medicines and acute health care for all Australians, including:

- national insurance for medical services through the Medicare Benefits Schedule;

Target:	*Quantity:* Medicare rebates will be provided for an estimated 237 million services.	
Result:	Target met.	Rebates were provided for an estimated 236.3 million services.
Target:	*Quantity:* Medicare rebates will be provided for an estimated 11.8 services per capita.	
Result:	Target met.	Rebates were provided for an estimated 11.6 services per capita.

- alternative funding for General Practice;

Target:	*Quantity:* The number of practices taking up the outcomes based elements of the Practice Incentives Program (such as diabetes, cervical screening and participation in activities approved by the National Prescribing Service).	
Result:	Increase on previous year.	The majority of general practices in Australia participate in the Practice Incentives Program (PIP). At May 2005, there were 4,681 practices (4,646 practices at May 2004) participating in the program, providing 80% of GP care provided to patients nationally. In the May 2005 payment quarter: • 26% of PIP practices participated in the Quality Prescribing Initiative; • 4,265 (91%) of PIP practices had agreed to participate in the Cervical Screening initiative. Of these practices, 3,103 (73%) practices achieved an outcomes payment for reaching the screening target for women patients in the practice aged 20 to 69 years; and • 4,202 (90%) of PIP practices had agreed to participate in the Diabetes Initiative. Of these practices 1,920 practices (46%) practices achieved an outcomes payment for providing an annual cycle of care to more than 20% of their patients.

2

OUTCOME

- development and support of medical services related to the Medicare Benefits Schedule;

Target:	*Quality:* 100% of new medical services listed for funding under the Medicare Benefits Schedule have been assessed for evidence of safety, effectiveness and cost-effectiveness (see also Departmental Output Group 2).	
Result:	Target met.	All new medical services listed on the Medicare Benefits Schedule were assessed by the Medical Services Advisory Committee for safety, effectiveness and cost-effectiveness.

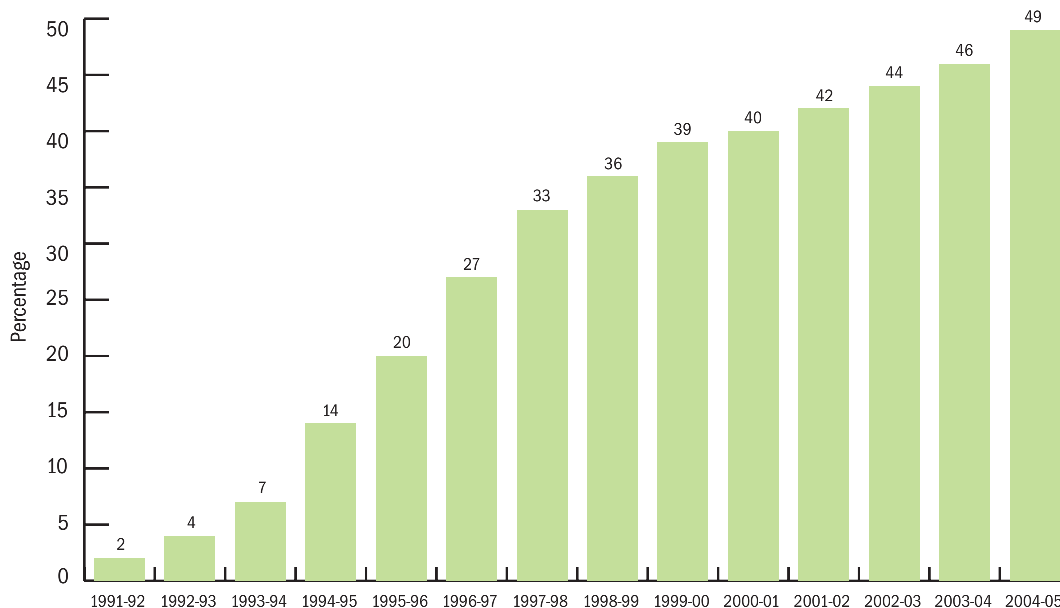
- access to subsidised medicines through the Pharmaceutical Benefits Scheme;

Target:	*Quantity:* An estimated 173 million Pharmaceutical Benefits Scheme prescriptions will be supplied for general and concessional patients.	
Result:	Target met.	The number of prescriptions dispensed in 2004-05 subsidised under the Pharmaceutical Benefits Scheme was 170 million. This compared with 165 million in 2003-04.
Target:	*Quantity:* An estimated 8.5 Pharmaceutical Benefits Scheme prescriptions per capita will be supplied.	
Result:	Target met.	The average number of PBS scripts supplied per capita was 8.3 for 2004-05, compared with 8.2 for 2003-04.
Target:	*Efficiency:* Cost of approved price increases to existing Pharmaceutical Benefits Scheme items compared with increases in previous years.	
Result:	Target met.	Price increases as a result of Pharmaceutical Benefits Pricing Authority recommendations amounted to $9.8 million in 2004-05, compared with $4.8 million in 2003-04.

- development and support of services related to the Pharmaceutical Benefits Scheme;

Target:	*Quantity:* Percentage of drugs listed on the Pharmaceutical Benefits Scheme which were subjected to evidence-based assessment of comparative effectiveness and cost.	
Result:	Target met.	In 2004-05, there were 661 drugs listed on the PBS of which 49% have been subjected to evidence-based assessment. See Figure 2.5.
Target:	*Efficiency:* Pharmacist remuneration as a proportion of Pharmaceutical Benefits Scheme outlays.	
Result:	Target met.	In 2004-05, the PBS pricing formula provided allowances for pharmacist dispensing fees and pharmacy retail mark ups representing 24.16% of all PBS outlays, compared to 24.5% in 2003-04. The formula also provided 9.55% of PBS outlays as allowance for the wholesale distribution of PBS medicines. This allowance is also paid to pharmacists.

Figure 2.5: Percentage of PBS Drugs Subject to Cost Effectiveness Requirements



Source: The Department of Health and Ageing.

Quantity: Percentage of Pharmaceutical Benefits Scheme benefits paid for pharmaceuticals listed following evidence based assessment of comparative effectiveness and cost.

- access to public hospital services for public patients;

Target:	*Quality:* Performance levels for emergency department and elective surgery waiting times relative to performance standards.	
Result:	See footnote below.	Figures on the waiting times for emergency departments and elective surgery are set out in Table 2.1 and Table 2.2 at the end of this chapter.
Target:	*Quantity:* Number of public patient weighted separations per 1,000 weighted population.	
Result:	Increase on previous year.	The number of public patient weighted separations per 1,000 weighted population for 2004-05 are currently unavailable. On the data currently available for 2003-04, a national average of 184.91 public patient separations per 1,000 weighted population was achieved.

[5] Slight improvement from 2002-03 (Table 2.1, page 98); and slight deterioration from 2002-03 (Table 2.2, page 99).

2

OUTCOME

• access to private medical services through the implementation of the medical indemnity package;

Target:	*Quantity:* Value of premium support payments made to Medical Indemnity Insurers.	
Result:	Not applicable.	The value of premium support payments made to Medical Indemnity Insurers was $25.7 million.
Target:	*Quantity:* Number of doctors receiving premium support payments.	
Result:	Increase on previous year.	The number of doctors that received premium support payments in 2004-05 was 4,441. This is around four times as many as participated in the Medical Indemnity Subsidy Scheme in 2003-04.
Target:	*Quantity:* Payments made to Medical Indemnity Insurers for claims made under the Incurred But Not Reported liabilities scheme.	
Result:	Not applicable.	The value of payments made to Medical Indemnity Insurers for claims made under the Incurred But Not Reported liabilities scheme was $8.7 million compared to $5.2 million in the 8 months from 1 November 2003 to 30 June 2004.
Target:	*Quantity:* Value and number of claims lodged under the High Cost Claims Scheme.	
Result:	Not applicable.	The High Cost Claims Scheme has continued to accrue liabilities during 2004-05. The accrual of these liabilities has reduced costs across the medical indemnity industry and put downward pressure on medical indemnity premiums.
Target:	*Quantity:* Payments made to Medical Indemnity Insurers for claims made under the Run-Off Cover Scheme.	
Result:	Not applicable.	In 2004-05, the first full year after its implementation the Run-Off Cover Scheme accrued liabilities arising from potential claims. No claims were lodged by Medical Indemnity Insurers under the Run-Off Cover Scheme in 2004-05. However, the scheme will allow the payment of accrued claims once lodged by Medical Indemnity Insurers.

• affordable Medicare services (bulk billing incentives);

Target:	*Quantity:* Percentage of GP attendances by concessional patients and children aged under 16 years where no gap fee is charged.	
Result:	No target number specified in 2003-04.	In 2004-05, the percentage of GP attendances by concessional patients and children under 16 where no gap fee is charged: • 84.3% of GP attendances (excluding practice nurse items); and • 84.8% of GP attendances (including practice nurse items).
Target:	*Quantity:* Number of Medicare services claimed by GPs for bulk billing concessional/child patients.	
Result:	No target number specified in 2003-04.	In 2004-05, the number of Medicare services claimed by GPs for bulk billing concessional/child patients: • 49.8 million GP attendances (excluding practice nurse items); and • 51.9 million GP attendances (including practice nurse items).

- affordable Medicare services (safety nets); and

Target:	*Quantity:* Number of families/individuals that are benefiting including: • concession card holders; • people covered by the Family Tax Benefit (A); and • other general population.	
Result:	Target met.	191,590 families and individuals have either received extended Medicare safety net benefits or will receive benefits when their claims have been substantiated.
Target:	*Quantity:* Number of families registering for the MBS safety net including families of concession card holders.	
Result:	Increased from previous year.	At 30 June 2005, a total of 3,898,855 families were registered for the Medicare safety net, compared with 2,956,733 registered families in 2003-04.
Target:	*Quantity:* Average benefits provided.	
Result:	It was inappropriate for the safety net to have a separate benefit total as it is only a part of the total Medicare Benefit.	
Target:	*Quantity:* Total benefits provided.	
Result:	Increased from previous year.	A total of $244 million was provided for Medicare Safety nets in 2004-05.

- access to services.

Target:	*Quantity:* Percentage of eligible practices participating in the practice nurse initiative.	
Result:	Increased from previous year.	In May 2005, over 75% of eligible PIP practices in rural areas received support to employ a practice nurse or Aboriginal health worker. This is an increase of 2% from May 2004. In urban areas of workforce shortage, 49% of eligible practices received support to employ a practice nurse or allied health worker. This is an increase of 6% from May 2004.
Target:	*Quantity:* Number of GPs participating in the PIP procedural loading initiative.	
Result:	Increased from previous year.	In May 2005, a PIP procedural GP payment was made to 340 (291 in May 2004) practices for services provided by 761 procedural GPs. It is estimated that over 75% of procedural GPs are participating in this initiative. Payments of $3.2 million were made in 2003-04 and $3.3 million in 2004-05.
Target:	*Quantity:* Number of aged care residents provided with a Comprehensive Medical Assessment on entry to an aged care home or where required.	
Result:	Target met.	24,471 residents were provided with a Comprehensive Medical Assessment in the programs first year.
Target:	*Quantity:* Number of patients with Enhanced Primary Care plans who access allied health services and/or dental services under the new Medicare items.	
Result:	Target met.	Over 85,000 patients benefited from access to the new rebates under Medicare for allied health or dental care services. Uptake for this new measure is still building. A delay in getting GPs, allied health providers and dentists involved was not unexpected.
Target:	*Quantity:* Number of Aboriginal and Torres Strait Islander people who access two-yearly adult health checks.	
Result:	Target met.	7,759 Aboriginal and Torres Strait Islander adults have received a health check from May 2004 to May 2005. The monthly uptake rate has risen from 249 in May 2004 to a peak of 753 in March 2005.

Performance Information for Departmental Outputs

Output Group 1. Policy advice, including:

- development of 2005-06 Budget measures that contribute to the Government's health and fiscal objectives;
- advice to the Minister on financing arrangements in health; and
- consideration of possible improvements to the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme.

Target:	*Quality:* A high level of satisfaction of the Ministers, Parliamentary Secretary and Ministers' Offices with the relevance, quality and timeliness of policy advice.	
Result:	Target met.	The Minister and Minister's Office were satisfied with the relevance, quality and timeliness of policy advice, Question Time Briefs, Parliamentary Questions on Notice and briefings.
Target:	*Quality:* Timely production of evidence-based policy research.	
Result:	Target met.	Evidence-based policy research undertaken by the Department was produced in a timely manner, such as, policy research into the provision of rebates to assist with the management of home dialysis for patients with end-stage renal failure awaiting transplant.
Target:	*Quality:* Opportunity for stakeholders to participate in policy and program development.	
Result:	Target met.	Stakeholders representing the health professions (including medical, pharmacy, nursing, dental, and optometry), medical and pharmaceutical manufacturing industries and consumers participate in policy and program development for the MBS, PBS and the National Medicines Policy. In order for stakeholders to participate in the policy and program development of MBS changes, Medicare Benefit Consultative Committee meetings are held between representatives from the relevant professional groups, the Australian Medical Association, the Health Insurance Commission and the Department. In 2004-05: • 7 Medicare Benefit Consultative Committee and 1 Optometrical Benefit Consultative Committee meetings were convened; • meetings and consultations with stakeholders were held; and • input to Senate inquiries on cancer and mental health was provided. During 2004-05, the Medical Services Advisory Committee (MSAC) received 30 submissions and provided enhanced opportunities for stakeholder participation in the MSAC process. The Australian Medical Association, Royal Australian College of General Practitioners, Rural Doctors Association of Australia and the Australian Divisions of General Practice have been involved in the progress of the Red Tape Review recommendations including the development of new Chronic Disease Management items, through the PIP and EPC Review Advisory Group and the Medicare Benefits Consultative Committee.

Output Group 2. Program management, including:

- managing the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme estimates;
- making payments to the States and Territories under the Australian Health Care Agreements;
- financial management and reporting on Outcome 2;
- managing partnership arrangements with the Health Insurance Commission for delivery of functions in relation to Outcome 2;
- management of contracts to support policy development;
- administration of grant programs;
- successful implementation of Budget initiatives;

Target:	*Quality:* Budget predictions are met and actual expenses vary less than 5% from budgeted expenses.	
Result:	Target met.	Actual expenses for Outcome 2 were $24,744 billion compared to a predicted $24,709 billion. Overall expenses were 0.14% from estimates. Actual expenses vary less than 5% from budgeted expenses for PB Other Special Appropriation and Aids and Appliances Special Appropriation.
Target:	*Quality:* 100% of payments are made accurately and in accordance with negotiated service standards.	
Result:	Target met.	All payments required to be made in respect of the Department's contractual obligations were made on time.
Target:	*Quantity:* Approximately 37 grants, 79 consultancies/contracts and 160 funding agreements (including 8 AHCAs) administered.	
Result:	Target not met.	Total agreements administered in 2004-05: • 20 grants; • 56 consultancies/contracts; and • 155 funding agreements.

- ongoing development and maintenance of the Medicare Benefits Schedule;
- ongoing development and maintenance of the Pharmaceutical Benefits Scheme;

Target:	*Quality:* All new listings included on the Schedule of Pharmaceutical Benefits have been assessed for evidence of safety, effectiveness and cost effectiveness.	
Result:	Target met.	All listings for new drugs included on the PBS have been assessed for evidence of safety, effectiveness and cost effectiveness.
Target:	*Quality:* All new medical services listed in the Medicare Benefits Schedule have been assessed for evidence of safety, effectiveness and cost effectiveness.	
Result:	Target met.	All new medical services were listed on the MBS following assessment by the Medical Services Advisory Committee.
Target:	*Quality:* Time taken to assess applications to the Medical Services Advisory Committee for public funding of new medical services.	
Result:	Increased from previous year.	The average time for all completed reviews increased slightly from 13 months in 2003-04 to 15.9 months in 2004-05. The increased average review time is attributable to the increased involvement by stakeholders in the assessment process in line with the outcomes of the Medical Services Advisory Committee Review.
Target:	*Quality:* Time taken to process new submissions for listing on the Schedule of Pharmaceutical Benefits. In 2003-04 all submissions for listing a medicine on the Pharmaceutical Benefits Scheme received by the relevant close off time were processed and considered by the appropriate advisory committees within agreed timeframes.	
Result:	Target met.	All applications for listing a medicine on the PBS received by the due date were processed by the Department within the agreed timeframes (i.e. 17 weeks) from lodgement of the application to consideration by the Pharmaceutical Benefits Advisory Committee (PBAC). All positive PBAC recommendations were considered at the next Pharmaceutical Benefits Pricing Authority meeting, unless withdrawn by sponsors. During 2004-05, the Pharmaceutical Benefits Advisory Committee received 129 submissions for new or varied PBS listings. This compares to 88 submissions in 2003-04.
Target:	*Quantity:* Number of new listings on the Medicare Benefits Schedule. There were 56 new listings in 2003-04.	
Result:	Increase from previous year.	There were 214 new MBS listings in 2004-05.
Target:	*Quantity:* Item descriptions amended on the Medicare Benefits Schedule. There were 132 descriptions amended in 2003-04.	
Result:	Decrease from previous year.	There were 109 item descriptions amended in 2004-05.

2

OUTCOME

Target:	*Quantity:* Number of new listings on the Pharmaceutical Benefits Scheme. - There were 18 new drugs (chemical entities) listed on the Schedule of Pharmaceutical Benefits in 2003-04. - There were 177 new forms and strengths (items) and 90 new brands listed on the Schedule of Pharmaceutical Benefits in 2003-04.	
Result:	Decrease in number of listings.	There were 23 new drugs (chemical entities), 90 new forms and strengths (items) and 82 new products (brands) listed on the Schedule of Pharmaceutical Benefits in 2004-05.
Target:	*Quantity:* Number of listings amended on the Pharmaceutical Benefits Scheme. There were 203 amendments to PBS listings (such as changes to eligibility rules and maximum quantities and repeats) included in the Schedule of Pharmaceutical Benefits in 2003-04.	
Result:	Decrease from the previous year.	There were 150 amendments to already listed PBS drugs (such as changes to eligibility rules and maximum quantities and repeats) included in the Schedule of Pharmaceutical Benefits in 2004-05.

- development of information activities for 2004-05 include: consumer, evidence-based, education strategy regarding safe and correct use of medicines;

Target:	*Quality:* Information campaigns conducted during the year are evaluated as being effective.	
Result:	Target met.	Media profile of Medicare has been high as a result of new initiatives to extend and strengthen the program and community perception of Medicare as reported in the media appears positive. This positive community perception of Medicare would, therefore, suggest that the Department's information campaigns have been effective.
Target:	*Quality:* A high level of stakeholder satisfaction with the relevance, quality and timeliness of information and education services.	
Result:	Target met.	Stakeholders have indicated a high level of support and satisfaction with the timeliness, quality and relevance of information and education services. In particular, stakeholders have demonstrated a high level of enthusiasm to be involved in data collections which have as a result progressed in both scope and size. Stakeholder satisfaction was achieved through: • advice provided by the Department was delivered in a timely manner; • education and consultation campaigns are developed in close consultation with stakeholders; and • information campaigns conducted under Outcome 2 throughout 2004-05 was generally successful and stakeholders are satisfied with their relevance, quality and timeliness.
Target:	*Quantity:* An estimated 35,000 calls to the Pharmaceutical Benefits Scheme information line.	
Result:	Decrease calls to PBS information line.	33,758 calls were received by the Pharmaceutical Benefits Scheme Information Line. Of these 33,725 (99.90%) were satisfied with the customer service provided, 20 (0.06%) were dissatisfied and 13 (0.04%) were abusive.

- production of the Medicare Benefits Schedule (and supplements) covering more than 4,500 individual items; including the Optometrical Services Schedule and the Cleft Lip and Palate Schedules;
- production of the Pharmaceutical Benefits Scheme schedule (and supplements) covering approximately 2,500 individual drug items;

Target:	*Quality:* Production of Medicare Benefits Schedule Supplement by 1 May 2005.	
Result:	Target met.	52,000 copies of the MBS supplement were distributed to doctors, hospitals, health insurance funds, software developers and Health Insurance Commission offices.
Target:	*Quality:* Three revisions of the Schedule of Pharmaceutical Benefits, produced by 1 August 2004, 1 December 2004 and 1 April 2005 respectively.	
Result:	Target met.	The Department prepared three issues of the Schedule of Pharmaceutical Benefits in August 2004, December 2004 and April 2005. 52,066 schedules were distributed on time.

- continued implementation of public hospital funding arrangements, the Diagnostic Imaging and Pathology Agreements, and the Community Pharmacy Agreement;

Target:	*Quality:* A high level of stakeholder satisfaction with the timely development and implementation of national strategies.	
Result:	Target met.	Stakeholders are generally satisfied with the timely development and implementation of national strategies. Despite significant investment by the Department in stakeholder consultation during 2004-05, stakeholders did not express satisfaction with all strategies and implementation arrangements, especially where there are funding constraints. For example, the pharmaceutical industry generally opposed the reference pricing policies under the PBS, arguing that this suppresses the prices of some medicines. On the other hand, the medical profession welcomed the extended Medicare safety net to assist patients with out of pocket costs of private medical services. While it is unrealistic to expect stakeholder satisfaction with all policies and implementation strategies in this area, a high level was maintained.

• production of the *State of our Public Hospitals Report*;

• implementation of the 2003-08 Australian Health Care Agreements; and

Target:	*Quality:* Production of the *State of our Public Hospitals Report* by 30 June 2005.	
Result:	Target met.	Report completed and publicly released on 29 June 2005 in accordance with the requirements of the Australian Health Care Agreements (AHCAs) (Clause 4, Schedule C).
Target:	*Quality:* All key milestones and results areas for 2004-05 specified in the AHCAs are implemented on time.	
Result:	Target met.	All key milestones for 2004-05 were implemented on time as specified in the AHCAs: • agreement to a new standardised system for determining recurrent health expenditure by 30 June 2005 (Clause 36); • agreement to new performance indicators on rehabilitation and geriatric evaluation and management services by 31 December 2004 (Schedule B, Clause 14); and • design of an approved outpatient care National Minimum Data Set completed in February 2005 and approved by the registration authority in March 2005 (Schedule C, Clause 6(g)).

• implementation of the new package of Medical Indemnity measures announced on 17 December 2003.

Target:	*Quality:* The Premium Support Scheme, United Medical Protection support arrangements, and the Run-Off Cover Scheme are operational in agreed timeframes.	
Result:	Target met.	The Premium Support Scheme, the Run-off Cover Scheme and the United Medical Protection support arrangements were implemented within agreed timeframes.

PERFORMANCE ASSESSMENT: EVALUATIONS AND REVIEWS

Evaluation/Review:	Cervical Screening Incentives for General Practitioners Program.
Timeframe:	Commencement date: August 2004. End date: September 2004.
Related Performance Indicator:	The number of practices taking up the outcomes based elements of the Practice Incentives Program (such as diabetes, cervical screening and participation in activities approved by the National Prescribing Service).
URL/Web Address for published results:	Not applicable.
Evaluation/Review:	**Home Medicines Review Program.**
Timeframe:	Commencement date: July 2004 End date: October 2004
Related Performance Indicator:	Departmental Output Group 2. • development of information activities for 2004-05 include: - consumer, evidence-based, education strategy regarding safe and correct use of medicines; A high level of stakeholder satisfaction with the relevance, quality and timeliness of information and education services.
URL/Web Address for published results:	Not applicable.
Evaluation/Review:	**Review of Competitive Neutrality in the Medical Indemnity Insurance Market.**
Timeframe:	Commencement date: 7 December 2004. End date: 15 March 2005.
Related Performance Indicator:	Indicator 11.
URL/Web Address for published results:	<www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicalindemnity-competitiveneutrality>.

2

OUTCOME

Table 2.1 Australian Health Care Agreements: 2003-04 Performance – Emergency Department Waiting Time

	Levels achieved (per cent)				
	Resuscitation	Emergency	Urgent	Semi-urgent	Non-urgent
New South Wales	100	76	58	65	86
Victoria	100	88	83	75	89
Queensland	100	76	56	57	84
Western Australia	100	72	68	67	92
South Australia	94	65	49	54	85
Tasmania	96	67	61	61	92
Australian Capital Territory	100	69	64	58	77
Northern Territory	100	57	63	59	86
National average	**99**	**77**	**64**	**65**	**87**

Source: Data provided by the states and territories under the Australian Health Care Agreements (AHCA).

Notes:
Category 1 – patients need resuscitation and require treatment immediately (eg cardiac arrest);
Category 2 – patients are deemed to be 'emergencies' and require treatment within 10 minutes (eg chest pain);
Category 3 – patients are deemed to be 'urgent' and require treatment within 30 minutes (eg moderate trauma);
Category 4 – patients are defined as 'semi-urgent' and require treatment within 1 hours; and
Category 5 – patients are defined as 'non-urgent' and require treatment within 2 hours.

Table 2.2 Australian Health Care Agreements: 2003-04 Performance – Elective Surgery Waiting Times

	Levels achieved (per cent)		
	Category 1	Category 2	Category 3
New South Wales	80	76	87
Victoria	100	80	93
Queensland	91	90	87
Western Australia	83	72	92
South Australia	82	81	93
Tasmania	64	51	61
Australian Capital Territory	98	52	71
Northern Territory	81	69	85
National average	85	80	89

Source: Data provided by the states and territories under the AHCAs.

Notes:
Category 1 – admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point it may become an emergency;
Category 2 – admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly; and
Category 3 – admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency (while no time frame is specified for category 3, 'within 12 months' is a widely used measure for this category).

Outcome 2 - Financial Resources Summary

	(A) Budget Estimate 2004-05 $'000[1]	(B) Actual 2004-05 $'000	Variation (Column B minus Column A) $'000
Administered Expenses			
Administered Item 1: Access through Medicare to Cost Effective Medical Services, Medicines and Acute Health Care for All Australians			
Health Insurance Act 1973 - Medical Benefits	9,763,957	10,063,400	299,443
National Health Act 1953 - Pharmaceutical Benefits	6,037,884	6,001,265	(36,619)
National Health Act 1953 - Aids and Appliances (p)	102,964	94,321	(8,643)
Health Care (Appropriation) Act 1998 - Australian Health Care Agreements - Provision of Designated Health Services	7,855,248	7,855,248	0
Medical Indemnity Act 2002	100,525	65,561	(34,964)
Total Special Appropriations	**23,860,578**	**24,079,795**	**219,217**
Appropriation Bill 1/3	756,478	572,388	(184,090)
Appropriation Bill 2/4	16,849	16,799	(50)
	24,633,905	**24,668,982**	**35,077**
Total Administered Expenses	**24,633,905**	**24,668,982**	**35,077**
Departmental Appropriations			
Output Group 1 - Policy Advice	66,627	67,038	411
Output Group 2 - Program Management	8,068	8,118	50
Output Group 3 - Agency Specific Service Delivery	26	26	0
Total price of departmental outputs *(total revenue from Government & other sources)*	**74,721**	**75,182**	**461**
Total revenue from Government (appropriations) contributing to price of departmental outputs	74,401	74,479	78
Total revenue from other sources	320	703	383
Total price of departmental outputs *(total revenue from Government & other sources)*	**74,721**	**75,182**	**461**
Total estimated resourcing for Outcome 2 *(total price of outputs & admin expenses)*	**24,708,626**	**24,744,164**	**35,538**
Average Staffing Level (Number)			
Department	**494.0**	**495.7**	**1.7**

The 2005-06 budget has not been provided. The Department of Health and Ageing has moved to a new Outcome structure for 2005-06 and is no longer appropriated under the 2004-05 Outcome structure. Accurate allocation of 2005-06 funding against the 2004-05 Outcome structure is not available and inclusion of notional allocations could be misleading to the reader.

1. Budgets taken from 2005-06 PBS and re-aligned to 2004-05 Outcome Structure.