QB22-000254

Date QTB created: 13 July 2022
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Standard QTB

MEDICARE BENEFITS SCHEDULE – PLANNED CHANGES

Key points

- Changes to the Medicare Benefits Schedule (MBS) and associated Private Health Insurance (PHI) regulations generally occur three times a year, on 1 March, 1 July and 1 November.
- Further minor changes to the MBS and PHI regulations are made outside of these scheduled times when necessary to support urgent patient access to services.
- Recent changes from 1 July 2022 included applying annual indexation of Medicare schedule fees using the long-standing indexation formula, changes to bulk billing incentives for magnetic resonance imaging to align with the arrangements for other diagnostic imaging items, implementing responses to MBS Review Taskforce recommendations on colorectal surgery services, and making new listings and changes as recommended by the independent Medical Services Advisory Committee (MSAC).
- For 1 November 2022, there will be further changes announced in previous Budget updates.
- Information about changes is published on MBS Online to provide doctors, hospitals and other interested people with more information about new or amended items.

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Background - Upcoming 1 November 2022 changes

- Changes to medical services include:
  - amendments to eight cardiothoracic surgery items;
  - amendments to six varicose vein services;
  - an amendment to oculoplastic surgery item 45617;
  - amendments to some orthopaedic services to address service gaps and patient safety in response to the MBS Taskforce Review recommendations;
  - changes to paediatric surgery services;
  - changes to melanoma excision services;
  - changes to acupuncture services;
  - a new item for remote programming of a neurostimulator for deep brain stimulation for Parkinson's disease, essential tremor and dystonia;
  - two new items for remote monitoring of cardiac internal loop recorders;
  - a new item for remote reprogramming of a neurostimulator for the management of chronic neuropathic pain; and
  - a new item for cryoablation of renal cell carcinoma.

- Changes to Diagnostic Imaging Services include:
  - an amendment to obstetric magnetic resonance imaging (MRI) item 63454;
  - an amendment to breast MRI item 63464 for patients at high risk of developing breast cancer;

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- an amendment to MRI item 63545 to expand indications from colorectal cancer to include all cancer types;
- changes to obstetric and gynaecological diagnostic imaging services;
- a new MRI item (63549) for patients with a multiple pregnancy where fetal abnormality is suspected;
- a new pelvic MRI item (63563) for the investigation of conditions affecting fertility, including endometriosis; and
- a new positron emission tomography (PET) item for initial staging for patients diagnosed with rare and uncommon cancers.

- Changes to Pathology Services include:
  - an amendment to genetic testing item 73410;
  - amendments to the National Cervical Screening Program (NCSP) items and other administrative and consequential amendments; and
  - a new genetic testing item for the diagnosis of neuromuscular disorders.

- The Regulations will also implement indexation for one clause and one item incorrectly omitted from the *Health Insurance Legislation Amendment (2022 Measures No. 1) Regulations 2022* (the July 2022 MBS Regulations) from 1 July 2022.
- The Medical Services Advisory Committee (MSAC), the MBS Taskforce and medical professional organisations were consulted on 1 November 2022 changes. There was general support from stakeholders on the changes being implemented on 1 November 2022.

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Background – upcoming August 2022 regulations

- A number of changes to the General Medical Services Table (GMST), Pathology Services Table (PST), Diagnostic Imaging Services Table (DIST) and *Health Insurance Regulations 2018* (HIR) will be implemented through the Health Insurance Legislation Amendment (2022 Measures No. 3) Regulations 2022 (the Regulations). These changes are scheduled to be considered at the Executive Council meeting on 18 August 2022.
- These changes were announced in the 2022-23 Budget under the *Guaranteeing Medicare – Medical Benefits Schedule new and amended listings, Women's Health Package* and *Guaranteeing Medicare – Supporting patient access to Magnetic Resonance Imaging measures*.

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PRIVATE HEALTH INSURANCE AND PRIVATE HOSPITALS

Key points

- Private health insurance (PHI) plays an important role in the health system by supporting 14.2 million Australians to access private health services.
- The Government is working to improve both the value PHI provides patients and the sustainability of the private health sector by:
    - modernising and improving the Prostheses List to reduce the costs to privately insured consumers for prostheses provided in hospital treatment
    - reviewing the key policy settings that incentivise consumers to take-up and maintain PHI cover, including the Medicare Levy Surcharge, PHI Rebate and Lifetime Health Cover
    - reviewing the protections provided to consumers that require insurers to pay benefits for hospital treatments in circumstances where there is no contract between the hospital and the consumer's insurer
    - reviewing the Risk Equalisation arrangements that underpin community rating of private health insurance premiums, ensuring consumers are not discriminated against when purchasing PHI because of their age, gender or health status
    - improving the transparency of medical specialist fees through the Medical Costs Finder website, which provides information on over 1,300 in-hospital procedures and out-of-hospital specialist services, so patients can avoid or minimise unexpected out-of-pocket costs.
- The Government is supporting Australians to take-up and maintain PHI cover through the PHI Rebate, which is estimated to provide $6.887 billion in 2022-23 and $28.652 billion from 2022-23 to 2025-26.

Next steps

- s47C
    - The Department is undertaking a number of reviews relating to private health care settings which are due to be finalised in the second half of 2022.
    - These reviews will inform Government consideration of reforms to improve the affordability and value of private care.
    - Responsibility for managing cost pressures on consumers access to private health services does not solely reside with government. Private insurers, hospitals and health providers must continue to make efforts to control their costs in the interests of members and patients, and the sustainability of our health system.

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- s47C

  - Commercial negotiations between Bupa and Ramsay are underway.
  - While Bupa and Ramsay's hospital service contract terminated on 2 August 2022, transitional arrangements apply with the result Bupa members remain fully covered at Ramsay hospitals for a further 60 day, that is until 1 October 2022.
  - I continue to encourage all parties to negotiate in good faith and in the interest of patients and policyholders. I expect the parties will continue to communicate with patients and policyholders in a clear and timely manner.
  - The Private Health Insurance Ombudsman is empowered to act as a mediator in these circumstances and I understand it has offered to arrange mediation in August to assist Ramsay and Bupa to reach agreement.
  - In the event that Bupa and Ramsay cannot reach a new agreement there are a number of regulatory safeguards that protect the interests of consumers, these include: (a) requirements that default benefits are paid by a consumer's insurer when there is no contract in place with a hospital; (b) informed financial consent needs to be provided to patients in advance of care being delivered; and (c) portability arrangements enable policyholders to change insurers if they are not satisfied with the benefits their insurer offers and the premium it charges.

- s47C

  - Since August 2021, insurers have been allowed to increase the maximum age of dependants from 24 to 31 years and remove the age limit for dependants with a disability.
  - While it is not mandatory for health insurers to offer this cover, eight do and more are expected to follow.

- s47C

  - In response to the COVID-19 pandemic, private health insurers have and continue to provide policy holders with premium relief, defer premium increases, provide cashbacks and expand the benefits available to Australians with PHI.
  - Insurers have also extended their products to cover COVID-19 related claims and waived premiums for customers experiencing financial hardship, while continuing to honour benefit claims.
  - The Department, the Australian Prudential Regulatory Agency, the Private Health Insurance Ombudsman and the Australian Competition and Consumer Commission are actively monitoring the sector to ensure health funds meet their public commitments to not profit from the pandemic.

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  - As was the case in the last premium approval process, all insurers will be required to set out their actions to meet their commitment in the next premium round.

- s47C
  - As recommended by the Ministerial Advisory Committee on Out-of-Pocket Costs (2018), participation by medical specialists in this initiative will be voluntary.
  - Publishing individual specialists' fees is not straightforward. Time is required to ensure the information is accurate and presented in a helpful way that supports patients without creating a large administrative workload for doctors.
  - The pace of progress also reflects the prioritisation of the COVID-19 pandemic response by the Government and the medical community.
  - The Medical Costs Finder website already shows median out-of-pocket costs based on aggregated, de-identified government data for the past financial year and it is expected that individual specialist fees will be published later this year.

Background/ funding

- Australian Prudential Regulation Authority data on PHI membership, 31 March 2022:
  - Hospital treatment: 45.1 per cent of the population or 11.6 million Australians.
  - General treatment: 55.0 per cent of the population or 14.2 million Australians.
  - Membership has increased in both number of persons covered and percentage of population over the last seven quarters, since September 2020.
- Benefits paid for the 12 months to March 2022:
  - Hospital treatment: $15.8 billion, representing an increase of 5.3 per cent. Total hospital episodes over the 12 months to March 2022 increased by 7.5 per cent, to a total of 4.6 million episodes.
  - General treatment: $5.4 billion, representing an increase of 4.6 per cent over the 12 months to March 2022. Services also increased by 2.6 per cent, to a total of 91.9 million services.
- As at July 2022 / 2022 Premium Round, there were:
  - 1,316 declared hospitals (eligible to receive private health insurance benefits), of which 641 were private hospitals and 695 were public hospitals.
  - 32 private health insurers operating in Australia, of which 11 are for-profit and 21 are not-for-profit.
- There is public demand for the Medical Costs Finder transparency website. Without any formal promotion, use of the website is increasing. From 30 December 2019 to 10 July 2022, there were over 171,992 sessions.

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- The Medical Costs Finder website shows median out-of-pocket costs based on aggregated, de-identified government data for the past financial year.
- The latest enhancements will be available for release shortly and allow individual medical specialists to publish indicative fees and private health insurer arrangements for common services at a postcode level.
- The enhancements will provide further transparency for consumers about the costs of private health services. The Department is progressing further enhancements in consultation with medical specialists, consumers and insurers.

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Standard QTB

CARE MINUTES AND 24/7 NURSING ELECTION COMMITMENTS

Key points

- s47E(d)

- This will deliver on the Government's election commitment to put more nurses back into nursing homes, giving carers more time to care.
- From July 2023, the Government is mandating the requirement for an RN to be onsite at all times in residential aged care facilities.
    - The commitment directly responds to recommendation 86 of the Royal Commission and will be delivered one year earlier than what was recommended.
    - The 24/7 registered nurse requirement will be included in primary legislation. The Aged Care and Other Legislation Amendment (Implementing Care Reform) Bill 2022 is scheduled for introduction in late July 2022.
- The Government is maintaining the planned mandatory sector average of 200 care minutes per person, per day, including 40 minutes of RN time, from October 2023. However, funding will be provided from 1 October 2022 to give facilities time to ramp up their staffing levels.
    - Facilities, in their 2021-22 financial report, provided an average of approximately 181 minutes of care per person per day.
- From October 2024 residential aged care facilities will be required to provide a minimum sector average of 215 care minutes per person, per day, including 44 minutes of RN time.
- The amount of time each aged care resident receives towards their care is significant part of aged reform with the Royal Commission identifying staffing levels as vital to the quality of care residents receive.

s47C

    - We have committed to supporting training for new and existing aged care workers through Fee Free TAFE, to increase the pipeline of new workers with qualifications, and to ensure existing workers know they are valued and recognised for their care of older Australians.

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s47C

- Amendments to the legislation (Aged Care Act 1997) to establish the 24/7 RN requirement will optionally permit an exemptions framework.
- The Department of Health and Aged Care will consult experts, unions, and the aged care sector to determine whether and on what terms exemptions may be appropriate. The Department will provide advice to Government on this matter in the second half of 2022.
- The Government is also consulting on alternative arrangements for the provision of 24/7 RN care such as on-call arrangements.

Background/ funding

- Residential aged care facilities will receive funding to support them in meeting the new 24/7 registered nurse requirement from July 2023 and the increase to care minutes to a sector average of 215, including 44 registered nurse minutes, from October 2024.
- The Parliamentary Budget Office costed these election commitments at $452 million and $1.99 billion respectively. Actual funding for the commitments will be announced as part of the October Budget.
- Details on the funding that will support the increase to care minutes and implementation of the 24/7 on site registered nurse requirements will be announced as part of the October Budget.
- These new measures to improve the quality of aged care will be supported by mandatory reporting through the Quarterly Financial Report and a new monthly report on instances where a registered nurse is not on site.
- The data captured by these reports will be used to measure and monitor provider compliance with the new 24/7 registered nurse and care minutes requirements. This data and intelligence will be provided to the Aged Care Quality and Safety Commission (the Commission) to review and consider an appropriate, risk-based and proportionate regulatory response.
- The Commission understands that the ability of services to meet the requirements may vary due to a range of factors such as thin markets (geographically or otherwise). The Commission will consider whether non-compliance is the result of genuine factors outside of the control of the providers (such as workforce shortages) versus provider inaction in determining its response.

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Recent Media

- The Brisbane Times, July 28 2022, has reported that 'Paul Sadler said one in five providers, operating about 500 aged care homes, would be unable to put a registered nurse on shift overnight, and weekends would also be a challenge' and 'that the homes that would struggle most were smaller metropolitan facilities and those in regional and rural areas.'
- The Guardian, 3 August 2022, has reported that Martin Bowles, CEO of Calvary Health Care, said that 'he was not confident the workforce would be available, echoing calls from other providers about the need for the government to consider exemptions, particularly in rural and remote areas' and 'There will not be enough nurses in this country at that rate, I would suggest, given all the other problems and shortages around the country, so we will have to look at how we make this up. I actually think there is a real option here for a virtual care option, for virtual care nurses, so people who can be on call all of the time, if we're not going to have enough nurses.'

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AGED CARE WAGES

Key points

- s47E(d)

- The Government will provide a submission to the Fair Work Commission (FWC) by 8 August 2022
- Approximately 350,000 current aged care workers may benefit from a decision to award a wage increase.
- This will deliver on recommendation 84 of the Royal Commission into Aged Care Quality and Safety.

s47C

- The Government has committed to supporting a **real wage increase for workers** and funding the outcome of the case.
- The Government has also announced a range of industrial relations reforms that will benefit workers in the aged care workforce.
    - An Equal Remuneration Principle will ensure the FWC considers equal pay for men and women.
    - Pay Equity and Care and Community Sector Expert Panels will strengthen expertise in the FWC on low-paid care sector work.

s47C

- The Commonwealth wrote to the FWC on 2 June 2022 to indicate an intention to provide a submission.
- In its letter to the FWC, the Australian Government Solicitor highlighted the Commonwealth does not wish to adversely affect the timing and limit disruption to the overall proceedings.
- The FWC agreed to vary its timetable to allow the Government to make a submission by 8 August 2022 without delaying the final outcome of the case.

s47C

- The Government has committed to funding the outcome of the case.

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- The Government will not know the true cost of a wage increase until the FWC makes its determination.

Background

- The Health Services Union (HSU) and Australian Nursing and Midwifery Federation (ANMF) have submitted work value applications to the FWC to vary the three modern awards covering most aged care workers (Aged Care Wages Matter).
- These applications seek, alongside other variations, a 25% increase to wages for aged care workers under the following awards:
    - Aged Care Award 2010 (Aged Care Award) – covering non-clinical residential aged care workers, including personal care workers (PCWs), cooks and administration staff.
    - Social, Community, Home Care and Disability Services Industry Award 2010 (SCHADS Award) – covering non-clinical home care workers.
    - Nurses Award 2020 (Nurses Award) – covering nurses and assistants in nursing.
- The HSU and ANMF have made competing applications to vary the Aged Care Award, and separate applications to vary the SCHADS Award and Nurses Award, respectively.
    - The HSU's application submits that all workers on the Aged Care Award should receive a wage increase, while the ANMF's application applies only to personal care workers.
- The Royal Commission into Aged Care Quality and Safety recommended the Government collaborate with union and employer parties to apply to the FWC to vary wage rates under the three awards covered in the case (recommendation 84).
- Wages and conditions for aged care workers are lower than in similar health and care and support sectors. A comparison of award wages is available at Attachment A.

Next steps

- Timetable for the case:
    - The parties will file closing written submissions by Friday **22 July 2022**.
    - The parties will file submissions in reply by Monday **8 August 2022.**
    - The Commonwealth will file written submissions by Monday **8 August 2022**.
    - The parties will file submissions in reply to the Commonwealth's written submissions by Wednesday **17 August 2022.**
    - The matter will be listed for oral hearing on:
        - 24 and 25 August for submissions by the Applicants and the Commonwealth;
        - 1 September for submissions by employer parties and reply submissions.

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Attachment A – Wage comparison between different sectors

Commented [s22]: Can we have some more context on these levels? What level would be the most common levels for aged care workers to be employed at? I think in a previous version we had an asterisk against the most common levels?

Table 1: Aged Care Award vs Retail and Fast Food Awards

	Aged Care Award 2010 as of 1 July 2022	**Aged Care Award 2010** with 25% uplift	**General Retail Industry Award** as of 1 July 2022	**Fast Food Industry Award** as of 1 July 2022
Level 1	$22.67	$28.33	$23.38	$23.38
Level 2	$23.57	$29.46	$23.92	$24.76
Level 3	$24.47	$30.59	$24.29	$25.14
Level 4	$24.76*	$30.95	$24.76	$25.45
Level 5	$25.60	$32.00	$25.78	
Level 6	$26.98	$33.73	$26.15	
Level 7	$27.46	$34.33	$27.46	
Level 8			$28.58	

Table 2: Aged care wages vs disability wages

	Aged Care Award 2010 as of 1 July 2022	**Aged Care Award 2010** with 25% uplift	**NDIA Cost Model, based on Schedule B** as of 1 July 2022	**SCHADS Home Care Schedule E** as of 1 July 2022
Level 1	$22.67	$28.33		$22.93
Level 2	$23.57	$29.46	$32.36	$24.26*
Level 3	$24.47	$30.59	$33.64	$24.76
Level 4	$24.76*	$30.95	$35.02	$27.02
Level 5	$25.60	$32.00	$42.25	$28.96

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Level 6	$26.98	$33.73		
Level 7	$27.46	$34.33		

*~~Note: In Tables 1 and 2~~ denotes the most common pay level for aged care workers on the Aged Care Award or SCHADS Award ~~is denoted with an asterisk~~. Note the Department does not hold this information about the General Retail Industry Award Fast Food Industry Award or NDIA workers.

Table 3: Comparison of entry-level registered nurse wages – Nurses Award vs State/Territory public sector registered nurses

Nurses Award 2020	$25.79
Nurses Award 2020 with 25% uplift	$32.24
NSW Award wage	$33.13
Vic enterprise agreement wage	$34.17
Qld Award wage	$37.46
ACT enterprise agreement wage	$36.67
SA Award wage	$34.55
Tas Award wage	$34.29
WA Award wage	$35.16
NT enterprise agreement wage	$36.15

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AGED CARE WORKFORCE SHORTAGES

Key points

- s47E(d)
- Improving wages and conditions for aged care workers is a vital step in improving attractiveness of the sector to all aged care workers.
- That is why the Albanese Labor Government is committed to supporting workers' calls for better pay through the Fair Work Commission case and funding the outcome of that case as part of the 2022 election campaign.
- The Government will provide a submission to the Fair Work Commission (FWC) by 8 August 2022
- I am also working with my Ministerial colleagues and stakeholders in the aged care sector, including Unions and Aged Care Providers to consider what further actions are needed to support the development of a bigger, better-skilled workforce.

Recent media

- **Aged care needs more than 800 extra nurses (The Canberra Times, 28 July 2022)**. By July 2023, an additional 869 nurses will be needed to ensure 24/7 coverage in residential aged care facilities, according to Minister Wells.
- **Aged care experts say government underestimates number of nurses required for 24-hour support (The Guardian, 31 July 2022).** The aged care sector says that they estimate 1,440 nurses needed.

s47C

- Improved wages are a vital step in improving attractiveness of the sector to all aged care workers.
- This will enhance recruitment of new workers and keep our current skilled workforce delivering the care that our older Australians deserve.
- The Government has committed to supporting a real wage increase for workers with a submission to the Fair Work Commission and funding the outcome of the case.
- For more detail on aged care wages, see QB22-000295.

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- The Royal Commission acknowledged that workforce shortages have been a long standing issue in aged care that needs to be resolved.

- The recently released CEDA report revised its 2021 projections (an additional 17,000 aged care workers required each year from 2020 to 2030) and expect an annual shortfall of 30,000 to 35,000 direct care workers due to more leaving the sector and fewer migrants coming in.

- The Department of Health and Aged Care modelling points to a larger gap than CEDA estimates (the estimated gap for direct care workforce is 28,000 for residential care and 24,000 for home care in 2023-24). The Government's modelling takes into consideration the need to increase care minutes and 24/7 registered nurse on site in all residential aged care facilities.

- **The National Skills Commission (NSC) Care Workforce Labour Market Study (the Study) reports that care workforce demand is expected to exceed supply, resulting in an emerging short-term workforce gap that will continue to grow over the next 30 years if no action is taken. The Study estimates the total care and support workforce gap will be at least 285,800 (headcount) by 2049-50; with mandatory extended care minutes (215 minutes per resident per day by 2024-25), the gap is estimated to reach 299,200 workers (headcount) by 2049-50.**

s47C

- It is clear that the workforce gaps are large.
- The Department's projections show a workforce gap of 127,100 for the aged care sector by 2031-32.
  - This includes direct care and ancillary staff. The workforce gap for registered nurses is estimated to be around 21,000 for 2031-32.
- The Department does not model out to 2049-50 as the Study does, and only includes the aged care sector
  - The Study takes into account the whole care workforce, including aged care, disability care, veterans and mental health.

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- It is difficult to compare the two sets of projections.
- The NSC modelling would also need to be updated now for the ongoing effects of the COVID-19 pandemic and changes in the economic environment, including the labour market.

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- While recruitment of Australians to fill roles in the aged care sector is a priority, migration will continue to play a role in the aged care workforce.
- I am working with Minister Giles and our respective departments on developing migration pathways for key workers such as personal care workers.
- We will also consult with the unions and aged care providers through this process.

Background/-funding

Migration

- Migration can provide relief to workforce pressures in the aged care sector. With border closures lifting, options for increasing overseas supply are being considered, including through the Pacific Australia Labour Mobility Scheme.
- Historically, the aged care sector has relied on international students, working holiday makers, family stream migrants and humanitarian entrants.
-

Skills and training

- The Government's Fee Free TAFE will support training to new and existing aged care workers, increasing the pipeline of new workers with qualifications, and providing existing workers with a recognition of their value in their care of older Australians.
- The Government has committed to deliver 20,000 new university places, which will prioritise opportunities for under-represented groups to attend university. These places will be focused in areas of national priority or skills needs, such as nursing.
-

Other initiatives to support recruitment of local aged care workers

- We will work with aged care stakeholders and unions to ensure workers are given greater secure jobs and receive the maximum hours of work that suits their needs.
- In addition, there are a number of workforce initiatives currently underway to support an increase in supply and the training of a quality workforce. These include:

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- **The Home Care Workforce Support Program** - a dedicated program to attract and train 13,000 new aged care workers for the home care sector.
- **The Workforce Advisory Service** - a free, independent and confidential service with places available to support residential and home care service providers with best practice advice on attracting, retaining and skilling their workforce.
- **The Aged Care Transition to Practice Program** – to support around 1,400 new aged care nurses with training and professional development opportunities.
- **Clinical placements for nursing students in the care and support sector** - 5,250 clinical placements for nursing students in the care and support sector.
- **Aged Care Nursing and Allied Health Dementia Care Scholarships** - 1,500 scholarships available to nurses, personal care workers and allied health professionals to improve expertise in relevant aged care fields.

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Facts and Figures

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- According to the 2020 Aged Care Workforce Census, the number of staff working across aged care sectors, including staff working duplicate roles, was estimated to be slightly over **434,000** at the end of 2020, comprising:
  - Residential Aged Care: **277,671** (direct care staff: 209,000 staff, 75% ~~per cent~~)
  - Home Care Packages Program: **80,340** (direct care staff: 64,000, 80% ~~per cent~~)
  - Commonwealth Home Support Program (CHSP): **76,096** (direct care staff: 59,029, 78% ~~per cent~~).
- The **estimated aged care workforce**, net of duplicate workers, was around **370,000 at August 2021** - **Direct care staff**: around **284,000** (77 per cent).
- The total number of **Personal Care Workers** net of duplication is estimated to be **215,000** across residential aged care, HCPP and CHSP. They are the largest group of direct care workers:
  - Residential aged care: **70%** ~~per cent~~ of direct care workforce
  - Home care Packages Program (HCPP): **88%** ~~per cent~~ of direct care workforce
  - Commonwealth Home Support Programme: **80%** ~~per cent~~ of direct care workforce.

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- **32**% ~~per cent~~ **increase in the number of direct care workers** in residential aged care facilities since 2016[1].
- **17**% ~~per cent~~ **increase in nurses** (registered and enrolled) working across all aged care sectors from 2016 to 2021 (National Health Workforce Dataset Nursing and Midwifery data)[2].
- Female: Around 87% ~~per cent~~ of all direct care workers in aged care.
- Part-time:
  - ~~R~~Residential aged care direct care: 71% ~~per cent~~ permanent part-time
  - Home Care Packages Program direct care: 50% ~~per cent~~ permanent part-time; ~~.~~ 88% ~~per cent~~ of all direct care workers part-time, including casual/contractor and agency staff
  - CHSP direct care: 68% ~~per cent~~ permanent part-time – 90% ~~per cent~~ of all direct care workers part-time.

Below tables illustrate aged care workforce gap over the next 10 years, for Registered Nurses and Nurse Practitioners (Table 1), Enrolled Nurses (Table 2), and Personal Care Workers (Table 3). Note: numbers may not add up due to rounding.

Table 1 Registered Nurses and Nurse Practitioners supply and demand (headcount) in Residential Aged Care Facilities, FY2023-24 to FY 2031-32

	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	FY 2031-32
A: Baseline demand (no policy change)	30,330	31,470	32,030	33,260	34,640	35,470	36,580	37,530	38,950
B: Additional demand due to care minutes increase to 200	8,940	9,280	9,450	9,810	10,220	10,460	10,790	11,070	11,490
C: Additional demand due to care minutes increase to 215	0	0	0	0	0	0	0	0	0
D: Additional demand due to 24/7 RN coverage	869	870	880	880	890	890	890	900	900
E: Baseline supply	28,380	28,780	29,180	29,570	29,970	30,360	30,750	31,140	31,540
Total workforce gap=A+B+C+D-E	**11,760**	**12,840**	**13,170**	**14,380**	**15,780**	**16,460**	**17,520**	**18,360**	**19,800**

[1] Source: Department of Health, 2020 National Aged Care Workforce Census
[2] National Health Workforce Dataset, Nursing and Midwifery 2021

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Table 2 Enrolled Nurses supply and demand (headcount) in Residential Aged Care Facilities, FY2023-24 to FY 2031-32

	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	~~FY 2031-~~ 32
A: Baseline demand (no policy change)	14,850	15,500	15,900	16,490	17,300	17,670	18,110	18,390	18,960
B: Additional demand due to care minutes increase to 200	530	550	570	590	620	630	650	660	680
C: Additional demand due to care minutes increase to 215	0	1,100	1,130	1,170	1,230	1,260	1,290	1,310	1,350
D: Additional demand due to 24/7 RN coverage	0	0	0	0	0	0	0	0	0
Baseline supply	14,150	14,380	14,600	14,830	15,050	15,270	15,490	15,720	15,940
otal workforce gap=A+B+C+D-E	1,230	2,770	3,000	3,420	4,100	4,290	4,560	4,640	5,050

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Table 3 Personal Care Workers supply and demand (headcount) in Residential Aged Care Facilities, FY2023-24 to FY 2031-32

	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	~~FY 2031-~~ 32
A: Baseline demand (no policy change)	134,940	139,800	142,230	147,850	153,670	157,500	162,470	167,130	173,550
B: Additional demand due to care minutes increase to 200	4,810	4,990	5,070	5,270	5,480	5,620	5,790	5,960	6,190
C: Additional demand due to care minutes increase to 215	0	9,950	10,130	10,530	10,940	11,210	11,570	11,900	12,360
D: Additional demand due to 24/7 RN coverage	0	0	0	0	0	0	0	0	0
E: Baseline supply	126,080	127,840	129,570	131,290	133,000	134,720	136,440	138,150	139,870
otal workforce gap=A+B+C+D-E	13,680	26,900	27,860	32,360	37,090	39,610	43,390	46,840	52,230

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MEDICINAL CANNABIS - OVERVIEW

KEY POINTS:

- Australian Government policy is to treat medicinal cannabis products as medicines, subject to the same regulatory framework and strict standards of safety, quality, and efficacy as all other medicines.
- Australia's approach to the cultivation and manufacture of medicinal cannabis, is also consistent with our obligations as a signatory to the United Nations Single Convention on Narcotic Drugs.
- Currently, there are two medicinal cannabis products included on the Australian Register of Therapeutic Goods (ARTG). Sativex (nabiximols) is used to treat certain patients with multiple sclerosis and Epidyolex (cannabidiol (CBD) is used for patients with certain epileptic conditions. All other medicinal cannabis products are considered 'unapproved' medicines.
- There are a number of legislative mechanisms to enable access to 'unapproved' therapeutic goods. For medicinal cannabis products these include access through:
    - Authorised Prescriber Scheme (AP)
    - Special Access Scheme (SAS)
    - clinical trials
- Any Australian doctor, including GPs and specialists, can apply to the TGA via the Special Access (SAS) or the Authorised Prescriber (AP) scheme to prescribe medicinal cannabis if they feel it is appropriate for their patient.
- Applications are reviewed by both the TGA and state/territory within 2 business days of submission.
- The TGA has established the Therapeutic Goods (Standard for Medicinal Cannabis) (TGO 93) Order 2017. The TGO 93 specifies the minimum quality requirements for all medicinal cannabis products available in Australia.
- Reforms to manufacturing, labelling and packaging of medicinal cannabis were put in place in March 2022 through amendments to Therapeutic Goods Order 93 (TGO 93) and the regulations applying to compounding of medicinal cannabis products.

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PATIENT ACCESS DATA

- More than 300,000 patients have accessed medicinal cannabis products though the Special Access and Authorised Prescriber Scheme in Australia, with most access to medicinal cannabis products occurring since 2016.
- As of 30 June 2022, over 260,000 approvals to access medicinal cannabis products have been granted in Australia.
- More than 4,500 individual medical practitioners have received approvals to prescribe medicinal cannabis treating over 200 different medical conditions.
- As of 30 June 2022, there are 1,246 Authorised Prescriber's of medicinal cannabis products.
- In October 2021, the TGA included a range of medicinal cannabis products for specified dosage forms and indications through the Authorised Prescriber Established History of Use

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pathway. Inclusion in this list means that endorsement from a Human Research Ethics Committee is not required before applying to the TGA to become an Authorised Prescriber. This vastly streamlines the application process for prescribers. As of 30 June 2022, 814 medical practitioners have been approved under the 'Established history of use pathway'.

- Over 320 different unapproved medicinal cannabis products have been prescribed via these patient access pathways. These products include a range of contents and ratios of CBD and THC, and also a wide variety of dosage forms including oral solution, capsules, oil formulations and lozenges.
- Medicinal cannabis is being prescribed for a range of conditions from chronic pain management, psychological conditions (anxiety, post-traumatic stress disorder, insomnia), cancer pain and symptom management and certain epileptic conditions

Down scheduling of low dose cannabidiol

- Since 15 December 2020, certain low dose cannabidiol (CBD) preparations have been down scheduled from Schedule 4 (Prescription Medicine) to Schedule 3 (Pharmacist Only Medicine).
- This allows certain TGA approved low-dose CBD containing products to be supplied over the counter by a pharmacist, without a prescription. Currently there are no TGA approved products on the ARTG that meet the Schedule 3 criteria, however, companies may lodge an application to the TGA for inclusion of a product in the ARTG.

Affordability

- Only medicines registered on the ARTG can be considered for PBS listing by the Pharmaceutical Benefits Advisory Committee (PBAC). On 1 May 2021, Epidyolex, used in combination with at least two other anti-epileptic medicines was included on the PBS.
- Some states (VIC, NSW, and TAS) are subsidising the cost to some patients through access programs or through clinical trials.

REFORMS

Office of Drug Control

- Amendments to the medicinal cannabis scheme in the *Narcotic Drugs Act 1967* commenced in December 2021. These changes:
  - introduce a single, perpetual licence model for medicinal cannabis regulation and a simpler permit regime, and
  - reduce the regulatory burden on Australia's domestic industry.
- The medicinal cannabis activity-based cost recovery model is being reviewed in 2022 following the single licence and permit reforms, so that fees and charges applied to the medicinal cannabis scheme are consistent with the Australian Government Charging framework.

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Standard QTB

HOME CARE PACKAGE ACCESS

Key points

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- At 31 March 2022, **227,209[1] people had access to a Home Care Package (HCP)**, an increase of 4% compared to 31 December 2021 (217,724[2]) and a 24% increase since 31 March 2021 (183,376[3]).
    - Of this number, 208,512 people were in a HCP, and
    - 18,697 people had been offered a HCP and were considering whether to take up their offer.

- The number of people waiting to receive a HCP is continuing to decrease.
    - There were **49,717[4] people waiting for their approved HCP** in the National Priority System (NPS) at 30 June 2022, a decrease of 15% since 31 March 2022 (58,282) and a decrease of 27% from 31 December 2021 (68,429).
    - **As at 30 June 2022, the estimated wait time for a HCP had decreased to 3 to 6 months[5] for all HCP levels** (for a person with medium priority approval).

- At 31 March 2022, 99% of older Australians waiting for a HCP at their assessed level had been offered an interim level HCP and/or had been approved for Commonwealth Home Support Programme (CHSP) services. This percentage was unchanged from 31 December 2021.
- There were 916 approved HCP providers with a home care service at 31 March 2022, an increase from 911 approved HCP providers at 31 December 2021.
- The Government is reviewing approaches to implementing the recommendations from the Royal Commission. The Department of Health and Aged Care has been consulting extensively with aged care stakeholders on reform options for in-home aged care.

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[1] All 31 March 2022 data references are from unpublished data.
[2] All 31 December 2021 data references from 2nd Quarter 2021-22 Home Care Data Report.
[3] All 31 March 2021 data references from 3rd Quarter 2020-21 Home Care Data Report.
[4] Unpublished data as at 30 June 2022
[5] Published 30 June 2022 - https://www myagedcare.gov.au/help-at-home/home-care-packages.

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- **QB22-000284** (*Capping Home Care Administration and Management Charges*) highlights the Albanese Labor Government's commitment to implementing a cap on administration and management charges in the HCP Program by January 2023.

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- 3,802 people had exited the NPS due to passing away in the first half of 2021-22. In 2020-21, a total of 8,608 people left the NPS due to passing away, a reduction of 23.6% (2,495) from 2019-20 (10,563).
- Data indicates that, for people aged 75 years or older, the percentage of people who pass away while waiting in the NPS for a HCP at their approved level is lower than for the general population of Australia (the mortality rate on NPS over 75 years of age is 3.7%; for population over 75 years of age it is 5.8%).
- The rate of people passing away whilst in a HCP (6.7%) is more than the rate of people passing away whilst waiting in the NPS for a HCP at their approved level.

	No. of people who spent at least one day in the 75+ population in 2020-21	No. of people who spent at least one day in the 75+ population in 2020-21 and exited that cohort in 2020-21 due to death	% of people who spent at least one day in the 75+ population in 2020-21 and exited that cohort in 2020-21 due to death
Population	1,919,921[6]	111,310[7]	**5.8%**
In the NPS	175,695[8]	6,451[9]	**3.7%**
In a HCP	176,380[10]	11,746[11]	**6.7%**

- The following table provides a percentage breakdown by age bracket for people aged 75 and over who passed away in 2020-21.

	75-79	80-84	85-89	90+	Total 75+
Population	2.5%	4.6%	8.4%	13.3%	5.8%
In the NPS	3.4%	3.4%	3.6%	4.4%	3.7%
In a HCP	5.2%	5.7%	6.5%	9.0%	6.7%

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[6] The 2018-19 population is derived from the population at 30 June 2019. (https://www.abs.gov.au/AUSSTATS/abs@ nsf/DetailsPage/3101.0Jun%202019?OpenDocument – population by age and sex tables) and those people who passed away in 2019 as a proxy for the outflow of people in 2018-19. This figure is then used as a proxy for the population in 2020-21.
[7] AIHW data (https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/summary) from 2019 was used as it was the most publicly available. Death rates in 2019 are used as a proxy for death rates in 2020-21 to assist with comparison purposes.
[8] Unpublished data.
[9] Unpublished data. Note that this figure differs to the 8,068 figure of people who exited the NPS in 2020-21 which included people aged 74 and under.
[10] Unpublished data.
[11] Unpublished data.

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- Often when older Australians are waiting for a HCP they are considering other options as well, including whether or not residential care is an appropriate option. HCPs supplements other services that older Australians may access, including palliative and health care services.

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- A HCP must only be used for ageing related care and services. When making decisions on inclusions and exclusions of a Home Care Package (HCP), providers are expected to consult the 'Inclusions/Exclusions Framework' in the Home Care Packages Operational Manual found at www.health.gov.au/resources/publications/home-care-packages-program-operational-manual-a-guide-for-home-care-providers
- The use of package funds for expenses that all citizens are expected to pay for themselves throughout their life, regardless of age, is excluded from the HCP Program. This includes items such as heating and cooling, purchase of food and payment for holidays/entertainment.
- The Government is committed to reforming the aged care system to deliver the supports older Australians need and deserve (see **QB22-000328** - *Reforms to in-home aged care*).

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Background/ funding

Home Care Packages Program Funding

- Older Australians are increasingly choosing to remain in their own homes for longer. HCPs allow consumers to access a range of services and equipment which assist them to live independently in the community. Recent HCP expenditure (rounded to $billions) and allocated HCPs are indicated in the table below, as well as estimates for 2021-22 through 2023-24.

	2020-21 (ACTUAL)	2021-22 (estimate)	2022-23 (estimate)	2023-24 (estimate)
HCP Funding	$4.2b	$5.3b	$6.5b	$7.15b
Allocated HCPs at 30 June	195,699[12]	235,597	275,597	275,597

Financial estimates are as per the 2022-23 Budget update. Home care forms part of the residential and home care special appropriation. Final numbers for 2021-22 are not yet available.

[12] 2020-21 Annual Report.

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Access to home care in remote Australia – equity through the NPS

- The National Priority System (NPS) is a mechanism for assigning packages to ensure equity for all older Australians requiring support.
    - People approved for a HCP and actively seeking services are placed on the NPS to wait for a HCP to be allocated. The NPS is refreshed each night to ensure the release of HCPs is up to date, and HCPs are released on a weekly basis to all four levels, across high and medium priorities.
    - A person's place in the NPS is determined by the time waiting for care, the ACAT approval for that level of care, and their priority for home care.
- The location of a person has no bearing on their wait time for a HCP; therefore wait times for HCPs in remote Australia are no different than elsewhere in Australia.
    - Between 27 February 2017 and 31 March 2022[13], the median wait times elapsed between approval and assignment of a HCP at each level and priority for service, were consistent across all of Australia.
- Since February 2017, there has been growth in the number of providers delivering care to people in all locations including remote and very remote. At least three approved HCP providers have operational capacity to deliver services across all four HCP levels in each of the 73 Aged Care Planning Regions, some of which are based solely in remote and very remote locations.

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[13] Consistent times between 27 February 2017 and 30 June 2021 are evident in the annual Report of Government Services publications. Consistent times in 2021-22 is detected in unpublished data held by the Department of Health and Aged Care.

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Standard QTB

AGED CARE FUNDING

Key points

- Australian Government (Government) funding for aged care was $27 billion in the last financial year (2021-22). This will increase by 11% to $30 billion in the current financial year (2022-23).
- s47E(d)

Residential Care

- Residential care funding will increase by 13 per cent this financial year (2022-23). This is due to annual indexation (1.7 per cent) and additional funding (such as care minutes) associated with the proposed new funding model – the Australian National Aged Care Classification (AN-ACC) from 1 October 2022 (note, that 9 months of AN-ACC is reflected in 2022-23).
- The average Government funding per resident will be over $85,000 in 2022-23. This is an increase of nearly 10 per cent per resident compared with funding levels in 2021-22.
- This increase is largely being driven by the introduction of the Australian National Aged Care Classification funding tool from 1 October 2022, and associated funding uplifts.
- Furthermore, from 1 July 2023, subject to the passage of legislation, the Independent Hospital and Aged Care Pricing Authority will inform Government decisions on annual funding increases in residential care.
- Under AN-ACC, subsidy paid to residential care providers will consist of three components:
  - a fixed component to account for shared costs across all residents, which vary by location and type of provider
  - a variable component based on each resident's individual care needs
  - a one-off adjustment payment for when a new resident enters a facility.
- Under the AN-ACC:
  - the viability, homeless, and basic daily fee supplements will be rolled into AN-ACC funding in addition to care minute funding
  - an additional basic subsidy will be paid for rural, remote and very remote services, and for services that specialise in caring for the homeless, and for services in remote and very remote areas that specialise in caring for Indigenous residents
  - the veterans and the accommodation supplements will both continue to be paid.

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Home Care

- Home care funding will increase by 21% in this financial year (2022-23) due to annual indexation (1.7%) and additional home care packages.
- 98% of home care recipients have unspent funds, totalling $2 billion across the sector, that can be drawn upon to supplement ongoing funding of $6.4 billion in this financial year.

s47C

s47C

- Indexation increases to funding that commenced on 1 July 2022, will deliver an additional $370 million to aged care providers in 2022-23, as part of the 11% or $3 billion increase in aged care funding in that year (outlined above). Furthermore:

s47C

  - under AN-ACC providers will no longer need to undertake and submit Aged Care Funding Instrument (ACFI) assessments, ACFI reassessments or meet ACFI record keeping requirements, as this function will be undertaken by an independent Government funded workforce. This will result in significant efficiencies in staffing time and resources which are estimated to save providers around $235 million per annum
  - in addition, from 1 July 2023, the Independent Hospital Pricing Authority's (IHPA) role will be expanded to inform Government decisions on annual funding increases in residential care
  - (see QB22-000281 - AN-ACC Implementation and Progress for further information on AN-ACC).

s47C

  - The Department of Health and Aged Care is working with the sector in relation to recent fair work rulings on the Social, Community, Home Care and Disability Services industry award (SCHADS). Providers are implementing a range of approaches to manage these changes including more efficient scheduling and rostering. Providers are able to renegotiate their prices where they are reasonable and justifiable and agreed with home care recipients through their home care agreements.

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Attachment A

Whole of Government - Total Aged Care Funding

	2021-22 (Estimate) ($m)	2022-23 (Budget) ($m)	2023-24 (Estimate) ($m)	2024-25 (Estimate) ($m)	2025-26 (Estimate) ($m)	Total *2022-23 to 2025-26* ($m)
Total Aged Care Funding	26,985.4	30,069.1	31,907.7	33,134.3	34,744.7	129,855.8
Annual increase in spend	3,220.1	3,083.7	1,838.6	1,226.6	1,610.4	7,759.3
Growth		11.4%	6.1%	3.8%	4.9%	

Residential Care Funding

Residential Care Funding	2021-22 (Estimate) ($m)	2022-23 (Budget) ($m)	2023-24 (Estimate) ($m)	2024-25 (Estimate) ($m)	2025-26 (Estimate) ($m)	Total *2022-23 to 2025-26* ($m)
Total Residential Care	14,902.7	16,953.4	18,606.4	19,652.6	20,884.6	76,097.0
Annual increase in spend	829.3	2,050.7	1,653.0	1,046.2	1,232.0	5,981.9
Growth		13.8%	9.8%	5.6%	6.3%	
Residential Care Places	223,951 places	230,000* places	235,000* Places	N/A**	N/A	

***Note: From 1 July 2024, residential care places will be allocated directly to consumers.*

Home Care Funding

Home Care Funding	2021-22 (Estimate) ($m)	2022-23 (Budget) ($m)	2023-24 (Estimate) ($m)	2024-25 (Estimate) ($m)	2025-26 (Estimate) ($m)	Total *2022-23 to 2025-26* ($m)
Total Home Care	5,306.8	6,461.5	7,099.3	7,189.5	7,306.1	28,056.4
Annual increase in spend	1,113.6	1,154.7	637.8	90.2	116.6	1,999.32
Growth		21.8%	9.9%	1.3%	1.6%	
Home Care Packages	236,000 packages	276,000 packages	276,000 packages	276,000 packages	276,000 packages	

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WORKFORCE CHALLENGES IN RURAL AND REMOTE AUSTRALIA

Key points

- The Australian Government is encouraging GPs to work in communities in need and provide regional and rural Australians with more equitable access to quality care.
- More than 700 areas will be able to recruit from a larger pool of doctors, including new entrant international medical graduates and Australian trained bonded doctors with return of service obligations through the expansion of the Distribution Priority Areas announced on 21 July 2022.
- This will make it easier for thousands of Australians in outer suburbs and regions to see a GP.
- The Government is taking immediate action to improve access to vital primary care health care services needed by the community.
    - The Government has committed $750 million to deliver the highest priority investments in primary care and established the Strengthening Medicare Taskforce that will report back to Government by the end of December 2022.
        - The Taskforce will consider how to improve patient access to primary care including after hours, GP-led multidisciplinary team care, with increased affordability, better management of ongoing and chronic health conditions, and decreased pressure on hospitals.
    - The Government has also committed to deliver 50 Medicare Urgent Care Clinics to make it easier for Australian families to see a doctor or a nurse when they have an urgent, but not life threatening, need for care.
        - Medicare Urgent Care Clinics will bulk bill, meaning there will be no out-of-pocket costs for patients.
- The Government is taking immediate action with state and territory governments to address gaps in the health workforce, by working together to urgently recruit more health workers from overseas. The Government is working with states and territories to attract more overseas workers, and smooth the various visa and registration processes.
- We are boosting workforce incentives for rural and regional GPs and supporting the engagement of nurses, allied health and other health professionals to provide rural team-based care. We have committed $146 million to boost rural health care, this includes:
    - expanding the innovative models of primary care program to more rural and remote communities

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- expanding the Murrumbidgee single employer model trial to more regions across rural Australia
- increasing funding to more than 1,000 placements under the John Flynn Prevocational Doctor program, to encourage more hospital-based junior doctors to enter general practice in rural Australia
- additional training posts for rural generalist registrars, GP registrars, and fellowed GPs to undertake advanced skills training to deliver the extra medical services their communities need
- greater incentives for GPs and multidisciplinary teams to work in general practice in rural areas under the Workforce Incentive Program.

- We know that where health professionals learn and train influences where they choose to work and that's why the Government is investing in more rural education and training.
  - The Government is increasing education, medical training and placement of doctors in Far North Queensland by providing $25 million and 20 medical Commonwealth Supported Places to James Cook University to deliver an end-to-end rural medical school program in Cairns.
  - To support the transition to College-led GP training, the Government is providing $42 million over four financial years from 2022-23, for General Practice Workforce Planning and Prioritisation at GP catchment level under the Australian General Practitioner Training (AGPT) Program to better plan for each community's GP workforce needs.
    - This will ensure that GP registrars are supported to train in the communities that are in greatest need of their services.
  - Scholarship programs are funded for medical university level courses to gain their initial medical qualifications, and also to increase the skills, capacity and/or scope of practice of existing health professionals.
- Sustainable rural services rely on teams of health professionals working together at the top of their scope of practice to care for their communities.
  - The Government is committing $2.8 million to build the Central Highlands Allied Health Clinic in Emerald, providing facilities for trainee health professionals to conduct their placements in Emerald and provide services to patients in the Central Highlands.
- As well as taking immediate action, the Government is not forgetting the necessary long-term work, and is making improvements to the way we plan and build our workforce.
  - The National Medical Workforce Strategy 2021–2031 (Strategy) is guiding long-term collaborative medical workforce planning across Australia, to

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rebalance supply and distribution of doctors across specialities, and build a flexible and responsive medical workforce.

- We are also developing a similar Nursing and Midwifery Workforce Strategy and a 10 Year Nurse Practitioner Plan, to support better long term planning and reform. This will ensure Australians have the health and aged care nursing workforce we need in future.

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PRIMARY CARE REFORM

Key points

- The Australian Government is committed to improving access to primary health care for all Australians, strengthening Medicare and relieving pressure on the health system.
- The Government established the **Strengthening Medicare Taskforce** on 1 July to provide recommendations on the highest priority investments in primary care.
- The Strengthening Medicare Taskforce members are health leaders, representing a cross section of perspectives on the primary care system.
- The Strengthening Medicare Taskforce will begin work immediately and build on the Primary Health Care 10 Year Plan. The Taskforce will provide practical recommendations to:
    - improve patient access to general practice, including after hours
    - improve patient access to GP-led multidisciplinary team care, including nursing and allied health
    - make primary care more affordable for patients
    - improve management of ongoing and chronic health conditions and
    - reduce pressure on hospitals.
- The Taskforce will report back to Government by the end of December 2022.
- The Government has committed to investing $750 million in a Strengthening Medicare Fund to deliver the highest priority investments in primary care, in line with recommendations of the Taskforce.
- The Government will also deliver the **$220 million Strengthening Medicare GP Grants program** to invest in local GP practices.
- The $220 million Strengthening Medicare GP Grants program will support GPs to provide better care and see more patients. The program will provide funding for GPs to:
    - upgrade ICT systems including to support telehealth consultations
    - upskill staff
    - purchase new equipment
    - upgrade ventilation and infection control, and
    - make other improvements to ensure GPs can see more patients and provide better care.
- Grants will be provided depending on practice size, with smaller practices being able to access grants of up to $25,000 and larger GPs being able to access grants of up to $50,000.
- The Government is also investing **$135 million to fund 50 Urgent Care Clinics** to make it easier for Australians to see a doctor or nurse when they have an urgent, but not life threatening, need for care.

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- The clinics, which will begin operations from mid-2023, are a key part of commitments made by the Government to strengthen Medicare and relieve pressures on the health system.
- The Urgent Care Clinics will:
  - be based in existing General Practice clinics and community health centres
  - provide free services
  - be open during extended business hours and accept walk-in patients and
  - provide treatments that do not require a hospital admission such as broken bones, wounds, minor burns, scrapes, and other illnesses.

Background/ funding

- The Australian Government will invest over $1 billion in additional funding over four years from 2022-23 in primary care reform.

Next steps

- s47C
  - I will chair the first meeting on 29 July in Sydney.
- s47C
  - The clinics will begin being operational from mid-2023.
- s47C
  - Grants will commence this financial year.

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Hot Issue QTB

AGED CARE – ELECTION COMMITMENTS

Key messages

s47E(d)

- Of the 148 recommendations made by the Royal Commission into Aged Care Quality and Safety, the former government only completed nine (6%) in the 17 months since the Royal Commission handed down its report.

s47E(d)

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s47E(d)

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Facts and Figures

- Administration and management costs make up a significant proportion of home care package expenditure. Some are charged separately (care and package management) usually as a percentage of the basic subsidy, while some are built into the unit price of direct care charges (e.g. cost of office accommodation).
- Over 40% of providers currently charge more than 25% in combined care and package management fees, and approximately 4% of providers charge more than 50 per cent in combined care and package management fees.

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