Cancer control priorities for the 2010-11 federal budget

Vital opportunities to translate Rudd Government health agenda into measurable, cost-beneficial outcomes

Summary statement

Healthcare costs of cancer are projected to more than double by 2032, from around $3.8 billion to more than $10 billion per annum.[1,2] Cancer is fifth on the list of disease groups by expenditure in Australia, a position it is expected to maintain for the next 25 years.[1] The economic impact of cancer is particularly significant, as:

- Around 65% of the $3.8 billion in cancer healthcare costs is spent on hospital admissions, the largest proportion of any major disease group, with a significant taxpayer-funded component;[2]

- More than one third of current cancer cases and associated costs can be prevented through lifestyle changes,[3] while a significant number (i.e. bowel, breast and cervical) can be prevented or treated at greatly reduced cost through improved screening;[4]

- Cancer has an inverse expenditure/disease burden ratio, accounting for 19% of all deaths and premature deaths (the highest of any disease group) and 7% of healthcare costs.[2,3] As 65% of those costs are for inpatient services,[2] greater investment in cancer prevention and early detection, as outlined in this submission, would reduce hospital costs while addressing the increasingly disproportionate human cost of cancer;

- Investment in cancer prevention will produce significant gains in the control of other major disease groups with common risk factors, such as cardiovascular disease, diabetes and stroke;[4] and

- Improved cancer control will be essential to the aims and implementation of the Rudd Government's health reform agenda, with investments from the 2010-11 budget critical to the Government's timelines and deliverables.

Cancer Council Australia understands that Treasury is scrutinising the economic and financial implications of the Government's Preventative Health Taskforce recommendations, which we support, along with the National Health and Hospital Reform Commission's final report. On this basis, our 2010-11 pre-budget submission is concise and re-emphasises two key points:

- The targets set by the taskforce and those in the draft National Partnership Agreements on preventative health will only be achieved through a substantial increase in tobacco excise, as both a lever for meeting the agreed smoking prevalence targets and a revenue source for required investments elsewhere in the strategy; and

- The economic benefits of the Government's most substantial new initiative in cancer control, its National Bowel Cancer Screening Program, will be delayed and the start-up costs increased unless ongoing capacity-building is funded in the 2010-11 budget.

These and other recommended funding priorities are briefly summarised as follows.

Priorities at a glance

Initiative	Investment	Cost benefit	Social benefit
Increase tobacco product price through tax by 21%	No outlay required	$1.3 billion p.a. Reduced healthcare costs	130,000 adults quitting smoking; 35,500 children not addicted
Abolition of duty free tobacco sales	No outlay required	$25m p.a.	Reduced bulk-purchase of lethal tobacco products
Tobacco control social marketing	$43m per annum	Self-funding within one year; more than 3:1 return in three years	Substantial reduction in smoking-related death (see taskforce report)
Fund Preventative Health Taskforce initiatives – in addition to $872m COAG grants	As advised by taskforce and agency	Substantial long-term gains (see taskforce report)	See taskforce report
Extend bowel cancer screening to 60, 70-year-olds	$15m per annum (estimated)	Reduced hospital costs; reduced need for “catch-up” investment	632 new early-stage cancers detected each year
Ongoing commitment to skin cancer awareness campaign	$32m over four years	$90m in annual productivity gains; $2.32 for every dollar invested	1900 premature skin cancer deaths prevented over 20 years
Recommendations from AHMC review of BreastScreen Australia	Uncosted (modest)	Critical investments for program integrity	Critical investments for program integrity
Commonwealth coordination of remote patient travel and accommodation schemes	Negotiated through AHMC	Critical complement to capital investment in RCCs	Addresses key regional health consumer concern

Responsibility for the content of this pre-budget submission is taken by the Chief Executive Officer of Cancer Council Australia, Professor Ian Olver.

Contact for further information is Paul Grogan, Director, Advocacy, at Cancer Council Australia. Contact: paul.grogan@cancer.org.au or (02) 8063 4155.

Tobacco excise: a key to meeting COAG health targets

The Australian Government has allocated $872 million over six years (2009-2015) for a range of public health programs, built into National Preventative Health Partnership Agreements with the states and territories. This funding and the target-based rewards system proposed for underpinning its full allocation are welcome.

However, our independent analysis, supported by the Preventative Health Taskforce research and recommendations,[5] shows that Australia would need to substantially increase tobacco excise in order to meet the agreed target of reducing Australian smoking prevalence to 10% within 10 years.

Evidence also suggests that a number of other targets will only be achieved by increasing the $872 million in partnership grants. Optimal investment in tobacco control social marketing is another example (see following).

Increased tobacco excise, abolition of duty-free tobacco sales (see following) and moving towards a tiered volumetric system for alcohol tax as recommended by the taskforce[5] would be ideal revenue sources for these critical investments. As well as funding essential investments in health system returns, they would provide significant health benefits in their own right[5] and build on the Government's leadership in closing the excise loophole in ready-to-drink spirit mixes.

Tobacco excise and the 'Henry' review

Price control through excise is the most effective measure available to government for reducing the economic and social costs of smoking.[6] As documented in successive pre-budget submissions and in our joint submission with the National Heart Foundation of Australia to the "Henry" review of Australia's Future Tax System, evidence shows a 21% increase in the price of a tobacco products would result in:

- Around $1.03 billion in additional Commonwealth revenue each year;
- 35,500 fewer children taking up smoking;[6]
- Smoking cessation in around 130,000 adults;[6] and
- Increased revenue despite fewer smokers purchasing tobacco products.

Assistant Treasurer Senator the Hon Nick Sherry has formally advised Cancer Council Australia that tobacco taxation remains within the scope of the "Henry" review. We are further advised that the review team has considered our joint submission and that recommendations on tobacco taxation will be included in the final report to the Treasurer, due at the end of 2009.
On this basis, rather than reiterate our rationale in this submission – the evidence for which has not changed and remains consistent with Preventative Health Taskforce recommendations – following is a point-by-point response to comments about tobacco excise in the "Henry" review consultation paper and a reiteration of our response to Q11.3:

Consultation paper Q11.3 What is the appropriate specific goal of taxing tobacco? Is it necessary to change the structure or rate of tobacco taxes?

Cancer Council Australia response: As detailed and supported by evidence in Cancer Council Australia and the National Heart Foundation's submission,[7] the core goal of taxing tobacco is to reduce the enormous social and economic costs of smoking. The related revenue stream is a spin-off benefit – and, in the context of potential sources of public health investment, a very significant one.

Currently, there is in our view no demonstrated necessity to change the structure of Australia's tobacco tax regime (other than to abolish the duty-free loophole, as follows). The problem is that the rate of tobacco excise in Australia has failed to keep pace with minimum WHO recommendations for a decade.[8] A 21% increase in product price would correct that lapse.

Consultation paper chart 11.4: Smoking prevalence and excise revenue, 1991-2008

Cancer Council Australia response: This chart, based on ABS and AIHW data, shows that revenue from tobacco excise increased in real terms over the 17-year reporting period, while adult smoking prevalence dropped from just under 30% to 19%. This is consistent with our analysis that shows a 21% excise increase would more than offset any loss of revenue attributable to fewer people purchasing tobacco products.

Consultation paper comment: "Compared with many other consumer goods, tobacco consumption is relatively unresponsive to price. Most estimates suggest that a 1 per cent increase in the price of cigarettes will reduce total consumption by 0.4 per cent. This suggests that taxing tobacco, like alcohol, provides a relatively efficient source of revenue."

Cancer Council Australia response: Cancer Council Australia contends that generating almost $6 billion in annual revenue while being supported by the majority of taxpayers shows *clearly* that taxing tobacco provides an efficient source of revenue. Community support includes 60% of smokers in favour of an excise increase, as shown in one recent study.[9]

Consideration of the "efficiency" of tobacco excise must, in our view, incorporate the enormous economic and social benefits derived from the resultant reduction in smoking prevalence.

Consultation paper comment: [Tobacco consumption's relative unresponsiveness to price] also implies that the scope to control consumption with tax is limited. However, the impact of tobacco taxes on different groups may vary, as some subgroups in the smoking population are more responsive to price than others. Data from the United Kingdom suggest women are more responsive to price than men, people in lower socioeconomic groups are more responsive than people in higher groups, and young people are more responsive than adults (Chaloupka 1999).

Cancer Council Australia response: As significant increases to tobacco excise have been introduced and promoted on the basis of population health benefit, the relationship between consumption and price should be evaluated in the context of smoking prevalence rather than any other measures of consumption.

Thus, implying that tax is a "limited" mechanism to control consumption is at odds with evidence showing price control through excise remains the best lever available to government for reducing tobacco prevalence and related disease burden. Importantly, tobacco excise is

particularly effective among population groups who incur most of the tobacco disease burden, and in preventing take-up by young people. This is shown in the Chaloupka/Warner study[10] referenced in the consultation paper and reinforced by more recent Australian research.[6]

Consultation paper comment: Studies using individual level data suggest the prevalence of smoking is less responsive to price than overall consumption — a 1 per cent increase in the price of cigarettes will decrease the proportion of the population that smokes by around 0.25 per cent.

Cancer Council Australia response: Cancer Council Australia contends that large population studies and longitudinal research are far more relevant to a review of the tobacco tax rate than individual level research. And evidence from the major studies shows that price control through taxation is the most effective policy measure for reducing prevalence.

Calculations based on minuscule increases in cost, e.g. 1%, are in our view irrelevant when a 21% overall price increase is required to pull Australia back into line with WHO recommendations. Moreover, the economic and social benefits of tobacco excise are maximised in step with the magnitude of any tax increase.

Consultation paper comment: "The tobacco industry argues the current regime of tobacco taxation provides certainty for industry, consumers and government, while helping to control tobacco use and providing government with a significant and stable revenue stream."

Cancer Council Australia response: Tobacco industry opposition to an excise rate increase reinforces the evidence showing that tobacco consumption is directly responsive to price.

In addition, an independent report released in October 2009[11] by economists Professor David Collins and Professor Helen Lapsley refutes a long-held misconception that the tobacco industry is a major contributor to Australia's economy, finding that:

- The Australian tobacco industry is a very minor, and declining, contributor to manufacturing output and to employment. Its balance of payments effects are largely negative;
- Data show the gradual but steady decline of tobacco as a component of household final consumption expenditure and a concomitant reduction in production and retail sales;
- Australia remains a net importer of tobacco and tobacco products, and it is presumed that tobacco industry profits are largely remitted to the overseas parent companies;
- The tobacco industry's economic contribution, with a value-added in the order of $1 billion per annum, is shown to be substantially less than the estimated community costs of tobacco – approximately $31 billion in the financial year 2004/05, including $5.7 billion in workplace productivity losses and $318 million in direct health system costs.

This data provides further rationale for reducing the short and long-term costs of tobacco use. Significantly increasing the tax rate will ensure that tax revenues from an industry in decline are

maintained, until the enormous burden imposed on the community by tobacco use is substantially reduced.

Cancer Council Australia's final point in calling for a 21% increase in tobacco product prices through excise is to note that, under the proposed National Partnership Agreements in preventative health, the states and territories may receive "reward payments" from the Commonwealth for reducing smoking rates to 10% in 10 years.

While we support this approach, the jurisdictions would in our view have a case for expecting the Commonwealth to raise tobacco tax to help ensure their state-based proportion of daily adult smokers reduces by the amount required to attract the reward payment. The state-based smoking cessation services required under the agreements to "complement" Commonwealth social marketing activities will be far more effective if tobacco tax is increased.

Increased tobacco tax would be more than a "complement" to the partnerships: it would be the key driver, underpinning the effectiveness of the agreed tobacco control measures.

Duty free tobacco: a $25 million budget black hole

Cancer Council Australia is advised that Treasury is also considering tax and duty free arrangements for tobacco products as part of the "Henry" review. The review's consultation paper asks:

> **Consultation paper Q11.4** If health and other social costs represent the principal rationale for specific taxes on alcohol and tobacco, is any purpose served in retaining duty free concessions for passenger importation of these items?

Cancer Council Australia response: There is no economic or social benefit in retaining duty free concessions for passenger importations of tobacco (and alcohol) products.

Australia's continued support for tax and duty-free tobacco sales for travellers at Australian airports costs Treasury more than $25 million per annum in potential revenue,[12] promotes smoking and flouts the obligation to abolish duty-free sales that Australia committed to when ratifying the WHO Framework Convention on Tobacco Control in 2004.[13]

Social marketing in tobacco control: a proven investment

There is an expectation that the 2010-11 federal budget will be tight; expenditure in social marketing campaigns has historically been seen as dispensable in a tight economic climate. However, with a substantial new revenue stream through increased tobacco excise (see previous proposal), government could be well-placed to increase and bring forward its planned investment in tobacco control social marketing.

Cancer Council Australia's successive calls for an increased commitment to tobacco control social marketing are consistent with the final taskforce recommendations, as they draw on the same evidence base. A study of the impact of anti-smoking mass media campaigns over 15

years, in Australia and internationally, shows the investment in media spend must be sufficient to achieve at least 700 target audience rating points in order to deliver maximum returns.[14]

As documented by the taskforce, this would require an annual commitment of around $43 million. While this is a substantial amount, it is also sound economics to ensure an investment delivers maximum returns. Added to increased tobacco excise (which on our recommendation could fund the campaign more than 20 times over) and other measures put forward by the taskforce, such a campaign commitment would generate exponential economic and social benefits.

For context, the $9 million invested in the Commonwealth's initial anti-smoking campaign in the late 1990s ('Every cigarette is doing you damage') is expected to return $740 million healthcare savings.[15] Moreover, a Commonwealth study showed that investment in anti-smoking campaigns between 1975 and 1995 saved costs of over $8.4 billion, more than 50 times greater than the amount spent on anti-smoking campaigns over that period.[16]

Extrapolating the benefits of previous campaigns, a $43 million investment in tobacco control mass media would return well over three-to-one within three years and pay for itself within one year. (Source: Extrapolation of independent analysis of National Tobacco Campaign 1997-2000.[17])

While Cancer Council Australia is encouraged by assurances that the Commonwealth's $872 million over six years for the Preventative Health Partnerships will proceed, this allocation alone may not be sufficient for adequately funding tobacco control mass media campaigns. Tobacco excise remains the key to simultaneously reducing tobacco burden and providing the funding stream for other essential public health investments.

Cost estimate: $43 million per annum, to achieve maximum returns.

Preventative Health Taskforce recommendations: 'just do it'

Cancer Council Australia reaffirms its full support for the recommendations of the Government's Preventative Health Taskforce.[5] While Treasury may have reservations about the level of recommended expenditure, there are key points to reinforce, including:

- As indicated throughout the taskforce's technical papers, comprehensive approaches will have the best economic and social effect;
- Increased tobacco excise, the abolition of duty free sales and the introduction of a volumetric alcohol taxation system would provide ideal revenue sources for re-investing, while delivering significant health benefits in their own right;
- While many of the taskforce-recommended investments would not be expected to provide major economic returns for more than 20 years, there would nonetheless be significant shorter-term gains, particularly in the area of tobacco control where dividends well in excess of outlay would be accrued within 10 years;[18]

- Cancer Council and our independent public health allies could assist in promoting the prevention agenda to the community and in delivering specific programs; and

- The Rudd Government has gained considerable support from the independent public health sector on the basis of its in-principle commitment to invest significantly more in disease prevention, but it will only succeed in practice with Treasury support for the taskforce strategy.

We therefore call on Treasury to allocate the necessary funds to translate this vision into outcomes.

Boosting the National Bowel Cancer Screening Program

Adding 60 and 70-year-olds the best interim investment in lives saved

Of all the cancer control measures available to government, extending the National Bowel Cancer Screening Program – currently available only once-off to people turning 50, 55 and 65 – has the greatest potential to save lives in the short and long term in a cost-effective way. A study published in the *Medical Journal of Australia* in October 2009 reported that, even in its current nascent form, the National Bowel Cancer Screening Program was highly effective in identifying early-stage tumours that are easier and far less expensive to treat.[19]

The program's introduction in 2006 was the most significant cancer-specific public health initiative from a Commonwealth Government since programs for breast and cervical screening were rolled out more than a decade earlier. It was also a landmark men's health event, as bowel cancer screening saves men's lives as well as women's.

While Cancer Council Australia welcomed the 2008-09 budget commitment for $87 million over three years (including $29 million in 2010-11) to continue the National Bowel Cancer Screening Program and add 50-year-olds to its limited eligible age cohort, delays in full implementation are costing lives and deferring the economic benefits of early detection.

Adding 60 and 70-year-olds to the program from 2010-11 would maximise lives saved while government moves to full implementation, which Cancer Council Australia believes should occur from 2012. Full implementation – i.e. screening all Australians aged 50 and over every two years – should be achieved from 2012.

Reducing hospital costs

As well as preventing 30 Australian deaths per week,[20] full implementation of the National Bowel Cancer Screening Program would significantly reduce hospital expenditure. For example, removing a precancerous polyp detected through screening costs around $1250, while treatment at a public hospital for cancers that develop from polyps can cost more than $23,000 per case.[21]

Moreover, a cost-benefit analysis by the Cancer Institute NSW found that full implementation of the program would cost the health system $36,080 for every healthy year of life saved.[22] Against an agreed benchmark that sums between $50,000 and $60,000 for every healthy life year saved

are cost-effective in Australia's economy, bowel cancer screening is a strong investment – particularly in view of the lives saved and the Government's commitment to the program.

Expanding the target age range

Under the WHO principles of screening,[23] the program is not valid until it moves from one-off faecal occult blood testing to continual (biennial) screening for the indicated age group, i.e. all Australians aged 50 and over.[24]

However, in recognition that full implementation is not achievable within 2010-11 and that maximum lives saved must be the interim priority, we call on Treasury to provide funding for the inclusion of 60 and 70-year-olds in the program.

Our analysis of the current program's effectiveness based on large studies indicates that adding 60 and 70-year-olds to the target group would detect at early stage 632 cancers (417 in 70-year-olds and 206 in 60-year-olds) each year, added to the 527 cancers the program is detecting among its established age cohort.[25] In addition, participation in the National Bowel Cancer Screening Program is substantially higher in 65 year-olds compared with 55 and especially with 50 year-olds – and it should be equally high in 60 and 70 year-olds. Also, prevalence of cancer increases progressively with advancing age. In combination, these two factors make it most appropriate to add the two older age groups to the program.

With the chances of surviving bowel cancer around 87% if it is detected early through FOBT, compared with as low as 12% for advanced cases, expansion to the program is an urgent life-saving priority. This differential is reflected in the hospital costs. There are few public health investments capable of this level of immediate return, particularly in a cost-effective program that government has already committed to fully implementing. Lives and money saved are entirely a matter of timing and investment; the evidence is clear.

It is also important to note that the principles of bowel cancer screening are consistent with the overarching objectives of the National Health and Hospitals Reform Commission's recommendations.

Cost estimate: $15 million per annum.[26] Should Treasury have concerns about this cost, note that a 21% increase in tobacco product price through excise would easily cover the estimated $15 million per annum required to add 60 and 70-year-olds to the National Bowel Cancer Screening Program, pending its full implementation, while also funding a range of other primary prevention investments.

Skin cancer: Australia's most expensive cancer, our easiest to avoid

Summary

Funding social marketing to prevent skin cancer, through a national SunSmart media campaign, has been shown to be one of the most cost-effective public health investments available to government. [27] Significantly, the research indicating the value-for-money in skin cancer prevention is based on independent analyses of the Government's skin cancer prevention campaign, which ran to good effect over the past three summers.[23]

No other common cancer is so directly attributable to a single primary, avoidable cause, UV radiation, yet Australia remains the world's skin cancer capital.

Each year skin cancer costs the Australian health system almost $300 million[28] and claims more than 1700 Australian lives.[29] GP consultations to treat non-melanoma skin cancer alone increased by 14% between 1998-2000 and 2005-2007, from around 836,500 to 950,000 visits each year.[30]

Evidence shows that government investment in social marketing can substantially reduce the economic and social cost of skin cancer. A comprehensive cost-benefit analysis conducted in 2008 shows that government investment in skin cancer prevention returns $2.32 for every $1 invested.[23]

This analysis draws on the longstanding success of state-based SunSmart campaigns[23] and is further supported by more recent analyses showing the effectiveness of the Commonwealth Government's skin cancer awareness campaign to encourage sun protection behaviour.[31] Extrapolating the previous successes, an ongoing commitment would reduce the number of melanoma cases by 20,000 over the next 20 years and the number of non-melanoma skin cancer cases by 49,000 – an enormous cost saving to the health system. The campaign is also estimated to have delivered $90 million in annual productivity gains.[5]

Funding an ongoing commitment to a national SunSmart media campaign would be cost-effective and consistent with the Government's health reform agenda.

Recommended commitment: $33.2 million over four years.

BreastScreen Australia: protecting program viability

Since the BreastScreen Australia program was introduced in 1991, there has been a steady decrease in breast cancer deaths in Australia from 66 per 100,000 women in 1991 to 47 per 100,000 in 2006.[32] Conversely, the number of cases, particularly the diagnosis of smaller tumours, has increased over the same period, showing the program's effectiveness in early detection.[32]

However, new evidence has emerged showing the program's viability is at risk of being seriously compromised by the erosion of many of its underpinning processes and integrity.

Commissioned by the Australian Health Ministers' Conference and independently conducted, a comprehensive evaluation of BreastScreen Australia has made 19 key recommendations for sustaining and improving the program's effectiveness and sustainability.[33] Some of these require investment in the 2010-11 budget if the program's viability is to be protected.

Governance and management

The evaluation included a review of BreastScreen Australia's governance and management arrangements, which found an absence of program leadership and a lack of clarity on policy directions. If not addressed, the review advised, these deficiencies are likely to "reduce public support" for the program and lead to difficulties in "re-establishing consistency as stakeholders seek to preserve existing arrangements in particular jurisdictions".[34]

Accreditation

Similarly, flaws in the National Accreditation System (NAS) that underpins BreastScreen Australia are also threatening the program's viability. The NAS review found that issues relating to currency, format, volume and lack of clarity regarding processes "weaken the accreditation system in general and the decision making process in particular".[35]

The review further reported that these weaknesses create "a burden that threatens the viability of the program in two ways: firstly, the burden on services to comply with accreditation processes detracts from the core business of breast cancer screening and other quality improvement activities and, secondly, the sustainability of multidisciplinary involvement in accreditation activities, particularly in the current environment of escalating workforce shortages".

These are significant concerns; such threats to BreastScreen Australia's viability and evidence of the program's inter-jurisdictional fragmentation contradict the recommendations of the Government's National Health and Hospitals Reform Commission.

Cancer Council recommendations

Cancer Council Australia, which through its members is closely involved in BreastScreen Australia's delivery, recommends that the 2010-11 budget include funding to:

- Increase Department of Health and Ageing resourcing for improved central coordination of BreastScreen Australia, to address the program's increasing fragmentation and to strengthen support for the program's National Accreditation System; and

- Fund the development of a mechanism for strengthening BreastScreen Australia's governance and management structure, as recommended in the program evaluation;

These are critical, low-cost investments towards implementing the full recommendations of the BreastScreen Australia evaluation.[33]

Commonwealth coordination of patient travel and accommodation schemes

Cancer Council Australia welcomed in 2009-10 the Commonwealth's allocation of $560 million to establish or expand up to 10 regional cancer centres, aimed at reducing the inequity in cancer outcomes between metropolitan and rural Australia.

Evidence shows the further from a metropolitan centre a cancer patient lives, the more likely they are to die within five years of diagnosis.[36,37,38] For some cancers, remote patients are up to 300% more likely to die within five years of diagnosis.[39] Developing new and expanding existing multidisciplinary centres is pivotal to reducing these disparities.

To help ensure the capital investment in facilities is effective, Australia's fragmented remote patient travel and accommodation schemes need to be harmonised and more appropriately funded as part of the national health reform process. The new cancer centres will only reach their potential if remote patients have adequate support to travel and be accommodated during treatment.

Addressing the inadequacies and fragmentation of the current array of patient travel and accommodation schemes has been a longstanding goal of healthcare advocates. More recently, the case has also been made by:

- The Government's National Health and Hospitals Reform Commission, which, in its final report, recommends "that a patient travel and accommodation assistance scheme be funded at a level that takes better account of the out-of-pocket costs of patients and their families and facilitates timely treatment and care";[40]

- A substantial number of submissions to the Government's 'yourHealth' consultation and recognition in the Government's discussion papers that "funding for patient travel and accommodation for patients and their families should be made more nationally consistent and this should take better account of people's out-of-pocket costs";[41] and

- The Australian Senate, which, following an inquiry in 2007, recommended that improved funding for the schemes be incorporated into the Australian Healthcare Agreements.[42]

Cancer Council Australia recommendation

As the national health reform agenda gains momentum, the state of patient travel and accommodation schemes (PATS) is expected to continue to dominate the discussion on addressing rural/metropolitan inequities in healthcare.

The 2010-11 budget should include an allocation for working towards a coordinated, national solution to the well-documented problems of PATS. One option would be to:

- Centralise the schemes and incorporate them into Centrelink, which already has a mechanism for payment of benefits nationally; and

- Link the database to Medicare Australia, so that eligibility for payment is confirmed on the patient record, rather than *ad hoc* (and inefficient) approvals from individual clinicians.

COAG's commitment to a national e-health system provides an additional and timely opportunity to phase out the fragmented array of PATS schemes and phase in a cohesive national system, beginning in 2010-11.

References

[1] J Goss (2008), Projection of Australian health care expenditure by disease, 2003–2033, Discussion paper commissioned by the National Health and Hospitals Reform Commission, 2009.

[2] Australian Institute of Health and Welfare, Health expenditure Australia 2007–08, 2009.

[3] Australian Institute of Health and Welfare, The Burden of Disease and Injury in Australia 2003, 2006.

[4] Ibid.

[5] Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – the roadmap for action, Commonwealth of Australia, 2009.

[6] Wakefield M, Durkin S, Spittal M, Siahpush M, Scollo M, Simpson J, et al. Impact of tobacco control policies and mass media campaigns on monthly adult smoking prevalence: time series analysis. American Journal of Public Health. 2008.

[7] http://www.taxreview.treasury.gov.au/content/submissions/pre_14_november_2008/Cancer_Council_and_National_Heart_Foundation.pdf

[8] World Health Organization. Tools for Advancing Tobacco Control in the XX1st century: Policy recommendations for smoking cessation and treatment of tobacco dependence. Tools for public health. Geneva: WHO, 2003.

[9] Wakefield et al, Approval for an increase in tax on cigarettes, approval for banning of duty free sale of cigarettes and the likely impact of a price increase of cigarettes: Findings from the Victorian 2008 Smoking and Health Survey, (unpublished) 2009.

[10] Chaloupka, FJ and Warner, KE 1999, The Economics of Smoking, NBER Working Paper Series No. 7047, National Bureau of Economic Research, Cambridge MA.

[11] Collins DJ, Lapsley HM. Weighing the evidence: evaluating the social benefits and costs of the Australian tobacco industry, Cancer Council Western Australia, 2009

[12] Tobacco Control: A Blue Chip Investment in Public Health, VicHealth Centre for Tobacco Control, 2003.

[13] World Health Organisation, Framework convention on tobacco control, 2004.

[14] The Role of the Media. Smoking and Tobacco Control Monograph No. 19, Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2008.

[15] Hurley S and Matthews J. Cost-effectiveness of the Australian national tobacco campaign. Tobacco Control, 2008.

[16] Abelson P and Applied Economics. Returns on Investment in Public Health. Canberra: Department of Health and Ageing, 2003.

[17] Commonwealth Department of Health and Aged Care 2004. Australia's National Tobacco Campaign evaluation report: volume three. http://www.quitnow.info.au/internet/quitnow/publishing.nsf/content/evaluation-reports. Accessed 31 August 2006.

[18] Magnus A, Mihalopoulos C and Carter R. Evaluation of Preventive Health Interventions: Report for Department of Treasury and Finance. Melbourne: Health Economics Unit School of Health and Social Development Deakin University, 2008.

[19] Ananda S, McLaughlin S et al, Initial impact of Australia's National Bowel Cancer Screening Program, Medical Journal of Australia, October 2009.

[20] Colorectal Cancer Screening, Report of the NSW Chief Medical Officer, October 2008.

[21] Corporate Value Associates, CRC Screening Strategy: Governing committee cancer control network presentation, 2002.

[22] Bishop J, Glass P, Tracey E, Hardy M, Warner K, Makino K, Gordois A, Wilson J, Guarnieri C, Feng J, Sartori L. *Health Economics Review of Bowel Cancer Screening in Australia*. Cancer Institute NSW, August 2008.

[23] Wilson JMG & Jungner G 1968. *Principles and practices of screening for disease.* Public health paper. Geneva: World Health Organization.

[24] Clinical practice guidelines for the prevention, early detection and management of colorectal cancer, National Health and Medical Research Council, 2006.

[25] Victorian bowel cancer statistics (registry data) extrapolated with findings from 13-year randomised control trial in Denmark (Jorgensen et al, 2002), also Med J Aust 2009;191:378-381.

[26] Based on extrapolation of current program costs with current numbers of 60 and 70-year-olds in Australia

[27] Shih STF, Carter R, et al Economic Evaluation of a National SunSmart Program, Health Economics Unit, School of Health and Social Development, Deakin University, in press.

[28] Australian Institute of Health and Welfare, *Health system expenditures on cancer and other neoplasms in Australia, 2000-01*. 2005.

[29] Australian Institute of Health and Welfare, Cancer in Australia: an overview, 2006, 2007.

[30] Australian Institute of Health and Welfare & Cancer Australia 2008. Non-melanoma skin cancer: general practice consultations, hospitalisation and mortality.

[31] Dobbinson, S, Jamsen K, Francis K, Dunlop S and Wakefield M, 2006–07, National Sun Protection Survey, 2008.

[32] Australian Institute of Health and Welfare, BreastScreen Australia monitoring report 2005-2006, 2009.

[33] Department of Health and Ageing, BreastScreen Australia Evaluation Evaluation Final Report, 2009.

[34] Nous Group, Evaluation Advisory Committee to BreastScreen Australia, Evaluation Report, Governance and Management, 2009.

[35] KPMG, Department of Health and Ageing, Review of the BreastScreen Australia Accreditation System, final report, 2009.

[36] Australian Institute of Health and Welfare and Australasian Association of Cancer Registries. Cancer survival in Australia 1992–1997: geographic categories and socioeconomic status. Canberra: AIHW, 2003. (Cancer Series No. 22. AIHW Catalogue No. CAN 17.)

[37] Jong KE, Vale PJ, Armstrong BK. Rural inequalities in cancer care and outcome. Med J Aust 2005; 182: 13-14.

[38] Australian Institute of Health and Welfare. Health in rural and remote Australia. Canberra: AIHW, 1998. (AIHW Cat. No. PHE 6.)

[39] Jong KE, Smith DP, Yu XQ, et al. Remoteness of residence and survival from cancer in New South Wales. Med J Aust 2004; 180: 618-622.

[40] Commonwealth of Australia, A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009, 2009.

[41] Commonwealth Department of Health and Ageing, National Health and Hospitals Reform Commission Fact Sheet, Support for People Living in Remote and Rural Areas, 2009.

[42] Australian Senate, Standing Committee on Community Affairs, Highway to health: better access for rural, regional and remote patients, 2007