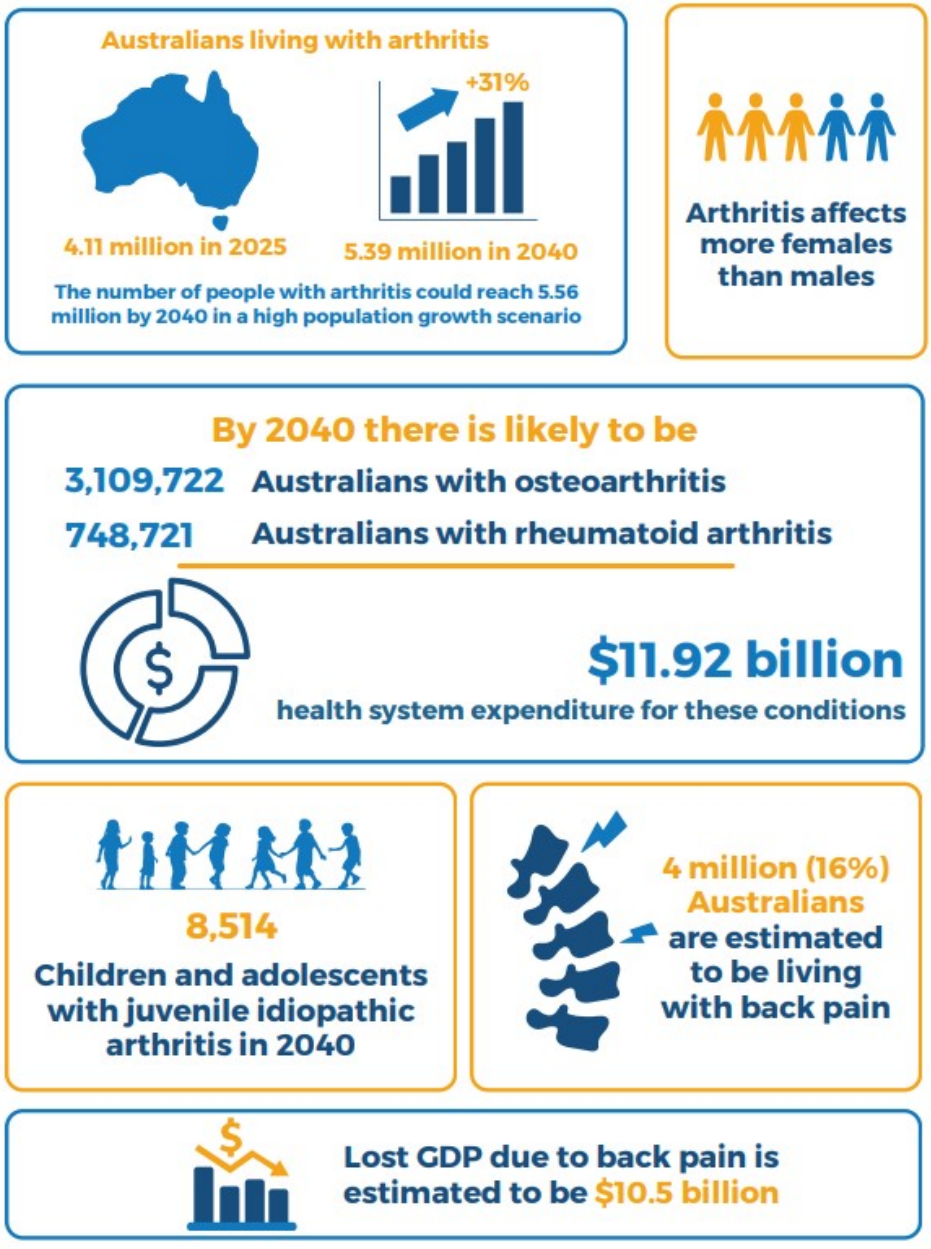
Arthritis Foundation of Australia
Level 2, 255 Broadway, Glebe NSW 2037
PO Box 550, Broadway NSW 2007
p: +61 2 9518 4441
e: info@arthritisaustralia.com.au
w: www.arthritisaustralia.com.au

Arthritis Australia 2025 Budget Submission



For further information on this submission contact:

Louise Hardy: Telephone 0424 055 149 or email: lhardy@arthritisaustralia.com.au

Contents

The impact of arthritis and musculoskeletal conditions on consumers, the health system and economy

Over 7 million Australians of all ages are currently living with painful musculoskeletal (MSK) conditions, including arthritis and back pain. Many live with life-altering chronic pain and disability, and some with autoimmune conditions that can affect not just their joints but eyes, lungs and other organs and cause severe fatigue and 'brain fog'. Three-quarters of those with arthritis have at least one other chronic health condition.

These are often invisible conditions that can flare up without warning, and many people are forced to give up or reduce work hours long before they want to. This not only impacts them and their families, as they struggle to meet living and healthcare costs on a reduced income, but it also costs the community in the form of lost income and greater welfare payments. Arthritis is a leading cause of early retirement due to ill health, with a projected 59,000 people of working age being forced out of the labour force by 2030. This will lead to a loss of personal income projected at $2.6 billion, with the cost to the government of over $1.1 billion a year in extra welfare payments and lost taxation revenue. Lost GDP due to arthritis-related early retirement will reach $9.4 billion a year by 2030[1]. Lost GDP due to back pain is estimated to be $10.5 billion.

Consumers are spending many thousands of dollars out of pocket. Younger people living with arthritis in Australia spent a median of $1,635 in just six weeks (over $14,000 a year) in a recent study.[2] Too many people struggle with the costs of managing their conditions and face the awful dilemma of choosing between buying basics like food or being able to afford their healthcare.

Yet the majority of Australians with arthritis and MSK conditions such as osteoarthritis and back pain are not receiving the care that clinical guidelines recommend. People with inflammatory conditions such as rheumatoid arthritis and children with juvenile arthritis face delays in diagnosis and treatment that lead to irreversible damage and disability. Not only does this lead to poorer health outcomes, but it increases costs to the health system.

These costs are on an unsustainable growth trajectory with the projected increase of the number of Australians with arthritis by 31% and health system costs of $11.92 billion by 2040[3]. A recent study has projected alarming growth in total knee replacements and total hip replacements by 276% and 208% by 2030, at a cost of $AUD5.32 billion.[4]

There is the opportunity for major cost savings and containment of future health system costs both through reducing low value care and better access to evidence based care and prevention, and by addressing the chronic underinvestment in research to support the work of Australia's world-leading researchers. For every Australian living with arthritis and MSK, the government spent just $6 on research through the NHMRC in 2023. This compares to $108 per person living with dementia, and $72 per person with a cardiovascular condition.

Table 1: Cost, burden and research funding for the four leading causes of disease burden by disease group, plus dementia.

Impact	Cancer	CVD	Arthritis & MSK	Mental health	Dementia
Burden of disease (2023)	17%	12%	13%	15%	4.4%
Health system cost (2022-23) $bn	$18.9	$16.2	$15.9	$11.9	$5.4*
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Out of pocket healthcare costs

People with arthritis carry a heavy burden of pain and disability that is often trivialised, and face a double financial hit – arthritis is a leading cause of early retirement and loss of work hours and income[5], and consumers face high out of pocket costs from the accumulated costs of care including general practice, specialist and allied health appointments, diagnostics and medicines. These conditions disproportionately affect women, particularly older women who often have low financial assets.

A recent study of younger people living with arthritis in Australia found median per person out of pocket expenditure of $1,635 in just six weeks (or over $14,000 per year)[6]. Another recent study estimated the total out of-pocket expenditure on osteoarthritis treatment for Australian women aged 50 years and over to be approximately $873 million annually[7].

The Australian Government's Measuring What Matters framework includes key metrics around the proportion of people delaying or missing out on healthcare due to cost and delays accessing appointments. Allied health is a particular area of need, with research from Arthritis Australia and the Australian National University expected to be published in 2025, gathered from a survey of 760 people living with arthritis and musculoskeletal conditions, has found:

- 44% of respondents reported spending over $100 a month out of pocket on allied healthcare, for which there is currently limited government-funded access
- 48% of respondents reported cutting back on allied healthcare spending this year due to cost-of-living pressures
- 43% of respondents reported increased pain and other symptoms as a result of cutting back on health care - with thirty-nine percent also reporting mental health impacts.

Funding proposals

The proposals outlined in this submission address key priorities for action that have emerged from consultation with consumers and the sector:

Priority area	Initiatives	Budget impact
1. Fund affordable and accessible care for people with arthritis and MSK conditions, including exercise and rehabilitation through allied health and social prescribing programs ...	1.a Targeted implementation of better osteoarthritis care to reduce demand for joint replacement surgeries	**$11.5m over 1 year**
	1.b Fund community based arthritis programs	**$5m over 4 years**
	1.c Funding affordable access to allied health individual and group services for those who need them:	**$5.5 million per year** to expand group allied health services under Chronic Disease Management Plans to people with musculoskeletal conditions **$500m investment in funding for allied health services**, which

		could be delivered via existing MBS items or bundled packages of care via Primary Health Networks.
2. Action on out-of-pocket healthcare costs - reform safety nets, and provide timely relief from fees when it is needed most	2a. Introduce a single, automated Health Safety Net covering both the PBS and MBS	Would require costing by government
	2.b Change the expenditure qualifying periods to a 12 month rolling period to replace the fixed calendar year qualifying period	Would require costing by government
	2.c Surge support for condition flares to provide timely fee relief when it is needed most	Would require costing by government
3. Invest in vital game-changing arthritis and musculoskeletal research to transform lives and generate health system savings	Increasing the Medical Research Future Fund annual spending by 50% and directing funding to neglected areas of need and high burden such as arthritis and other musculoskeletal (MSK) conditions.	Increase MRFF disbursement to $1b per year
	Funding for consumer centred research and innovative approaches such as adaptive platform clinical trials in the most common arthritis conditions	$5m over 5 years
	Establishing a Medical Research Future Fund Arthritis and Musculoskeletal Mission	$100m

Arthritis Australia also strongly supports the budget proposals of the Australian Rheumatology Association to address the rheumatology workforce crisis, including for the Commonwealth to increase funding of paediatric and adult rheumatology training positions in private, rural and remote settings through the Specialist Training Program, and to expand the 'Other Medical Practitioner' program to rheumatology registrars.

1. Fund affordable and accessible care for people with arthritis and MSK conditions, including exercise and rehabilitation through allied health and social prescribing programs

Proposals

1.a Funding a program of lifestyle and behavioural care targeting 10,000 people with osteoathritis at high risk of being placed on a surgical waiting list, at a cost of **$11.5 million**, including program design and evaluation.

1.b Funding the national community-based delivery of evidence-based group exercise and education programs designed to improve health outcomes for children and adults with arthritis and MSK conditions, at a cost of **$5 million over 4 years**.

1.c Funding affordable access to allied health individual and group services for those who need them:

- **$5.5 million per year** to expand group allied health services under Chronic Disease Management Plans to people with musculoskeletal conditions
- **$500m investment in funding for allied health services**, which could be delivered via existing MBS items or bundled packages of care via Primary Health Networks.

Benefits:

- Containment of joint replacement costs which are on an unsustainable trajectory and represent about 3% of the current health budget
- Funding arthritis state and territory affiliated community-based organisations to provide education and support for people with arthritis will supplement allied health to assist people to change lifestyles and fully gain lasting benefits from allied health expertise and help manage current gaps in the provision of care and support within the health system, leading to improved health outcomes and quality of life.
- Reduced out of pocket costs to consumers and more affordable access to multidisciplinary care, leading to improved quality of life, delayed disease progression, reduced disability and improved workforce retention for people with severe arthritis

1.a Targeted implementation of better osteoarthritis care to reduce demand for joint replacement surgeries

- Osteoarthritis is a leading cause of disability, chronic pain and early retirement. Most consumers currently don't receive appropriate clinical care, and face high out of pocket costs
- Management of osteoarthritis costs the health system $4.3 billion in 2020–21 or 2.9% of total health system expenditure, with approximately 75% of this cost due to surgery. According to the Australian Commission on Safety and Quality in Healthcare, the majority of these surgeries are avoidable with proper first line care
- A recent high-quality budget impact analysis has estimated that national delivery of a first-line osteoarthritis management program including education and support for symptom management, physical activity, weight loss would translate to health system savings of over $1 billion a year by 2029 through avoidance of knee replacement surgeries[8].

Recommendation

- Fund a program based on existing proven models of care to be phased in by initially targeting 10,000 people at highest risk of being placed on a surgical waiting list, and by targeting geographic areas with high rates of clinical variation suggesting inappropriate or overuse of arthroscopy or MRI.
- The program would be based on existing models of care that have been shown to be cost effective, for example the NSW Chronic Care Program[9] which has been scaled up statewide, and the Medibank Better Knee Better Me program[10]. It could be delivered remotely using telehealth to ensure equitable access for people living in rural or regional areas and at lower cost. Participants could be identified in using existing stratification tools.
- Participants could be identified and services delivered either in primary care or via Local Health Districts as part of a Commonwealth-state collaboration as recommended in the Huxtable Mid Term Review of the National Health Reform Agreement:

  > *The NHRA should prioritise the development of optimal models of care, using agreed innovative financing mechanisms, through:*
  >
  > *Enhancements that both respond to, and shape demand for health services, with a priority focus on:*
  >
  > *• Reducing rates of potentially preventable hospitalisations*
  >
  > *• Scaled adoption of the ACSQHC Clinical Standards and Pathways*
  >
  > *• Bundling care for certain agreed pathways (maternity care, hip and knee replacement, stroke)*

- Arthritis Australia, as the lead national consumer peak, would propose inviting key groups to join a consortium to work on this program, including the relevant professional groups and the private health insurance sector

Cost

- We have provisionally costed the targeted model of care rollout at **$11.5 million,** including program design and evaluation.
- Costs have been estimated based on existing programs, with costs of $1000 per participant for a telehealth delivered program, including training, patient assessment and delivery. A staged rollout targeting 10,000 people likely to need a knee replacement would cost $10 million over a year to cover the cost of the program per participant
- A more detailed project budget would need to be developed for program design and evaluation but we have costed this provisionally in the range of $1.5 million including:
  - Assessment of areas to target through evaluation of variation in arthroscopy, MRI usage etc which would build on work undertaken by the ACSQHC Atlas of Healthcare Variation.
  - Program design – this could involve a stepped wedge or cluster rollout (ie participants would have a staggered start to the program)
  - Evaluation of the effectiveness and cost effectiveness of the program
  - Support for meetings/consultation

Potential cost containment and savings from implementing the program

- Assuming a program price of $1,000 per recipient and an average saving of $12,331 per person likely to require a knee replacement, if we conservatively estimate that the program implementation results in 50% of participants avoiding a knee replacement, this would equate to approximately $60 million in savings within the 12 month period.
- While latent demand may mean that surgical capacity is soaked up, a program like this would assist in containing cost growth and would ensure that expenditure is more efficient, so that patients who most need surgery are prioritised.

A more detailed proposal has been submitted to the Department of Health and can be provided on request.

1.b Fund community based arthritis programs

- The majority of Australians with arthritis and MSK conditions are not receiving the recommended clinical care. They can also suffer from social isolation and loneliness and lack access to education and support to empower them to self-manage their condition. People with arthritis commonly report that they are advised to 'put up with' their condition and offered few options for their treatment.[11] [12] [13] A recent survey found that only half of people receiving care for their arthritis were satisfied with the information and support they received for their condition and only 30% were satisfied with the support they received for their emotional and mental wellbeing.[14]
- Community-based affiliated arthritis organisations stand ready to deliver the education and support programs needed to assist people to improve their lifestyles and gain lasting benefits from allied health expertise, but ongoing Commonwealth funding for the implementation of the National Strategic Action Plan for Arthritis is critical to support programs ranging from the National Arthritis Infoline, to kids camps and exercise programs. Funding these programs and linkages to social prescribing will supplement more expensive care such as allied health services. They need funding so that more consumers can access evidence-based education and support programs that have been shown to improve pain and quality of life, to reduce use of painkillers and sick leave.[15]
- The National Arthritis Infoline received a record 10,779 calls in 2023, supporting people with arthritis to self-manage their condition, return to work, reconnect with loved ones, and develop healthier eating and exercise habits. It is a free and trusted place for people to turn in moments of crisis, particularly in the current setting of the high cost of living and difficulty accessing primary care. The Infoline links people to a range of other services and resources in their local area to help them manage their condition more effectively.
- Exercise is one of the most effective management strategies for arthritis and can also delay or avoid expensive joint replacement surgery. However only 25% of Australians with arthritis report that they exercise most days and 14% do strength training to manage their condition. On the other hand, 83% report taking medication[16] and arthritis is one of the most common conditions for which opioids are prescribed, despite limited clinical benefit and a high risk of adverse events.[17]
- The Joint Movement was developed by Arthritis Australia with the support of leading health and fitness experts. It offers both warm-water and land-based strength exercise programs which are led by trained and accredited exercise professionals. During the covid pandemic, we pivoted to offer online classes, providing consumers with better access and choice.

- The Joint Movement was delivered from 2019-2021 in some states and territories with funding from Sport Australia's Better Ageing program. Participants either responded to local advertising or were referred by their GP. However, initial funding expired in 2021 and was restricted to participants aged 65 years or more, which meant that younger people who could have benefited had to be turned away.
- An evaluation of The Joint Movement Program found statistically significant changes, including a reduction of pain and stiffness and improvements in functional outcomes. Qualitative survey responses indicated that increases in physical activity had positive effects on participants' daily activities and mental and social wellbeing.
- The Joint Movement program will be reviewed and updated to incorporate recommendations from the evaluation, including:
    - Increase in number of available sessions per week to improve the chance of greater improvements in symptoms, as well as health and wellbeing
    - Opening up the program to younger age groups
    - Provide opportunities to re-enrol into the program so participants can maintain their progress
    - A nationally agreed evaluation plan and data audit

In the words of participants:

> *"[The program] convinced me how much exercises help me mentally and physically everyday"*
>
> *"I have been given some exercises by an Exercise Physiologist but as I found it wasn't as good as our group sessions as the socialising was missing which I found by doing it online with other people"*.
>
> *"It gave me confidence to restart an exercise program as it catered for my current low fitness levels and arthritic knee and shoulder problems"*.

1.c Funding affordable access to allied health individual and group services for those who need them:

- **$5.5 million per year** to expand group allied health services under Chronic Disease Management Plans to people with musculoskeletal conditions
- **$500m investment in funding for allied health services**, which could be delivered via existing MBS items or bundled packages of care via Primary Health Networks.

- For those who need them, allied health services, for example physiotherapy, exercise physiology, dietetics, clinical psychology and occupational therapy, are highly valued to help them manage their condition. However, cost is a significant barrier to access. New research from Arthritis Australia and the Australian National University, gathered from a survey of 760 people living with arthritis and MSK conditions, has found:
    - Nearly half (44%) spend over $100 a month out of pocket on allied healthcare, for which there is currently limited government-funded access.

- Almost half (48%) surveyed report cutting back on allied healthcare spending this year due to cost-of-living pressures.
- 43% report that reducing their spending on healthcare has resulted in increased pain and other symptoms, with 39% also reporting mental health impacts[i].

- Arthritis Australia believes based on years of consumer surveys and feedback that there is a pressing need for more affordable access to allied health. Multidisciplinary team care is consistently recommended in local and international guidelines and standards of care for people with most forms of arthritis, but is not widely available in Australia. There is an over-reliance on medications and surgery for management of arthritis. Current funding through the MBS and private health insurance is heavily weighted in favour of providing support for expensive interventions, such as joint replacements, rather than for less invasive and costly interventions that evidence has shown are effective in slowing and in some cases stopping the progression to more severe disease.
- Whilst the existing access to five allied health services in a year provides some help for consumers, the limited number of sessions available for the entire year – even if a patient would benefit from seeing more than one type of allied health professional often limits the effectiveness of the treatment. This is especially the case where consumers have more severe conditions or where they have co-morbid conditions.
- For example, a person living with a musculoskeletal condition may often receive treatment from a range of allied health providers, including physiotherapists, dieticians, psychologists and social workers.
- Consumers report that the relatively low subsidy received not only leaves a large gap fee but the total value of the subsidy for the 5 visits is often little more than the out of pocket cost of the GP appointment to access the plan.
- Increased access to allied health could be funded in a number of ways and stratified according to need, with use of social prescribing, group sessions and innovative workforce approaches, such as health coaching and 'the psychologically informed physiotherapist' or dietician.
- Bundles of care could be funded through PHNs using pooled funding from the Commonwealth and States to support access to a range of tiers of care bundles which would be available to patients based on the severity and nature of their condition as assessed by their GP. Care bundles could include programs of individual or groups sessions; and remote access for health equity and to reduce costs.
- Existing CDMP MBS funding could be increased, both the quantum and number of individual sessions. Group session access could be expanded. Currently people with type 2 diabetes can access additional Medicare-subsidised care for group allied health treatment services, including diabetes education services, exercise physiology and dietetics. In the last financial year, 66,471 of these services were claimed at a cost of $1.8 million. The expansion of this access to people with arthritis would make such support more affordable and accessible.

[i] Unpublished research, August 2024

2. Action on out-of-pocket healthcare costs - reform safety nets, and provide timely relief from fees when it is needed most

> *"With my job I can afford food and living expenses but spend all spare money on doctors and medication. But I have to push through the pain to keep my job."*

> *"I prioritise my health over social activities so I can keep working. The decline in my general health and ability to work full time worries me as I am a 53 yr old single woman with no children. With excessive rent increases in the rural town I live in, I am very concerned about my future."*

Proposals

2.a Introduce a single, automated Health Safety Net covering both the PBS and MBS

2.b Change the expenditure qualifying periods to a 12 month rolling period to replace the fixed calendar year qualifying period

2.c Surge support for condition flares – timely fee relief when it is needed most

These proposals would need to be costed by government.

- People in the most socioeconomically disadvantaged section of the population are 67% more likely to report that they have arthritis than those in the least disadvantaged section18. Often people with arthritis have had to reduce their working hours or retire from work early as a result of their condition and experience significant financial hardship as a result of the combined impact of reduced income and the high costs associated with managing their condition.
- Arthritis has a major impact on the costs of the welfare system and the broader economy. Welfare payments have been projected to exceed $780 million by 2030, and lost annual taxation revenue is projected to increase to $660 million. A loss of $9.4 billion in GDP was projected by 2030[19].
- While initiatives such as 60 day scripts and bulk billing have helped, the cost of living crisis has pushed many to breaking point, with people forced to choose between food and basics or paying for their medical care or that of a family member.
- A recent study of younger people living with arthritis in Australia found median per person out of pocket expenditure of $1,635 in just six weeks[20]. Another recent study estimated the total out of-pocket expenditure on osteoarthritis treatment for Australian women aged 50 years and over to be approximately $873 million annually[21]. Women, who are at significantly greater risk of arthritis, also face greater financial disadvantage, with gender pay and superannuation gaps, and time out of the workforce caring for children.

2a. Introduce a single, automated Health Safety Net covering both the PBS and MBS

- The safety nets for the MBS and PBS are complex and not easy to understand – even by experienced health care professionals. They also operate independently of each other.
- This means that even though a consumer may have spent enough money out of pocket to qualify for one safety net (for say PBS subsidised medicines) on the one hand, or MBS subsidised clinical services on the other, they will only be able to access the safety net of the scheme for which they have reached the threshold. To access the safety net for the other scheme, they will have to separately spend the full amount of out of pocket cost required to reach the threshold of the other scheme.
- This can disadvantage a consumer who may, for example, spend ninety percent of the threshold amount for both schemes, yet will not qualify for either safety net. By contrast another consumer, spending the same amount of money, whose expenditure is concentrated in either paying for medicines or accessing medical services is able to reach the threshold (and thereby qualify for additional support) for one of the schemes.
- It would be fairer for all patients if both safety nets were amalgamated into a single health safety net that is clear to understand, automated and is neutral as to the composition of the health care out of pocket expenditure.

2.b Change the expenditure qualifying periods to a 12 month rolling period to replace the fixed calendar year qualifying period

- The current safety nets calculate the qualifying out of pocket expenditure threshold on the basis of expenditure within a calendar year starting on 1 January each year and concluding on the following 31 December. This criterion is both arbitrary and potentially unfair and can result in two people with exactly the same expenditure patterns (and budget stresses) being treated quite differently depending on when in the year their expenditure occurs.
- For example, a person whose out of pocket expenditure occurs within a January to June period and reaches the threshold during that time will then receive additional safety net relief for the remainder of that calendar year (ie from June through to the end of December). By contrast, another person spending the same amount of money over a similar 6 month period that happens to occur from October to March, will not qualify for the threshold in either calendar year and receive no additional safety net relief.
- Arthritis Australia considers it would be fairer for the safety net calculation to be based on a rolling 12 month period. This means that if a person reaches the expenditure threshold in the preceding 12 months (calculated daily), they would then be entitled to receive the additional safety net support for a specified period. Arthritis Australia proposes that this additional support should be provided for at least the following 9 months (when the clock would start to run again).

2.c Surge support for condition flares to provide timely fee relief when it is needed most

"Due to fibromyalgia and the bed ridden flare-ups that could happen to me at any time/day, I've been unable to work full-time and when I had casual work, I was still labelled as being unreliable. It's extremely hard to live without an income and the amount that Centrelink provides just barely covers rent for two weeks and maybe leaves me with $20 for groceries for the next two weeks."

- Arthritis conditions, along with other chronic conditions, can be subject to flares in symptoms, which can be extremely painful and debilitating and result in an inability to work (which may in some cases lead to a loss of permanent employment) or undertake caring and other responsibilities and activities.
- During flares, a consumer may be required to undergo a period of intensive clinical interventions, including visits to doctors and allied health providers, diagnostic tests and investigations, as well as reviews of and expenditure on additional medications. This can result in a sharp, short-term spike in out of pocket costs which some consumers may face great difficulty in affording.
- Current safety net financial support mechanisms through the PBS or MBS, which do not take the consumer past an annual threshold expenditure are not able to be accessed in the event of short-term condition spikes.
- An option to address this could take the form of a short-term surge safety net mechanism (covering say a one month period), which can be accessed when a person is subject to a sudden short-term spike in health expenditure.
- To qualify for a surge safety net, we would propose that the existing annual safety net threshold be divided into a notional rolling monthly threshold (of one twelfth the annual amount). If a person incurs out of pocket costs of more than twice the notional monthly threshold in a one month period, the surge safety net would automatically come into operation for a further three months. This would mean that for the next three months, the consumer would receive MBS or PBS safety net rebates at the rate they would have received if they had reached the annual qualifying threshold.
- This proposal would also go some way to addressing the situation where a person faces a surge in expenditure close to the end of a calendar year, which carries over to the next calendar year (resulting in the person not reaching the threshold in either calendar year).
- We propose that a surge safety net would run parallel to and complement the above proposal for a 12 month rolling qualifying period for the non-surge safety net

3. Invest in vital game-changing arthritis and musculoskeletal research to transform lives and generate health system savings

Proposals

- Increasing the Medical Research Future Fund annual spending by 50% and directing funding to neglected areas of need and high burden such as arthritis and other musculoskeletal (MSK) conditions.
- Providing $5m over 5 years for consumer centred research and innovative approaches such as adaptive platform clinical trials in the most common arthritis conditions.
- Establishing a Medical Research Future Fund Arthritis and Musculoskeletal Mission, as recommended in the National Strategic Action Plan for Arthritis, to increase strategic investment in research and research capacity including consumer led research, to transform care and quality of life, and generate health system cost savings.
- Ensuring that the new National Health and Medical Research (NHMRC) strategy guides funding decisions to better reflect burden of disease and impact.

The issue

- Despite Australia having many of the world's top researchers in arthritis and MSK conditions, research funding is shockingly low relative to the disease burden and cost of these conditions.
- For every Australian living with arthritis and MSK, the government spent just $6 on research through the NHMRC in 2023. This compares to $108 per person living with dementia, and $72 per person with a cardiovascular condition.

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- The Medical Research Future Fund (MRFF) was intended to direct research funding to neglected areas of need and high burden. However, a recent analysis found that targeted, disease-based funding provided through the MRFF tends to go to disease groups with a high mortality burden and overlooks disability burden.[22]

- Without additional investment in research, we will not be able to improve care and treatment, reduce inequity gaps, or find a cure for arthritis in its many forms. We also risk losing experienced researchers overseas or to other fields, so that our overall capacity for arthritis research will decline.

Solutions

- The MRFF provides the opportunity to direct research funding to neglected areas of need and high burden, such as arthritis and MSK conditions, and to take innovative research from the laboratory right through to clinical practice and commercialisation.
- The drive for consumer centred and consumer led research presents opportunities to make research more impactful at every stage, from reflecting consumer priorities and unmet needs to genuine codesign through to implementation. The arthritis and MSK community have engaged and experienced consumers and consumer-researchers who can drive transformative outcomes with the right support.
- Implementation of arthritis and MSK research has a proven track record of reducing health system costs while improving care. The outcomes of a MRFF Mission could generate significant savings that could be reinvested into a sustainable source of funding for research
- Investing $5m over 5 years into innovative approaches such as adaptive platform clinical trials in each of the most common arthritis conditions could be a game changer, with further investment for those progressing to new treatments.
- According to Research Australia, the Australian Government could spend 50% more per year on research if it fully utilises MRFF funding[23]. This unused funding could transform the lives of millions of Australians.
- The Government's planned development of a new national health and medical research strategy provides the opportunity to improve transparency and ensure that funding decisions better reflect the burden of disease and its impact.

Benefits of action

- People of all ages living with the pain and disability of arthritis and MSK conditions could have transformed quality of life, better ability to work, and the hope of a cure for these debilitating conditions.
- A MRFF Mission would bring Australia's world leading researchers together to develop a roadmap to supercharge research, with a longer-term strategic focus and funding to take research from the lab to clinical practice and tackle key challenges including prevention and lifestyle behaviour change.
- Investing in research into the most effective and affordable strategies to deal with these conditions could save the health system many hundreds of millions of dollars a year. Some areas of expenditure where research could achieve substantial cost savings include:
    - **Approximately $3.7 billion** a year is spent on joint replacement surgery for osteoarthritis (OA). At least **$1 billion** of this cost could be avoided by 2030 by delivering better management and lifestyle modifications for people at risk of knee replacement.[24] In addition, 20-40% of people who have this surgery achieve little

clinical benefit[25] for reasons that are not clear at the time of making a decision for surgery.[26] Research into better patient selection for surgery and the delivery of more effective models of care for OA in primary care would achieve improved health and quality of life outcomes at much lower cost.

- **Over $757 million** a year is spent on biological drugs for rheumatoid and other inflammatory forms of arthritis[27], which have revolutionised care for these patients. However, research to improve drug targeting (personalised medicine) and immunotherapy that may lead to a cure could ultimately provide improvements to care and cost savings:
  - Australian researchers are currently leading early detection and intervention research for people at high risk for rheumatoid arthritis (RA), the most common form of inflammatory arthritis. Early detection, lifestyle interventions and immunotherapy may lead to a cure.
  - The Australian Arthritis and Autoimmune Biobanking Collaborative is being rolled out with philanthropic support to provide the infrastructure, biospecimens, data linkage and big data analysis capacity to support research in this area. Additional funding could accelerate the roll-out and allow additional conditions to be included.
- **$397 million** a year is spent on imaging for back pain,[28] which may be mostly unnecessary[29] and which could be addressed by a modest investment in research into better models of care.

About Arthritis Australia

Arthritis Australia is the peak national arthritis consumer organisation in Australia and is supported by affiliate organisations in ACT, New South Wales, Northern Territory, Queensland, South Australia, Tasmania and Western Australia.

Arthritis Australia provides support and information to people with arthritis and related musculoskeletal conditions, as well as their family and friends. It promotes awareness of the challenges facing people with arthritis across the community, and advocates on behalf of consumers to leaders in business, industry and government.

In addition, Arthritis Australia funds research into potential causes and possible cures as well as better ways to live with these conditions.

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