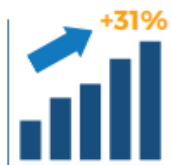


Arthritis Australia 2026 Budget Submission

Australians living with arthritis



4.11 million in 2025



5.39 million in 2040

The number of people with arthritis could reach 5.56 million by 2040 in a high population growth scenario



Arthritis affects more females than males

By 2040 there is likely to be

3,109,722 Australians with osteoarthritis

748,721 Australians with rheumatoid arthritis



\$11.92 billion

health system expenditure for these conditions



8,514

Children and adolescents with juvenile idiopathic arthritis in 2040



4 million (16%)
Australians
are estimated to be living with back pain



Lost GDP due to back pain is estimated to be \$10.5 billion

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

Background

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.

Economic and health system and personal costs

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 2030¹. Lost GDP due to back pain is estimated to be \$10.5 billion.

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 2040². 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.³

Out of pocket healthcare costs

Beyond the costs to the wider economy and health care system, arthritis and musculo-skeletal conditions impose a heavy burden of pain and disability on those living with them, which is often trivialised. People living with these conditions often face a double financial hit – arthritis is a leading cause of early retirement and loss of work hours and income⁴, and consumers face high out of pocket costs from the accumulated costs of accessing 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)⁵. 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 annually⁶.

Imperative for Reform

Unfortunately the majority of Australians with arthritis and MSK conditions such as osteoarthritis and back pain are not currently 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.

Arthritis Australia considers that there are significant opportunities for reform through:

- providing better access to evidence-based care and prevention whilst simultaneously reducing low value care;
- addressing the chronic underinvestment in research to support the work of Australia's world-leading researchers (for every Australian living with arthritis and musculoskeletal

conditions (MSK), the government spent just \$6 on research through the NHMRC in 2023 compared to \$108 per person living with dementia, and \$72 per person with a cardiovascular condition).

- addressing clinical workforce shortages
- providing greater access to care for children with arthritis; and
- addressing out of pocket costs through reforming safety nets.

Crucial programs such as the National Arthritis Infoline, juvenile arthritis kids camps, development of consumer resources and the ATLAS health professional education program, currently funded under Action Plan grants, must continue to be funded through the rollout of the the Chronic Disease Framework. Maintaining and increasing funding support for these programs as well as other innovative approaches as proposed in this submission will be even more important in the future as the prevalence of chronic disease across the community continues to grow.

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 Target implementation of better osteoarthritis care to reduce demand for joint replacement surgeries	\$11.5m in expenditure over 1 year with potential savings of up to \$60m pa scaling to over \$100m going forward.
	1.b Fund community based arthritis programs , including support for the Joint Movement program and the National Arthritis info line	\$5m over 4 years Investment of \$1.7m over 2 years to provide funding for the national delivery over 2 years of an evidence-based, evaluated group exercise program designed to improve health outcomes for people with arthritis and musculoskeletal conditions Investment of \$180,000 per year for the info line service.
	1.c Fund 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 GP Chronic Conditions Management Plans to people with musculoskeletal conditions

		\$500m investment in funding for allied health services delivered via: expanding the number of existing MBS allied health items claimable within a year, or through individually tailored bundled packages of care, and/or increasing the rebate payable for an allied health service to reduce the associated allied health provider out of pocket costs.
	1.d Equitable access to arthritis information and support for Aboriginal and Torres Strait Islander peoples Fund the creation of tailored, culturally appropriate programs, in collaboration with Aboriginal and Torres Strait Islander peoples to ensure equitable access to information, health services and support	\$900,000 over 2 years
2. Invest in vital game-changing arthritis and musculoskeletal research to transform lives and generate health system savings	Increase the Medical Research Future Fund (MRFF) annual disbursements from \$650m to \$1bn in order to address neglected areas of need and high burden such as arthritis and other musculoskeletal (MSK) conditions.	No impact on Budget as \$25bn funding already available in the MRFF
	Establish a Medical Research Future Fund Arthritis and Musculoskeletal Mission of at least \$100m over 10 years	No impact on Budget as \$25bn funding already available in the MRFF
	Fund consumer centred research and innovative approaches such as adaptive	\$5m over 5 years

	platform clinical trials in the most common arthritis conditions	
3. Workforce skills	Fund the maintenance, dissemination, evaluation and updating of the ATLAS health professional training program to upskill health professionals in best practice arthritis management for adults	\$1,800,000 over 5 years (\$360,00 per year)
4. Action on out-of-pocket healthcare costs - reform safety nets, and provide timely relief from fees when it is needed most	4a. Introduce a single, automated Health Safety Net covering both the PBS and MBS	Would require costing by government
	4.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
	4.c Provide surge support for condition flares to provide timely fee relief when it is needed most	Would require costing by government

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

Proposals

1.a Funding delivery of a first-line osteoarthritis management program including education and support for symptom management, physical activity and weight loss targeting 10,000 people with osteoarthritis who are 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 GP 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.

1.d Creation of tailored, culturally informed and responsive arthritis care, in collaboration with Aboriginal and Torres Strait Islander peoples to ensure equitable access and reduce disease burden **\$900,000 over 2 years**

Benefits:

- Containment of joint replacement costs which are on an unsustainable trajectory and which 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 providers 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 cost the health system \$4.8 billion in 2023–24⁷, 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 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 surgeries⁸.

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 Program⁹ which has been scaled up statewide, and the Medibank Better Knee Better Me program¹⁰. 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.

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** has received over 50,000 calls since 2019, 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 to 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 medication¹⁶ 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 or an equivalent 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 GP Chronic Conditions 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, podiatry, clinical psychology and occupational therapy, are highly valued to help them manage their condition. However, cost is a significant barrier to access. 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 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 impactsⁱ.
- 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 under a GP Chronic Conditions Management Plan 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.
- 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. A diabetic patient, for example, may need to visit a podiatrist 5 times a year- this would then mean that they are no longer able to receive support for other allied health treatments they may need.
- 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 required to access the plan. Arthritis Australia strongly supports both increasing the number of eligible MBS subsidised appointments each year; as well as increasing the rebate to more closely reflect the cost of accessing an allied health service.
- Increased access to allied health could also 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.
- One option is to provide pooled funding from the Commonwealth and States to provide access to care bundles which would be tailored to the needs of patients based on the severity and nature of their condition as assessed by their GP. Care bundles could include

ⁱ Unpublished research, August 2024

programs of individual or groups sessions; and remote access to support health equity and to reduce costs.

- It should also be noted that Aged Care Packages currently fund participation in group exercise programs but the Act only lists allied health providers. This needs to be expanded to include qualified exercise professionals (Personal Trainers, and Aqua Trained Exercise Professionals) as they are not on the list and yet provide the majority of affordable programs.

Our affiliated organisations have reported that participants have been knocked back as warm water exercise is not aqua physio led. In States such as Tasmania, there are no aqua physio led group programs available (either public or private) so people are left with nothing which doesn't make a lot of sense. Especially, when they can use their package for more expensive items but not \$15/week for a warm water exercise class or strength training class offered by a qualified exercise professional.

1.d Equitable access to arthritis information and support for Aboriginal and Torres Strait Islander peoples

Culturally informed and responsive healthcare delivery is essential to improving health and wellbeing outcomes for Aboriginal and Torres Strait Islander peoples with arthritis conditions. The **Staying Moving Staying Strong** project, funded by the Commonwealth via an Action Plan grant, involved a national collaboration of interprofessional Aboriginal and non-Indigenous health practitioners, health service staff, and research leaders, working in partnership with Aboriginal Communities, Arthritis and Osteoporosis Western Australia, and Arthritis Australia. The project developed Australia's first culturally appropriate resources for osteoarthritis, rheumatoid arthritis, lupus and gout for Aboriginal and Torres Strait Islander peoples (www.stayingstrongwitharthritis.org.au). It involved strong engagement with Aboriginal and Torres Strait Islander Community members and a rigorous review of clinical practice guidelines, resulting in five academic publications¹⁸.

To date, 10,000 brochures have been disseminated to Aboriginal Community Controlled Health organisations and mainstream health services around the country and the videos have collectively received over 7,000 views.

Community engagement through the Staying Moving Staying Strong project identified that currently, arthritis care does not consider the broader determinants or impacts on wellbeing of Aboriginal and Torres Strait Islander people. This is despite best practice recommendations in Aboriginal and Torres Strait Islander healthcare.

To address this gap, improve care access, and reduce arthritis burden for Aboriginal and Torres Strait Islander Communities, \$900,000 investment over a two-year period would produce the following outcomes:

- Continued fostering of strong partnerships with Aboriginal Community Controlled Organisations and Aboriginal Medical Services across Australia (specifically, Victoria, Western Australia and Queensland), mainstream healthcare settings, Arthritis Australia and other relevant stakeholder groups.
- Co-design of a Wellbeing framework to guide culturally informed arthritis service delivery that meets the needs of local Aboriginal and Torres Strait Islander Communities.

- A toolkit to guide implementation of the Wellbeing framework (including for example, arthritis yarnning circles). (REF Paper)
- Training resources to build capabilities in culturally informed arthritis care, aligned to domains of wellbeing (for example, online learning materials and in-person training support from the project team at the pilot sites).

The toolkit and training resources will be delivered to Aboriginal and Torres Strait Islander health professionals and non-Indigenous health professionals, and made accessible to health professionals and health services Australia-wide. Dissemination of the wellbeing framework to Communities across Australia will increase awareness and support implementation of strategies for living well with arthritis.

2. 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 to \$1bn per year from the current cap of \$650m (Maximum Annual Distribution Amount) and directing additional funding to neglected areas of need and high burden such as arthritis and other musculoskeletal (MSK) conditions.
- Arthritis Australia notes that the MRFF was initially set up to reach a pool of \$20bn which would be able to provide a sustainable pool of funding to support medical research and innovation. As at September 2025, the MRFF funding pool has almost \$25 billion in funding¹⁹. This was projected to reach \$30 billion by 2033-34 if disbursements remained at the current level of \$650m per annum²⁰.
- 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. Recent work undertaken by Research Australia shows that the establishment of a MSK mission would have a cost benefit return of \$4.61 for every \$1 invested.
- Ensuring that the new National Health and Medical Research (NHMRC) strategy guides funding decisions to better reflect burden of disease and impact.
- Providing \$5m over 5 years for consumer centred research and innovative approaches such as adaptive platform clinical trials in the most common arthritis conditions.

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.

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 (2022-22) \$bn	\$18.9	\$16.2	\$15.9	\$11.9	\$5.4*
NHMRC funding (2023) \$m	\$165.6	\$93.1	\$43.1	\$105.5	\$44.2
Medical Research Future Fund Missions \$m	\$135 (brain cancer)	\$220	Nil	\$125	\$185

- 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.²¹
- 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
- According to Research Australia, the Australian Government could spend 50% more per year on research if it fully utilises MRFF funding²². This unused funding could transform the lives of millions of Australians. This is supported by the Statutory Review of the MRFF Act

undertaken by the Departments of Finance, Department of the Treasury in consultation with Department of Health and Aged Care and the Future Fund Management Agency, December 2024 which estimates that the MRFF could reach \$30 billion by 2033-34 if the current level of disbursement continues²³.

- The Government's 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.
- 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.

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 benefit²⁵ 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 arthritis²⁷, 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 unnecessary²⁹ and which could be addressed by a modest investment in research into better models of care.

3. Workforce

Updating ATLAS: driving sustainability and scalability of an Australian digital training platform for health professionals to improve arthritis care

The Arthritis Training, Learning and Upskilling (ATLAS) platform is a flexible and accessible digital learning resource for health professionals and trainees to improve their competencies in arthritis care. ATLAS was developed by a consortium of organisations over 2022-2024, supported by the Australian Government as a key implementation strategy of the National Strategic Action Plan for Arthritis.

Despite the high burden and costs of arthritis, health professionals across disciplines report a lack of confidence in their knowledge and skills of best-practice care. For busy health professionals, professional development needs to be accessible, flexible, modular and appealing. Similarly, for pre-licensure training, new curricula need to be modular and assessable. ATLAS was created as a digital solution that embodies these criteria by a consortium of organisations bringing internationally-regarded expertise in clinical care, research, education and lived experience (including Arthritis and Osteoporosis WA, Curtin University, The University of Sydney and The University of Melbourne), as well as industry partners Go1, Arthritis Australia and the Australian Rheumatology Association.

ATLAS was launched in 2024 and is available to health professionals and trainees for upskilling and professional development. Findings from the Phase 1 evaluation demonstrate strong feasibility for implementing ATLAS as a training tool, with high usability, acceptability, and engagement across a broad range of health professionals.

To maximise the impact of ATLAS, the current post-development phase of work (2025-26) focuses on developing a sustainability model with a fit-for-purpose governance structure to support revenue generation and scalability. Once established, continued investment will be needed to support:

- Ongoing governance and operational management, ensuring coordinated oversight and day-to-day delivery
- Legal and accounting services to maintain the operational, governance and revenue framework
- Annual hosting and licensing fees and ongoing platform development costs
- Monitoring, evaluation and content updates to maintain quality and demonstrate impact
- Content curation to ensure training materials are remain contemporary. A strategic communication and dissemination program to drive continued uptake and embedding within existing training programs.

Currently, ATLAS provides education in three areas: 'arthritis essentials' (entry-level arthritis care) and more detailed disease-specific pathways in osteoarthritis and rheumatoid arthritis. The

microarchitecture of ATLAS accommodates integrating training for other diseases, such as juvenile arthritis and gout.

The current phase of work focuses on developing a sustainability model with a fit-for-purpose governance structure to support revenue generation and scalability. Once established, continued investment will be needed to support:

- Ongoing governance and operational management to ensure coordinated oversight and day-to-day delivery
- Legal and accounting services to maintain the operational, governance and revenue framework
- Annual hosting and licensing fees and ongoing platform development costs
- Monitoring, evaluation, and content updates to maintain quality and demonstrate impact
- A strategic communication and dissemination program to drive continued uptake

The estimated budget needed to support these activities is \$360k per year for 5 years (\$1.8m total).

Increase training positions for adult and paediatric rheumatology

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 (see below) 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.

There is also an urgent need to increase the rheumatology nurse workforce.

4. 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

- 4.a Introduce a single, automated Health Safety Net covering both the PBS and MBS**
- 4.b Change the expenditure qualifying periods to a 12 month rolling period to replace the fixed calendar year qualifying period**
- 4.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 section³⁰. 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 2030³¹.
- 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 weeks³². 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 annually³³. 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.

4a. 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.

4.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).

4.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

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.

References

¹ Schofield DJ, Shrestha RN, Cunich M 2016. Counting the cost: the current and future burden of arthritis. Part 2 Economic Costs. Arthritis Australia 2016

- ² The projected burden of arthritis among adults and children in Australia to the year 2040: a population-level forecasting study. Ackerman, Ilana N et al. *The Lancet Rheumatology*, DOI: [10.1016/S2665-9913\(24\)00247-9](https://doi.org/10.1016/S2665-9913(24)00247-9)
- ³ Ackerman, I.N., Bohensky, M.A., Zomer, E. et al. *The projected burden of primary total knee and hip replacement for osteoarthritis in Australia to the year 2030. BMC Musculoskelet Disord* 20, 90 (2019). <https://doi.org/10.1186/s12891-019-2411-9>
- ⁴ Schofield DJ, Shrestha RN, Cunich M 2016. Counting the cost: the current and future burden of arthritis. Part 2 Economic Costs. Arthritis Australia 2016
- ⁵ Berkovic D, Ayton D, Briggs AM, Ademi Z, Ackerman IN. Personal healthcare costs borne by younger people living with arthritis in Australia: An exploratory observational study. *Health Soc Care Community*. 2021 Dec 26. doi: 10.1111/hsc.13697. Epub ahead of print. PMID: 34957623.
- ⁶ Sibbritt D, Sundberg T, Ward L, et al, What is the healthcare utilisation and out-of-pocket expenditure associated with osteoarthritis? A cross-sectional study, *BMJ Open* 2022;12:e055468. doi: 10.1136/bmjopen-2021-055468
- ⁷ Australian Institute of Health and Welfare, <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-system-spending-on-disease-and-injury-aus/contents/summary> accessed 15 Januray 2026
- ⁸ Ackerman IN, Skou ST, Roos EM, Barton CJ, Kemp JL, Crossley KM, Liew D, Ademi Z. Implementing a national first-line management program for moderate-severe knee osteoarthritis in Australia: A budget impact analysis focusing on knee replacement avoidance. *Osteoarthritis Cartilage*. 2020 May 6;28(3):100070. doi: 10.1016/j.jocarto.2020.100070. PMID: 36474677; PMCID: PMC9718332
- ⁹ Osteoarthritis Chronic Care Program Model of Care, Agency for Clinical Innovation, <https://aci.health.nsw.gov.au/statewide-programs/lbvc/osteoarthritis-chronic-care-program> 24 Deloitte Access Economics, Osteoarthritis Chronic Care Program evaluation, Agency for Clinical Innovation, 22 July 2014 - https://aci.health.nsw.gov.au/__data/assets/pdf_file/0004/338242/OACCP_Evaluation.pdf
- ¹⁰ Harris A, Hinman RS, Lawford BJ, Egerton T, Keating C, Brown C, Metcalf B, Spiers L, Sumithran P, Quicke JG, Bennell KL. Cost-Effectiveness of Telehealth-Delivered Exercise and Dietary Weight Loss Programs for Knee Osteoarthritis Within a Twelve-Month Randomized Trial. *Arthritis Care Res (Hoboken)*. 2023 Jun;75(6):1311-1319. doi: 10.1002/acr.25022. Epub 2023 Jan 20. PMID: 36106928; PMCID: PMC10953202
- ¹¹ Ackerman IN, Livingston JA, Osborne RH. (2016) Personal Perspectives on Enablers and Barriers to Accessing Care for Hip and Knee Osteoarthritis. *Physical Therapy*. 96(1):26-36.
- ¹² Nolan G, Koutsimanis H, Page C, Briggs A, Harris B 2016, Consumer feedback on the current and future management of hip and/or knee osteoarthritis in Victoria, MOVE muscle, bone & joint health, Melbourne. MOVE muscle, bone & joint health
- ¹³ Arthritis Australia, 2011. *The Ignored Majority: The Voice of Arthritis 2011*
- ¹⁴ Australian Healthcare and Hospitals Association 2017. *Rheumatology nursing: Adding value to arthritis care*. Arthritis Australia 2017
- ¹⁵ Skou, S.T., Roos, E.M. Good Life with osteoArthritis in Denmark (GLA:D™): evidence-based education and supervised neuromuscular exercise delivered by certified physiotherapists nationwide. *BMC Musculoskelet Disord* 18, 72 (2017). <https://doi.org/10.1186/s12891-017-1439-y>
- ¹⁶ Australian Bureau of Statistics. 4364.0.55.002 - Health Service Usage and Health Related Actions, Australia, 2014-15. Available at <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.002~2014-15~Main%20Features~Arthritis~10002>. 2017
- ¹⁷ Harrison, C.M., et al., Opioid prescribing in Australian general practice. *Med J Aust*, 2012. 196(6): p. 380-1.
- ¹⁸ Lin, I.B., et al, Unmet Needs of Aboriginal Australians With Musculoskeletal Pain: A Mixed Method Systematic Review. *Arthritis Care Res (Hoboken)*, 2018. 70(9): p. 1335-1347.
- ¹⁹ <https://www.health.gov.au/our-work/mrff/about> accessed on 21 January 2026 states that the MRFF contained funding of \$24.83bn as at September 2025
- ²⁰ Statutory Review of the Medical Research Future Fund Act 2015, Department of Finance, Department of the Treasury in consultation with Department of Health and Aged Care and the Future Fund Management Agency, December 2024, p16
- ²¹ Gilbert S, Buchbinder R, Harris IA, Maher CM. A comparison of the distribution of Medical Research Future Fund grants with disease burden in Australia. *Med J Aust* 2021;214(3):111-3
- ²² <https://researchaustralia.org/2024-25-budget-update/>
- ²³ Statutory Review of the Medical Research Future Fund Act 2015, Department of Finance, Department of the Treasury in consultation with Department of Health and Aged Care and the Future Fund Management Agency, December 2024, p16

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- ²⁴ Ackerman IN, Skou ST, Roos EM, Barton CJ, Kemp JL, Crossley KM, Liew D, Ademi Z. Implementing a national first-line management program for moderate-severe knee osteoarthritis in Australia: A budget impact analysis focusing on knee replacement avoidance. *Osteoarthr Cartil Open*. 2020 May 6;2(3):100070. doi: 10.1016/j.ocarto.2020.100070. PMID: 36474677; PMCID: PMC9718332
- ²⁵ Choong PF and Dowsey MM 2014. The grand challenge – managing end-staged joint osteoarthritis. *Frontiers in surgery*. doi: 10.3389/fsurg.2014.00009
- ²⁶ Dowsey MM, Gunn J, Choong PF. Selecting those to refer for joint replacement: who will likely benefit and who will not? *Best Pract Res Clin Rheumatol*. 2014 Feb;28(1):157-71. doi: 10.1016/j.berh.2014.01.005. PMID: 24792950, <https://pubmed.ncbi.nlm.nih.gov/24792950/>
- ²⁷ Australian Institute of Health and Welfare (2024) [Rheumatoid arthritis](#), AIHW, Australian Government, accessed 29 November 2024
- ²⁸ Australian Institute of Health and Welfare (2024) [Back problems](#), AIHW, Australian Government, accessed 29 November 2024.
- ²⁹ Downie Aron, Williams Christopher M, Henschke Nicholas, Hancock Mark J, Ostelo Raymond W J G, de Vet Henrica C W et al. Red flags to screen for malignancy and fracture in patients with low back pain: systematic review *BMJ* 2013; 347 :f7095
- ³⁰ Australian Bureau of Statistics 2018 .4364.0.55.001 National Health Survey: First Results, 2017-18
- ³¹ Schofield D, S.R., Cunich M, Counting the cost: the current and future burden of arthritis: Part 2 Economic Costs. 2016
- ³² Berkovic D, Ayton D, Briggs AM, Ademi Z, Ackerman IN. Personal healthcare costs borne by younger people living with arthritis in Australia: An exploratory observational study. *Health Soc Care Community*. 2021 Dec 26. doi: 10.1111/hsc.13697. Epub ahead of print. PMID: 34957623.
- ³³ i Sibbritt D, Sundberg T, Ward L, et al, What is the healthcare utilisation and out-of-pocket expenditure associated with osteoarthritis? A cross-sectional study, *BMJ Open* 2022;12:e055468. doi: 10.1136/bmjopen-2021-055468