APPENDIX C – PRO-FORMA REQUEST FOR COSTING AN ELECTION COMMITMENT[1]

Name of policy	**The Coalition's Policy to Help Families with Diabetes**
Person requesting costing (Prime Minister/Leader of the Opposition/Leader of a minority party):	Prime Minister
Date of public release of policy:	15 May 2016
Date of request to cost the policy:	17 June 2016
Summary of policy (please attach copies of relevant policy documents):	The proposal would invest $54.1 million over four years to provide Continuous Glucose Monitors (CGM) devices to approximately 4,000 children under 21 years of age, who have severe poorly controlled, type 1 diabetes. This program would be managed through the National Diabetes Services Scheme (NDSS). Distribution would commence from 1 January 2017. It is assumed that 29% of total patient cohort has poor hypoglycaemic awareness in accordance with the Medtronic CGM submission. Eligibility criteria, particularly in terms of poor hypoglycaemic control, is to be determined by the patient's endocrinologist, to restrict the identified population. The cost of the CGM is based on the Government negotiating a minimum 10% discount on current market prices, consistent with bulk purchasing. No co-payments assumed for the CGM or its consumables.
Intention of policy:	This proposal would fund CGM devices for younger Australians with type 1 diabetes who have difficulty monitoring their glucose levels.
Certification that this, or a substantially similar costing request, has not been submitted to the Parliamentary Budget Office	This costing has not been previously submitted to the PBO.

[1] An electronic version of this pro-forma can be found at www.electioncostings.gov.au/templates.

Description of policy (please note that, where the request to cost a proposal differs from the announced policy, the costing will be on the basis of information provided in the costing request) **What are the key assumptions that have been made in the policy including:**	
Is the policy part of a package? If yes, list and outline components and interactions with proposed or existing policies.	No.
Where relevant, is funding for the policy to be demand driven or a capped amount?	Demand driven, with eligibility criteria as outlined above and below, and the program will be reviewed in 2019-20.
Will third parties (for instance the States/Territories) have a role in funding or delivering the policy? If yes, is the Australian Government contribution capped, with additional costs to be met by third parties, or is another funding formula envisaged?	No
Are there associated savings, offsets or expenses? If yes, please provide details.	These changes would be core business for the Department of Health, and therefore it is assumed there would be no additional departmental funding, as it could be met within existing resources.
Description of policy (please note that, where the request to cost a proposal differs from the announced policy, the costing will be on the basis of information provided in the costing request) **What are the key assumptions that have been made in the policy including:** **(continued)**	
Does the policy relate to a previous budget measure? If yes, which measure?	No
If the proposal would change an existing measure, are savings expected from the departmental costs of implementing the programme? Will funding/cost require indexation? If yes, list factors used.	• No additional insulin pumps (IP) have been funded as part of this costing, if patients choose to get an IP they may apply through the Juvenile Insulin Pumps Programme or purchase the IP privately. • The Juvenile Insulin Pumps Programme is an Appropriation Bill 1 capped program which provides subsidised access to IP for eligible patients under the age of 18 years. Should uptake for the

	program increase as a result of use of the CGMs, then there may be additional costs for Government. • Costs of this proposal would be reduced by an assumed 80% decrease in the use of blood glucose test strips. This would not drop to zero as some testing still needs to occur to validate that the CGM is functioning. • No changes in specialist/GP visits are assumed as part of this costing. It is assumed that these patients would currently be seeing their clinician regularly due to the poor control of their condition any increase to obtain access to the CGM would be offset by reduced visits overall. If this is not the case, additional costs or savings for the Medicare Benefits Schedule may result.
What are the estimated costs each year? Are these provided on a cash or fiscal basis?	The policy will have a negative fiscal impact of $54.1 million over the forward estimates, with the following profile: 2016-17: $7.7 million 2017-18: $15.4 million 2018-19: $15.5 million 2019-20: $15.5 million

What assumptions have been made in deriving the expected financial impact in the party costing (please provide information on the data sources used to develop the policy)?	Provision of Continuous Glucose Monitors (CGM) devices to approximately 4,000 children under 21 years of age, who have severe poorly controlled, type 1 diabetes. This program would be managed through the National Diabetes Services Scheme (NDSS). Distribution would commence from 1 January 2017. It is assumed that 29% of total patient cohort has poor hypoglycaemic awareness in accordance with the Medtronic CGM submission. Eligibility criteria, particularly in terms of poor hypoglycaemic control, is to be determined by the patient's endocrinologist, to restrict the identified population. The cost of the CGM is based on the Government negotiating a minimum 10% discount on current market prices, consistent with bulk purchasing. No co-payments assumed for the CGM or its consumables.
Has the policy been costed by a third party? If yes, can you provide a copy of this costing and its assumptions?	No
What is the expected community impact of the policy? How many people will be affected by the policy? What is the likely take up? What is the basis for these impact assessments/assumptions?	Assumed that 100% of eligible patients would take part, approximately 4,000.
NOTE: it will be up to the professional judgment of the relevant Secretary as to whether these assumptions are adopted in a Treasury or Finance costing of the policy.	

Administration of policy	
Who will administer the policy (for example, Australian Government entity, the States, non-government organisation, etc)?	Department of Health
Should departmental expenses associated with this policy be included in this costing? If no, will the Department be expected to absorb expenses associated with this policy? If yes, please specify the key assumptions, including whether departmental costs are expected with respect to programme management (by policy agencies) and additional transactions/processing (by service delivery agencies).	No departmental funding is included in this proposal. These changes would be core business of Health and would be met from within existing resources.
Intended date of implementation.	Distribution would commence from 1 January 2017.
Intended duration of policy.	Ongoing but subject to a review in 2019-20.
Are there transitional arrangements associated with policy implementation?	No
List major data sources utilised to develop policy (for example, ABS cat. no. 3201.0).	
Are there any other assumptions that need to be considered?	The cost of the CGM is based on the Government negotiating a minimum 10% discount on current market prices, consistent with bulk purchasing. No co-payments assumed for the CGM or its consumables. While there is a risk that costs could increase to the whole cohort, the invasive nature of the treatment and the cost of purchasing an IP make it less likely that patients with better awareness would take up CGM. The policy will be evaluated in 2019-20 to ensure it meets objectives and takes into account relevant medical technological advances.