2 The Australian health system

The Australian health system is a complex system characterised by differing roles and responsibilities of different levels of government, along with a mixture of service providers and types of services, and with a unique balance between public and private sector involvement. The public sector plays a greater role than that of the United States by ensuring universal access to most health services under Medicare, with the private sector playing a greater role than that of the United Kingdom, allowing greater responsiveness to individual choice of services and providers.

The Australian Government and the state and territory governments play important roles in the provision and funding of health care in Australia. In some jurisdictions, local governments also play a role. All of these levels of government are collectively called the public sector.

The private and non-government sector provides about 60% of health services and is also a major funder of these services through private health insurance, workers' compensation, compulsory motor vehicle third-party insurance and individual out-of-pocket payments.

The delivery of health care occurs in a diverse range of settings. These include hospitals (public and private), aged care homes (public, private for profit and private not for profit), hospices and rehabilitation centres. Delivery can also occur in community health centres, health clinics, ambulatory care services, private consulting rooms of doctors and other health professionals, and patients' homes or workplaces.

Most health care in Australia is delivered by private or non-government providers. These include private medical and dental practitioners, other health professionals (such as physiotherapists, optometrists and podiatrists), private hospitals, non-government aged care homes and pharmaceutical retailers.

Public, occupational and environmental health interventions may be delivered in several ways: through health promotion and education; through preventive screening and immunisation programs; and through health protection programs.

Funding arrangements for the different components of the health system are complex (see Figure 2.1). The Australian Government allocates funding to the States and Territories, private and non-government service providers and private health insurers in the form of:

- grants to the States and Territories, including health care funding grants to support the provision of public hospital services free of charge, under the Australian Health Care Agreements and other specific purpose payments;
- subsidies for the delivery of medical services under the Medicare Benefits Schedule (MBS);
- subsidies for pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS);
- direct grants to non-government organisations for the provision of health care;

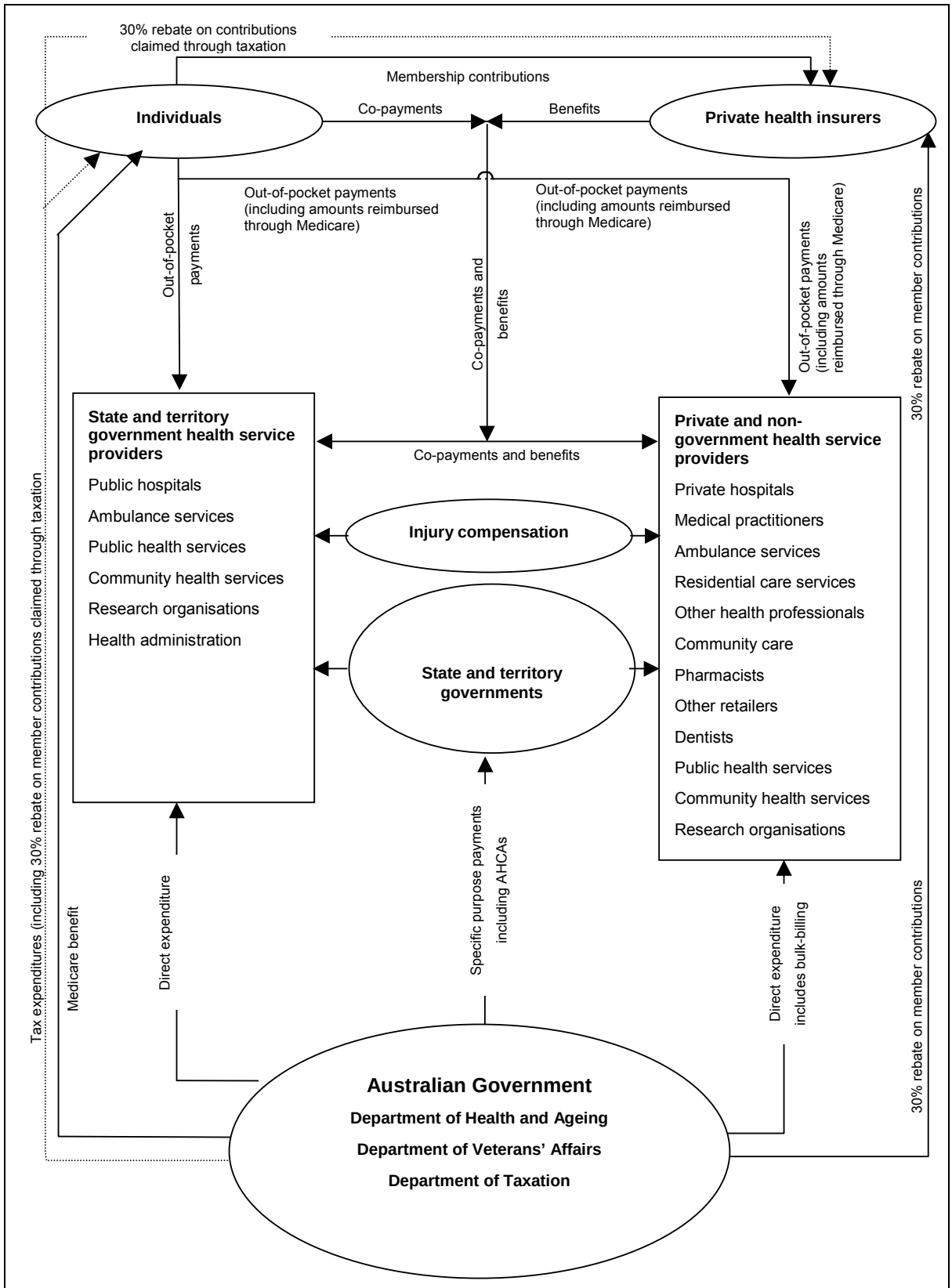

Figure 2.1: The structure of the Australian health care system and its flow of funds

Note: The Commonwealth undertakes research itself through organisations like the CSIRO, and the universities (not shown on this diagram) are major providers of health research and teaching services.

Source: Derived from Australian Institute of Health and Welfare (2003d).

- Public Health Outcome Funding Agreements to States and Territories to undertake particular public health activities; and
- rebates to help offset the cost of purchasing private health insurance.

The States and Territories have primary responsibility for the delivery and management of public hospital services and a wide range of community and public health services (including school, dental, maternal and child and environmental health programs). The States and Territories fund these services through income raised from taxes, their share of the goods and services tax (GST), grants from the Australian Government, and charges applied to users of services. The States and Territories largely determine the following:

- budgets for individual hospitals and the arrangements under which they are paid (e.g. casemix), including specialist medical services (e.g. salaried, sessional and/or fee-for-service payment models);
- number and location of hospitals and community health services;
- nature and extent of services available at each hospital; and
- public health priorities according to their respective perspectives.

The States and Territories are also primarily responsible for the regulation of medical practitioners and other health care professionals, and private hospitals.

In 2001–02 total expenditure (recurrent and capital) for health care services in Australia was $66.6 billion. Real growth in per person health expenditure averaged 4.6% per year between 1991–92 and 2001–02 (see Table 2.1). At the beginning of the 1990s, health expenditure accounted for 7.9% of the gross domestic product (GDP) (Table 2.2). The 2000–01 figure of 9.1% is close to the median of expenditures/GDP ratios of OECD countries (OECD 2003a).

Table 2.1: Total health expenditure, per capita, 1991–92, 1996–97 and 2001–02

	1991–92	1996–97	2001–02	Per cent change* 1991–92 to 2001–02
Current prices	1,904	2,458	3,397	6.0
Constant prices (2000–01)	2,357	2,733	3,292	3.4

Source: AIHW (2003c).

**Note:* Annual average percentage change.

Table 2.2: Ratio of health expenditure to gross domestic product (GDP) (%), 1990–91 to 2001–02

Year	Per cent of GDP	Year	Per cent of GDP
1990–91	7.9	1996–97	8.5
1991–92	8.1	1997–98	8.6
1992–93	8.2	1998–99	8.7
1993–94	8.3	1999–00	8.9
1994–95	8.3	2000–01	9.1
1995–96	8.4	2001–02	9.3

Source: AIHW (2002f); AIHW (2003c).

Within the overall increase in health expenditures, there have been changes in the sources of funding. By 2001–02, the Australian Government's funding of health services was estimated at $30.7 billion (46.1%) of total expenditure on health services from all funding sources

(Table 2.3). State or Territory and local government sources provided $14.8 billion (22.3%) of all health services funding. The remaining $21.0 billion (31.6%) was provided by non-government funding sources (e.g. individual out-of-pocket expenditure, private health insurance funds, workers' compensation and compulsory motor vehicle third party insurance funds). Of the non-government funding sources for 2001–02, individuals accounted for 58.6%, private health insurance funds provided 24.1% (down from 34.7% in 1990) and the remaining 17.2% came mainly from motor vehicle third party and workers' compensation insurance (AIHW 2003d).

Table 2.3: Health expenditure by broad source of funds, 1991–92, 1996–97 and 2001–02

	1991–92	1996–97	2001–02
	%	%	%
Australian Government	42.8	43.7	46.1
States, territories and local government	23.4	22.9	22.3
Non-government	32.7	33.3	31.6
Total	**100.0**	**100.0**	**100.0**

Source: AIHW (2003c).

Australian Government and state and territory government policies affect the levels and distribution of funding for health services. For example, the Australian Government's subsidy to private health insurance members contributed to a reduction in the proportion of total funding that came from members of private health insurance funds after 1996–97. Total expenditure on this rebate in 2001–02 was $2.0 billion, or 2.9% of total health expenditure (AIHW (2003c)).

Between 1991–92 and 2001–02, expenditure on health services by governments in Australia grew at a higher average annual real rate (5.4%) than did total expenditure on health by all sources, which averaged 4.6% per year. As a consequence, the contribution of governments to the funding of total expenditure on health services increased from 67.3% in 1991–92 to 68.4% in 2001–02.

Out-of pocket expenses increased somewhat from 17.7% of recurrent expenditure in 1991–92 to 19.7% in 2001–02. About 30% of out-of-pocket payments were for private dental and allied health professional services, 32% was for pharmaceuticals (mostly complementary medicines) and 11% was for medical services.

Over the last decade there have been some changes to the distribution of funding across the major categories of expenditure (Table 2.4). Between 1991–92 and 2001–02, there was a reduction in the proportion of expenditure on hospitals from 40% to 35% and an increase in the proportion of expenditure on pharmaceuticals, from 9.9% to 12.0%.

Almost all reported recurrent expenditure on medical services in Australia relates to services that are provided by practitioners on a 'fee-for service' basis. This is reflected in the distribution of funding for medical services. Of the $10.3 billion spent on medical services in 2000–01, some 81.8% was funded by the Australian Government. This was made up of medical benefits paid under Medicare, payments by the Department of Veterans' Affairs and payments to practices under programs like the Practice Incentives Program (PIP).

Table 2.4: Health expenditure by area of expenditure, Australia, 1991–92, 1996–97 and 2000–01

Area of expenditure	1991–92	1996–97	2000–01
	%	%	%
Hospitals (public & private)	39.7	37.5	35.0
High level residential aged care[(a)]	8.4	7.5	6.8
Medical services[(b)]	19.0	19.2	18.0
Pharmaceuticals[(c)]	9.9	12.0	14.2
Other[(d)]	23.0	23.8	26.0
Total	**100.0**	**100.0**	**100.0**

Source: AIHW (2003c).

Notes

(a) Only the expenditure on care for the more dependent residents of aged care homes is included here (Residential Classification Scale (RCS) categories 1 to 4).

(b) Includes private medical services (in and out of hospital) funded under Medicare and by worker's compensation and third party insurance. The cost of medical services provided in public hospitals by state and territory governments is included under 'Hospital' expenditure.

(c) Includes over-the-counter medicines, vitamins and minerals and herbal supplements as well as prescription pharmaceuticals.

(d) Includes dental services, other private allied health professionals, aids and appliances, patient transport services, research and administration.

Over the period from 1990–91 to 2000–01, recurrent expenditure on medical services increased, in real terms, at an average of 3.7% per annum. (Most of the expenditure in this category is for private medical services delivered out of hospital, but private medical services delivered in hospitals are also included. state and territory government funded medical services delivered in public hospitals are not included here, but are part of hospital expenditure). While growth in medical services expenditure partly reflects an increase in the number services delivered, from 147 million services (8.5 services per person) in 1990–91 to 221 million services (11.2 services per person) in 2001–02, there were also other factors that contributed to the increase, including: population growth; rearrangement of medical service responsibilities between the States and Territories and the Australian Government; changes to the structure of the Medicare Benefits Schedule (MBS) and the inclusion of new items in the MBS; and changes to funding arrangements. In 2001–02, GP consultations accounted for nearly half (45%), and diagnostic imaging and pathology just over a third (37%), of the number of Medicare services provided (Table 2.5). In terms of benefits paid, pathology was a lower proportion at 16% and GP consultations were 35% of the total. Diagnostic imaging was a higher proportion of benefits paid (16%) than of number of services (6%).

Table 2.5: Medicare services and benefits paid, by broad type of service, 2001–02

	Number of services provided	Benefits paid
	%	%
GP consultations	45.3	35.0
Specialist consultations	9.0	13.3
Pathology	30.8	16.0
Diagnostic imaging	5.8	15.5
Other	9.2	20.2

Source: Commonwealth Department of Health and Ageing (2002b).

Note: GP consultations include unreferred attendances and enhanced primary care (EPC) items. Pathology includes pathology patient episode initiation items as well as pathology tests. 'Other' includes obstetrics, anaesthetics, optometry and other medical services.

Expenditure on pharmaceuticals—whether on prescription pharmaceuticals, over-the-counter medicines or alternative medicines—grew strongly between 1991–92 and 2001–02 at an average of 9.4% per year in real terms.

Government funding of pharmaceuticals through the PBS and RPBS was 53% of the total expenditure of $9.0 billion in 1991–92. Government funding grew at 11.8% per year in real terms.

In 2001–02, there were 724 public acute hospitals and 22 public psychiatric hospitals in Australia (AIHW 2003b). Public hospitals accounted for 28.6% of recurrent expenditure on health goods and services in Australia in 1999–00. From 1997–98 to 2000–01, the rate of separations from public hospitals decreased slightly, while separation rates for private hospitals increased (Table 2.6). Separation rates then slightly increased in 2001–02. Rates of patient days per 1,000 population and average length of stay fell for public hospitals, reflecting the increase in the proportion of hospital services delivered on a same day basis and improvements in health care treatments and technology.