HiT summary Australia

Introduction

Government and recent political history

Australia has a federal system of government with fiscal and functional responsibilities divided between the Australian Government and the six States and two Territories (hereafter referred to as States). The governments are popularly elected, and the parliaments mostly have an upper and a lower house, with the leader of the political party with a majority of seats in the lower house becoming the Prime Minister (in the national Parliament) or in the case of the States, the Premier. At national level, Labor formed governments between 1983 and 1996, and Liberal and National Coalitions have governed since 1996.

Population

The population exceeded 20 million in 2004, with growth slowing to around 1.2% per year in the late 1990s. Migration has been a key factor in population growth and the population is culturally diverse with almost 23% born overseas. Until the late 1940s, most migration was from the United Kingdom and Ireland, then from various European countries, and since the 1970s mainly from the Asia–Pacific region. People of Aboriginal and Torres Strait Islander descent represent approximately 2.4% of the population. The majority of the population (66%) live in cities and towns. People aged 65 years and over comprise 12.8% of the population and future trends point to an ageing population and continuing low fertility (currently, 1.7 children per woman).

Average life expectancy

Life expectancy is among the highest in the world; it has risen 8.4 years since 1960 and has continued to increase. Life expectancy at birth for men is 78 years and 83 years for women. Infant and maternal mortality are very low.

Leading causes of death

Australia's population in general enjoys good health with a low incidence of life-threatening disease. Over 70% of the burden of disease (premature mortality in terms of years of life lost) can be attributed to circulatory disease, cancer and injury. Indigenous Australians, however, have much poorer health than the rest of the population.

Recent history of the health system

Australia is committed to public financing and substantial public delivery in health care. The health system offers universal access to health care, regardless of ability to pay, through the government health insurance system, Medicare, which is financed through general taxation and a health tax levy. This provides the entire population with subsidized access to the doctor of their choice for out-of-hospital care, free public hospital care and subsidized pharmaceuticals.

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Reform trends

Health sector reform in Australia has involved microeconomic reform, as part of wider public sector reform; the aims being to contain costs, shift the public–private balance, and achieve greater efficiency and effectiveness. The universal, tax-funded health insurance system, Medicare, consolidated under Labor governments, is supported by the current Liberal and National Coalition Government (1996–). Although private insurance remains voluntary, from the late 1990s the Australian Government has introduced both financial incentives and sanctions for people to take out private insurance cover for hospital and some allied health services.

Health expenditure and gross domestic product

Australia spends 9.7% of its gross domestic product (GDP) on health and growth is projected to continue. Expenditure per capita in terms of purchasing power parity (PPP) is US$ 3652, which puts Australia slightly above the Organisation for Economic Co-operation and Development (OECD) average, but in line with the predicted level, given the country's relatively high per-capita income. Australia is a generally prosperous country with GDP per capita close to the OECD aver age.

Overview

Australians have ready access to comprehensive health care of a high standard. The mainly tax-funded health system achieves reasonably cost-effective health care and good health outcomes, and generally enjoys public support. Despite considerable achievements, however, some continuing problems present challenges for the 21st century. Tensions in the system arise from concerns about the sustainability of rising health expenditures, long-standing accountability and funding disagreements between the Australian Government and the States, complaints about waiting lists for elective surgery, disparities in urban and rural service access, and the continuing poor health status of Indigenous Australians.

Organizational structure of the health system

The complex health system involves both levels of government, as well as public and private funders and providers. The Australian Government funds rather than provides health services; the States fund, administer and provide; private medical practitioners provide most community-based treatment, and there is a large private health sector.

The Australian Government has a leadership role in health policy-making and financing, given its constitutional mandate as well as the "power of the purse". The Government funds and administers the Medicare Benefits Schedule, which subsidizes ambulatory medical services, the Pharmaceutical Benefits Schedule, which subsidizes essential drugs, and the Australian Health Care Agreements, which contribute funds to the States to run public hospitals. The Department of Health and Ageing is the principal national agency in the health care field; it engages in national policy formulation and health care funding, and is concerned with population health, and with research and information management.

The States essentially are autonomous in administering health services and thus vary somewhat in policies, organizational structures, per-capita expenditure, resource distribution and service utilization rates. State health departments administer public hospitals and other public health-related services, including mental health services, some dental health services, some child and family health services, health promotion, and home and community care. Local governments (over 850 municipal and shire councils) are responsible for some environmental health services, such as sanitation and hygiene, food safety and water quality.

The private health sector includes the majority of general practitioners and specialists, many private hospitals, a large diagnostic services industry, several private health insurance schemes, and numerous professional associations and industry and consumer groups, which influence policy-making at both national and state levels.

Planning, regulation and management

Given the division of powers within the federal system of government, and the many players in the fragmented health field, the ability of any one authority to plan and regulate is limited. Governments exert considerable influence, however, in that they fund nearly 70% of total health expenditure. Most major policies require agreement between the Australian Government and the States, often through intergovernmental programmes, while the Australian Health Ministers' Conference, and the Council of Australian Governments provide forums for agreeing upon and taking collaborative action.

While health sector funding is heavily regulated, the governance of clinical performance involves mainly self-regulation by professional and industry groups. Each State has statutory registration boards that register health professionals, and there are also statutory health complaints commissioners. Most health service providers are licensed by the state and most also seek accreditation; most hospitals are accredited, as are most general practices, and accreditation is compulsory for aged-care homes. Both national and state authorities set targets, define health indicators and assess health sector performance, and encourage health facilities to implement quality assurance programmes.

Decentralization of the health system

The Australian Government has expanded its policy, funding and regulatory roles over the last few decades, but the States administer and deliver many health services, while local government has only limited health care functions. After a phase of decentralization, most State health departments have tightened both their policy and funding powers and management of public hospitals in the last few years, in response to rising health costs and concerns about accountability and health care quality.

Health care financing and expenditure

Main system of finance and coverage

Australia has a mainly tax-funded health system financed through general taxation and a compulsory tax-based health insurance levy. The mandatory Medicare health levy on personal income (currently 1.5%) contributes approximately 8.5% of total health expenditure. Governments accounted for 68% of total health expenditure in 2004: the Australian Government contributed 46%, and state and local governments 22% (the latter a very minor amount); the remaining 32% came from private sources.

Health care benefits and rationing

Medical treatment is largely free to the user and its use is largely unlimited. Treatment in public hospitals is free to the user, treatment by general practitioners and specialists is free (if the doctor bulk-bills Medicare), while essential pharmaceuticals are subsidized. Subsidies are limited to items on the respective medical and pharmaceutical benefits schedules. Pensioners are entitled to substantial concessions or to free treatment. There is no limit upon the amount of medical services that an individual may use; health care benefits are not rationed; and there is little public debate on whether, or how, to ration services. Public hospital services, however, are prioritized (a form of rationing) through often-lengthy waiting lists for elective surgery.

Complementary sources of finance

Out-of-pocket payments by individuals have risen and in 2004 accounted for 20% of total health expenditure. The main consumer payments are for pharmaceuticals not covered under the Pharmaceutical Benefits Scheme, for dental treatment, to cover the gap between Medicare benefits and the schedule fee charged by doctors, for payments to other health care professionals and for co-payments for pharmaceuticals.

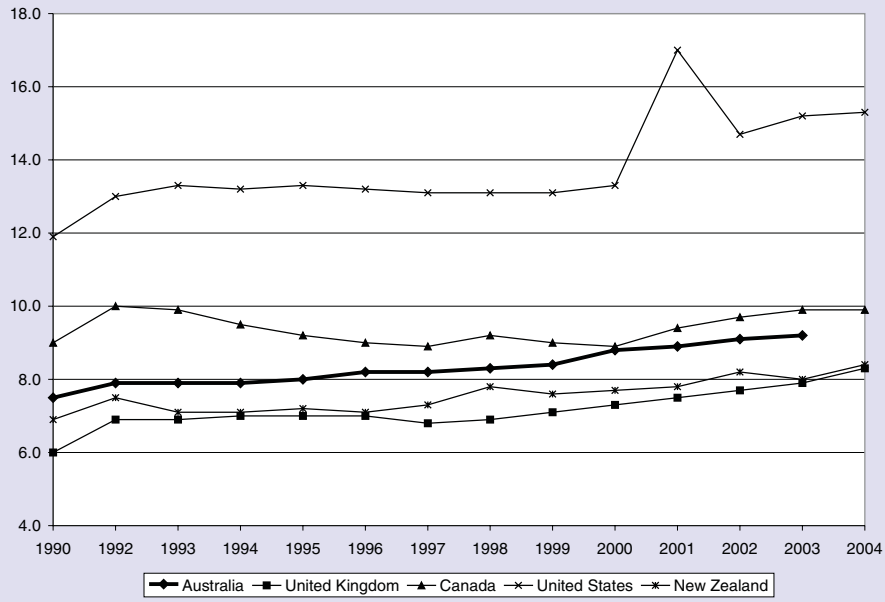
In 1997 the Australian Government initiated measures to halt falling membership in private insurance schemes and to ensure the long-term viability of the sector. Private insurance coverage, which supplements statutory insurance, has risen from approximately one third to 43% of the population. Private insurance accounts for 7% of total health expenditure.

Health care expenditure

Health expenditure in Australia as a percentage of GDP rose in the 1970s, evened out in the 1990s, and had risen again in the last few years to reach 9.5% of GDP in 2004 (Fig. 1). Health expenditure as a percentage of GDP is slightly above the OECD average but far below that of the United States (an outlier in international terms).

Dips and peaks in intergovernmental funding shares reflect changes in fiscal arrangements, depending partly upon the political party in power. The proportion funded by governments has dropped slightly, while the nongovernmental share dipped in the mid-1990s and has since increased. The hospital share of the health budget has declined, while the ambulatory care share has risen. The pharmaceuticals share of total health expenditure has been rising steadily and is likely to rise further. Public health (disease prevention and health promotion at the population level) receives less than 2% of the total health budget

Fig. 1 **Trends in health care expenditure as a share of GDP (%) in Australia and selected other countries, 1990–2004**



Source: OECD Health data 2006.

(although this broad area is difficult to assess). Investment in the health sector has declined, an increasing problem for public hospitals, thus prompting a search for private finance. Since different sectors fund different health services, it is politically and fiscally difficult to significantly change expenditure patterns, for example, moving funding from hospitals to primary health care.

Health delivery system

The States, with financial assistance from the Australian Government, fund and administer public hospitals, mental health services and community health services. Private medical practitioners provide most community-based medical and dental treatment, and there is a large private hospital sector.

Primary care

General practitioners (over 66% of active medical practitioners) provide the bulk of medical care and most are self-employed, although their fee-for-service source of income has mostly shifted from the private to the public purse (Medicare). General practitioners provide general medical care, family planning and counselling, perform minor surgery in their clinics, offer preventive services, including immunization, offer health advice to patients, dispense pharmaceutical prescriptions, and initiate the majority of pathology and radiology investigations. Individuals are free to choose their general practitioner and may consult more than one general practitioner, since there is no requirement to enrol with a practice. As general practitioners are the first point of medical contact, they act as referral gatekeepers to the rest of the health system. Other health care professionals, notably nurses, also provide primary health care, as well as allied health professionals, such as physiotherapists and dieticians, many of whom are in private employment.

The Australian Government funds Divisions of General Practice, and 118 geographic groups (each consisting of around 100–300 general practitioners) cover most general practitioners. The Divisions offer general practitioners a network for professional support, connect them to other health professionals, run continuing medical education activities, fund and administer health promotion projects, and coordinate shared-care arrangements.

Population health services

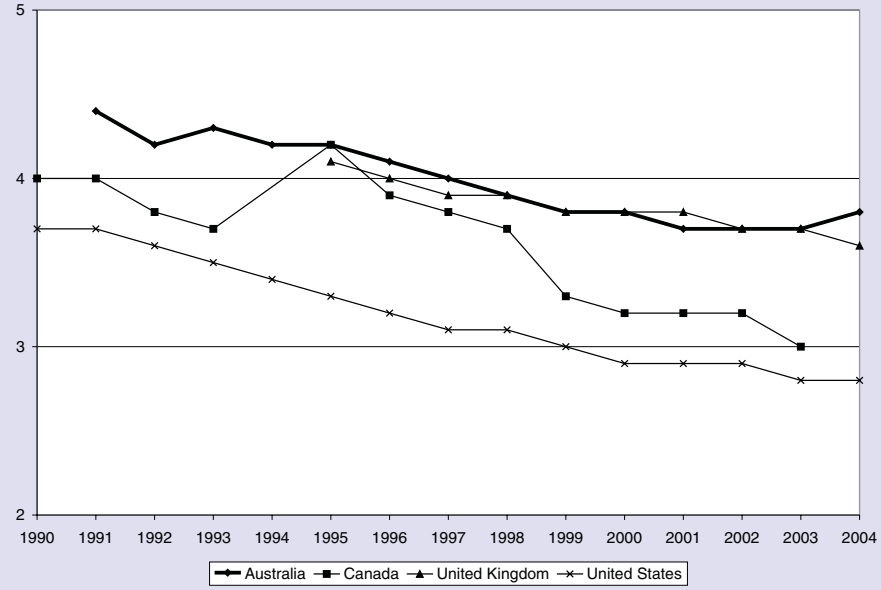
The Australian Government and the States collaborate through the National Public Health partnership on many successful public health initiatives; noteworthy achievements include a dramatic reduction in coronary heart disease, a reduction in the incidence of HIV/AIDS in some at-risk populations, a reduction in cigarette smoking, and a decrease in mortality from road traffic accidents. Australia has high levels of immunization for most vaccine-preventable diseases. The impact of infectious disease is much reduced but still causes considerable morbidity. The emergence of new strains of infectious diseases in the region, such as SARS and avian influenza, has prompted the establishment of an Office of Health Protection within the national Department of Health and Ageing. The Communicable Diseases Network of Australia and New Zealand coordinates surveillance, responds to outbreaks, develops national policy and trains staff.

Secondary and tertiary care

Medical specialists provide ambulatory secondary care, either in private consulting rooms or in outpatient departments of public hospitals.

Australia had 1029 acute care hospitals in 2004, with public hospitals providing 70% of the bed stock. The configuration of hospitals has changed with the closure of many small hospitals, mergers between hospitals and the growth of day hospitals for same-day treatment (253 day hospitals in 2005). The number of acute hospital beds has dropped in the last few decades, in line with the reduction in most OECD countries (Fig. 2), and in 2003 was around 4.0 per 1000

Fig. 2 Acute hospital beds per 1000 population, Australia and selected OECD countries, 1990–2004



Source: OECD Health data 2006.

(including psychiatric beds), including 3.6 public acute hospital beds per 1000 population, reflecting shorter stays, more same-day procedures and more community-based care. Hospitals have recently opened more beds, however, in order to reduce waiting lists for elective surgery.

In Australia, admissions for acute care per 100 population rose in the 1990s, partly owing to an increased number of same-day procedures, and if these are excluded, there were 15.6 discharges per 100 people in 2004. The average length of stay in acute care hospitals (excluding same-day admissions) has fallen to 6.2 days (or 4.1 days including same-day cases), reflecting more active patient management, less invasive surgical techniques and greater cost pressures. Bed occupancy rates have risen recently from approximately 74% to 78%. Hospital productivity measures therefore compare well to other OECD countries (Table 1). The key change in Australia is that many patients are now treated on a same-day basis, the number rising from 31% in 1992 to 52% in 2004; some of these, however, represent new patients who otherwise would not enter hospital, rather than patients diverted from inpatient stays.

Social care

Social care is funded by all levels of government and delivered by a mixed economy of government, voluntary sector and for-profit providers. The Australian Government is involved in formulating policies and funding social programmes, but the States traditionally are responsible for social welfare, and many services are delivered by voluntary sector agencies. The boundary between health and social care is subject to continuing negotiations and requires collaboration, since the needs of frail older people, people with physical or learning disabilities, and people with mental

Table 1 Inpatient utilization and performance in acute hospitals in Australia and selected OECD countries, 2004 or latest available year

Country	Acute beds per 1000 population	Discharges per 100 population	Average length of stay (ALOS) in days	Occupancy rate
Australia	3.6	15.6	6.2	73.9
Canada	3.2	8.8	7.4	86.6
New Zealand	–	20.4	–	–
United Kingdom	3.7	23.7	6.7	85.1
United States	2.8	11.7	5.7	66.2

Source: OECD Health data 2005.

health problems, might be met by health or social care and by institutional or community-based services.

Human resources and training

The health care workforce (approximately 570 000 people) comprises nearly 6% of the total workforce. With shortages of some key health professionals, including doctors and nurses, the current policy is to increase the number of university and training places. Australia has 2.5 practising doctors per 1000 population (Fig. 3), which is slightly above comparable OECD countries but below the European Union average, and the intake of overseas-trained doctors had been increased since the mid-1990s to staff public hospitals and rural areas. The current policy is to increase places in university medical schools and to offer incentives for doctors to locate in rural and remote areas.

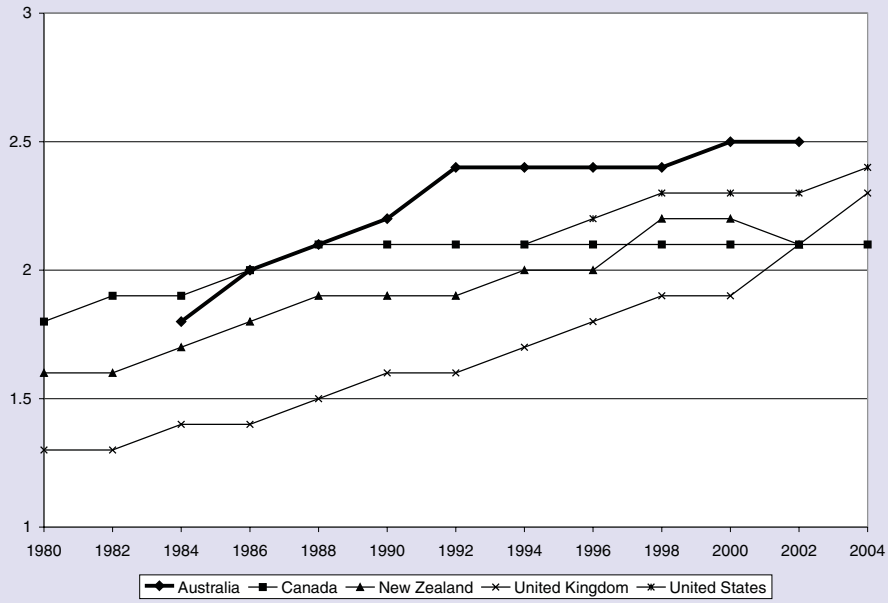
There are around 10.2 practising certified nurses per 1000 population, which is around the middle range for many OECD countries, and the skill-mix has shifted to more highly trained registered nurses (with at least a three-year university degree). There are shortages in many areas of nursing, and there is growing concern about declining numbers of nurse trainees and the loss of nurses from the workforce, which is an issue in many OECD countries.

Pharmaceuticals and health care technology assessment

The Australian Government controls the supply and costs of drugs through the Pharmaceutical Benefits Scheme, and although both the consumption and cost of drugs have risen, the scheme has been relatively successful in regulating quality and cost compared to other countries. All pharmaceuticals listed on the schedule of the Pharmaceutical Benefits Scheme are subsidized (nearly three-quarters of prescriptions), although most consumers make a significant flat-rate co-payment (recently increased).

Several stages are involved before a drug is listed on the Pharmaceutical Benefits Scheme schedule. First, a drug must be registered for marketing in Australia; this involves an exhaustive assessment process whereby a pharmaceutical company submits an application to the Commonwealth Department of Health, which considers evidence on pharmaceutical chemistry, toxicology, clinical pharmacology, clinical efficacy and safety. Second, the Pharmaceutical Benefits Advisory Committee, an independent statutory authority, must recommend that the registered drug be

Fig. 3 **Active doctors per 1000 inhabitants in Australia and selected OECD countries, 1980–2004**



Source: OECD 2005.

listed. Third, the Minister of Health must decide whether to accept the recommendation. Finally, the Commonwealth negotiates a price with pharmaceutical wholesalers. Most pharmacies are community-based and privately run, and their number is regulated by the Australian Government.

Financial resource allocation

Third-party budget setting and resource allocation

Spending by the Australian Government on health is mostly determined by commitments under three schemes: Medicare, the Pharmaceuticals Benefits Scheme, and the Australian Health Care Agreements. State government funding for health care comes from their own general revenue base and also from the Australian Government via general revenue, untied revenue from goods and services tax, and specific-purpose grants. Health grants to the States from the Australian Government, under the Australian Health Care Agreements, are five-year agreements (currently, 2003–2008) that offer a capped prospective block grant for public hospitals based on a population formula plus components of performance measurement. The States thus bear most of the risk if demand and costs increase over the five-year period.

A State health department is an important player in the State budgetary process, since health recurrent funds appropriate approximately one third of the State budget, with payments to hospitals taking at least half that amount. The States differ in the way they allocate funds to health care administrators and providers. For example, the New South Wales health department allocates funds to area health services according

to a "resource allocation formula", based on historical funding and a population-based formula weighted for age and sex, with some adjustment for resource use, including activity-related measures based on the mix of hospital cases. Other States negotiate contracts with providers and fund hospitals using both fixed and case-mix payments.

Payment of hospitals

The period since the mid-1990s has seen substantial changes in the way that public hospitals are funded, and purchaser specificity and provider accountability have increased. Most public hospitals are responsible for managing the funds they receive. Public hospitals are generally funded through global prospective budgets that include payments for fixed costs and for non-patient costs, such as research and education, plus a substantial element of case-mix funding. State governments may also purchase hospital services from private providers under purchase-of-service contracts.

Australia has progressively adopted case-mix funding, that is, paying hospitals a benchmark price for the mix of patients (cases) they treat, and has developed its own version of diagnosis-related groups (DRGs) and cost weightings. Case-mix funding is credited with achieving service targets through efficiencies in the context of hospital budget constraints, with no evidence reported of adverse impacts upon patient health outcomes.

Payment of physicians

The Workplace Relations Act 1996 shifted the industrial relations focus away from centrally determined awards towards enterprise-level bargaining. Many doctors in public hospitals are salaried medical officers who are paid a salary to work at the hospital full time, while independent visiting medical officers are paid on either a fee-for-service or a sessional basis.

Medical practitioners charge on a fee-for-service basis. General practitioners can bulk-bill Medicare Australia, provided that the doctor accepts the Medicare Benefits Schedule fee as full payment for the service, or alternatively they can bill patients directly. Most general practitioners bulk-bill so that their services effectively are free to patients. Following a decline in bulk-billing, the Government in 2005 raised the benefit paid to general practitioners to 100% of the schedule fee. Alternatively, general practitioners may charge the patient a higher amount, and the patient may then claim the 85% rebate on the schedule fee from Medicare Australia. Although the Medical Benefits Schedule fee acts as a break on medical fees (while also providing guaranteed payments to doctors), funding has not been used as a lever to change clinical practice. The Medicare Benefits Scheme reimburses 85% of the schedule fee for out-of-hospital specialist consultations.

Health care reforms

Health care reform in Australia has proceeded through incremental steps. Radical change is difficult in the Australian political system (compared, for example, to New Zealand and the United Kingdom), given the federal system of government, the many checks and balances, and the necessity to achieve agreement between the Australian Government and the States, and the private sector is also a powerful stakeholder.

The main hallmarks of Australian reform include the preservation of universal tax-financed health care; the dominance of "supply-side" theory in order to contain costs; a strong "stewardship" role for the governments; some alteration in the public–private mix with attempts to strengthen the market; and a continuing commitment to equity. The main objectives of the current Australian Government have been to build a high-performing and sustainable health system that provides cost-effective health services; to ensure that the public sector is complemented by a private sector that is fair and affordable, and represents good value for money; and to

improve the health outcomes of all Australians, particularly Indigenous Australians and those living in rural and remote areas.

Current concerns in Australia include cost pressures upon governments given limited budgets and rising health expenditure; the need to ration supply in the face of growing demand; the lack of integration of health care services, particularly for patients with complex health needs; controversies over the "right" balance between public and private health insurance; the need to raise and monitor health service standards; and most urgently, the persistence of serious health inequalities, most notably among Aboriginal and Torres Strait Islander people.

The main changes since the mid-1990s include the following: public support for private health insurance (for example, tax rebates for those taking out private health insurance cost the Australian Government AU$ 2 billion in 2001–2002); a rise from 85% to 100% of the Medicare schedule fee for general practitioners to counteract a drop in bulk-billing; efforts to formulate and implement national policies through intergovernmental forums such as the Australian Health Ministers Conference and the Council of Australian Governments; national government funding for coordinated care programmes; increased attention to workforce planning following a report by the Productivity Commission on shortages of health care professionals and inflexible work practices; more e-health initiatives; and greater attention to the quality and safety of patient care.

Conclusions

The public have high expectations for their health care with continuing lively public debate, well covered by the media, on the tensions and shortcomings within the health system. Despite a generally positive assessment, there is dissatisfaction with particular aspects (such as long hospital waiting lists), and among particular population groups (such as people in rural areas). Recent consumer satisfaction surveys also suggest little room for complacency, and the health status of Aboriginal Australians remains very poor.

The three basic goals of the Australian health care system are equity (fair payments and fair access to and use of services), efficiency (value for money), and quality (high standards and good health outcomes). Equity has been partly protected in a health system primarily funded by progressive taxation, although out-of-pocket payments have increased, and there is concern that a two-tier health system could develop between public patients covered by Medicare and private patients with supplementary private insurance. Efforts have been made to improve allocative (or distributional) equity across States, across geographic areas and across population groups. The health status of Indigenous Australians, however, remains a glaring and intractable problem, as are disparities in health access and outcomes for people in the vast rural and remote areas of Australia. Efficiency is problematic, given duplicated governance between the Australian Government and the States, although some gains have been made in microeconomic reforms. Quality is receiving more attention, despite the lack of formal monitoring systems on clinical outcomes, and there is more emphasis upon quality assurance schemes and measuring specific health outcomes. Health outcomes for the population generally are positive, with long life expectancies and falling mortality rates for many diseases and conditions.

Health care reform in Australia is an ongoing process in the context of changing population health needs, advances in technology, and changes in governments and their ideological preferences. Concerns about health system viability, efficiency and effectiveness will continue to be addressed in the 21st century. Major reforms will depend upon the ideological preferences of governments and their political will to achieve change in a complex health care system.

HiT summary

Australia

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