

### Introduction

#### Government and recent political history

Australia has had a federal form of government since federation in 1901 between the six self-governing colonies of the former British Empire.

Setting health policy involves ongoing negotiations over funding and functional responsibilities between the Commonwealth of Australia (national government) and the six states and two territories (hereafter referred to as states).

#### Population

The population reached nearly 19 million in 2000, with growth at around 1.5% per year. Migration has been a key factor in population growth and the population is culturally diverse with almost 40% either born overseas or with a parent born overseas: 91% of the population is of European descent, 7% Asian and 2% Aboriginal or other. 64% of the population live in cities and towns. Future trends point to an ageing population and a continuing decline in fertility (currently 1.7 children per woman).

#### Average life expectancy

Life expectancy is 76 years for men and 82 years for women. In terms of disability adjusted life expectancy, Australia ranks second in the world after Japan.

#### Leading causes of death

Australia's population in general enjoys good health with increasing life expectancy and 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 cardiovascular disease, cancers and injury. Indigenous Australians, however, have much poorer health than the rest of the population with life expectancy up to 20 years lower.

#### Recent history of the health care system

Australia is committed to public financing and public involvement in health care. It 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.

#### Reform trends

Health sector reform in Australia since the mid-1980s 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 Labour governments (1983–96), continues to be supported by the current Liberal government (1996–). Although private insurance remains voluntary, the Commonwealth from the late 1990s controversially introduced both financial incentives and sanctions for people to take out private insurance cover for hospital and some allied health services.

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## Health expenditure and GDP

Australia spends 8.5% of its GDP on health, having averaged 2.7% annual rate of growth in real per person expenditure from 1985 to 1997. Expenditure per capita in terms of purchasing power parity was PPP US \$1909 in 1997, which puts Australia in the mid-range among OECD countries, and is in line with the predicted level given the country's per capita income.

## Overview

Australians have among the highest life expectancy in the world and most have ready access to comprehensive health care of high quality. The primarily tax-funded health care system achieves reasonably cost-effective health care and good population health outcomes. The health care system generally enjoys public support with no calls for radical change despite ongoing intergovernmental tensions, and public concern about waiting lists for elective surgery; inequities in service access between urban and rural Australians and the continuing very poor health status among Aboriginal Australians.

## Organizational structure of the health care system

Australia has a complex health care system with both public and private providers and applies a range of funding and regulatory mechanisms. The pluralist health care field involves many stakeholders, involving considerable overlap between Commonwealth and state governments, and there is a substantial private sector. The Commonwealth funds rather than provides health services; the states fund, administer and provide; private practitioners provide most community-based treatment, and there is a large private hospital sector and private insurance industry.

The Commonwealth has a leadership role in health policy-making and financing given its constitutional mandate as well as the "power of the purse". The Commonwealth funds and administers the Medicare Benefits Schedule that

subsidizes ambulatory medical services, the Pharmaceutical Benefits Schedule that subsidizes essential drugs, and the Australian Health Care Agreements that fund the states to run public hospitals. The Department of Health and Ageing is the principal national agency in the health care field ([www.health.gov.au](http://www.health.gov.au)), and is concerned with public health, research and information management as well as national policy and funding.

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 undertake policy-making, budgeting and financial control, plan, set standards of performance, negotiate industrial and personnel matters, undertake major capital works and administer public hospitals. Other state health-related services include mental health services; dental health services; child, adolescent and family health services; women's health programmes; health promotion; rehabilitation services; home and community care; and the regulation, licensing and monitoring of premises and personnel.

Local government (nearly 700 municipal or shire councils) are responsible for some environmental health services, such as sanitation and hygiene, food safety and water quality, and for some public health programmes such as immunization.

The large private sector includes the majority of physicians; private hospitals provide 30% of the bed stock; there is a large diagnostic services industry; nearly 45% of the population are members of private health insurance schemes; and finally, numerous professional associations and consumer groups 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 pluralist health field, the ability of any one authority to plan and regulate is limited.

Governments exert considerable leverage, however, in that they fund nearly 70% of total health expenditure. Most major policies require agreement between the Commonwealth and the states, many being implemented through inter-governmental programmes, while the Australian Health Ministers' Conference provides an annual mechanism for agreeing upon collaborative action.

The health sector is heavily regulated through self-regulation and voluntary regulation as well as compulsory compliance. For example, the Australian Council on Health Care Standards offers voluntary hospital accreditation, and statutory registration boards in each state accredit health professionals. Both national and state bodies increasingly set targets, define indicators and assess health sector performance, and encourage health facilities to implement quality assurance programmes.

### **Decentralization of the health care system**

The Australian health care system is decentralized and pluralist. The Commonwealth 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. State health departments in the 1980s decentralized to regional health administrations, which are retained in New South Wales, but largely abolished in other states. The management of public hospitals mostly was devolved from state health departments to autonomous hospital boards by the mid-1980s.

“Privatization” has advanced over the last two decades, ranging from selling public facilities to private providers, to delivering public services in a more “business-like” fashion, with outsourcing to the private sector being a common strategy. The policy thrust in most states has been to reduce the role of government in service delivery and to increase reliance on the non-government and private sectors.

## **Health care financing and expenditure**

### **Main system of finance and coverage**

Australia has a mainly tax-funded health care system financed through general taxation and a compulsory tax-based health insurance levy. State governments accounted for 71% of health expenditure in 1999–2000: the Commonwealth contributed 48%, and state and local governments 23% (the latter a very minor amount), while the remaining 29% came from the private sources. The mandatory Medicare health levy on personal income (currently 1.5%) contributes about 8.5% of total health expenditure.

### **Health care benefits and rationing**

Medical treatment is largely free and its use 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 waiting lists for elective surgery.

### **Complementary sources of finance**

Out-of-pocket payments accounted for 17% of total health expenditure in 2000 and private insurance 7%. The main consumer payments are for pharmaceuticals not covered under the Pharmaceutical Benefits Scheme, for dental treatment, the gap between the Medicare benefit and the schedule fee charged by physicians (up

to 25% above the benefit), payments to other health care professionals, and co-payments for pharmaceuticals.

The Commonwealth initiated a number of controversial measures from 1997 aimed at halting falling membership in private insurance schemes and ensuring the long-term viability of the sector. Private insurance coverage, which supplements statutory insurance, thereafter rose from about one third to 45% of the population by 2000.

### Health care expenditure

Health expenditure in Australia in the 1960s was relatively low as a percentage of GDP, increased from the 1970s (as in comparable OECD countries), then slowed in the 1990s reaching 8.5% of GDP in 2000 (Fig. 1).

Dips and peaks in Commonwealth and state funding shares reflect changes in fiscal arrangements depending partly upon the political party in power. The hospital share of the health budget grew from the mid-1960s to the early 1980s but then declined to around 43% of total expenditure. The ambulatory care share of the health budget increased slightly to nearly 23% in 1997.

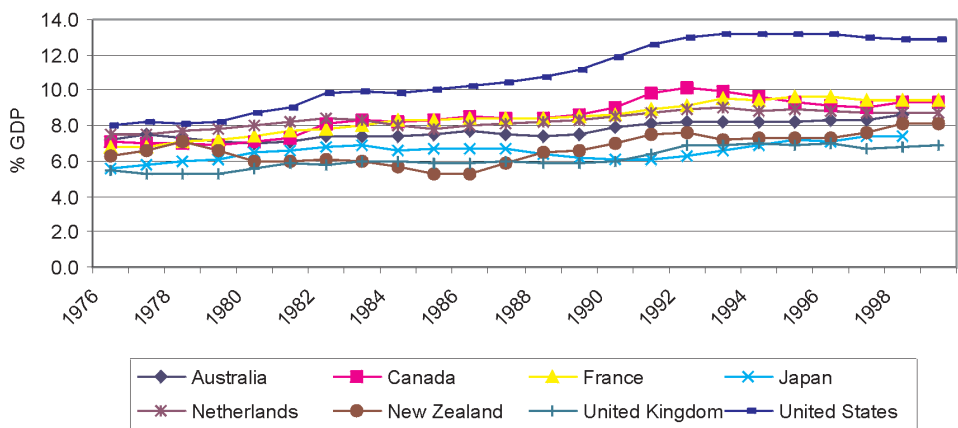
Expenditure on nursing homes stabilized from the mid-1980s while expenditure on aged care community services increased. Thus there has been a slight shift in funds from hospital to community-based care.

The pharmaceuticals budget rose to 11.3% of total health expenditure in 1997. Public health (disease prevention and population health promotion) receives less than 2% of the total health budget (although this broad area is difficult to estimate). 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, from hospitals to primary health care.

### Health delivery system

The Commonwealth funds the bulk of the health system as well as pharmaceuticals and aged residential care. The states, with Commonwealth financial assistance, fund and administer public

Fig. 1. Total health expenditure as % of GDP, Australia and selected OECD countries, 1976-1999



Source: OECD Health Data 2001

hospitals, mental health services and community health services. Private practitioners provide most community-based medical and dental treatment and there is a large private hospital sector.

### **Primary care**

General practitioners (over 40% of active physicians) provide the bulk of medical care and most are self-employed, although their fee-for-service source of income mostly has shifted from the private to the public purse (Medicare). General practitioners provide general medical care, family planning, counselling, perform minor surgery in their clinics, offer preventive services including immunisation, 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 care 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 Commonwealth funds Divisions of General Practice: 123 geographic groups (each around 100–300 general practitioners) now 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.

### **Public health services**

The high level of health enjoyed by most Australians is due partly to investments in public health. The impact of infectious disease is much reduced but still causes considerable morbidity. The Communicable Diseases Network of

Australian and New Zealand coordinates surveillance, responds to outbreaks, develops national policy, and trains staff. Australia has high levels of immunization for most vaccine-preventable diseases. The Commonwealth and states collaborate on many successful public health initiatives, such as 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.

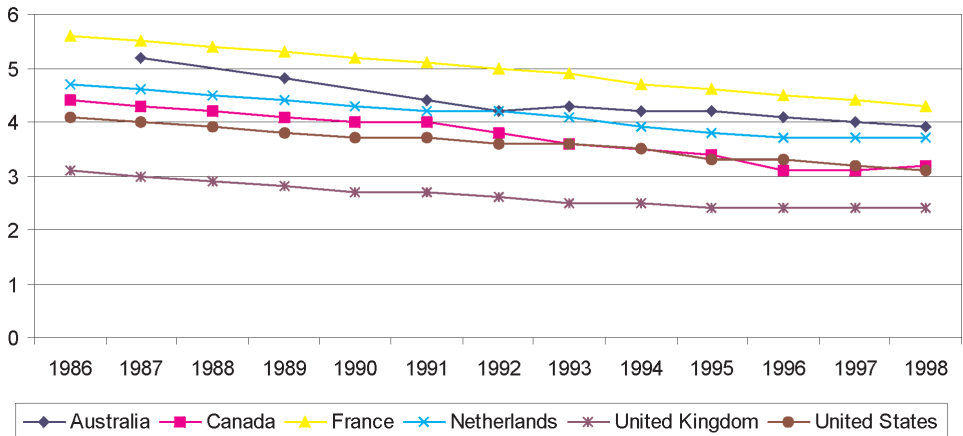
### **Secondary and tertiary care**

Medical specialists provide ambulatory secondary care, either in private consulting rooms or in outpatient departments of public hospitals. The Medicare Benefits Scheme reimburses 85% of the schedule fee for out-of-hospital specialist consultations.

Australia had 1051 acute care hospitals in 1998, of which public hospitals provide 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 separate day hospitals for same-day treatment. The number of acute hospital beds per 1000 population has nearly halved from 8.3 per 1000 population in 1970 to 4.3 per 1000 in 1997, in line with the reduction in most OECD countries (Fig. 2). Australia is just below the European Union average of 4.4 acute hospital beds per 1000 population, reflecting shorter stays and more community-based care.

In Australia, admissions for acute care per 100 persons rose sharply in the 1990s. The average length of stay in acute care hospitals (excluding same-day admissions) has fallen to 6.2 days (4.1 days including same-day cases), reflecting more active patient management, less invasive surgical techniques and greater cost pressures, while bed occupancy rates rose. These hospital productivity measures compare well to other OECD countries (Table 1). A key change in Australia is that many more patients are treated on a same-day basis, with 46% being same-day discharges in 1998, some of whom, however, represent new patients

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



Source: OECD Health Data 2001

who otherwise would not enter hospital (as suggested by rising admissions) 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 commercial providers. The Commonwealth increasingly 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 intellectual disabilities, and people with mental health problems, might be met by health or social care and institutional or community-based services.

### Human resources and training

Structural changes in the health labour force during the 1990s included a growth in part-time employment (38% work part-time), continuing contraction in hospital employment, and growth in community health services. Health care is a feminised sector with 77% of the total workforce being women, while the proportion of women doctors has risen above 30%. The ethnic composition also is changing with a drop in the proportion of medical practitioners born in Australia (to 62%) and an increase in Asian-born physicians.

Table 1. Inpatient utilization and performance in acute hospitals, Australia, EU and selected OECD countries, 1998

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Australia	3.9	15.8	6.2	68.5
EU average	4.2	17.1	8.2	77.0
Canada	3.1	9.9	7.0	–
United Kingdom	2.4	–	–	80.8
United States	3.1	11.8	5.9	63.4

Source: OECD Health Data 2001

Australia had 2.4 physicians per 1000 population in 1998, which is lower than many countries (Fig. 3). There is no agreement, however, on the optimal number of doctors, and future medical workforce needs are difficult to predict. The current policy is to contain the growth of the medical workforce by limiting entry to the 11 university medical schools, limit the immigration of trained doctors, and restrict the number of medical practitioners eligible to bill Medicare. A second (and somewhat conflicting) policy aims to increase the supply of physicians in rural and remote areas.

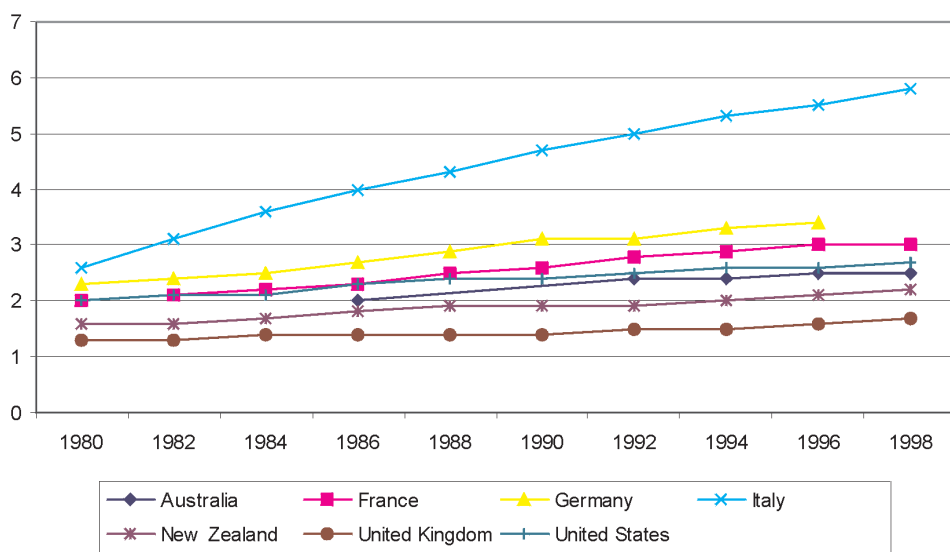
Australia has 9.5 nurses per 1000 population, which is around the middle range for many OECD countries. Nurse employment declined throughout the 1990s, while the skill mix has shifted to registered nurses (a three-year university degree). There are shortages in many areas of nursing, however, and growing concern about dropping numbers of nurse trainees and the loss of nurses from the workforce – an issue in many OECD countries.

## Pharmaceuticals and health care technology assessment

The Commonwealth 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 PBS schedule. First, a drug must be registered for marketing in Australia, which 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

Fig. 3. Practising physicians per 1000 population, Australia and selected OECD countries



Source: OECD Health Data 2001

Pharmaceutical Benefits Advisory Committee, an independent statutory authority, must recommend that the registered drug be listed. Third, the Minister of Health must decide whether to accept the recommendation, and finally, the Commonwealth negotiates a price with pharmaceutical wholesalers.

## Financial resource allocation

### Third-party budget setting and resource allocation

Commonwealth spending 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 the Commonwealth via general revenue, untied revenue from the goods and services tax (GST), and specific purpose grants, and at state-level from state general revenue. Commonwealth health grants to the states, under the Australian Healthcare Agreements, are 5-year agreements 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 5-year period.

A state health department is an important player in the state budgetary process since health recurrent funds take about 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 17 area health services according to a “resource allocation formula” based variously on historical funding, a population-based formula weighted for age and sex, with some adjustment for resource use including activity-related measures such as casemix. Other states negotiate contracts with

providers and fund hospitals using both fixed and casemix payments.

### Payment of hospitals

The last decade has seen substantial changes in the way that public hospitals are funded and purchaser specificity and provider accountability have increased. Most public hospitals (as autonomous organizations) are responsible for managing the funds they receive from the state. Public hospitals generally are 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 casemix funding. State governments also may purchase hospital services from private providers under purchase-of-service contracts.

Australia has progressively adopted casemix 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. Casemix 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 a fee-for-service or on a sessional basis.

General practitioners charge a fee-for-service. They can ‘bulk-bill’ the Health Insurance Commission, provided that the physician accepts 85% of the Medicare Benefits Schedule fee as payment for their service, or alternatively they can bill patients directly. Most general practitioners “bulk-bill” so that their services effectively are free to patients. Alternatively, general practitioners may charge the patient a higher amount



who may then claim the 85% rebate on the schedule fee from the Health Insurance Commission. Although the Medical Benefits Schedule fee acts as a break on medical fees (but also provides guaranteed payments to doctors), funding has not been used as a lever to change clinical practice.

## Health care reforms

Changes, although numerous and cumulative, have been incremental. Radical change is difficult in the Australian political system (compared, for example, to New Zealand) given the federal form of government, the many checks and balances, and the necessity to achieve agreement between the Commonwealth and the states.

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 government; some alteration in the public/private mix with attempts to strengthen the market; and a continuing commitment to social solidarity and equity. The main objectives of the current government have been to build a high performing and sustainable health care system that provides cost-effective health services; to ensure that the public sector is complemented by a private sector that is fair, affordable, and represents good value for money; and to improve the health outcomes of all Australians.

Current concerns in Australia include cost pressures upon governments given limited budgets and rising health expenditures; 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.

## Conclusions

There are no calls for radical change on sources of revenue, amount of spending or the basic structure of the health care system. The public have high expectations, however, with continuing lively public debate, well covered by the media, on the many tensions and shortcomings within the health care 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, while the health status of Aboriginal Australians remains abysmal.

The three basic goals of health care system reform are equity (fair payment contributions and fair access to and use of services), efficiency (value for money), and quality (high standards and good health outcomes)

Equity mostly is protected in that Australia retains a largely tax-funded health care system. Medicare has retained bipartisan political support since its introduction in 1984 and the major political parties are committed to its continuation. Patient co-payments have increased but concessions made for low-income and high-use groups. Efforts have been made to improve allocative (or distributional) equity across states, across geographic areas and across population groups. The health status of indigenous people, however, remains a glaring and intractable problem. To this can be added more recent concerns with the poorer health access and outcomes for people in the vast rural and remote areas of Australia. These differences between groups threaten “social solidarity”. Further, there is serious concern that a two-tier health system could develop between public patients covered by Medicare and private patients with supplementary private insurance.

Efficiency has improved over the last decade. Commonwealth and state funding programmes

## HiT summary

## Australia

have achieved some success in containing costs, principally through supply-side methods, with considerable effort invested in microeconomic measures. Australian spending on healthcare is about the level that might be expected for a prosperous country (around 8.5% of GDP).

Quality is firmly on the health policy agenda with more attention being paid to establishing quality assurance schemes and measuring specific health outcomes. Australia collects considerable health data but has few formal systems in place for monitoring standards. The country produces

well-trained health professionals and education and training curricula are regularly reviewed. 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.

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The Health Care Systems in Transition profile on Australia was written by Melissa Hillless, Australian Department of Health and Aged Care, and by Judith Healy, European Observatory on Health Care Systems. Janet Quigley and Kim Webber of the Australian Department of Health and Aged Care provided further assistance.

The European Observatory on Health Care Systems is grateful to the following reviewers of the report: Professor Tony Andrews and Dr Jim Butler, National Centre for Epidemiology and Population Health, Australian National University; Professor Stephen Duckett, Faculty of Health Sciences, La Trobe University; Assoc. Professor Jane Hall, Centre for Health Economics Research and Evaluation, University of Sydney and John Goss, Australian Institute of Health and Welfare. We are also grateful to the Australian Department of Health and Aged Care for its support and to Bob Eckhardt of the International Section for overseeing the writing of this report.

The full text of the HiT can be found in [www.observatory.dk](http://www.observatory.dk).

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.