Commonwealth Department of Health and Aged Care

Reforming the Australian Health Care System

The Role of Government

Occasional Papers:
New Series No. 1

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1 Introduction and context of government role in health

> *… if you were going to get ill and you don't have a high income it is better that that occur in Australia than in any other country of the world.*
>
> Prime Minister of Australia (on the hustings)

Overall, Australians have reason to be satisfied with the performance of their health care system — at least in terms of overall health outcomes and access to health care in relation to aggregate costs. On average, Australians are a healthy lot and getting healthier. This trend manifests itself in declining death rates, increasing life expectancies, a low rate of life-threatening infectious diseases and, for most people, ready access to health care when needed. And the cost is not exorbitant: Australia devotes around 8½ per cent of gross domestic product to health (which is, for example, only slightly above the average for industrialised OECD countries).[1] However, like other countries, we cannot afford to be complacent: the ageing of the population will put increasing pressures on costs (and therefore resources devoted to health); good health is not enjoyed by all — indeed serious health inequalities persist (eg Aboriginal and Torres Strait Islander peoples' health is poor by any standard); and it remains an ever-present challenge for Australian governments to ensure that the (mainly public) health care dollar buys as much health as possible for the citizenry.

Australia's health care system is extensive, loosely organised, complex and technically sophisticated. High standards of medical care generally prevail throughout the health care industry and the country. The system is characterised by:

- Australia's federal structure of government, with all three tiers — Commonwealth, State and local — involved in the health system;
- The dominant role of private practitioners in providing care, mostly on a fee-for-service basis, but with governments increasingly influencing the structure of health services through their financing arrangements;
- Universal access to quality medical care via Commonwealth and State funding for Medicare; and
- Substantial private funding (particularly through private health insurance) supported and regulated by the Commonwealth — so that the system offers a degree of choice (particularly for hospital care).

[1] This percentage of overall resources allocated to health has remained steady for a number of years. It should be noted, however, that Australia has a relatively young population structure compared with some OECD countries.

This paper begins (Section 1) with a review of why Australian governments are extensively involved in health, the ongoing challenges that involvement brings, and evolving views on how best to respond. The following three sections set the scene for a consideration of major recent reform to the system. Section 2 provides an international context, by comparing the overall performance of Australia's health system with that of other OECD countries. Section 3 provides the domestic context, by describing the Australian health system in some detail. Section 4 provides the historical context, by identifying recurring reform themes as the system has evolved in response to powerful forces for change. Sections 5 and 6 then review some important health care reforms undertaken in the 1990s, describing major initiatives both for Medicare and for private health insurance. The focus shifts to population health in Section 7, where Australia has enjoyed some considerable successes (eg in combating the spread of AIDS). The paper concludes (Section 8) by turning to ongoing issues and the wider context of health in the Australian community.

1.1 Government involvement and forces for change

As is the case in many other countries, Australia's health system (and reforms to it) are guided by evolving responses to problems thrown up by the basic rationales for a major government role in health:[2]

- Many health-related services, such as information and control of contagious disease, are *public goods*. Thus one person's use of health information does not leave less available to others; just as one person cannot benefit from control of disease-carrying vectors to the exclusion of others in the same area. Because private markets alone provide too little of the public goods crucial for health, government involvement is necessary to increase their supply. Other health services are associated with significant *externalities*: where consumption by one individual affects others (for better or worse). Thus immunising a child slows transmission of disease, conferring a positive externality. On the other hand, polluters and drunk drivers create negative health externalities. The task for government is to encourage behaviours that confer positive externalities while discouraging those with negative externalities (in ways that are cost-effective). Services classified as public goods, and some of those characterised by large externalities, constitute what is known as population or 'public' health (see Section 7).
- Provision of cost-effective health services to the poor is an effective and socially accepted approach to addressing poverty (and disadvantage more generally) — by effectively redistributing access to the goods and services produced in an economy

[2] A more complete consideration of why governments tend to be so involved in health can be found in the World Bank's 1993 *World Development Report*, on which this discussion draws.

independently of the distribution of income. Most countries view access to basic health care as a human right. This perspective is embodied in goals such as "to improve the health of the worst off in society and to narrow the health gap."[3] Private markets will not give the economically or socially disadvantaged adequate access to health care, nor the insurance necessary to pay for such services at prices that they can afford. Public financing of (essential) health care is thus justified to alleviate poverty — including the poverty that might result from having to pay unexpected, large health bills. This is the rationale that underpins major Australian health care interventions, even though a good proportion of the population may be able to pay for basic health care.[4]

- Government action may be needed to compensate for problems generated by *uncertainty and insurance market failure.* Uncertainty about long-term health costs is a challenge for government and insurers alike.[5] The considerable uncertainties surrounding the probability of illness and the cost and efficacy of care give rise both to strong demand for insurance (especially long-term insurance) and to shortcomings in the operation of (unregulated) private markets. One reason why markets may fail is that variations in health risk create incentives for insurance companies to refuse to insure the very people who most need it — those who are already sick or are likely to become ill (the problem is sometimes referred to as *adverse selection*). A second has to do with *moral hazard*: insurance reduces the incentive for individuals to avoid risk and expense by prudent behaviour, and can create both incentives and opportunities for health care providers (eg doctors and hospitals) to give patients more care than they need.
- There is also the problem of *asymmetry of information* between provider and patient concerning appropriate treatments and their possible consequences: providers advise patients on choice of interventions, and when the provider's income is linked to that advice, the result can be over-treatment.

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[3] UK Green Paper *Our Healthier Nation: A Contract for Health*, Cmd 3854, HMSO, 1998 (available at http://www.official–documents.co.uk/document/ohnation).

[4] In order to secure widespread political support (especially among the middle classes) there has been a tendency to extend (public) insurance arrangements to the whole population, while setting in place arrangements which encourage those who can afford it to contribute to financing the system (by taking out private health insurance).

[5] Technological and pharmaceutical innovations continue to increase the range of treatments available, and the pace of change is only likely to accelerate in the future. In the past few years, it is these kinds of advances (rather than demographic factors) that have driven up the cost of health care. A current instance is whether to subsidise the cost of Viagra (eg some US private health insurers have refused to pay for the drug, and in Australia — like Britain — it is currently unavailable on the PBS/NHS pending government consideration of its candidacy for subsidised consumption).

- If the last two problems (ie moral hazard and asymmetry of information) are not addressed, in unregulated private markets costs can be expected to escalate without appreciable health gains to the patient.[6] Governments have an important role to play in regulating privately provided health insurance, and/or providing alternatives in order to ensure widespread access to health care and to hold down costs. In Australia, these concerns provide another rationale for universal access to the government-subsidised Medicare program, as well as regulation of private health insurance and efforts to gather and disseminate reliable health information to inform consumers of health care.

Realisation of the undoubted potential for government health interventions to help people enjoy longer, healthier and more productive lives needs to be cognisant, however, of the risk that resources will be misallocated, wasted or that there will be an inequitable distribution of access to health care. This potential for undesired outcomes is heightened in circumstances where governments control large health budgets (eg of the order of one-tenth of all spending in the economy).

It is hard for government-dominated health systems to come up with adequate responses to such challenges, and to problems posed by such issues as ageing populations and the need to ration supply in the face of potentially unlimited demand (ie how to ration care in a way that the public finds acceptable, yet which makes it clear that resources which society can afford to devote to health are not unlimited).

1.2 Particular challenges for the Australian health system

Beside these general considerations favouring government involvement in health, there are also peculiarities of the Australian health system (and how it has evolved over time) that provide additional challenges for government, and continue to do so. For example, although roughly the same size as Western Europe or the USA (excluding Alaska), Australia's population is only some 18.5 million, most of whom live close to the sea. This pattern of settlement means that vast areas of the continent are very thinly populated, so that providing health care services in rural and remote areas of Australia is particularly difficult — given its relative expense in relation to the number of people serviced by individual facilities and programs.

And it is not just geography that presents a particular challenge in the Australian context. Aside from its indigenous inhabitants (the Aboriginal and Torres Strait Islander peoples), European settlement began in 1788 and continuing net migration has meant that Australia has one of the largest overseas-born populations in the world (nearly

[6] The USA appears to typify this possibility, with health care resources accounting for around 14 per cent of gross domestic product — yet the health status of the population is not, on average, any better than in Australia.

1 in 4). As a result, Australians exhibit a considerable diversity of cultural and ethnic backgrounds. These diverse characteristics, plus the complication of the involvement of three tiers of government[7] present considerable potential obstacles to the effective and efficient operation of Australia's health care system.[8]

Other contemporary challenges also reflect our history, particularly the proud independence of the medical profession — with its emphasis on professional standards and on the centrality of the doctor-patient relationship. The Australian Constitution has, since World War II, given power to the Commonwealth to provide medical and pharmaceutical benefits, "but not so as to authorise any form of civil conscription." As universal access has gained bipartisan support from the Australian body politic, the means of achieving this has preserved the primacy of fee-for-service arrangements and placed a greater emphasis on consumer choice than in most other OECD countries. This emphasis on choice is also very much a reflection of community attitudes, and shows no sign of abating as the community grows wealthier, more informed and ever more demanding.

1.3 Shifting emphasis and changing priorities

As alluded to above, the problem for government is that — largely because of market failures (which are particularly severe when it comes to health):

- growth in expenditure on care can be unsustainably high;
- yet not all justified care is provided; and
- care of doubtful value can end up being paid for.

This has led recent reforms to attempt to transform the Australian health care system along the following lines.

Shifting the focus from providers to consumers

Until relatively recently, the Australian health financing system — with its emphasis on subsidising health inputs — could be fairly characterised as dedicated to providers rather than to patients. There has been a concerted effort to change the focus to the patient, and in particular to measure and monitor what the system produces for consumers in terms of quality health care and the outcomes of that care.

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[7] Since 1901 Australia has had a federal system of government modelled on the Westminster system. The Australian Constitution established the Commonwealth (federal) government with nominated powers, with residual powers exercisable by state and territory governments. Within states and territories, local government takes the form of municipal and shire councils.

[8] Some have argued that it is not a (single) system at all; rather it is a series of largely *ad hoc* and uncoordinated interventions by all three levels of government with resources to devote to health.

Empowering the patient (or the patient's agent) with information to inform choice has the potential to further change the focus from producers to consumers of health care. Thus an obvious way to combat the problem of *information asymmetry* is for government to act as the source of authoritative health information and to successfully communicate it to target populations in cost-effective ways. There is mounting evidence that properly informed consumers can make rational choices about health care. And better-informed patients should not threaten the traditional decision-making role of providers. Rather, decisions should be made jointly — reflecting and encouraging a genuine partnership between doctor and patient.

A prominent role for patients — amounting to a consumer democracy in health care — is perhaps the best guarantee that reforms to the system will be soundly based.

Accepting and responding to the ongoing challenges of containing costs

Governments have a responsibility to spend well — to get 'value for money' whenever they devote public resources to health. This means allocating scarce resources so as to obtain the most improvement in health per public dollar spent, taking into account the private market's response to such public sector spending. Because private health care markets can also fail to deliver value for money, government policy has a role in providing information and incentives to improve the allocation of resources by the private sector.

Practical steps that can be (and are being) taken in the Australian context (and which address cost problems from both the demand and supply sides) include:

- modifying what was a fairly pure 'fee-for-service' system (eg by rewarding 'best-practice' behaviours on the part of service providers, as well as throughput);
- controlling the list of services to be publicly subsidised, and the extent of those subsidies (eg by insisting that services listed under the Medical and Pharmaceutical Benefits Schemes — the MBS and the PBS — only get there on the basis of evidence of their efficacy and cost-effectiveness as health interventions); and
- attempting to ensure that the health workforce is of the right size and composition, is properly trained and equipped to do the job, and is appropriately located in relation to those making demands on the system.

The shift in focus from providers to consumers is also seen in Australia as a potential means to better control costs, particularly through the better management of chronic conditions (which is the driver of a substantial proportion of health care costs).

Addressing quality concerns

Quality of care can be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

The principal players in health care (eg governments, insurers) need to confront quality-of-care issues with the same determination and sophistication that they direct to issues of cost. Trying to balance cost-containment initiatives with efforts to maintain and improve the quality and availability of care is a major challenge and requires good information for policy makers, patients, consumers and others to use in judging whether we are on the right track. To a considerable extent quality and cost control can go hand in hand as measures are taken to ensure greater consistency and discipline in the care process.[9]

Tools for measuring and improving health care must confront three broad kinds of quality-of-care concerns:

- Over-use of unnecessary or inappropriate care: examples include the excessive or unnecessary use of x-rays and other diagnostic tests, unnecessary hysterectomies and open-heart surgery, and over-prescribing of antibiotics. Those practices make patients vulnerable to harmful side effects. They also waste money and resources that could be put to better use.
- Under-use of needed, effective and appropriate care: people do not get proper preventive, diagnostic or therapeutic services if they delay seeking care or receive no care at all. In spite of the universal nature of Medicare, geographic, cultural, organisational or other barriers can limit Australians' abilities to seek or receive appropriate care.
- System failure: including inadequacy in technical and interpersonal aspects of care. Inferior care results when health care providers lack necessary expertise, do not properly explain proposed interventions, or cannot communicate adequately with consumers. Examples include preventable drug interactions, failure to monitor or follow up abnormal test results, failure to coordination care, and failure to cater for ethnic and cultural differences among patients.

[9] Organisation-wide quality-improvement efforts are beginning to be adopted in the service sectors around the world, and health care is no exception.

Quality issues are receiving increasing attention in Australia, both to improve the effectiveness of health services and to complement more traditional demand- and supply-side controls. For example, the Commonwealth Government is to establish a National Institute of Clinical Studies to look at best practice in treating the illnesses that most commonly cause admission to hospital.[10]

Promoting cost-effective health interventions

Medical science knows far more today than in the past. Yet, when it comes to securing maximum possible health gains for Australians for the health dollar, we still do not know enough about what health care interventions work, for what conditions, under what circumstances, and at what cost. This means that ensuring a firmer evidence basis for health care is not easily achieved: for example, 1998 marks only the 50th anniversary of one of the main tools of scientific medicine: the modern clinical trial.

Gathering and using good information

Effectively functioning markets require that consumers of health care services are in a position to make informed decisions about their health, including the efficacy and cost-efficiency of proposed treatments (both new and established), and about things like the future performance of private health insurance plans in which they may be considering enrolling. If the patient — the ultimate consumer of health care — is merely a passive party to decision making then the health system cannot function effectively, and reform is made more difficult. Fortunately, health consumers are becoming better-informed and assertive. Increasingly, they have access to new sources of information on diseases and treatments (eg via the Internet), and they want to have a say in how they and their families are treated by the health care system. Making information that is relevant to patient and consumer concerns more widely and easily available is something that governments can do in the public interest (eg via agencies' presence on the Internet).

Reliable health information made available to health care providers and consumers, and for policy making, means that Australia will continue to need access to high-quality research and development (eg via the National Health and Medical Research Council), and cost-effective ways to ensure that research findings and 'best practice' are widely disseminated and acted upon.

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[10] The Institute will work with the medical profession to ensure best practice is actually carried out, to provide world-class service in both the public and private hospital systems. Issues such as criteria for admission to hospital, appropriate length of stay, hospital in the home and best practice in discharge planning are part of the work to be undertaken. In the private sector the Institute will be able to work on simplified billing and informed financial consent, as well as the evidence basis for various procedures currently undertaken in the private sector which are not covered by Medicare.

A potential key to the system being able to better deliver desired health outcomes is the capacity to systematically track consumers through the care network via a longitudinal patient record (a so called electronic patient record, or EPR). This could ensure that every time the system deals with an individual, information on what was wrong, what was done about it and what was the outcome (if known) would be sent by the provider to be incorporated in the individual's EPR. Over time, individual EPRs would contain increasingly comprehensive information — including potentially vital information on which to base future decisions not only on appropriate care for the individual but also for Australians in general. Australia's central payments system for medical and pharmaceutical benefits offers the potential for enormous gains in health care outcomes, and in population health management, through the use of EPRs. While this potential is well recognised, strategies need to be developed to satisfy the public and clinicians alike that privacy will be protected and that the doctor-patient relationship will not be subject to unwarranted non-clinical pressures.

Focusing on priority areas

Australia has identified five national health priority areas for special effort: cancer control, injury prevention and control, cardiovascular health, diabetes and mental health. A sixth (asthma) has been proposed to be added. These have been selected because they are significant causes of premature death and poor health, there are marked inequalities in who suffers from them, there remains much that can be done to prevent or treat them more effectively, and because they are real causes for public concern. These are good places to focus effort on — via more effective treatments, more efficient delivery systems, and in terms of continual gains in quality and productivity — in order to lower the cost of disease (in both human and economic terms).

Targeting priority areas — often with quite specific programs and actions — nevertheless recognises the role played by broader population health initiatives in realising improvements in the health status of Australians. For example, getting people to quit smoking will help their general health, as well as benefiting more than one priority area (eg cardiovascular health and cancer).

2 International comparisons

Policy makers and commentators often use international comparisons to assess the relative performance of a country's health system. Thus, comparable data can suggest where a country is doing well, poorly or simply pursuing different priorities. Typically, comparisons are made in a number of areas: for example, health outcomes, quality, spending, insurance coverage, and financing and delivery. Attention may also focus on sub-groups (eg indigenous populations) — although comparative data are usually hard to come by (and tend to be less reliable).

2.1 Health outcomes

Measuring health outcomes is challenging enough, let alone establishing cause and effect between system inputs and outputs/outcomes (eg between the pattern and extent of health spending and the health status of the population). As well, widely available indicators of health outcomes (eg longevity, infant mortality rates and premature deaths) tend to be fairly crude proxies of wellness and well-being. Nevertheless these tend to be the measures on which cross-country comparisons rest.

Live expectancies at birth

In OECD countries, men live an average of 6 years fewer than women. According to OECD data,[11] in 1996, life expectancies at birth for males ranged from a 72.7 years in the US to 77.0 years in Japan — with Australia at 75.2 years (and the median OECD expectancy at 74.2 years). The corresponding figures for females ranged from 79.3 years in the UK to 83.6 years in Japan — with Australian at 81.1 years (and the median OECD expectancy at 80.3 years).

Infant mortality

In 1996, Japan had the lowest rate infant mortality rate (3.8 per 1000 live births) and the US the highest (7.8 per 1000 live births) — with Australia at 5.8 (the same as the OECD median). Over the 1960-96 period, infant mortality rates have dropped in most countries, with Germany recording the greatest reduction (from 33.8 down to 5) and Australia the least (from 20.2 down to 5.8).

2.2 Health spending

Based on OECD data (and restricting the comparison to eight selected industrialised countries),[12] in 1997 per capita spending on all health care services ranged from a low of $1347 in the UK to a high of $4090 in the US — with Australia in the mid-range at $1805.[13] Growth in per capita health spending over the period 1960-97 ranged from a low of 7.5 per cent per annum for New Zealand to a high of 12 per cent per annum in the case of Japan — with Australia's health spending growing at 8.3 per cent per annum (considerably less that the OECD median of 9.3 per cent per annum.). In terms of the proportion of gross domestic product (GDP) devoted to health spending (a measure of the percentage of a country's resources devoted to health care), in 1997 the figures ranged from a low of 6.7 per cent in the case of the UK to a high of 14.0 per cent for the US — with Australia at 8.3 per cent (and the OECD median at 7.6 per cent).

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[11] OECD Health Data 98, A Comparison of 29 Countries, CD-ROM. (Information on the Internet at http://www.oecd.org/els/health/software98.htm).

[12] The other countries were Canada, France, Germany, Japan, New Zealand, the UK and the US.

[13] The OECD adjusts all expenditures to US dollars using purchasing power parities — a commonly used method to adjust for cost-of-living differences among countries.

Table 1 shows how spending on health as a proportion of GDP has grown over the period 1960-97, while Table 2 reports the corresponding per capita estimates.

Table 1: Health spending as a percentage of GDP, selected countries, 1960-97

Country	*1960*	*1970*	*1980*	*1990*	*1997(a)*
Australia	4.9	5.7	7.3	8.3	8.3
Canada	5.5	7.1	7.3	9.2	9.3
France	4.2	5.8	7.6	8.9	9.9
Germany	4.8	6.3	8.8	8.7	10.4
Japan	na	4.4	6.4	6.0	7.3
New Zealand	4.3	5.2	6.0	7.0	7.6
United Kingdom	3.9	4.5	5.6	6.0	6.7
United States	5.2	7.3	9.1	12.6	14.0

Notes: (a) Most recent available year. na not available.

Source: OECD Health Data 1998.

Table 2: Per capita health spending at purchasing power parity, selected countries,1960-97(a)

Country	*1960*	*1970*	*1980*	*1990*	*1997(b)*
Australia	94	207	663	1320	1805
Canada	103	251	717	1696	2095
France	72	206	701	1539	2103
Germany	68	175	649	1279	2339
Japan	26	131	524	1082	1741
New Zealand	92	177	458	937	1352
United Kingdom	74	144	444	955	1347
United States	149	357	1086	2799	4090

Notes: (a) Purchasing power parity (PPP) is the number of units of a country's currency required to buy the same amounts of goods and services in the domestic market as $1 would buy in the 'average' country. The average price index thus equalises dollar prices in every country so that cross-country comparisons based on PPP reflect differences in quantities of goods and services (ie they are free of price-level differentials).

(b) Most recent available year.

Source: OECD Health Data 1998.

Australia's relatively high level of private expenditure on health means that public expenditure is relatively low among OECD countries,[14] even though total spending is about average. Public spending in 1997 was about 5.7 per cent of GDP in Australia compared, for example, to 6.4 per cent in Canada and 6.5 per cent in the US.

3 Australia's health system

A distinguishing feature of the Australian health care system is the extent to which responsibilities are split between different levels of government, and between the public and private sectors. Thus, the Commonwealth Government funds universal benefits schemes for private medical services (via the MBS) and for pharmaceuticals (via the PBS), while State and Territory Governments have the major responsibility for the financing and public provision of health services, including public and psychiatric hospitals and for public health.[15] Local government mainly focuses on environmental health and the provision of community-based and home-care services.

3.1 Raising and spending the health care dollar

Figure 1 shows, in broad terms, where the Australian health dollar comes from and what it is spent on. Thus, of the approximately $A43.2 billion spent on health in 1996-97:

- The Commonwealth provided $19.7 billion (45.5 per cent);
- The States and Territories provided $10 billion (23.2 per cent); and
- The private sector, including out-of-pocket expenditure by individuals, contributed the remaining $13.5 billion (31.3 per cent).

As an indicative estimate, total spending on health in 1997-98 is likely to be of the order of $A47-48 billion.

Almost all Commonwealth funding for health services comes from general revenue sources. However, some hypothecated taxes are raised through the Medicare levy which, for example, contributed $A3.6 billion in 1996-97 (representing 8.4 per cent of health spending in that financial year, or 18.5 per cent of Commonwealth outlays).

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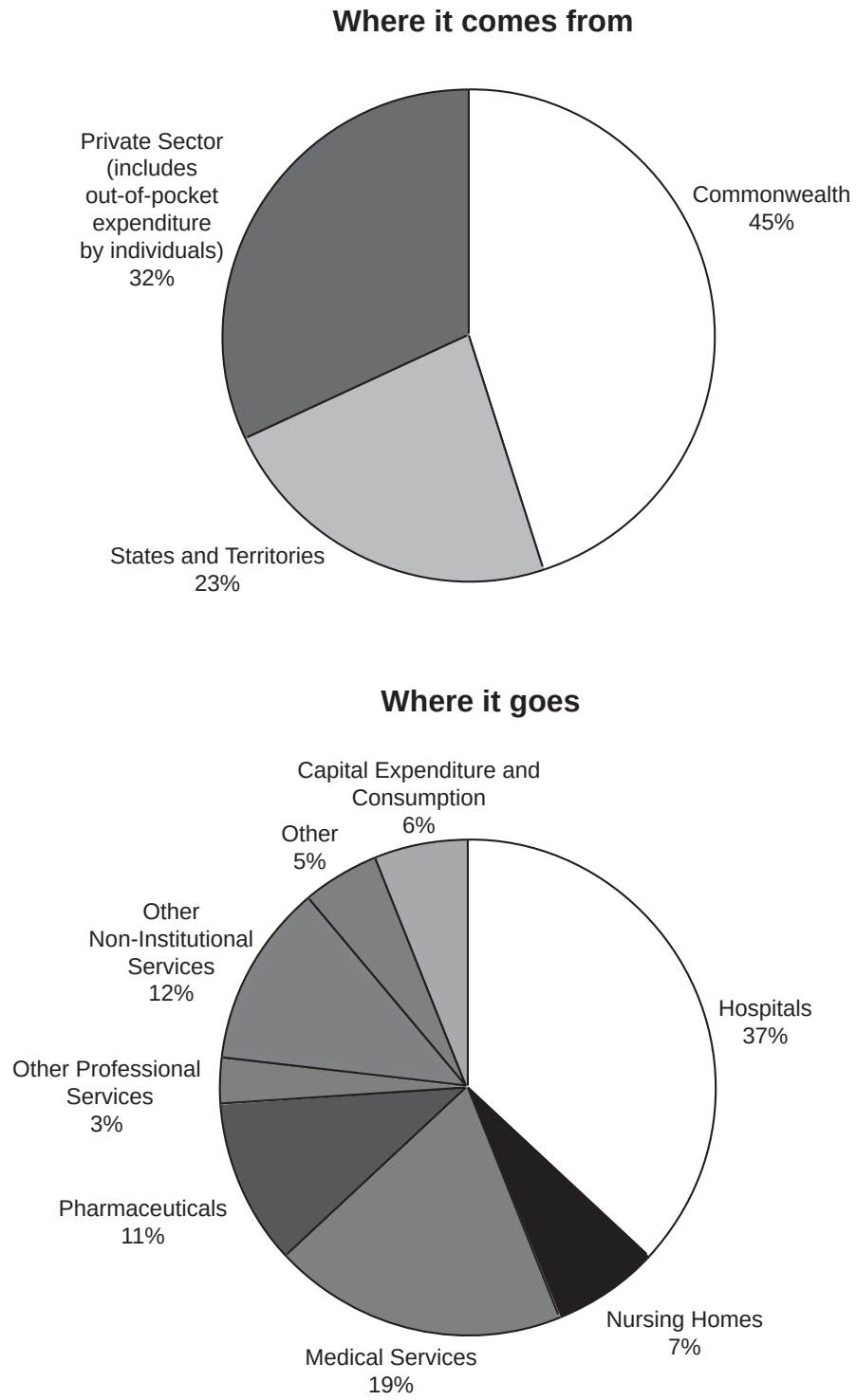
[14] Australia ranked equal 8th lowest (along with the UK, Japan and Austria) of the 29 OECD countries in terms of public health spending as a proportion of GDP (5.7 per cent in 1997).

[15] The Commonwealth, in fact, funds most of the health care system — since it indirectly funds acute care services operated by the States and Territories via hospital funding agreements under Medicare (Australian Health Care Agreements running over 5 years). The first Commonwealth-State/Territory hospital funding agreement covered the years up to 1987-88, the second from 1988-89 to 1992-93, the third from 1993-94 to 1996-97, and now the fourth has just been concluded covering 1997-98 through 2002-03.

Figure 1: The health dollar, 1995-96



The relative importance of the different sources of funding for health services varies according to the type of service: the Commonwealth mainly funds medical services, pharmaceuticals and nursing homes; the Commonwealth and the States and Territories jointly fund public acute care hospitals and community and public health services; while private hospitals are mostly funded from the non-government sector.

On a per capita basis, the average annual real rate of growth in health spending has been 2.7 per cent since 1984-85 — with the spending in 1996-97 at $A2345 per person. This reflects the combined effects of changes in the intensity of use of health services and the quality of the services provided. Part of the increase in real per capita health spending was due to the ageing of the population, and part reflected greater use of services by people of all ages. It has been estimated that 22 per cent of the total increase in health spending between 1975-76 and 1996-97 could be attributed to the increasing proportion of older people in the population.[16]

Most health spending (94.3 per cent in 1995-96) is recurrent — with major areas of expenditure being for acute care hospitals (38.1 per cent of recurrent expenditure), medical services (20.2 per cent) and pharmaceuticals (12.0 per cent). [17]

3.2 Australia's Medicare

Australia's Medicare system of public funding to ensure universal access comprises:

- The Medicare Benefits Scheme (MBS), under which the Commonwealth directly reimburses patients a proportion of their medical costs, according to a Government-determined fee ($A5.8 billion in 1994-95, $A6.4 billion in 1997-98);
- The Pharmaceutical Benefits Scheme (PBS), under which the Commonwealth directly reimburses patients the costs of prescription drugs above identified co-payment levels or annual 'safety net' levels ($A2 billion in 1994-95, $A2.8 billion in 1997-98);
- The Medicare (now Australian Health Care) Agreements between the Commonwealth and the States/Territories which guarantees free access to hospital care according to clinical need for anyone who presents as a public patient (the Commonwealth share of which was $A4.4 billion in 1994-95, $A4.8 billion in 1997-98).

All persons normally resident in Australia, with the exception of foreign diplomats and their dependents, are eligible for Medicare benefits.

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16 Australian Institute of Health and Welfare (AIHW) 1998, *Australia's Health 1998*, AIHW Cat. No. AUS 10, Canberra, p.168.

17 Australian Institute of Health and Welfare (AIHW) 1998, *Health Expenditure Bulletin No. 14*, November, Canberra, p. 13.

The Commonwealth also funds residential aged care services provided mostly by charitable and private organisations ($A2.7 billion in 1994-95 and $A3.2 billion in 1997-98) and, with the States, supports home care services for the aged.

The States also provide community and public health services (around $A1.3 billion in 1994-95), with the Commonwealth also contributing towards national population health activity (around $A256 million in 1994-95 and $A279 million in 1997-98).

Medicare Benefits Scheme

Through the MBS the Commonwealth provides publicly funded, universal access to private medical services:

- A rebate of 85 per cent of the schedule fee is provided for private medical services;
- A rebate of 75 per cent of the schedule fee for private hospital medical services;[18] and
- Where the doctor agrees to charge no more than these amounts, the benefit may be paid directly to the doctor at no cost to the individual (about 70 percent of all medical visits are 'bulk-billed' in this way — so that there are no out-of-pocket expenses for the patient).

There are no limits on access to services under Medicare, actual usage depends on demand. Around 7 out of 10 Australians rely solely on Medicare to meet their health care needs.

The schedule fee is set by the Commonwealth Government, but in practice is subject to detailed discussion with the Australian Medical Association (AMA), and the relevant professional colleges and associations.

Pharmaceutical Benefits Scheme

The PBS limits the cost of pharmaceuticals for consumers:

- For general consumers, the maximum cost is $20 per prescription, with the Commonwealth Government paying the rest. The cost is reduced further when the safety net threshold (currently $612.60 annually) is reached; and
- For concession card holders (most social security recipients), the cost is capped at $3.20 per prescription, while additional prescriptions are free once the safety net threshold (of $166.40) is reached.

As with MBS, government expenditure is uncapped and depends on demand.

[18] Such services are free to patients when provided in public hospitals.

Australian Health Care Agreements

Under these five-year agreements, the Commonwealth provides block grants to the States, essentially for acute care services. The States bear most of the risk from increasing demand within each five-year period, and there is a five-yearly intensive public debate over appropriate Commonwealth funding. The agreements set out a number of conditions and performance indicators, but are essentially block grants allowing the States considerable flexibility over resource allocation. The agreements also play a major part in Australia's overall federal fiscal arrangements, and are subject to 'fiscal equalisation' under which the States are compensated for differences in revenue-raising capacity and in the expenditure needs of their populations.

Private health spending

Private spending includes a substantial private health insurance system, as well as out-of-pocket payments (co-payments). The Australian private health insurance system contrasts with both the supplementary benefit approach in the UK and Canada (where private insurance focuses on benefits for services not available through the publicly funded system) and the contracting out approach in the US (where private insurance, or alternative private sector health arrangements, is the primary means of funding health care for employees and their families, and is increasingly being contracted to manage health care organisations under Medicare and Medicaid). The Australian system may be better described as an 'opting-out' system, offering the same hospital services available under Medicare, as well as additional services and products, with greater choice of hospital and doctor and opportunities to gain earlier access to elective services.

Private health insurance is regulated by the Commonwealth, and is supported both directly (through premium subsidies) and indirectly (through the payment of Medicare benefits for relevant services for private patients in hospitals, and through lower public hospital charges for private patients).

4 Recurring themes in Australia's evolving health system

A number of recurring themes have influenced Australia's evolving health system in recent years. They include various supply-side approaches to contain government outlays while at the same time ensuring access and efficiency (and, more recently, to support quality and outcomes also), and demand-side measures not only to mediate pressures on publicly funded services but also to maintain Australia's capacity to offer consumers choice when it comes to health care.

4.1 Supply- and demand-side controls

The ability of a nation's health financing system to control health prices is an important factor in controlling growth in total spending on health care. Increasing numbers of general practitioners and specialists, new medical technologies, and expanding health insurance in combination with fee-for-service payments are a potent combination — with the potential to generate a rapidly growing demand for ever more costly tests, procedures, and treatments.[19] Containing health costs within affordable limits is therefore a continuous challenge for Australian governments.

Various approaches have been tried to contain costs in Australia, including limiting the range of items attracting subsidies under the MBS and the PBS,[20] the extent to which listed items are subsidised from the public purse,[21] and encouraging 'best practice' behaviour on the part of providers of subsidised health care.[22] Other approaches are being explored, such as budgeting a fixed amount for each person (so called 'capitation') as is now done by health maintenance organisations in the US and by the UK National Health Service.[23]

Demand-side measures have included the introduction of co-payments for pharmaceuticals (plus the fact that demand for health care interventions is mediated to the extent that consumers have to pay out-of-pocket for any 'gap' not covered by government subsidy).

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19 Open-ended, fee-for-service compensation for health providers encourages the development of new equipment, drugs and procedures — since neither providers nor patients have much of an incentive to moderate health care utilisation or restrain health spending. It is a pleasant fiction to think that someone else (eg the government) will pay for your health care. However, it is the employed who ultimately bear the cost for themselves, their families and those unable to pay — either directly or indirectly (via taxation).

20 For example to medical interventions and drugs that have proven to both work and represent value for money compared with alternatives.

21 With consumers having to finance the difference between the actual and subsidised price.

22 For example via widely accepted treatment protocols — so that the knowledge of those at the leading edge of good practice is made available to others.

23 A variant of this approach is to provide each hospital, or network of providers, with a fixed overall budget — thereby relying on informed spending decisions from a pool of funds which is nevertheless capped. This could lead, for example, to regional health and aged care budgets which are managed on behalf of all the residents of a particular area.

4.2 Promoting competition

Experience suggests that when it comes to the delivery of health care services diversity and competition lead to better results than, say, purely public provision. In a competitive system, people seeking health services can be in a position to choose from a variety of providers: public, private non-profit, or private for-profit. Because competition can improve quality and drive down costs, governments have encouraged it in the supply of health services and inputs, particularly pharmaceuticals and medical equipment.

There is also scope for improving the quality and efficiency of government-provided health services through a combination of decentralisation, performance-based payments and other incentives. Exposing the public sector to competition from private suppliers can also help to spur desired improvements.

However, strong government regulation is also crucial: including regulation of privately delivered health services to ensure safety and quality; and of private insurance to encourage universal access to coverage and to discourage practices that encourage overuse of services and unwarranted escalation of costs.[24]

4.3 Emphasising evidence-based health care interventions

No matter how health services are organised and paid for, what is actually provided are health interventions: specific activities meant to reduce disease risks, treat illness, or palliate the consequences of disease or disability. In health, as in other areas of the economy, customers want value for money — whether they pay directly or indirectly (eg via taxes or insurance premiums).

Knowing the cost-effectiveness of a health intervention — the net gain in health (compared to doing nothing) divided by the cost — is invaluable in this regard. The challenge is to expand coverage of interventions with high cost-effectiveness, if necessary at the expense of less cost-effective ones.

[24] Another reason why governments may need to regulate private provision of health care is that the 'product' being contracted for is not necessarily easy to define. Light (1997) explains the problem in the following terms: Health care is often emergent as diagnosis and treatment unfold. Clinical decisions are contingent on what is found and how the patient reacts. Cases are highly variable, and the course of treatment is uncertain. These qualities mean that no clear product, with clear property rights, can be defined and its price set, as can be done for hotel rooms or computers. Put another way, health care has a large grey area in which services and products can be manipulated by the provider/seller, or by a contractor of services, so as to appear cheaper by treating less illness or by treating illness less.

Increased scientific knowledge has accounted for much of the dramatic improvement in health that has occurred in this century (by providing information that forms the basis of individual, household and government action, and by underpinning the development of preventive, curative, and diagnostic technologies). It is equally the case, however, that medicine is characterised by uncertainty (and many treatments in use today have never been properly evaluated).[25] At the same time new treatments which are cost-effective can take a long time to gain widespread acceptance.

In Australia, pharmaceuticals have long been subject to efficacy and safety evaluations and, more recently, to cost-effectiveness assessments for them to qualify for listing on the PBS. This has contributed to Australia's relatively low spending on pharmaceuticals. Additionally, a new National Prescribing Service supports and promotes quality and cost-effective prescribing of medicines.

Steps are now being taken to establish evidence-based medicine in the MBS process. Thus, a Medical Services Advisory Committee (MSAC) has been established to provide advice on the inclusion of new procedures and services on the MBS. MSAC will oversee the assessment of new procedures and the review of existing MBS items, to ensure that Medicare benefits are paid only for those procedures supported by evidence as being safe, of benefit to the patient and cost-effective.

4.4 Separating purchasers, providers and regulatory functions

There has been a move away from government as funder, purchaser, provider and regulator of health services all rolled into one — particularly at the Commonwealth level. Thus several formerly government-owned providers of health services have either been privatised (eg Commonwealth Serum Laboratories) or corporatised (eg Australian Health Services) — with the Commonwealth progressively vacating the field of direct service provision in favour of funder/purchaser (and regulator) of services provided by others (operating in public, private non-profit and private for-profit arenas). Adopting purchaser/provider splits — with regulation undertaken by a third party — is being pursued for a variety of reasons, most notably: to improve performance, enhance contestability, minimise conflicts of interest, improve operational efficiency and to shift the focus firmly from providers to consumers of health services.

It has therefore become increasingly the case that government, as prudent buyer of health care services on behalf of the citizenry, is effectively entering into contracts with providers (either explicitly or implicitly) to supply high-quality, appropriate and cost-

[25] Efforts are being made to gradually remedy this state of affairs. For example, the Cochrane Collaboration (and other cooperative efforts) are allowing health professionals to gain access to an increasing body of evidence that evaluates the effectiveness of different clinical, surgical, pharmaceutical and other treatments.

effective health and aged care services. Examples include State governments contracting with hospitals to provide acute care services and the Commonwealth Government contracting with public and private hospitals to provide services for war veterans. Increasingly, Commonwealth funding agreements with the States for acute care services and population health programs also set out outcome targets and performance measures, while payments of general practitioner (GP) medical benefits include rewards for specific outcomes — such as immunisation coverage and cancer-screening rates.

Thus, contracting for services has meant having to specify in detail exactly what government wants to buy on behalf of Australians in terms of health and related care, which has also necessitated specifying expected performance. This has led to intense interest in measuring performance in all its aspects (eg specifying outputs/outcomes, targets, performance indicators, and quality assurance systems).

This redefinition of its role has transformed what government actually does in health care — away from merely subsidising the cost of inputs (eg reimbursing providers for services rendered) and more towards focusing on what the outputs and outcomes of the health system actually are (and ought to be) — in terms of improving Australians' health, and their general satisfaction with their health care system.

4.5 Increasing the emphasis on primary care and prevention

'Best at home' (or in a community care setting) — rather than in hospital or residential care — sums up the emphatic preference of most people: be they prospective patients or in the equally compelling situation of having to find the dollars necessary to run expensive institutions. There is now widespread acceptance that increased emphasis on primary health care can prevent many hospital admissions.

Better still is trying to prevent morbidity and disability in the first place, by investing in prevention and population health generally. Yet striking an appropriate balance between prevention and cure is difficult, given the urgency of the need to resource acute care services for those in urgent and immediate need. In the face of such urgent and immediate need what is required are sound analyses of the cost-effectiveness of early interventions and preventive action (eg burden of disease studies and cost-benefit analyses of population health initiatives). For example, persuasive studies are now available of the potential returns to society of getting people to quit smoking.

4.6 Better systems integration

The price of organising health spending along functional lines is to create islands of specialised care, which people have to negotiate as they attempt to navigate their way around the system. The result is unnecessary repetition, as those seeking help have to supply personal details and recount their medical histories at every turn. The chronically ill are perhaps the most acutely aware of the problem of lack of coordination.

As in other countries, Australia is grappling with this problem — and coordinated care trials have been one response (see below). Another is to develop much better information systems — so that medical histories (in the form of electronic patient records, for example) can follow patients around. Such systems are progressively being built and deployed to help secure better health outcomes, while at the same time respecting and preserving the individual's right to privacy.

5 Major government initiatives

Many of the reform themes in Australia (discussed above) are similar to those in other countries: separating purchasers from providers; encouraging effective competition among providers; increasing the emphasis on primary care; striving for more systems integration; and focusing on quality and health outcomes. They have had, however, to be pursued in Australia in the particular setting of a federal system of government and mixed public/private arrangements for delivery.

In recent years, there has been a preference in Australia for steady incremental reform (rather than radical change) — to gain public acceptance, to limit disruption and to manage the financial risks associated with change.

5.1 Medicare benefits

MBS fees are set so as to contain public outlays and health cost inflation while continuing to encourage high levels of bulk-billing (and thus limiting above-the-schedule-fee charging). While there has been a considerable degree of success in this, pressure points continually emerge which have to be managed.

Recent initiatives include price-volume caps and targets negotiated with pathologists and radiologists, and restrictions on provider numbers (ie in the number of doctors eligible to bill Medicare). Other options are being canvassed, including: 'blended payments' to reduce purely fee-for-service incentives which encourage maximum throughput; 'reward-sharing' from better prescribing and referral patterns; and payments for achieving population health targets (eg incentives for child immunisation are now in place). A common theme is to ensure that financing initiatives support improved quality and health outcomes (and not just cost control).

5.2 Pharmaceutical benefits

The PBS has been subject to a series of reforms aimed at increasing the efficiency and effectiveness of drug consumption in Australia. As detailed above, reforms have included the introduction of 'catastrophe' insurance (whereby consumers make co-payments up to a nominated amount beyond which further consumption is wholly subsidised). There is also now a limited ability on the part of pharmacists to suggest

alternative drugs to consumers (generic substitution), and limited aggregation of similarly acting drugs into classes which are subsidised to the same extent (creating therapeutic goods premiums — which consumers have to pay to obtain the more expensive drugs in any class).

Australia has a sophisticated system of approving, listing and subsidising drugs, and its record in containing prices and costs is good by international standards. Yet the PBS remains the fastest growing component of health outlays, partly because of technological advances and increased effectiveness of new drugs. Australia may be close to exhausting demand-side measures to contain costs (over 80 per cent of PBS costs now go to subsidising consumption by concession card holders), and the emphasis now is turning to quality use of medicines and translation of the successful cost-effectiveness approach to pricing into cost-effectiveness in prescribing practice.

5.3 Hospitals

Hospitals are very much at the heart of the Australian health care system. They are also expensive to build and operate.

Commonwealth spending on public hospital care has traditionally been through capped block grants to the States under five-year agreements. The Commonwealth thereby limits its risks to a five-yearly ‘political stoush’, and to whatever indexation arrangements are put in place to apply over the intervening period (usually a formula based on an economy-wide price index, adjusted for changes in the age-weighted population make-up of individual states).

The States have worn the risks, within the agreement periods, for financial blow-outs, hospital waiting lists (queuing by rationing) and so on. One outcome of this approach has been major conflict over real and perceived cost shifting between the Commonwealth and the States. In the latest Australian Health Care Agreement, significant steps have been taken to better share the risks, and to encourage closer links between MBS, PBS and the Australian Health Care Agreements. While the traditional strong disagreement over funding was as intense as ever, a more sensible framework is now in place for the next five years.

The developments under each of the three arms of Medicare (MBS, PBS and hospital funding) can be viewed as consistent with a more integrated approach — allowing a better focus on patients and health outcomes, rather than on just providers and inputs.

There is substantial bipartisan support for the Medicare universal access system, which has strong public approval ratings (notwithstanding ongoing criticisms of aspects such as long hospital waiting lists and, at times, indifferent quality of care).

Casemix introduced in paying for hospital care

One way of attempting to control burgeoning hospital costs is to only pay for what is actually done in hospitals, rather than for the myriad inputs that go into supplying acute care services in a hospital setting. To this end, the 1990s saw the initiation of the casemix development program to support the building of casemix systems suited to Australian settings.[26] Casemix data facilitate the management, monitoring and planning of health services by supplying: information about the quality of care; a basis for funding, paying and charging for health care services; measures of hospital output; and comparisons between different care options at national and local levels.

Partly as a result of the changed incentives involved in casemix-based payments (rather that the former system which involved squabbling over annual budget bids to run public hospitals), the average length of stay in Australian hospitals is declining and more hospital patients are being treated on a same-day basis (about 30 per cent of hospital admissions are now day-only). There is also a trend towards day-surgery procedures, and for the provision of non-acute care for people in their own homes (or in community settings).

There is clear evidence that those States that moved quickly and firmly to implement casemix-based purchasing of hospital services achieved more substantial efficiency gains, setting the example for other States.

5.4 Primary care

General practice remains the cornerstone of the Australian health system. Medical care outside hospitals is based on GPs in private practice who constitute the principal gateway to specialist services and hospitals (GP 'gatekeeper' model).

A major primary care initiative was the start of the General Practice Strategy in 1991, aimed at enhancing the skills and quality of GPs to ensure that they can meet the challenges arising from the greater technological sophistication of medicine and the important relationships between primary and acute care, and the potential role of GPs in population health activity. By 1996, the strategy took in more than 100 Divisions of General Practice[27] covering the whole of Australia and involving most GPs.

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[26] There are several hospital casemix classifications (covering acute, non-acute and ambulatory episodes) in operation throughout the world. They tend to be concerned with measuring the 'products' of hospitals — that is, the bundles of goods and services provided for the diagnosis and treatment of illnesses — and are based on the assumption that commonalities exist among patients' attributes and medical problems on the one hand and patterns of treatment, medical approaches, and levels of service on the other. Diagnosis Related Groups (DRGs) represent the best known casemix classification. They consist of a manageable number of distinct classes which have been identified on the basis of their clinical meaning and resource-use homogeneity. Australia's DRG classification is known as the Australian National Diagnostic Related Groups (AN-DRG) classification.

[27] Each Division compromises around 150 GPs.

In 1998, the Strategy was reviewed and initiatives pursued to encourage greater efforts by the profession itself to improve quality and capacity, and to develop financial rewards for quality care, continuity of care, and patient loyalty and support, rather than throughput.

Coordinated care trials

At the core of an 'integrated' health care system is the belief that a single, integrated system — built around the needs of people, rather than providers or institutions — can realise natural synergies by effectively managing a continuum of care for a defined population. The goal is to provide a seamless system of care which is quick, reliable, and (hopefully) close at hand.

A natural focus for trialing integrated systems of care is those Australians with above-average needs (eg those suffering from a chronic illness). These are a group of people most likely to be bumping up against the health care system in uncoordinated ways, repeatedly having to describe their ills and having to recount their medical histories. They are also a group which is most likely to suffer when the system fails to deliver in a coherent and coordinated way.

There are now some 13 coordinated care trials being developed across Australia (including 4 trials aimed specifically at improving the health of Aboriginal and Torres Strait Islander peoples). Although not formally evaluated yet, early indications are that there are enormous gains to be made in terms of improved patient care if that care is seamlessly coordinated and funded more flexibly than is the case with individual programs like the MBS and the PBS.

5.5 Aged care

Aged Care is provided through both residential care in nursing homes and hostels and via domiciliary and community support services. Acute care services are also available through the public hospital system and primary health care via Medicare. Assistance is also provided for carers of older Australians.

The growth of residential care is controlled via a planning ratio for the number of beds in proportion to the increase in older Australians. In order to increase the sustainability of the publicly funded system, the Commonwealth recently:

- introduced income-tested fees for care;
- allowed accommodation payments to be levied on those able to pay (these payments contribute to outstanding capital requirements for nursing homes and hostels); and
- set in train initiatives designed to improve the quality of care (eg the Aged Care Standards and Accreditation Agency was established in 1997 to ensure that residential aged care facilities achieve and maintain high standards of care and accommodation).

The original proposals were modified to address community concerns, to provide greater protection for residents and to make implementation easier for service providers.

Where possible, emphasis is placed on assisting people to live independently. Hostel standard care is provided to people in their homes. Other flexible arrangements include Multi Purpose Services where combined health and aged care services are provided to increase the viability of services in rural and remote areas.

6 Private sector reforms

Private health insurance can be purchased to cover charges in private hospitals, and for private status in public hospitals. Registered health benefit funds also sell ancillary insurance for services not covered by Medicare, notably private dentistry, optometry (glasses, contact lenses), physiotherapy, chiropractic and appliances, and for prescribed medicines not covered by pharmaceutical benefits.

It is difficult for private health insurance products to compete with Medicare given the prices and other characteristics of the respective products.[28] Nevertheless the private sector manages to fund around one-third of total health expenditure (including out-of-pocket payments to cover the 'gap' between the cost of services and the government subsidy).

Government support for a private health system in parallel to Medicare has not always been unequivocal. This is not an area of bipartisanship, with the political parties expressing different views on the relative importance of support for private health insurance and choice, and further public funding of Medicare.

In spite of differences, by international standards Australia has a substantial private sector involvement in health care financing, and private health insurance plays a significant role in supporting this.

The challenge for Australia is to build a sustainable balance of public and private, which offers both choice and universal access. Such a balance may well involve encouraging Australians (especially the better off) to increasingly provide for their own health care during their working career and/or in old age. If a decision is made to substantially shift the balance away from government dominance in spending the health care dollar, what is likely to be involved is a fundamental rethink of the incentives at work in the system (to which the various participants are currently responding in predictable ways).

[28] Compared with Medicare, private health insurance offers individuals their choice of doctor, private accommodation in (private or public) hospitals, and the opportunity to avoid public hospital waiting lists.

6.1 Problems with rising premiums and falling numbers

The period since the introduction of Medicare in 1984 has seen a progressive decline in the number of people with private health insurance. This is hardly surprising, since Medicare offers the promise of care which is free at the point of delivery, while the private alternative has to be paid for. National coverage has fallen from 61.5 per cent in 1983 to 30.3 per cent in September 1998.[29] Falling numbers put pressure on premiums, which have to rise to cover what becomes an increasingly higher-risk pool of people with private health insurance.

These trends have been exacerbated by a number of factors including the perceived adequacy of Medicare-funded services, increasing insurance premiums because of the rising costs of hospital care (driven substantially by the shift of private patients from highly subsidised public hospitals to private hospitals), the impact on premiums of adverse selection (driven by community-rating regulation), and the failure of insurers to protect members from unexpected out-of-pocket charges ('gaps') by doctors.

The Commonwealth Government is keen to redress the decline in membership and to ensure that Australia's health system offers choice as well as universal access (and has a vibrant private sector to make that possible). Direct support to offset premiums has been introduced and is being extended, measures are being taken to improve competition between funds and encouragement is being given to funds, private hospitals and doctors to address 'gaps'. Consideration is also being given to changing the current community-rating regulations to a lifetime basis — which could overcome incentives for adverse selection, while retaining the politically important principle that premiums will not vary according to health risk.

Thus, moves have been made to make private health insurance more attractive to take out through measures which improve its 'value for money' and provide an incentive for people to remain in or join private health insurance. Initiatives include:

- a 30 per cent rebate on premiums;
- moves to eliminate unknown out-of-pocket costs through simplified billing and contracting arrangements with providers; and
- the establishment of an independent regulator for the private health insurance industry (to oversee premium setting, solvency rules and takeovers).

[29] Private Health Administration Council (1998), 'Coverage of Hospital Insurance Tables Offered by Registered Health Benefits Organisations by State, Persons and Percentage of Population (available at http://www.phiac.org.au/frames/stats/hosquar.htm).

7 Population health

Most of us know that the way we live affects our chances of a long life and that things like smoking, drinking too much, and lack of exercise are important risk factors — even if we do not necessarily act on that knowledge. Government initiatives at the national and local levels can encourage people to make healthy choices. However, it is finally up to individuals to choose whether to modify their behaviour for the interests of their health.

On the other hand, interventions that *require* people to change high-risk behaviours (eg because they damage people's health but are beyond the control of the individual) need to be supported by public policy which promotes population health and safety. Examples include the maintenance of standards and regulations for water, milk and food quality, sewerage control, housing standards, road and vehicle safety, and occupational hazards.

Population health at the Commonwealth level is increasingly recognising the benefits of working collaboratively and setting nationally shared goals, while still valuing the flexibility to develop policy and deliver programs that are adapted to local community needs. In Australia the result of such discussions at a national level has resulted in the development of the National Public Health Partnership.

Under the Partnership, the Commonwealth and State and Territory Governments have agreed to work collaboratively to improve the health of the Australian population by enhancing national efforts and supporting a sustainable and systematic approach to population health across the country. Priority initiatives under the Partnership include the harmonisation and modernisation of public health legislation, the development of a national public health information model, and the introduction of a national planning framework for core public health functions. The Partnership aims to ensure that our health system is responsive to current and emerging population health issues, such as food safety and environmental health.

In another significant move, in the 1996-97 Federal Budget the Government introduced new funding arrangements for public health programs which involved broadbanding, or pooling of Commonwealth public health program money provided to the States and Territories. This consolidation and rationalisation of existing arrangements was designed to eliminate duplication, reduce fragmentation of service delivery and provide greater flexibility for the States and Territories in public health planning and delivery. Population health funding is now provided to the States and Territories under Public Health Outcome Funding Agreements.

Spending on preventive health measures that reduce the incidence of disease and disability represents a long-term investment in the health of all Australians, and can produce big savings in terms of health care costs avoided in the future. To the extent that

population health initiatives are as cost-effective as other health care interventions, they should compete on equal terms for their share of the health care dollar.

In 1997-98, the Commonwealth allocated $462 million for population health. This included funding for tobacco regulation, for communicable disease prevention strategies (including HIV/AIDS), to boost childhood immunisation rates, to counter excess drinking and the use of illicit drugs, and for medical research.

7.1 Smoking

As in other countries, cigarette smoking is a leading cause of mortality and morbidity in Australia. It plays a main or large role in many serious and common diseases, including heart attack, stroke, lung cancer, a range of other cancers, and chronic lung disease. The prevalence of smoking in Australia has been declining for some time. Between 1985 and 1995, the proportion of males aged 16 years and over who were regular smokers declined from 37.0 per cent to 30.4 per cent, with the corresponding decline for females falling from 30.1 per cent to 25.1 per cent (Williams 1997).[30] However, it appears that the rate of decline may be slowing.

Smoking is much more common among Aboriginal and Torres Strait Islander peoples than in the Australian population generally. Comparing the results of a survey of Indigenous peoples in 1994 with a similar survey of the whole population in 1995, a greater proportion of the Indigenous population had smoked at some time in their life (77 per cent compared with 63 per cent), and they were almost twice as likely to be current regular smokers (47 per cent compared with 23 per cent).[31]

7.2 Excess alcohol consumption

Like tobacco, alcohol is associated with considerable mortality and morbidity in the Australian community. Alcohol abuse also results in lost productivity, while alcohol-related crime and social problems are a further burden on the community.

Alcohol use at hazardous or harmful levels among adult Australians declined slightly between 1991 and 1995, with approximately 27 per cent of current drinkers (those who drank in the last 12 months) in 1995 reporting that they had consumed at these levels in the last week. Among current drinkers, males consumed alcohol at these levels more so than females (35 per cent compared with 20 per cent). However, in the younger age groups, females tended to drink at hazardous or harmful levels more than males. Of

30 Williams, P. (1997), *Progress on the National Drug Strategy: Key National Indicators*, Commonwealth Department of Health and Family Services, Canberra.

31 *Australia's Health*, p. 145.

current drinkers, 69 per cent of females and 48 per cent of males aged 14-19 years, and 66 per cent of females and 45 per cent of males aged 20-24 years usually drank at hazardous or harmful levels. In older age groups, the pattern was reversed and the differences between males and females diminished, as did the overall levels of at-risk drinking.[32]

Although a smaller proportion of Indigenous people drink alcohol when compared with the Australian population as a whole, those Indigenous people who do drink are more likely to drink at higher levels. Comparing the results of a survey of Indigenous peoples in 1994 with a similar survey of the whole population in 1995, a higher proportion of the Indigenous population drank at hazardous or harmful levels on a daily or weekly basis than the Australian population as a whole. This was the case for both males and females.[33]

7.3 Use of illicit drugs

Illicit drug use refers to the non-prescribed use of cannabis (marijuana), heroin, cocaine, amphetamines, hallucinogens, inhalants, anabolic steroids, ecstasy and other 'designer' drugs, and various derivatives of these substances. By far the most common illicit drug used in Australia is cannabis. In 1995, approximately 32 per cent of the population aged 14 years and over reported having tried the drug at some time in their life. Lifetime prevalence was highest in the age groups 20-24 years (63 per cent) and 25-34 years (54 per cent).[34]

The use of illicit drugs is associated with considerable social problems, morbidity and mortality. Applying the methodology of English *et al.* (1995) for attributing mortality and morbidity to use of illicit drugs, there were an estimated 780 deaths in 1995 and 8,500 hospital admissions in 1995-96 due to illicit drug use.[35]

7.4 Inadequate physical activity

Reported participation in exercise undertaken for sport, recreation or fitness increased slightly between 1989-90 and 1995 from 64.5 per cent to 66.7 per cent in men, and from 64.0 per cent to 65.8 per cent in women, due mainly to an increased participation by people aged 35-54 years. Walking for recreation or exercise continued to increase in popularity during 1990s, with 44.9 per cent of men and 53.3 per cent of women reporting walking in 1995 compared with 41 per cent and 49 per cent respectively in

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32 *Australia's Health*, p. 146.

33 *ibid.*

34 *Australia's Health*, p. 147.

35 *Australia's Health*, p. 148.

1989-90. This may reflect an increased public awareness of walking as an activity suitable for health benefit. The proportions of people undertaking physical activity at low, moderate and high levels remained fairly constant between 1989-90 and 1995.[36]

7.5 Communicable diseases

Communicable diseases were responsible for considerable morbidity and mortality in Australia in the early part of this century. However, the incidence and impact of communicable diseases have been much reduced, with improvements in hygiene (building on advances begun in the nineteenth century), the introduction of antibiotics and mass immunisations making major contributions. In 1921, for example, communicable diseases (those now categorised in the Ninth Revision of the International Classification of Diseases (ICD-9), as infectious and parasitic diseases, together with meningitis, influenza and pneumonia) accounted for about 18 per cent of all deaths but, by 1946 they accounted for only about 11 per cent of all deaths, and by 1971, for about 3.4 per cent of deaths. In 1996, by which time AIDS had been added to the list of communicable diseases, only about 2.8 per cent of deaths were attributed to these diseases.[37]

HIV/AIDS

There has been a continuing decline in the annual number of HIV diagnoses in Australia, from a peak of over 2,500 in 1985 to around 800 each year since 1993. It is estimated that at the end of 1997 the cumulative number of HIV infections was 16 900 and there were 11 150 people living with HIV infection. Sexual contact between men has been the most common mode of transmission of HIV, with over 85 per cent of infections estimated to have been via this route. The annual number of AIDS diagnoses in Australia, after adjustment for reporting delay, appears to have reached a peak in 1994.[38]

7.6 Childhood immunisation

There has been a major push to boost childhood immunisation rates (which had been falling away), involving a public education campaign, improved vaccine supply arrangements, and monetary incentives to parents (by linking Maternity Allowance and Childcare Assistance to the immunisation status of children).

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[36] *Australia's Health*, pp. 147-8.

[37] *Australia's Health*, p. 116.

[38] National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS and related diseases in Australia, Annual Surveillance Report, 1998*, Sydney. (Available on the Internet at http://www.med.unsw.edu.au/nchecr).

The National Health and Medical Research Council (NHMRC) released the 6th edition of the *Australian Immunisation Handbook* in 1997, detailing recommended immunisations for children, adults and people travelling overseas. The NHMRC's recommended standard immunisations protect children from diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, invasive *Haemophilus influenzae* type b (Hib) disease, measles, mumps and rubella.

An aid to management of the childhood immunisation program, the Australian Childhood Immunisation Register (ACIR) came into operation in January 1996. ACIR uses enrolments information from the Medicare database to register children under the age of 7 years. Details of immunisations given to these children are recorded on the ACIR using information from those giving the immunisations, usually GPs in private practice or nurses in local government clinics.

The main purpose of the ACIR is to provide a recall and reminder system so that parents are told when their children's immunisations are due or overdue. The ACIR also produces reports for managers of immunisation programs. These reports provide information such as the number of children in an area who are overdue for immunisation and the number of vaccines of each type used in a given area.

7.7 Asthma

Asthma is a common and growing problem in Australia and worldwide which affects both children and adults. The disease occurs more in affluent societies than in poor ones, and Australia's levels are high along with those of a range of other countries. There are signs that asthma is becoming increasingly common in Australia and more severe as well. Asthma is a major cause of disability and a leading cause of hospitalisation among Australians, especially children. Attacks are occasionally fatal. The total health system costs of asthma in 1993-94 have been estimated at $477 million (AIHW unpublished data).[39]

7.8 Nutrition

Nutrition has long been recognised as an important contributor to health. Because nutrition cuts across so many spheres of public health and influences the health status of many Australians, a national policy on food and nutrition was developed. The policy's goal is to improve health and reduce the preventable burden of diet related early death, illness and disability among Australians. The evidence suggests that diet contributes to conditions such as coronary heart disease, stroke, hypertension, some forms of cancer, non-insulin-dependent diabetes mellitus, osteoporosis, dental caries, gall bladder

[39] *Australia's Health*, pp. 125-6.

disease, diverticular disease, constipation, haemorrhoids and iron deficiency anaemia. Diet can also be linked to a number of risk factors for diseases such as coronary heart disease. These risk factors include raised blood lipids (cholesterol and triglycerides), overweight and obesity, and physical inactivity. In Australia, as with most developed countries, diet-related diseases and their risk factors are due more to over-consumption than under-consumption, and to a sedentary lifestyle. For example, the proportion of overweight and obese people is rising in the Australian population. However, some populations such as the Indigenous, still suffer from under-nutrition.[40]

8 Ongoing issues and the bigger picture

While Australians generally may have reason to be satisfied with their health system, there remain particular and prospective areas of special concern. Two of these are the less-than-satisfactory health status of Aboriginal and Torres Strait Islander peoples and those living in rural and remote areas of Australia. The prospective ageing of the Australian population, including the implications for the health care system, is also attracting increasing attention.

8.1 Aboriginal health

Aboriginal and Torres Strait Islander peoples can expect to live 15-20 years less than other Australians, and infant mortality rates remain 3 to 5 times higher than those for other Australians.

In 1997-98 the Commonwealth allocated $136 million specifically for Aboriginal and Torres Strait Islander health to provide additional services to those available through the broader health system.

Australia's Aboriginal and Torres Strait Islander peoples continue to experience much poorer health than the general Australian population (see ABS & AIHW 1997 for a more detailed report). It is difficult to measure precisely the extent of this health disadvantage because population survey data are scarce and not all Indigenous people are identified as such in administrative data collections such as deaths, hospital separations, cancer registries and communicable disease notifications. Incomplete identification leads to an underestimation of the difference in health between Indigenous and other Australians, the magnitude of which may vary from State to State and for different types of collections. Despite the lack of good-quality national health statistics for Australia's Indigenous population, evidence from those jurisdictions where the data are considered to be of reasonable quality indicates large differences between the health of Indigenous and other Australian populations across a range of health status measures.

[40] *Australia's Health*, pp. 136-7.

8.2 Health of rural and remote area populations

The health of populations living in rural and remote areas of Australia is worse than those living in capital cities and other metropolitan areas (Mathers 1994).[41] Mortality and illness levels increase as one travels away from metropolitan centres to rural areas and remote locations (Titulaer *et al.* 1998).[42]

Relatively poor access to health services, lower socioeconomic status and employment levels, exposure to comparatively harsher environments, sparse infrastructure and occupational hazards contribute to these inequalities. Attitudes towards illness, poor uptake of health promotion and self-care messages, and more frequent indulgence in risky behaviours are other possible contributory factors.

Improving the delivery of health and community services to Australians living in rural and remote regions continues to be a major concern and focus of action. Under the umbrella of the National Rural Health Strategy, a range of measures have been pursued, including strengthening health service development, improving recruitment and retention rates of health care workers and doctors, and establishing infrastructure to support the workforce in rural and remote Australia.

8.3 Population ageing

The Australian population has been ageing since the early 1970s, and this trend is expected to continue for at least the next 50 years (with the projected median age to rise from 34.3 years presently to 44.1 years in 2051).[43] Annual rates of population increase projected for the period 1976 to 2016 are significantly higher for the older population than for the overall population, with rates of increase highest among the very old (ABS 1996). Twenty years ago, 9 per cent of the population (or 1.3 million people) were aged 65 years and over. By 1996, this had increased to 12 per cent (2.2 million) and by 2016 is projected to increase to 16 per cent or 3.5 million people. In 1976, one in six older people was aged 80 and over; by 1996 it was one in five and by 2016 it will be one in four.

Ageing of the Australian population is of particular relevance with regard to planning for health services and long-term care, and their likely cost. Health care costs tend to accelerate towards the end of a person's life, mainly because of admissions to hospital for episodes of acute care. Costs also rise because there is often no alternative but to admit the increasingly frail aged to nursing homes. In spite of these cost pressures,

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41 Mathers, C., 1994, 'Health differentials among adult Australians aged 25-64 years', *Health Monitoring Series No. 1*, AGPS, Canberra.

42 Titulaer, I., Tricket, P., & Bhatia, K. 1998, Rural public health in Australia, 1997, AIHW, Canberra.

43 Retirement Income Modelling (RIM) Unit, Commonwealth Treasury quoted in OECD Economic Survey of Australia, 1998-99.

population ageing is only expected to contribute about 0.6 percentage points to the annual growth rate ih health care expenditures over the next two decades — the same as in the past two decades.[43] Nevertheless, the OECD considers that "The major risk to government finances in the long-term comes from rising health care expenditures", mainly driven by underlying growth in real, age-adjusted health care expenditure per capita (rather that ageing).[44] The extent to which there is an 'ageing' problem for health care expenditures will continue to be debated in Australia (as elsewhere), as will appropriate policy responses.

8.4 The bigger picture

According to the World Bank, advances in income and education have allowed households almost everywhere to improve their health. In the 1980s, even in countries in which average incomes fell, death rates of children under 5 declined by almost 30 per cent. But the child mortality rate fell more than twice as much in countries in which average incomes rose by more than 1 per cent a year. Economic policies conducive to sustained growth are thus among the most important measures governments can pursue to improve their citizens' health.[45] The Bank went on to point out that "policies that promote equity and growth together will … be better for health than those that promote growth alone."[46] Prosperous and growing economies are better able to provide universal access to high-quality health care. Equally, it is incumbent on policy makers to recognise the role health care plays in the broader economy — such as the substantial contribution healthy workers make to the productivity of the Australian economy, and to economic growth directly (eg via the export of health-related goods and services).

A sound education has been shown in a series of studies to be central to better health and emotional well-being for all, particularly in helping children who are disadvantaged socially and economically.[47]

Thus there is a range of services — education, social, transport, housing, environmental and leisure — which have an important impact on health. For this reason, although clearly a vital contributing factor, it would be wrong wholly to attribute the improving health status of Australians over time to the health system and the services its delivers.

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43 OECD, 1999, *Economic Surveys, 1998-1999 Australia*, Paris.

44 *ibid*, p.144.

45 World Bank, *World Development Report 1993*.

46 *ibid*.

47 See, for example, Wadsworth, M (1997), 'Changing social factors and their long term implications for health', *British Medical Bulletin*, 53, pp.198-209 and Sylva, K (1997), 'Critical periods in childhood learning', *British Medical Bulletin*, 53, pp.185-97.

8.5 Concluding comment

Good health is what we all want for ourselves, our family and our friends. For the sake of the individual, for society and for the economy, it is therefore a priority for government. Australia has made good progress on improving the health of the population, but more needs doing. There are still (and will continue to be) major opportunities to improve the health of Australians. Yet at the end of the day there are limits to what government can do beyond which it is up to the individual.

Bibliography

Australian Bureau of Statistics (1996) *Population Projections* ABS Catalogue No. 3222.0. Canberra.

Australian Bureau of Statistics and Australian Institute of Health and Welfare (1997) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* ABS Catalogue No. 4704.0. Canberra.

Australian Institute of Health and Welfare (AIHW) (1998), *Australia's Health, 1998*, AIHW Cat. No. AUS10, Canberra.

Australian Institute of Health and Welfare (AIHW) 1998, *Health Expenditure Bulletin* No. 14, November, Canberra.

Light, D. W. (1997), 'From Managed Competition to Managed Cooperation: Theory and Lessons from the British Experience', *The Millbank Quarterly*, Vol 75, No. 3, p. 299.

Mathers, C., 1994, 'Health differentials among adult Australians aged 25-64 years', *Health Monitoring Series No. 1*, AGPS, Canberra.

National Centre in HIV Epidemiology and Clinical Research, *HIV/AIDS and related diseases in Australia, Annual Surveillance Report, 1998*, Sydney. (Available on the Internet at http://www.med.unsw.edu.au/nchecr).

National Health and Medical Research Council (NHMRC) (1997), *Australian Immunisation Handbook*, 6th edition, Canberra.

Organisation for Economic Co-operation and Development (OECD) (1999), OECD *Economic Surveys, 1998-1999* , Australia, Paris.

OECD Health Data 98, A Comparison of 29 Countries, CD-ROM. (Information on the Internet at http://www.oecd.org/els/health/software98.htm).

Private Health Administration Council (1998), 'Coverage of Hospital Insurance Tables Offered by Registered Health Benefits Organisations by State, Persons and Percentage of Population (available at http://www.phiac.org.au/frames/stats/hosquar.htm).

Sylva, K (1997), 'Critical periods in childhood learning', *British Medical Bulletin*, 53, pp.185-97.

Titulaer, I., Tricket, P., & Bhatia, K. 1998, *Rural public health in Australia, 1997*, AIHW, Canberra.

UK Green Paper *Our Healthier Nation: A Contract for Health*, Cmd 3854, HMSO, 1998 (available at http://www.official –documents.co.uk/document/ohnation).

Wadsworth, M (1997), 'Changing social factors and their long term implications for health', *British Medical Bulletin*, 53, pp.198-209.

Williams, P. (1997), *Progress on the National Drug Strategy: Key National Indicators*, Commonwealth Department of Health and Family Services, Canberra.

World Bank 1993, *World Development Report 1993*, Oxford University Press, NY.