Health Care Expenditure and Financing in Australia

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EXECUTIVE SUMMARY

1. In Australia, health care services and products are provided by both the public and private sectors. The money spent on health care services mainly comes from the Commonwealth, State and Territory and Local Governments (67%) through taxation and Medicare levy. Other sources such as private health insurance funds which collect premiums from individuals contribute 10% and individuals' direct payments constitute about 20%.

2. About 30% of the Commonwealth's expenditure on health care is spent on public hospitals and a similar proportion on medical services. In contrast, private health insurance funds spend almost half of their claims payments on private hospitals whereas individuals spend 60% of their health care expenditure on pharmaceuticals, dental and other professional services.

3. Medicare is a compulsory national insurance scheme which allows universal access to free treatment in public hospitals, full or subsidized out-patient medical treatment and pharmaceuticals. In 1997-98, Medicare levy is 1.5% of an individual's taxable income and there is an additional 1% Medicare surcharge on singles earning more than A$50,000 and couples and families earning more than A$100,000 but who have not subscribed to any private hospital insurance. Medicare levy covers 8% of total health care expenditure. Since the cost for joining Medicare is low, it is likely to generate excess demand on health care services.

4. Private health insurance subscription is on a voluntary basis and provides cover for private hospital accommodation, in-patient medical services not covered by Medicare, and ancillary services such as dentistry. Private health insurance covers 11% of total health care expenditure.

5. Premiums of private health insurance are subjected to community rating, of which insurers cannot charge premiums according to age, sex and state of health. Thus, there are only four rates of premiums for a given insurance product: single, couple, single parent family and family. To underpin the principle of community rating, there is a reinsurance arrangement which redistributes the risk from the low claimed insurance firms to those with high proportion of aged and chronically ill customers. However, such arrangement may induce adverse selection whereby low risk people will withdraw but those expecting to make claims will join. The cost for joining private health insurance is far higher comparing to that of Medicare.

HEALTH CARE EXPENDITURE AND FINANCING IN AUSTRALIA

PART 1 - INTRODUCTION

1. Background

1.1 The Research and Library Services Division (RLS) of the Provisional Legislative Council (PLC) Secretariat was requested by the Panel on Health Services to conduct research on health care expenditure and financing in Hong Kong and overseas. This research report which discusses health care financing in Australia is one of the series of reports on overseas systems. The research report entitled Health Care Expenditure and Financing in Hong Kong (RP06/PLC) was discussed by the Panel on Health Services in March 1998.

2. Objective and Scope

2.1 The objective of this research is to analyze the expenditure pattern and financing arrangements of the Australian health care system so as to assist the Panel on Health Services in considering the Health Care System review which is expected to be completed by the Government by the end of 1998.

2.2 The scope of this research is as follows:

- describe the health care system of Australia;
- describe and analyze changes in the expenditure pattern of the health care system in Australia; and
- describe and analyze the health care financing arrangements in Australia.

3. Methodology

3.1 This study involves a combination of information collection, literature review and analysis, telephone interviews and correspondence with the Australian authorities.

3.2 Literature studied includes publications from the Commonwealth Department of Health and Family Services of Australia, Australian Institute of Health and Welfare, Department of Administration and Finance of Australia, Australia Industry Commission, Australian Bureau of Statistics and other relevant institutions. Telephone interviews were held with a number of general practitioners who had previously practised or are currently practising in the public and private hospitals or clinics in Australia. Letters were also sent to the Commonwealth Department of Health and Family Services of Australia to obtain the necessary information and statistics.

3.3 This research paper is based on the information obtained from these sources.

3.4 The average exchange rate of the Australian Dollar was A$1.00=HK$5.73 in 1995; A$1.00=HK$6.06 in 1996 and A$1.00=HK$5.76 in 1997.[1]

[1] Hong Kong Monthly Digest of Statistics, February 1998, Table 7.12, p108.

PART 2 - HEALTH CARE DELIVERY SYSTEM

4. Development of Health Care Delivery System

4.1 At federation in 1901, the Commonwealth assumed little role in health care services, and each State had its own health authorities and services.

4.2 In 1921, the Department of Health was established. It was mainly responsible for a variety of services including quarantine, health laboratories, public health education, occupational health, tropical health research and education.

4.3 In 1926, to better coordinate health care services of the Commonwealth and the States, the Federal Health Council which consisted of the top Commonwealth and State health department administrators was established to make recommendations to the involved parties on health issues and priorities. Many services were introduced including cancer prevention, medical research, poisons regulation, maternal health and medical advertising.

4.4 In 1946, there was a Constitutional referendum and welfare benefits were extended to cover hospital, medical, pharmaceutical and dental services. A steady expansion of health care services followed in the 1950s and 1960s.

4.5 In the 1970s and 1980s, the Commonwealth advocated health insurance; a compulsory universal health insurance (Medicare) was introduced in 1984 which provided subsidies for out-patient medical services and allowed eligible patients free access to public hospitals.

4.6 In the mid-1990s, the Commonwealth saw the impediments which affected the growth in health care and community services, and launched a reform on the health care system. The objectives were to meet people's needs better and deliver services in an efficient and cost-effective manner. National goals and targets for health and related community services were identified and pursued through the organization of services, planning and funding arrangements and information support.

4.7 The Australian health care system is characterized by the following:

- Health care services and products are provided by both the public and private sectors.

- There is universal access to free treatment in public hospitals.

- Out-patient medical services are provided by private medical practitioners on a fee-for-service basis, but the patient can claim the money back from Medicare, i.e. the compulsory national insurance scheme. Details on Medicare will be discussed in Section 9.

- There is universal access to pharmaceuticals at reasonable cost through the Pharmaceutical Benefits Scheme (PBS). Details on PBS will be discussed in Section 10.

- There are voluntary insurance schemes offered by the registered private health insurance funds to cover hospital accommodation; medical services which are not covered by Medicare; and ancillary services[2] such as dentistry, optical services and ambulance services.

5. Role of Public and Private Sectors in Health Care System

5.1 The Commonwealth has a broad policy leadership and financing role in health care matters while the State and Territory Governments are responsible for the delivery of health care services and the regulation of health workers in the public and private sectors. The division of responsibilities is complex, functionally and geographically.

5.2 One-third of the health care services are provided by profit-making private enterprises and by non-government not-for-profit organizations.

6. Policy Objective

6.1 Australia's health care policy conformed to that set by World Health Organization (WHO). In 1977, the World Health Assembly decided that "by the year 2000, all people of the world should attain a level of health that would permit them to lead a socially and economically productive life".[3] In 1981, the Assembly adopted a "Global Strategy for Health for All by the Year 2000". Under this strategy, it was hoped that everyone could gain access to essential health care services and resources for health care should be evenly distributed.

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2 Ancillary services include dentistry, optical, chiropractic, physiotherapy, dietetic and other services, ambulance services, and aids and appliances, e.g. spectacles.

3 Health for All, World Health Organization.

7. National Structure of Health Care System

Commonwealth Government

7.1 At the national level, health care services are administered by two ministers, namely, the Minister for Health and Family Services and the Minister for Family Services in the Commonwealth Government.

7.2 The Minister for Health and Family Services has an overall responsibility for both health and family services, though his main responsibility is to administer most of the health services. These include Medicare benefits, private health insurance, hospital services and medical workforce issues. He is also responsible for public health, health research and Aboriginal health matters.

7.3 The Minister for Family Services is responsible for family and children's services, aged and community care services and disability programmes.

State and Territory Health Authorities

7.4 Each State and Territory has its own health authority which is administered by the corresponding State or Territory Minister. State and Territory health authorities are mainly responsible for hospital services, mental health programmes, dental health services, home and community care, child, adolescent and family health services, women's health programmes, health promotion, rehabilitation systems, regulation, inspection, licensing, and monitoring of premises; institutions and personnel.

Local Governments

7.5 Local Governments are responsible for immunization services. They also provide community-based services for people with disabilities, and a variety of environmental services that contribute to good health.

8. Health Care Delivery System

8.1 Health care services in Australia are delivered through institutional and non-institutional services. Institutional services include hospital and nursing home services. Hospitals provide episodic and intensive care to patients who are at critical condition or with complex health problems while nursing homes provide long term care to the chronically ill and frail aged people. Non-institutional services include community health care, environmental hygiene and health research and administration services. Non-institutional services mainly provide primary care to the general public.

Institutional Health Care Services

Public Hospitals

8.2 Public hospitals are administered either by hospital boards, religious or charitable bodies, or district boards. The broad range of services include emergency, medical, surgical, paediatric, obstetric, rehabilitation, intensive care, vascular and cardiothoracic services. Public hospitals also provide out-patient services.

Private Hospitals

8.3 Private hospitals are run by proprietors operating for profit, or as not-for-profit enterprises run by religious or charitable organizations. They provide medical, surgical, obstetric, psychiatric and rehabilitative services.

Nursing Homes and Hostels

8.4 Nursing homes provide accommodation and long-term nursing care for the chronically ill, disabled or demented patients who need full-time care. Hostels provide accommodation and domestic assistance such as meal services, laundry, and personal care for the aged, distressed, or disabled person who cannot live independently but do not need nursing care in a hospital or nursing home. They are run by both the public and private sectors.

Community Health Care Services

Home and Community Care

8.5 To enable the frail aged and people with disabilities to live at home, supporting services are provided through the Home and Community Care Programme. These include home help and personal care, home maintenance and modification, food services, community-based care, transport services, community paramedical services, community nursing, education and training services.

Out-patient Medical Services

8.6 Out-patient medical services are provided by private medical practitioners on a fee-for-service basis. They also constitute the principal gateway to specialized services.

Health Promotion and Disease Prevention

8.7 Both the State, Territory and Local health authorities are active in health promotion and disease prevention. They provide immunization and advisory services at infant health centres, antenatal clinics, immunization clinics and community health centres.

Environmental Health and Hygiene

8.8 While the State and Territory authorities are responsible for monitoring air quality, Local Governments are responsible for environmental hygiene and sanitation practices.

Information, Coordination and Research

8.9 To enable the governments and the community to plan and formulate health care policies, there are many statutory and non-statutory organizations which provide information, coordination and research on health care system.

9. Compulsory National Health Insurance - Medicare

9.1 Medicare is a compulsory national health insurance system which came into operation in 1984. The scheme is administered by the Health Insurance Commission (HIC). It provides protection to all Australian residents and visitors from countries with which Australia has Reciprocal Health Care Agreements.[4]

Objective of Medicare

9.2 According the Commonwealth Department of Health and Family Services, Medicare is "to enable eligible patients to obtain appropriate private medical services which are necessary for their health care, without excessive price barriers, through payment of Medicare benefits and associated arrangements."[5]

[4] Those countries include Finland, Italy, Malta, the Netherlands, New Zealand, Sweden and the United Kingdom.

[5] Annual Report 1996-97, Commonwealth Department of Health and Family Services, p81.

Medicare Benefits Schedule

9.3 Medicare Benefits Schedule (MBS) is the list constructed by the Government which sets the standard fee for each medical service. The Schedule covers services rendered by legally qualified medical practitioners and certain prescribed services rendered by approved specialists. The Schedule is constantly reviewed through on-going consultations with the medical profession and is updated twice yearly to reflect current medical practice.

Medicare Benefits

9.4 Any patient under Medicare can choose to be treated as a public or private patient. A public patient does not have the choice of doctors and must be being treated in a public hospital whereas a private patient has his choice of doctors and can go either to a public or private hospital.

Out-patient Services

9.5 Medicare provides the beneficiary with access to:

- Free treatment in a public hospital if the beneficiary chooses to be a public patient; and
- Free or subsidized treatment[6] provided by general practitioners, specialists, participating optometrists or dentists in out-patient clinics. Patients have the choice of practitioners.

9.6 For out-patient services rendered by general practitioners, Medicare will pay either 85% of the Schedule fee, or the Schedule fee less an amount of up to A$50[7], whichever is larger. The rest is borne by the patients. However, many practitioners only bill Medicare for the 85% Schedule fee, and do not require the patients to pay the balance. This means that the practitioner accepts the 85% Schedule fee as full payment for the service rendered.

9.7 If a fee is charged, the patient can either pay the bill and then claim the benefits from Medicare; or claims on Medicare for the unpaid account and receives a cheque made out in the practitioner's name, then gives the cheque and any outstanding balance to the practitioner.

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6 Including X-rays, pathology tests, other medical tests, examinations and certain surgical procedures; eye tests; some surgical procedures performed by approved dentists; and specified items under the Cleft Lip and Palate Scheme.

7 This figure is adjusted for inflation on November 1 each year.

In-patient Services

9.8 Anyone chooses to be admitted as a public patient in a public hospital will receive free treatment by doctors and specialists nominated by the hospital. Medicare does not cover all medical services. Appendix II lists the services which are not covered by Medicare.

9.9 For private patients, Medicare will pay 75% of the Schedule fee for the services and procedures provided either in a public or private hospital. The remaining 25% can be covered either by private health insurance or from the patient's own resources. If the doctor charges more than the Schedule fee, the patient will have to pay the difference.

9.10 A private patient will also be charged for hospital accommodation and items such as theatre fees and any medicines. These costs have to be borne by the patient or covered by his private health insurance.

Medicare Safety Net

9.11 Medicare Safety Net caps the expenditure which patients make for out-patient services; thus, if the sum of the gaps between benefits and schedule fees exceeds A$276.8,[8] the full schedule fee will be reimbursed for services rendered during the remainder of the year. This 'safety net' threshold is linked to the Consumer Price Index, and is adjusted each year.

10. Pharmaceutical Benefits Scheme (PBS)

10.1 The Pharmaceutical Benefits Scheme (PBS) was established under the provisions of the National Health Act 1953. It subsidizes the cost of a wide range of drugs and medicinal preparations so that individuals are not financially precluded from access to these items. PBS provides subsidy to all Australian residents and visitors from countries with which Australia has Reciprocal Health Care Agreements.[9] The scheme is also administered by the HIC.

Objective of PBS

10.2 The objective of PBS is to provide "timely, reliable and affordable access for the Australian community to necessary and cost effective medicines".[10]

[8] 1997 figure. Information is from Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services.

[9] Including United Kingdom, Finland, Italy, Malta, the Netherlands, New Zealand and Sweden.

[10] Annual Report 1996-97, Commonwealth Department of Health and Family Services, p87.

PBS Benefits

10.3 Except for concessional patients (i.e. pensioners, the unemployed and low income families), all patients pay a maximum of A$20 for each PBS medicine.[11] The Government pays the rest. For concessional patients, they pay A$3.20.[12] PBS subsidies are paid as cash transfers direct to pharmacists who dispense the medicines.

PBS Safety Net

10.4 The PBS safety net limits the expenditure of an individual and/or his immediate family on PBS medicines. In 1997-98, the thresholds for general patients and concessional patients are A$612.60 and A$166.40 respectively; over these limits general patients only need to pay A$3.20 and concessional patients are free for all PBS medicine for the rest of the calendar year. [13]

[11] The figure is adjusted annually. The figure does not include a surcharge for more expensive brands. The 1997 prices include an increase announced in the 1996 Federal Budget.

[12] Ibid.

[13] Ibid.

PART 3 - FINANCING ARRANGEMENTS FOR HEALTH CARE SYSTEM

11. Development of Health Care Financing Policy

11.1 Health care services in Australia are mainly funded by the Commonwealth Government. Its health care financing policy began in 1946 after a Constitutional referendum. The Commonwealth subsidized the States to provide free in-patient services in public hospitals. It also subsidized patients in private hospitals. In 1953, the National Health Act was passed and the Commonwealth began to provide medical, pharmaceutical and optometrical benefits.

11.2 In 1975, the Commonwealth introduced Medibank which was a universal insurance scheme providing free public hospital services and subsidized medical, pharmaceutical and optometrical services to all Australians. In 1976, the Commonwealth imposed a 2.5% levy on taxable incomes for those who joined Medibank. It also introduced a private health insurance fund called Medibank Private to compete directly with other private insurance funds. Although Medibank and Medibank Private charged different medical levy and provided different protections, their characteristics were similar. Thus, the Commonwealth abolished Medibank but retained Medibank Private in 1978. Yet, the Commonwealth still provided free public hospital services and 40% of scheduled medical fees to all Australians.

11.3 In 1984, the Commonwealth reintroduced a compulsory universal health insurance - Medicare. Under Medicare, all tax payers had to pay an additional 1% of taxable income as Medicare levy; and medical and pharmaceutical benefits would be provided directly by the Commonwealth. Under Medicare Agreements, i.e. the agreements between the Commonwealth Government and State and Territory Governments, the Commonwealth would provide financial assistance to State and Territory hospitals so as to ensure that public patients had free shared ward accommodation and treatment for both in-patient and out-patient services.

12. Objective of Health Care Financing Policy

12.1 According to the 1997-98 Budget, the major purpose of the Commonwealth health care outlays is to "ensure that all Australians have access to necessary health services without excessive price barriers".[14]

[14] 1997-98 Budget, Statement 4 - Outlays, Section 5 - Health, Nature of Outlays.

Figure 1 - Financing of Health Care Services

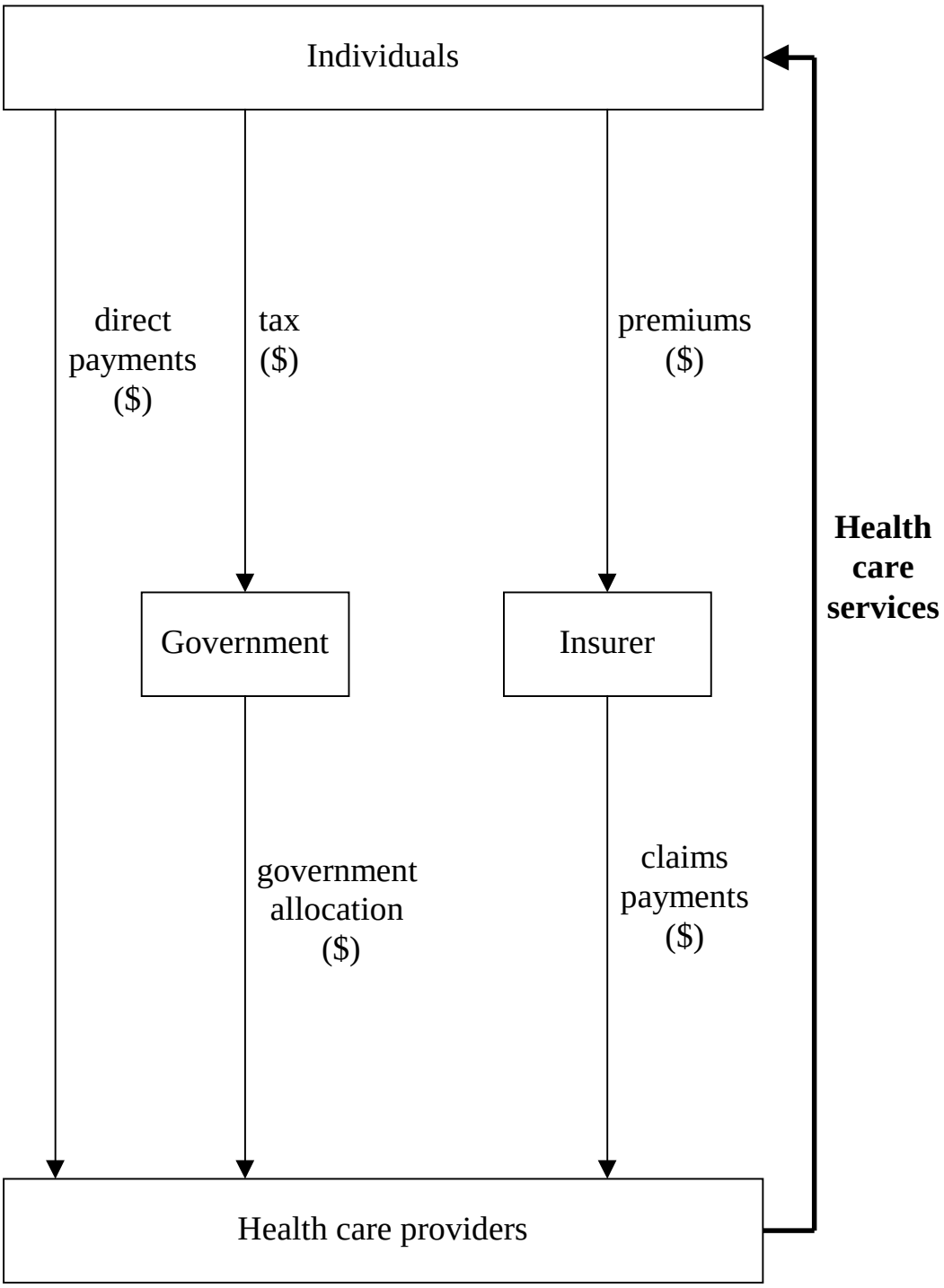
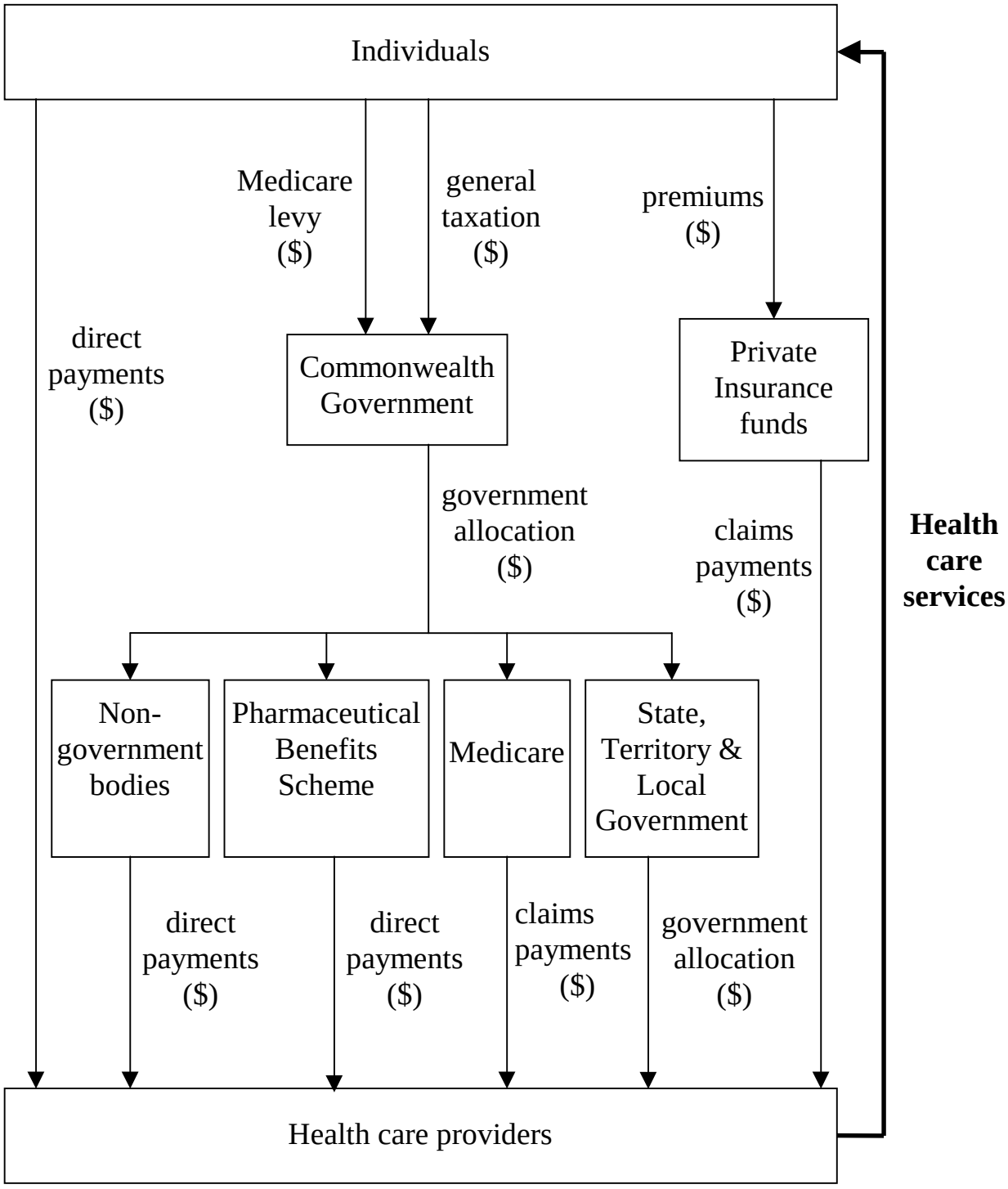


Figure 2 - Financing of Health Care Services in Australia



13. Financing Arrangements

13.1 From the point of health care providers, the financing arrangements for health care services refer to the various ways of which the providers can acquire funding. Figure 1 depicts the flow of funds from various sources to health care providers in return for health care services offered to individuals.

13.2 In Australia, health care providers receive funding from all levels of government in the form of government allocation, Medicare benefits and PBS payments. They also receive claims payments from private health insurance funds. Individuals pay the health care providers through taxation, Medicare levy or direct out-of-pocket payments (Figure 2).

Government Allocation

13.3 The Commonwealth allocates public funds to finance health care services in the form of:

- Medicare benefits;
- Pharmaceutical benefits;
- Direct grants to non-government organizations;
- Specific purpose payments to State and Territory Governments to support public hospitals and other infrastructure;
- Financial Assistance Grants (FAGs) which provide general assistance to states. These grants are not required to be spent by States in a specific area; and
- Contribution through Hospital Funding Grants (HFGs) to the states.

General Taxation

13.4 Table 1 shows that individual income tax accounts for over 50% of general revenue in 1997-98.

Table 1 - General Revenue by Major Categories 1997-98 [(a)]

Revenue category	% to total revenue
Individual income tax [(b)]	52
Company tax	14
Fringe benefit tax	2
Collections from superannuation funds and withholding tax	4
Excises	10
Sales tax	10
Customs duty	3
Other taxes, fees and fines	2
Non-tax revenue [(c)]	3
Total	100

Remarks:
(a) Budget estimate.
(b) Including Medicare levy collections and refunds.
(c) Including interest, dividends and other revenue not classified.
Source: Budget 1998-99, Department of Administration and Finance, Table BIV

13.5 In Australia, taxation on individual income is progressive. Table 2 lists the individual income tax rate for an Australian resident. Those who earn less than A$5,400 a year do not need to pay income tax, but those who earn more than A$50,000 pay 47 cents on every dollar above A$50,000.

Table 2 - Individual Income Tax Rate 1997-98

Individual taxable income (A$)	Tax rate
1 - 5,400	Nil
5,401 - 20,700	20 cents for each A$1 over A$5,400
20,701 - 38,000	34 cents for each A$1 over A$20,700
38,001 - 50,000	43 cents for each A$1 over A$38,000
50,001 and over	47 cents for each A$1 over A$50,000

Source: Tax Pack 97, Australian Taxation Office, p128

Medicare Levy

13.6 On top of income tax, the Commonwealth charges an additional percentage on the taxable income to finance solely medical services.

13.7 Medicare levy for 1997-98 is 1.5% of an individual's taxable income.[15] No Medicare levy is applied to single people earning less than A$13,389, couples and sole parents earning less than A$22,594 per year. The additional threshold for each dependent child is A$2,100.[16]

13.8 As of 1 July 1997, an additional 1% Medicare levy surcharge is introduced to encourage those who are better off to join private health insurance so as to relieve the pressure on public hospital system. The people being affected include singles with an annual income greater than A$50,000; and couples and families[17] with combined taxable incomes greater than A$100,000, and who do not hold private hospital cover through private health insurance.

Private Health Insurance

13.9 After the introduction of Medicare in 1984, private health insurance now covers the following:

- Up to 100% of the charges levied by public and private hospitals on services such as accommodation,[18] theatre fees, etc;
- Up to 25% of the MBS fee to cover the Medicare gap for medical services received in private and public hospitals;
- Medical cover beyond that 25% gap if a contract exists between the private health insurance fund and the doctor specifying the fees to be charged; and
- Charges on ancillary services.

It does not cover out-patient medical services.

Community Rating

13.10 Under the principle of community rating which ensures access by all members of the community to private health insurance, the premiums charged by the funds cannot vary according to the age, sex, state of health or family size of an insured. Thus, a sick older person will pay the same rate as a healthy younger person, but the premiums for similar cover vary with different insurance funds.

[15] 1997-98 Budget, Statement 5, p6.
[16] http://tax.cls.com.au/tax/budget97/b9702.html
[17] A family includes a spouse or defacto spouse, children aged under 16 years and dependent full-time students under 25 years of age.
[18] Patient staying in hospital for over 35 days in succession will be regarded as a Nursing Home Type Patient (NHTP). NHTPs have to pay part of hospital accommodation cost.

13.11 There are four rates of premiums for a given insurance product: single, couple, single parent family and family.[19]

Reinsurance Arrangements

13.12 Community rating is underpinned by the reinsurance arrangements - a mechanism which redistributes the risk among funds with high proportion of aged and chronically ill customers and those with low proportion of such customers.

13.13 This system is administered by the Private Health Insurance Administration Council (PHIAC). Each insurance fund pays claims from two separate accounts, namely, the standard account and the reinsurance account. Standard account is used to pay the total value of claims to low cost members (aged below 65 years and stay in hospital for less than 35 days in the previous 12 months) and 21% of each claim to high cost members (aged 65 years or above; or stay in hospital for over 35 days). Reinsurance account will then pay the remaining 79% of the claim to high cost members. Each quarter, PHIAC will pool the reinsurance account payments and divide the sum in proportion to their membership. If a fund has paid more from its reinsurance account than its proportion of the pool, it will receive the difference from PHIAC, and vice versa.[20]

Private Health Insurance Incentives

13.14 To encourage people to join private health insurance funds so as to reduce the financial burden on the Commonwealth, from 1 July 1997, private health insurance rebates became available to single people earning less than A$35,000 a year; and couples and families earning less than A$70,000. The income threshold for families rises by A$3,000 for each additional child.[21]

[19] Private Health Insurance, Industry Commission, Report 57, p34.
[20] Operation of Reinsurance, apha on Line, Australian Private Hospitals Association.
[21] Private Health Insurance Incentives Scheme, Commonwealth Department of Health and Family Services.

13.15 The current annual rebates[22] are as follows:

- Single - A$100 for hospital cover, A$25 for ancillary cover, A$125 for combined hospital and ancillary cover;
- Couples - A$200 for hospital cover, A$50 for ancillary cover, A$250 for combined cover;
- Families - A$350 for hospital cover, A$100 for ancillary cover, A$450 for combined cover.

Fees and Charges

13.16 Patients who are not entitled to Medicare such as non-Australian residents and expatriates are being charged for medical treatment and accommodation in all public and private hospitals. They may also be charged for services such as operating theatres and physiotherapy. Yet, most of the fees and charges can be covered by private health insurance.

[22] Ibid.

PART 4 - ANALYSIS OF HEALTH CARE EXPENDITURE AND FINANCING

14. Total Health Care Expenditure

14.1 Total health care expenditure is the sum of all the expenditure spent on health care services and products by public and private sectors.

Total Health Care Expenditure vs. GDP

14.2 Table 3 and Figure 3 show the changes in total health care expenditure and GDP between 1986-87 and 1995-96. During this period, the growth of total health care expenditure was higher than that of GDP, and the proportion of total health care expenditure to GDP was increasing. It rose from 8.0% to 8.5% of GDP.

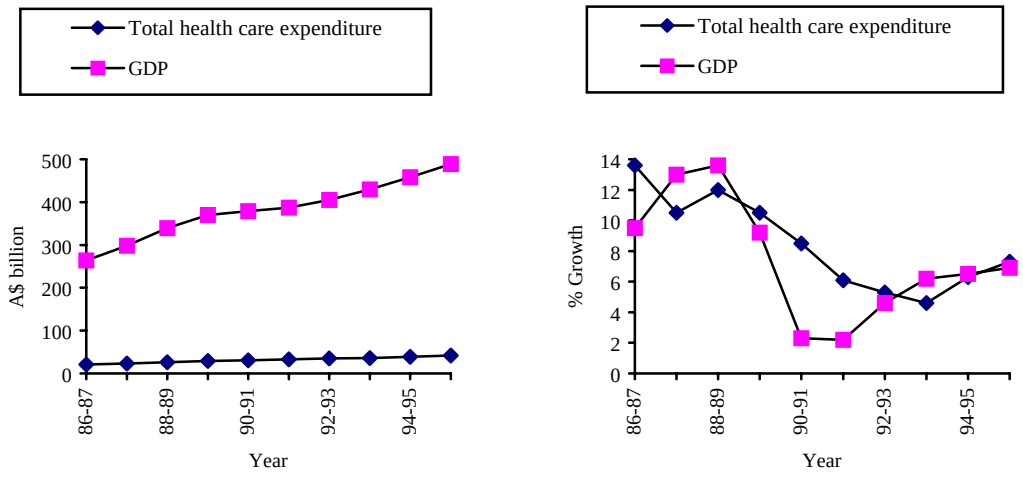
Table 3 – Total Health Care Expenditure and GDP 1986-87 to 1995-96

Year*	Total health care expenditure		GDP		Health care exp. as % of GDP
	A$ million	% Growth	A$ million	% Growth	
1986-87	21,115	+13.6	264,007	+9.5	8.0
1987-88	23,333	+10.5	298,395	+13.0	7.8
1988-89	26,127	+12.0	339,068	+13.6	7.7
1989-90	28,874	+10.5	370,188	+9.2	7.8
1990-91	31,316	+8.5	378,716	+2.3	8.3
1991-92	33,213	+6.1	387,045	+2.2	8.6
1992-93	34,976	+5.3	404,802	+4.6	8.6
1993-94	36,577	+4.6	429,713	+6.2	8.5
1994-95	38,898	+6.3	457,646	+6.5	8.5
1995-96#	41,742	+7.3	489,184	+6.9	8.5

Remarks : * Information of 1989-96 is from Health Expenditure Bulletin No. 13, July 1997, Table 3, p3.
Based on preliminary AIHW and ABS estimates.

Sources : Health Expenditure Bulletin No. 12, December 1996, AIHW, Table 17, p20
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 3, p3

Figure 3 – Total Health Care Expenditure and GDP 1986-87 to 1995-96



Sources: Health Expenditure Bulletin No. 12, December 1996, AIHW, Table 17, p20
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 3, p3

14.3 The increases in the proportion of total health care expenditure to GDP can be attributed to the recession in 1990-91 and 1991-92. Health care expenditure growth was not particularly high in this period but the decline in real GDP in these two years led to an increase in the proportion, and had stayed at the higher proportion as GDP growth recovered.

Health Care Expenditure Per Capita

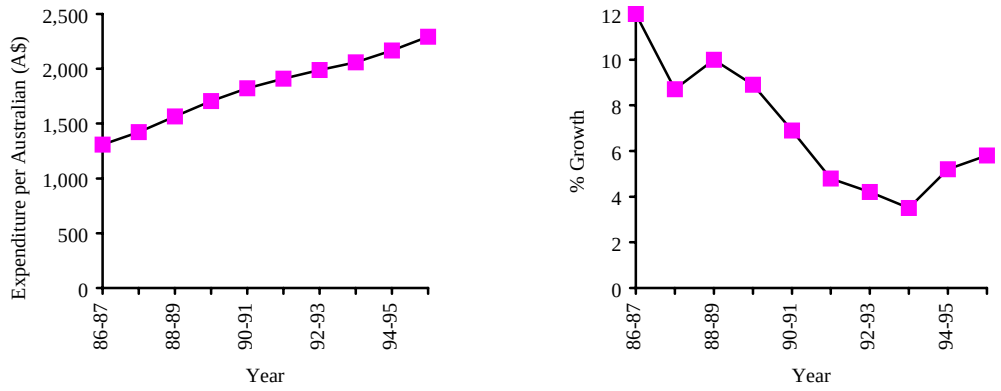
14.4 Table 4 and Figure 4 show the health care expenditure per Australian. In 1986-87, the growth in health care expenditure per capita was 12.0%, but this rate decreased substantially to 3.5% in 1993-94. It slightly increased to 5.2% in 1994-95 and further to 5.8% in 1995-96. The average health care expenditure per Australian was A$2,294 in 1995-96.

Table 4 – Health Care Expenditure Per Australian 1986-87 to 1995-96

Year*	Expenditure per person (A$)	% Growth
1986-87	1,309	+12.0
1987-88	1,423	+8.7
1988-89	1,566	+10.0
1989-90	1,705	+8.9
1990-91	1,823	+6.9
1991-92	1,910	+4.8
1992-93	1,990	+4.2
1993-94	2,060	+3.5
1994-95	2,168	+5.2
1995-96#	2,294	+5.8

Remarks: * Information of 1989-96 is from Health Expenditure Bulletin No. 13, July 1997, Table 2, p3.
Based on preliminary AIHW and ABS estimates.
Sources : Health Expenditure Bulletin No. 12, December 1996, AIHW, Table 2, p4
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 2, p3

Figure 4 – Health Care Expenditure Per Australian 1986-87 to 1995-96



Sources : Health Expenditure Bulletin No. 12, December 1996, AIHW, Table 2, p4
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 2, p3

14.5 According to the information provided by Australian Institute of Health and Welfare (AIHW), the reasons for the continuous growth in health care expenditure per Australian are due to ageing of population, and the greater use of health care services by people of all ages because of the changes in pattern of medical practice and patient's expectation. As people become more health conscious, they demand more medical check-up.

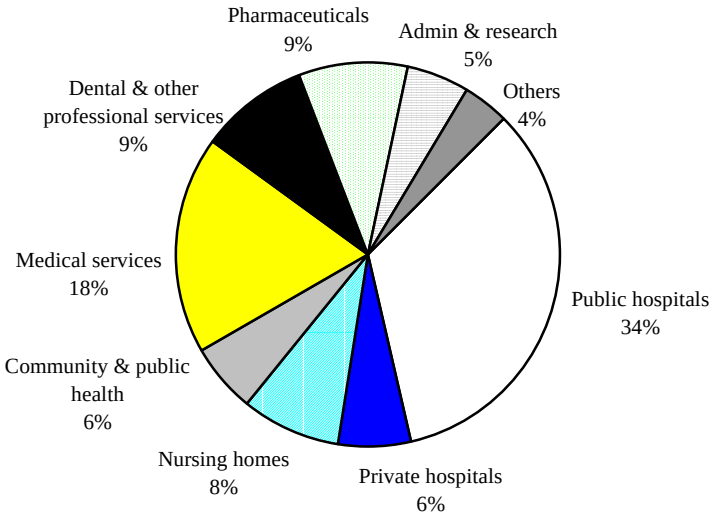
Total Health Care Expenditure by Area of Expenditure

14.6 Figure 5 shows the difference in the various areas of health care expenditure in the years of 1989-90 and 1994-95. During this period, the proportion of expenditure on public hospitals decreased from 34% to 29% whereas the share on private hospitals increased from 6% to 8%. The decline of the former might be due to the establishment of the Home and Community Care Programme which enabled the aged and people with disabilities to live at home instead of staying in hospitals.

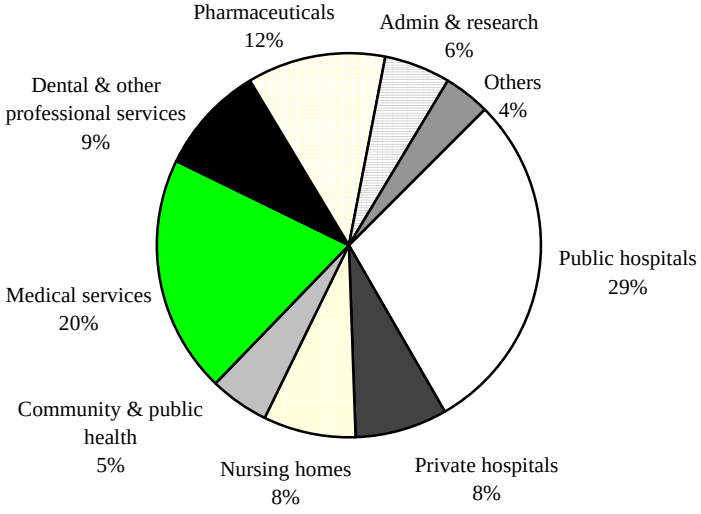
14.7 For non-institutional services, the proportion of expenditure on pharmaceuticals saw a substantial growth from 9% in 1989-90 to 12% in 1994-95. This was due to a change from prescribing older drugs to prescribing newer, more expensive ones which had entered the PBS.

Figure 5 - Total Health Care Expenditure by Area of Expenditure in 1989-90 and 1994-95

1989-90



1994-95



Remarks:

(a) Public hospitals include public acute hospitals, repatriation hospitals and public psychiatric hospitals.

(b) Others include ambulance services, aids and appliances and services which are not elsewhere classified.

Source: Health Expenditure Bulletin, No. 13, July 1997, AIHW, Table 12 & 17

15. Total Health Care Financing

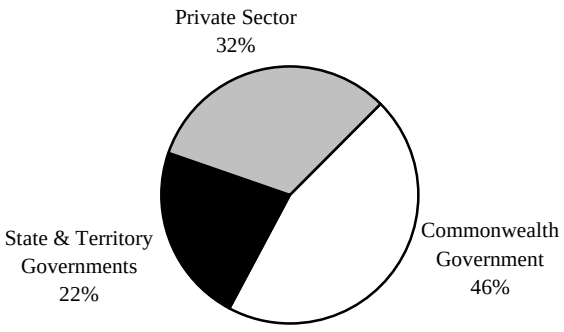
15.1 The source of funding for total health care expenditure comprises both public and private sectors. As indicated in Table 5 and Figure 6, two-thirds of total health care expenditure is funded by governments. In 1995-96, the Commonwealth paid 45.2% and State and Local Governments paid 22.4% of total health care expenditure. The private sector paid about one-third of total health care expenditure.

Table 5 – Total Health Care Financing 1986-87 to 1995-96 (%)

Year*	Public Sector			Private Sector	Grand total
	Commonwealth Govt.	State & Local Govt.	Sub-total		
1986-87	44.3	26.4	70.8	29.2	100.0
1987-88	44.0	26.0	70.1	29.9	100.0
1988-89	42.6	26.0	68.6	31.4	100.0
1989-90	42.1	26.0	68.1	31.9	100.0
1990-91	42.2	25.4	67.6	32.4	100.0
1991-92	42.7	24.5	67.2	32.8	100.0
1992-93	43.7	23.6	67.3	32.7	100.0
1993-94	45.4	21.9	67.2	32.8	100.0
1994-95	44.8	22.2	67.0	33.0	100.0
1995-96#	45.2	22.4	67.7	32.3	100.0

Remarks: * Information of 1989-96 is from Health Expenditure Bulletin No. 13, July 1997, Table 6, p4.
Based on preliminary AIHW and ABS estimates.
Sources : Health Expenditure Bulletin No. 12, December 1996, AIHW, Table 4, p5
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 6, p4

Figure 6 – Total Health Care Financing 1995-96



Sources : Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 6, p4

1986-87 to 1989-90

15.2 From 1986-87 to 1989-90, the proportion of total health care expenditure funded by all levels of government fell from 70.8% to 68.1%. In particular, the Commonwealth's funding fell from 44.3% to 42.1%, and the State Governments' share remained constant.

15.3 There are few reasons for this change. In 1986, the Commonwealth abolished private hospital bed-day subsidy, and reduced the subsidized portion of the cost of pharmaceuticals. In 1987, it increased the gap between the Schedule fees and the medical benefit paid, i.e. from 15% to 25% for medical services undertaken in hospitals.

1990-91 to 1995-96

15.4 From 1990-91 to 1995-96, total health care expenditure by the Commonwealth increased from 42.2% to 45.2% whereas State, Territory and Local Governments' share decreased from 25.4% to 22.4%.

15.5 As discussed in paragraphs 14.5 and 14.7, medical and pharmaceutical services increased as the population became more health conscious and as old drugs were replaced by newer, more expensive drugs. The spending by the Commonwealth increased accordingly since it had to pay Medicare and PBS benefits. Besides, the government could not control the amount of spending on health care services as it was determined by doctors and patients.

15.6 As for State Governments, there was a reduction in the number of psychiatric hospital beds because treatment of patients was shifted to other Commonwealth health care programmes which did not incur institutional stay; as a result, expenditure on psychiatric hospitals decreased during this period.

15.7 Besides, there was a real decrease in the funding from the Commonwealth to the State and Local Governments on health care services. Between 1984-85 and 1989-90, the average growth was at 5.5%, but from 1989-90 to 1993-94, it fell to 0.6% in real terms. [23]

[23] Australia's Health 1996, AIHW, p126.

16. Public Expenditure on Health Care and Funding

Public Expenditure on Health Care

Public Expenditure on Health Care vs. Total Public Expenditure

16.1 Public expenditure on health care is the money spent on health care services by all levels of government. Table 6 shows the proportion of public expenditure on health care to total public expenditure. Public expenditure on health care accounted for about 15% of total public expenditure between 1991-92 and 1995-96.

Table 6 –Public Expenditure on Health Care vs. Total Public Expenditure 1991-92 to 1995-96 (A$ million)*

Year	Public expenditure on health care	Total public expenditure	% of public exp. on health care to total public exp.
1991-92	21,425	160,176	13.4
1992-93	22,594	163,687	13.8
1993-94	23,572	165,373	14.3
1994-95	25,147	176,937	14.2
1995-96	27,424	174,213	15.7

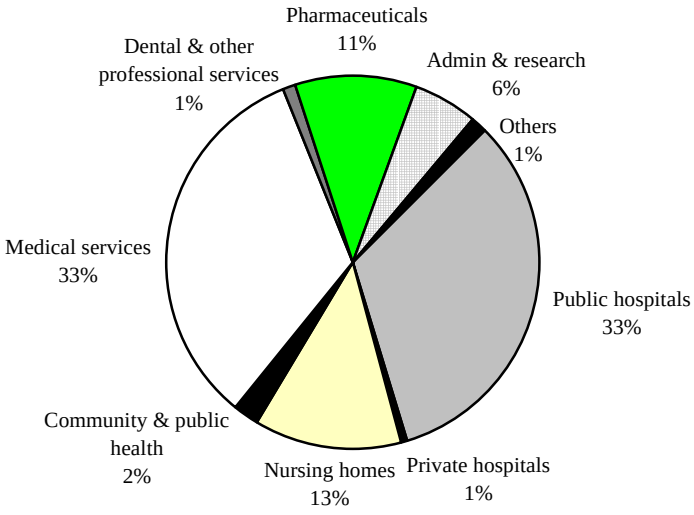
Remark: * Figures are consolidated outlays of all levels of governments.
Source: 1997 Year Book Australia, ABS, Table 26.7, p633

Public Expenditure on Health Care by Area of Expenditure

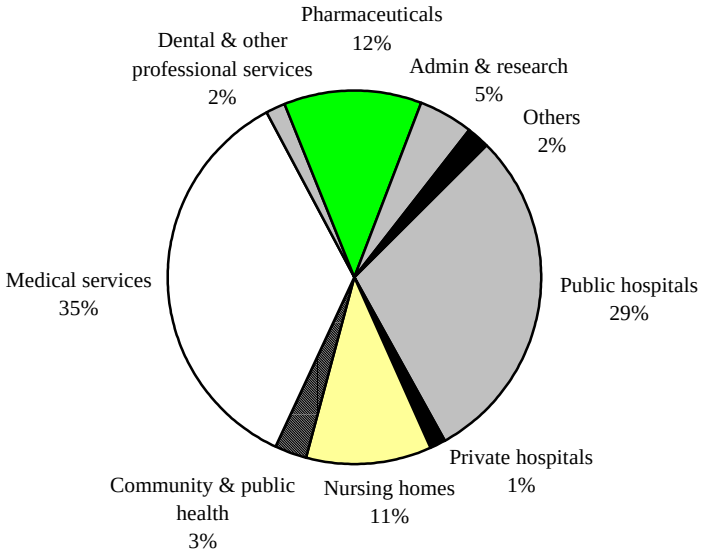
16.2 Figure 7 shows the difference in the various areas of public expenditure on health care by the Commonwealth in the years 1989-90 and 1994-95.

Figure 7 - Public Expenditure on Health Care by Commonwealth Government by Area of Expenditure in 1989-90 and 1994-95

1989-90



1994-95



Remarks:

(a) Public hospitals include public acute hospitals, repatriation hospitals and public psychiatric hospitals.

(b) Others include ambulance services, aids and appliances, other institutional and non-institutional services not elsewhere classified.

Sources: Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 12 & 17

16.3 It can be seen that the proportion of medical and pharmaceutical services increased from 33% and 11% to 35% and 12% of the Commonwealth's expenditure on health care respectively. Such growth reflected an increase in utilization of medical and pharmaceutical services.

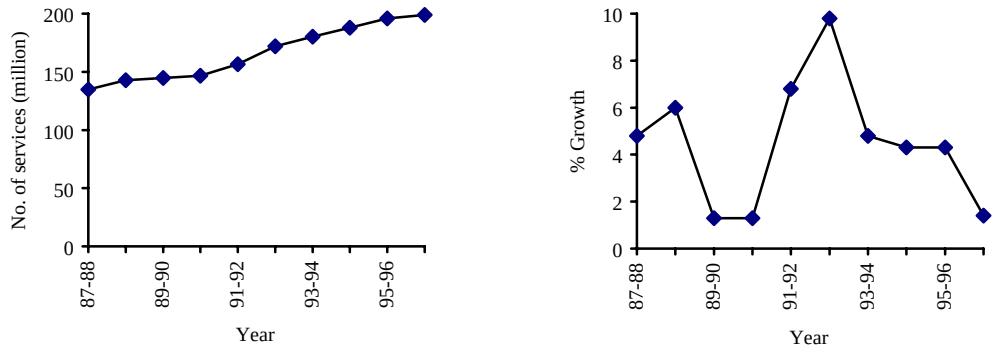
16.4 Table 7 and Figure 8 show the changes in the number of medical services covered by Medicare. In 1991-92 and 1992-93, the number of medical services covered by Medicare had a significant growth by 6.8% and 9.8% respectively. By 1996-97, the number almost reached 200 million.

Table 7 - Number of Medical Services Covered by Medicare 1987-88 to 1996-97

Year	No. of services (million)	% Growth
1987-88	134.8	+4.8
1988-89	142.9	+6.0
1989-90	144.7	+1.3
1990-91	146.6	+1.3
1991-92	156.6	+6.8
1992-93	172.0	+9.8
1993-94	180.2	+4.8
1994-95	188.0	+4.3
1995-96	196.0	+4.3
1996-97	198.8	+1.4

Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A1

Figure 8 - Number of Medical Services Covered by Medicare 1987-88 to 1996-97



Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A1

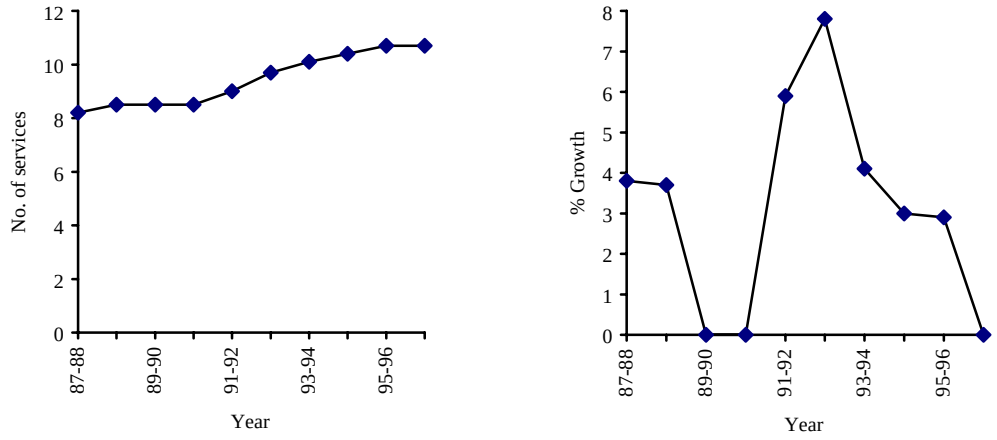
16.5 Table 8 and Figure 9 show that the per capita medical services covered by Medicare increased by 5.9% and 7.8% in the corresponding periods. As discussed in paragraph 14.5, people have become more health conscious and use more health care services.

Table 8 - Per Capita Medical Services Covered by Medicare 1987-88 to 1996-97

Year	No. of services	% Growth
1987-88	8.2	+3.8
1988-89	8.5	+3.7
1989-90	8.5	-
1990-91	8.5	-
1991-92	9.0	+5.9
1992-93	9.7	+7.8
1993-94	10.1	+4.1
1994-95	10.4	+3.0
1995-96	10.7	+2.9
1996-97	10.7	-

Source: Medicare Statistics, December Quarter 1997, Department of Health and Family Services, Table B1

Figure 9 - Per Capita Medical Services Covered by Medicare 1987-88 to 1996-97



Source: Medicare Statistics, December Quarter 1997, Department of Health and Family Services, Table B1

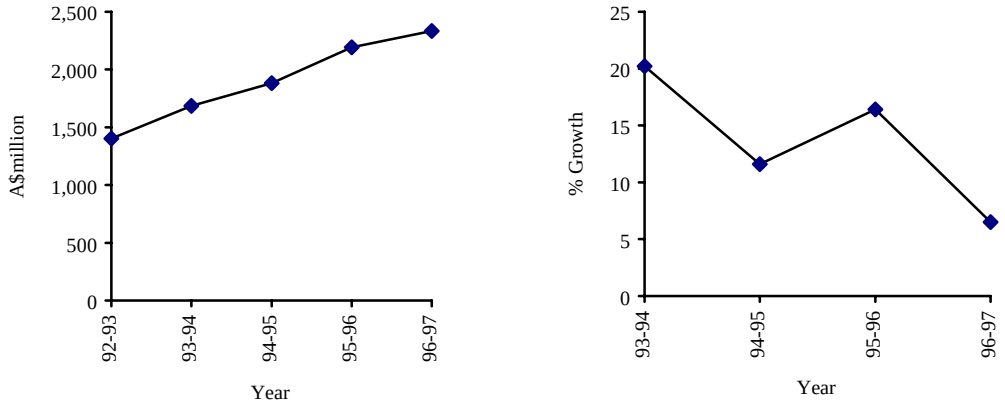
16.6 Table 9 and Figure 10 show the benefits paid under PBS from 1992-93 to 1996-97. PBS benefits registered a growth of 11.6% to 20.2% in 1993-96. The factors attributed to the growth were the ageing of population, increasing prevalence of chronic disorders, increasing number of concessional patients, increasing prices of new products, changes in prescribing more expensive drugs and changes in patient and community expectations.

Table 9 - Benefits Paid Under Pharmaceutical Benefits Scheme 1992-93 to 1996-97

Year	A$ million	% Growth
1992-93	1,403	n.a.
1993-94	1,686	+20.2
1994-95	1,882	+11.6
1995-96	2,191	+16.4
1996-97	2,333	+6.5

Remark: n.a. Not available.
Source: Annual Report 96-97, Health Insurance Commission, Table 15

Figure 10 - Benefits Paid Under Pharmaceutical Benefits Scheme 1992-93 to 1996-97

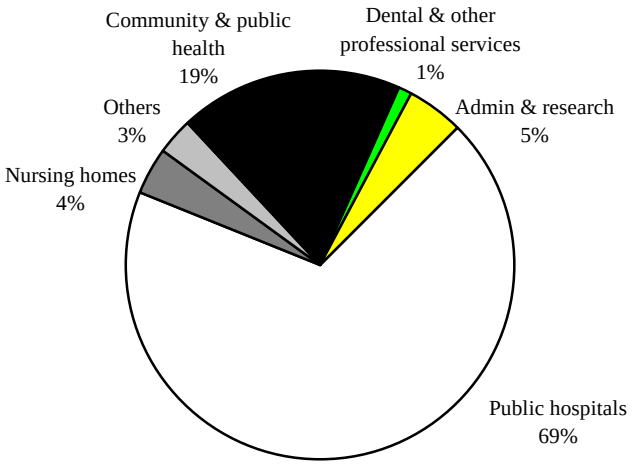


Source: Annual Report 96-97, Health Insurance Commission, Table 15

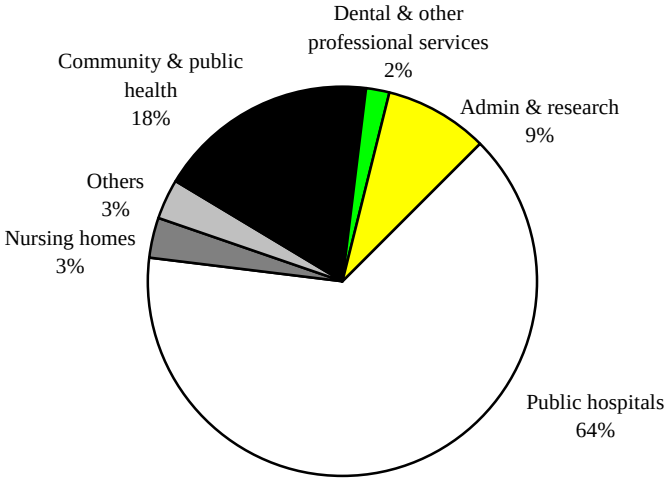
16.7 Figure 11 shows the public expenditure on health care of State and Local Governments by area of expenditure in 1989-90 and 1994-95. The proportion of expenditure on public hospitals decreased from 69% to 64%. The decline might be due to the establishment of Home and Community Care Programme and Mental Health Care Programme which reduced institutional admissions. State and Local Governments also spent a lot (18% in 1994-95) on community and public health care services.

Figure 11 - Public Expenditure on Health Care by State and Local Governments by Area of Expenditure in 1989-90 and 1994-95

1989-90



1994-95



Remarks:

(a) Public hospitals include public acute hospitals, repatriation hospitals and public psychiatric hospitals.

(b) Others include ambulance services, aids and appliances, other institutional and non-institutional services not elsewhere classified.

Sources: Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 12 & 17

16.8 The decreasing utilization of public acute hospitals is further illustrated by Table 10. From 1985-86 to 1993-94, the total number of admissions had increased, but the average length of stay decreased from 6.9 days to 4.8 days and the total number of bed-days remained stable. Besides, there was negative growth in non-admitted patient services. This reflected a shift from in-patient services to out-patient care.

Table 10 - Utilization of Public Acute Hospitals 1985-86 to 1993-94

Utilization of public acute hospitals	**1985-86**	**1987-88**	**1989-90**	**1991-92**	**1992-93**	**1993-94**
No. of admissions ('000)	2 466	2 622	2 790	3 025	3 118	3 387
% growth	n.a.	+6.3	+6.4	+8.4	+3.1	+8.6
Average length of stay (days)	6.9	6.5	6.0	5.3	5.2	4.8
% growth	n.a.	-5.8	-7.7	-11.7	-1.9	-7.7
No. of bed-days	16 891	17 098	16 669	16 122	16 212	16 289
% growth	n.a.	+1.2	-2.5	-3.3	+0.6	+0.5
Non-admitted patient services ('000)	37 666	43 711	38 209	30 676	33 093	30 562
% growth	n.a.	+16.0	-12.6	-19.7	+7.9	-7.6

Remark: n.a. Not available.
Source: Australia's Health 1996, AIHW, Table 5.9, p152

Public Funding for Health Care

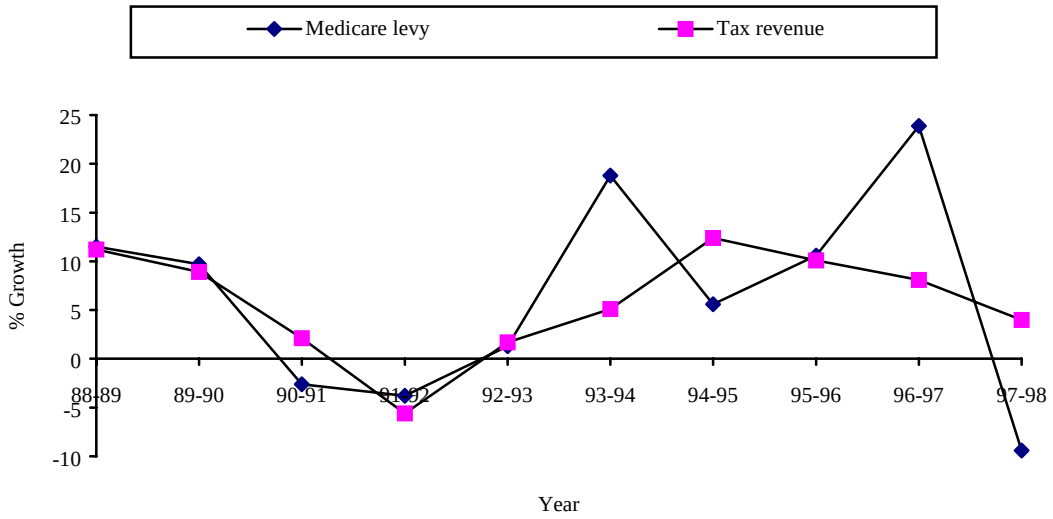
16.9 As discussed in Section 13, the main source of income of the Government in funding health care services is from tax revenue including Medicare levy. Table 11 and Figure 12 show the fluctuations in government revenue.

Table 11 – Changes in Medicare Levy and Tax Revenue* 1988-89 to 1997-98

Year	Medicare levy			Tax revenue		
	A$ million	% to total revenue	% Growth	A$ million	% to total revenue	% Growth
1988-89	2,320	2.6	+11.5	83,897	94.5	+11.2
1989-90	2,545	2.7	+9.7	91,343	95.2	+8.9
1990-91	2,480	2.5	-2.6	93,225	95.0	+2.1
1991-92	2,385	2.6	-3.8	87,970	94.1	-5.6
1992-93	2,415	2.5	+1.3	89,434	94.1	+1.7
1993-94	2,870	2.8	+18.8	94,024	93.3	+5.1
1994-95	3,030	2.7	+5.6	105,687	95.7	+12.4
1995-96	3,350	2.8	+10.6	116,386	95.6	+10.1
1996-97	4,150	3.2	+23.9	125,815	96.0	+8.1
1997-98 (a)	3,760	2.8	-9.4	130,827	96.6	+4.0

Remarks: (a) Revised Estimate.
* Tax revenue includes Medicare levy.
Source: 1998-99 Budget, Department of Administration and Finance, Table BI and BIV

Figure 12 – Changes in Medicare Levy and Tax Revenue* 1988-89 to 1997-98



Remark: * Tax revenue includes Medicare levy.
Source: 1998-99 Budget, Department of Administration and Finance, Table BI and BIV

16.10 It can be seen that between 1988-89 and 1997-98, Medicare levy accounted for only 2-3% of total revenue. In this period, the fluctuation was due to the upward adjustment of Medicare levy from 1% of taxable income from its commencement to 1.25% in 1986, 1.4% in 1993, 1.5% in 1995. In the early 1990s Medicare levy registered a negative growth because of the adverse economic situation and lower taxable income.[24]

16.11 Table 12 demonstrates the significance of Medicare levy in funding total health care expenditure between 1991-92 and 1995-96. Medicare levy covered about 8% of total health care expenditure, and about 12% of public expenditure on health care.

Table 12 - Proportion of Medicare Levy to Public and Total Health Care Expenditure 1991-92 to 1995-96

Year	Medicare levy		
	A$ million	% to public exp. on health care	% to total health care exp.
1991-92	2,385	10.7	7.2
1992-93	2,415	10.3	6.9
1993-94	2,870	11.8	7.8
1994-95	3,030	11.7	7.8
1995-96	3,350	11.9	8.0

Sources: 1997-98 Budget, Department of Administration and Finance, Table B1
Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 12-17

17. Private Health Care Expenditure and Financing

Private Health Care Expenditure

17.1 In Australia, private health care expenditure is the amount of money spent on health care services in the form of claims payment made to health care providers by private health insurance funds, Workers' Compensation, Compulsory Motor Vehicle Third Party insurance providers and by individuals directly; among which individuals and private insurance funds account for about 55% and 35% of private health care expenditure respectively.

17.2 Table 13 shows the private health care expenditure as a proportion of private consumption. Private health care expenditure accounted for 4.5% of total private consumption.

[24] In 1996-97, the Commonwealth collected an extra 0.2% Medicare levy to finance the National Firearms Programme under which firearm owners, dealers and collectors would receive compensation for surrender of designated guns, but this was an one-off measure.

Table 13 - Proportion of Private Health Care Expenditure to Private Consumption 1991-92 to 1995-96 (A$ million)

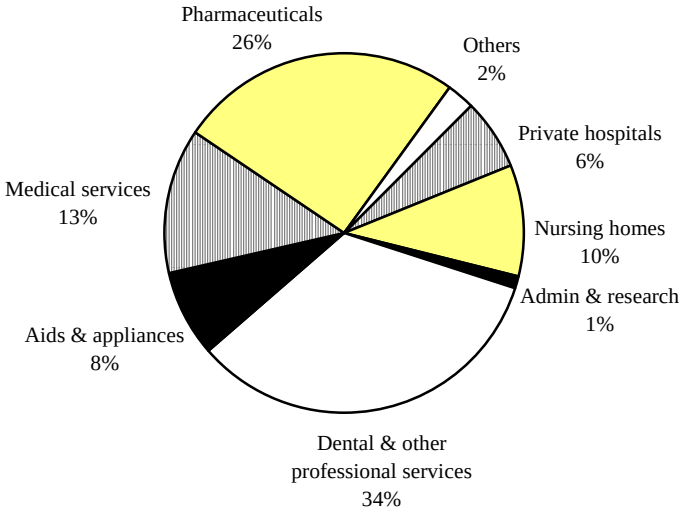
Year	Private health care exp.	Private consumption	% of private health care exp. to private consumption
1991-92	10,908	242,328	4.5
1992-93	11,435	254,277	4.5
1993-94	11,988	266,478	4.5
1994-95	12,840	283,983	4.5
1995-96	13,501	303,766	4.4

Sources: 1997 Year Book Australia, ABS, Table 28.4, p675
Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 5, p4

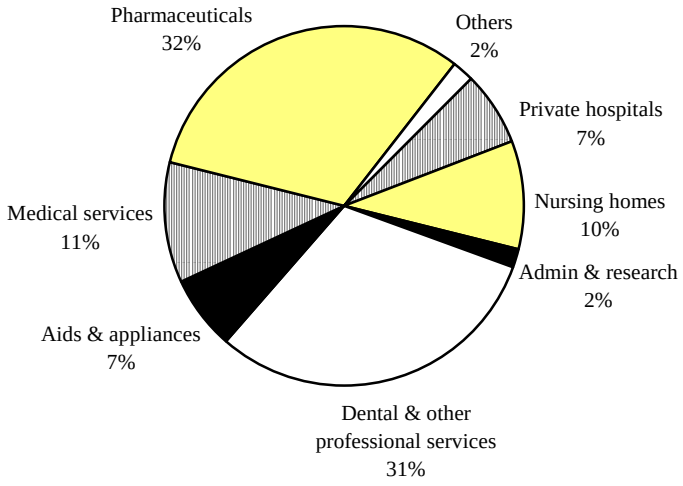
17.3 Figure 13 shows the difference in spending pattern by individuals on areas of health care services in 1989-90 and 1994-95. It can be seen that individuals' expenditure on dental and other professional services, and on pharmaceuticals is comparatively high. In particular for pharmaceuticals, the proportion increased from 26% in 1989-90 to 32% in 1994-95. This could be due to the increase in newer and more expensive drugs being prescribed as discussed in paragraph 14.7.

Figure 13 - Health Care Expenditure of Individuals by Area of Expenditure in 1989-90 and 1994-95

1989-90



1994-95



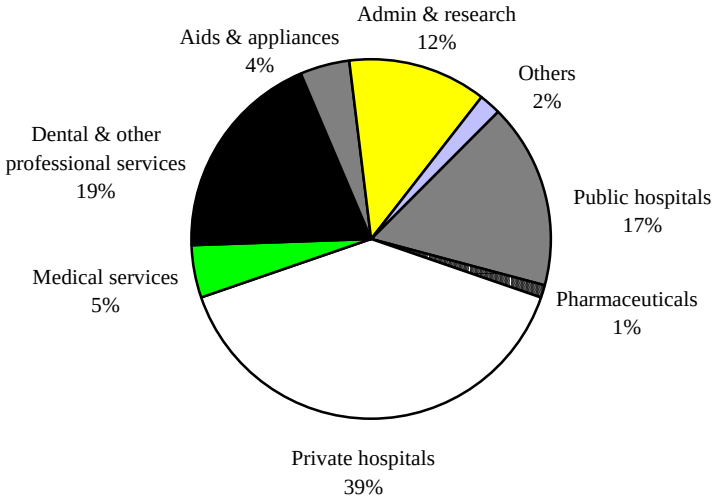
Remark: Others include ambulance services, other institutional and non-institutional services not elsewhere classified.

Source: Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 12 & 17

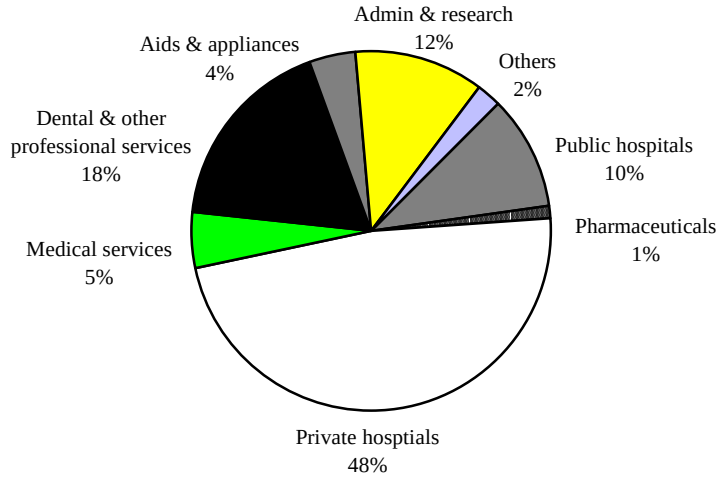
17.4 Figure 14 shows the changes in health care spending by private health insurance funds. Nearly half of the insurance claims are to cover private hospital charges. It could be due to the increase in utilization of private hospitals and the increase in the cost of hospital services. Table 14 shows the utilization of private hospitals. It can be seen that the number of bed-days had a steady growth during this period. The growth rate of 3% in bed-days in private hospitals contrasted strongly with that of 0.5% in public hospitals.

Figure 14 - Health Care Expenditure of Private Health Insurance Funds by Area of Expenditure in 1989-90 and 1994-95

1989-90



1994-95



Remarks:

(a) Public hospitals include public acute hospitals, repatriation hospitals and public psychiatric hospitals.

(b) Others include ambulance services, other institutional and non-institutional services not elsewhere classified.

Sources: Health Expenditure Bulletin, No.13, July 1997, AIHW, Table 12 & 17

Table 14 - Utilization of Private Hospitals 1985-86 to 1993-94

Use/Acute hospital type	1985-86	1987-88	1989-90	1991-92	1992-93	1993-94
No. of admissions ('000)	872	878	1 018	1 157	1 202	1 251
% growth	n.a.	+0.7	+15.9	+13.7	+3.9	+4.1
Average length of stay (days)	5.5	5.2	4.6	4.2	4.2	4.1
% growth	n.a.	-5.5	-11.5	-8.7	-	-2.4
No. of bed-days ('000)	4 766	4 532	4 731	4 891	5 006	5 172
% growth	n.a.	-4.9	+4.4	+3.4	+2.4	+3.3

Remark: n.a. Not available
Source: Australia's Health 1996, AIHW, Table 5.9, p152

Private Health Care Financing

Financing by Individuals

17.5 The 1993-94 Household Expenditure Survey provides estimates of expenditure on medical and health care by households across Australia. Expenditure in this context is net of any refunds and rebates received from Medicare, private health insurance funds and employers, i.e. the out-of-pocket money each household spent on health care services.

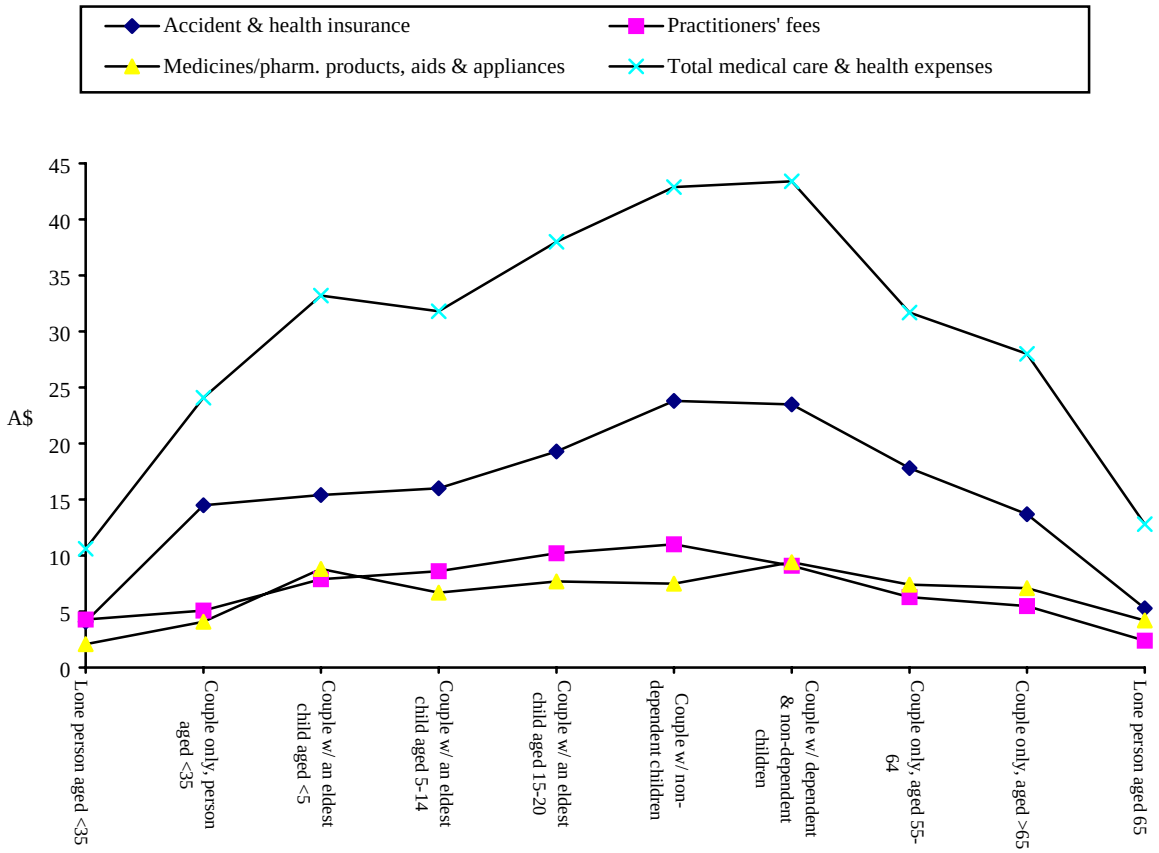
17.6 Table 15 and Figure 15 provides an analysis of the expenditure on medical and health care services by households in 1993-94. It can be seen that household expenditure on medical and health care services varies according to different stage of the life cycle of a household. For single persons aged under 35 years, whose household size and income were relatively low, spending on medical and health care services was A$10.6 per week, accounting for 2.2% of weekly household income. As the cycle progressed and household size and income increased, spending on medical and health care services also increased, reaching its highest at the stage when the household consisted of a couple with non-dependent children, i.e. A$43.4 per week, equivalent to 3.9% of weekly household income. By the time a household comprised one person only, aged 65 years and over, spending on health care decreased to A$12.8 per week; however, it then accounted for 6.0% of weekly household income.

Table 15 – Weekly Household Spending on Medical and Health Care Services by Different Stage of Life Cycle 1993-94 (A$)

Types of family	Accident & health insurance	Practitioners' fees	Medicines/ pharm. products, aids & appliances	Other health charges	Total medical care & health expenses	% of total medical care & health exp. to average weekly household income
Lone person aged <35	4.1	4.3	2.1	0.1	10.6	2.2
Couple only, person aged <35	14.5	5.1	4.1	0.3	24.1	2.5
Couple w/ an eldest child aged <5	15.4	7.9	8.8	1.1	33.2	4.2
Couple w/ an eldest child aged 5-14	16.0	8.6	6.7	0.6	31.8	3.8
Couple w/ an eldest child aged 15-20	19.3	10.2	7.7	0.8	38.0	3.7
Couple w/ non-dependent children	23.8	11.0	7.5	0.7	42.9	3.2
Couple w/ both dependent & non-dependent children	23.5	9.1	9.4	1.4	43.4	3.9
Couple only, aged 55-64	17.8	6.3	7.4	0.2	31.7	5.8
Couple only, aged >65	13.7	5.5	7.1	1.7	28.0	7.2
Lone person aged >65	5.3	2.4	4.2	0.9	12.8	6.0

Source : Year Book Australia 1997, ABS, Table 8.25, p222

Figure 15 – Weekly Household Spending on Medical and Health Care Services by Different Stage of Life Cycle 1993-94 (A$)



Source : Year Book Australia 1997, ABS, Table 8.25, p222

Financing by Private Health Insurance Funds

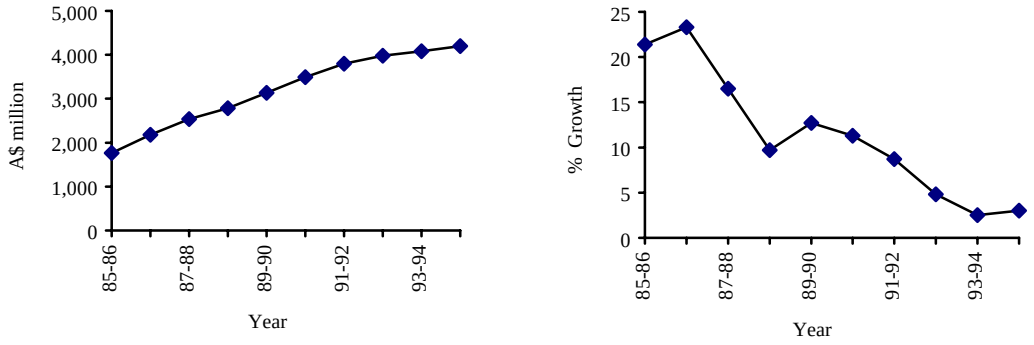
17.7 Table 16 and Figure 16 show the financing of health care services by private health insurance funds. Private health insurance had a significant growth in the mid-1980s but the rate slowed down since early 1990s.

Table 16 - Health Care Spending by Private Health Insurance Funds 1985-86 to 1994-95

Year	Private health insurance		
	A$ million	% Growth	% to total health care exp.
1985-86	1,767	+21.4	9.5
1986-87	2,178	+23.3	10.3
1987-88	2,537	+16.5	10.9
1988-89	2,783	+9.7	10.7
1989-90	3,136	+12.7	10.9
1990-91	3,491	+11.3	11.2
1991-92	3,796	+8.7	11.5
1992-93	3,979	+4.8	11.4
1993-94	4,078	+2.5	11.2
1994-95	4,201	+3.0	10.9

Source : Health Expenditure Bulletin, No.12, December 1996, AIHW, Table 7, p8

Figure 16 - Health Care Spending by Private Health Insurance Funds 1985-86 to 1994-95



Source : Health Expenditure Bulletin, No.12, December 1996, AIHW, Table 7, p8

17.8 One reason attributed to the significant growth in the mid-1980s was the abolition of the Commonwealth's private hospital subsidy in 1986 as mentioned in paragraph 15.3. This led to an increase in health insurance contributions since the abolition required funds to compensate the benefits claimed.

17.9 The other reason was that in 1987, the Commonwealth reduced the benefit paid for in-patient medical services from 85% to 75% of the schedule fee, the rest was paid by individuals or covered by private health insurance. Usually this gap is covered by the latter.

17.10 The increase was also due to the high growth in benefits paid for private hospital services.

Increasing Premiums

17.11 The source of income of private insurance funds comes from premiums contributed by individuals. According to the Industry Commission, average annual growth of health insurance premiums was higher than that of inflation, 9.8% vs. 2.9%. It was due to the increase in hospital utilization, in particular the shift of the insured to obtain treatment in private hospitals rather than in public hospitals. Other reasons were due to the increase in private hospital admission charges, increase in insurance cover, increase in volume of aids and appliances used, ageing, adverse selection, and the increase in health fund management expenses.

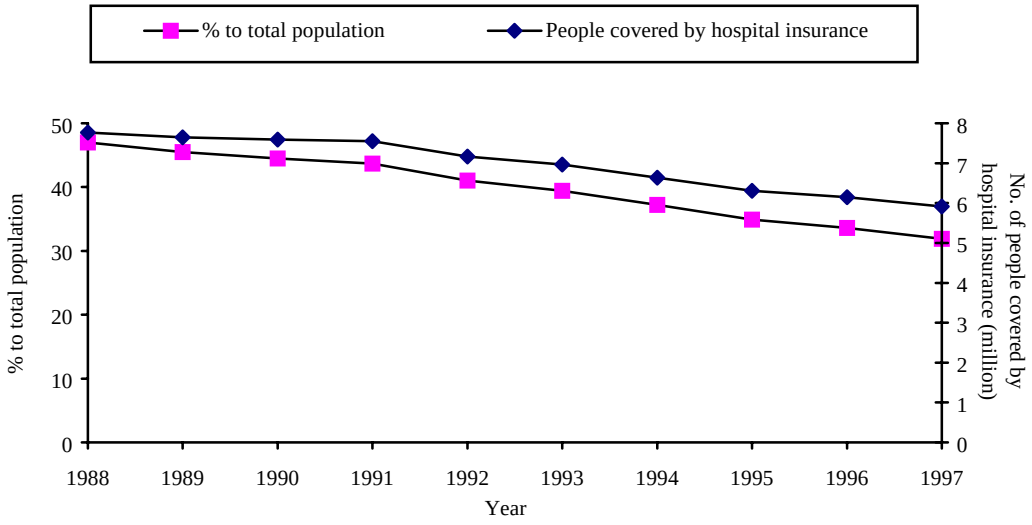
17.12 Since premiums for private health insurance are rising, fewer people can afford to choose private health insurance and fund membership is falling. Table 17 and Figure 17 illustrate the number of people covered by hospital insurance in 1988 to 1997. Both the size of membership and the proportion to total population were declining.

Table 17 - Number of People covered by Hospital Insurance 1988 to 1997 (as at 30 June)

Year	No. of people (million)	% to total population
1988	7.8	47.0
1989	7.6	45.5
1990	7.6	44.5
1991	7.5	43.7
1992	7.2	41.0
1993	7.0	39.4
1994	6.6	37.2
1995	6.3	34.9
1996 (revision)	6.1	33.6
1997 (preliminary)	5.9	31.9

Source: Private Health Insurance Administration Council, Quarterly Statistics, June 1997

Figure 17 - Number of People covered by Hospital Insurance 1988 to 1997 (as at 30 June)



Source: Private Health Insurance Administration Council, Quarterly Statistics, June 1997

PART 5 – ANALYSIS ON HEALTH CARE FINANCING ARRANGEMENTS

18. Evaluation on the Performance of Medicare

18.1 As discussed in paragraph 16.1, the governments spend 15% of total public expenditure on health care, with a large portion being used to finance Medicare. Therefore, it is necessary to evaluate the performance of Medicare.

Consumer Acceptance

18.2 The 1996 customers satisfaction research conducted on behalf of the HIC indicated that 93% of customers supported the Medicare programme. The key reasons given were that everyone was covered, it gave assistance to low income earners, and it was considered good value for money.[25] Table 18 and Figure 18 below show the average patient contribution per service.

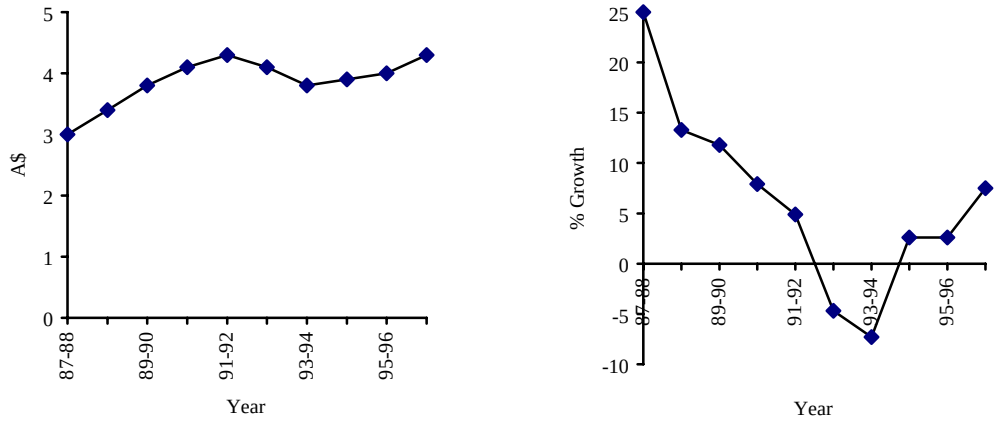
Table 18 - Average Patient Contribution Per Service under Medicare (Patient and Direct Billed Services) 1987-88 to 1996-97

Year	A$	% Growth
1987-88	3.0	+25.0
1988-89	3.4	+13.3
1989-90	3.8	+11.8
1990-91	4.1	+7.9
1991-92	4.3	+4.9
1992-93	4.1	-4.7
1993-94	3.8	-7.3
1994-95	3.9	+2.6
1995-96	4.0	+2.6
1996-97	4.3	+7.5

Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A6

[25] Annual Report 1996-97, Commonwealth Department of Health and Family Services, p84.

Figure 18 - Average Patient Contribution Per Service under Medicare (Patient and Direct Billed Services) 1987-88 to 1996-97



Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A6

Access

18.3 Under Medicare, all citizens have access to out-patient medical services at reasonable charges, free access to public hospital services and access to a comprehensive range of drugs at reasonable cost.

Waiting Time

18.4 Since all Australians have free access to in-patient treatment, concern over equity has shifted to public patients' waiting time for elective surgery in public hospitals.

18.5 Table 19 shows the clearance time for elective surgery by clinical specialty for public hospitals in 1995. The longest clearance time was for orthopaedic surgery (4.2 months) while the shortest was for cardio-thoracic surgery (1.1 months). The national average was 2.7 months.

Table 19 - Clearance Time for Elective Surgery by Clinical Specialty For Public Acute Hospitals 1995

Clinical Specialty	Clearance Time (months)
Cardio-thoracic surgery	1.1
Ear nose and throat	4.0
General surgery	2.2
Gynaecology	1.8
Neurosurgery	1.3
Ophthalmology	3.6
Orthopaedic surgery	4.2
Plastic surgery	3.8
Urology	2.9
Vascular surgery	2.5
Other	1.0
All patients	2.7

Source: Report on Government Service Provision 1997, Volume 1, Steering Committee for the Review of Commonwealth/State Service Provision, Table 5A.17, p213

Quality of Services

18.6 The Australian Council on Healthcare Standards (ACHS) is an independent not-for-profit organization which aims at improving the quality of health care in Australia. ACHS is governed by a Council of 22 member organizations who represent key stakeholders in health care. In 1996, it launched the Evaluation and Quality Improvement Programme (EQuIP) and developed a set of clinical indicators which measures the management and outcome of patient care.

18.7 The percentage of beds accredited by the ACHS has been selected as an indicator of quality of health care because success in the ACHS programme requires demonstrated adherence to quality assurance practices. Table 20 shows the percentage of public hospital beds accredited by ACHS. Except for Queensland, over 70% of public hospitals in various States are accredited by ACHS.

Table 20 - Public Hospital Beds Accredited by the ACHS as at 30 June 1995 (%)

	NSW	Vic	Qld	WA	SA	Tas *	ACT	NT	Aust
Public	76	83	48	76	71	87	100	na	na
Private	Na	72	77	75	81	66	100	na	na
Total	na	na	58	76	74	79	100	na	na

Remarks: * indicates as at 30 June 1996.
na Not available.
Source: Report on Government Service Provision 1997, Volume 1, Steering Committee for the Review of Commonwealth/State Service Provision, Table 5A.15, p212

Consumer Choice

Choice of Provider

18.8 People have free choice of providers for out-patient services, although there may be limitations in rural areas because of the small number of providers. However, they do not have the choice of in-patient doctors and specialists.

Choice of Consumer Contribution

18.9 Since Medicare levy is a kind of compulsory tax contribution, even one does not use any health care services, one still needs to pay Medicare levy. Only people earning less than the specified income are exempted.

Complaints on Medicare

18.10 In 1996-97, the Commonwealth Department of Health and Family Services received 2,194 complaints. Complaints related to the payment of Medicare benefits were passed to the HIC for investigation. Complaints about inappropriate treatment which did not have a Medicare component were referred to State and Territory health care complaint authorities.

Moral Hazard

18.11 Although the Commonwealth has control over the benefit per service reimbursed through Medicare, there is no control on the volume of services provided and thus on total expenditure. Much of the growth in the volume of medical services has been in pathology and diagnostic radiology, areas which are suggestive of supplier-induced demand. In addition, as patients value health care services at less than the cost of provision, they may over-use the services.

Financial Burden on Governments

18.12 As Medicare is well received by the Australians and as they become more health conscious, increase in usage is inevitable. However, the payment for these services is mainly funded by the Commonwealth, the source of income of which is taxation. The amount of tax generated from salary, wages and profit may decrease in the trough of the economic cycle. However, demand for health care is not affected by economic downturn. Hence, a possible reduction in tax revenue in an economic downturn may affect government spending on public services, and to some extent, hamper the amount of health care service provided.

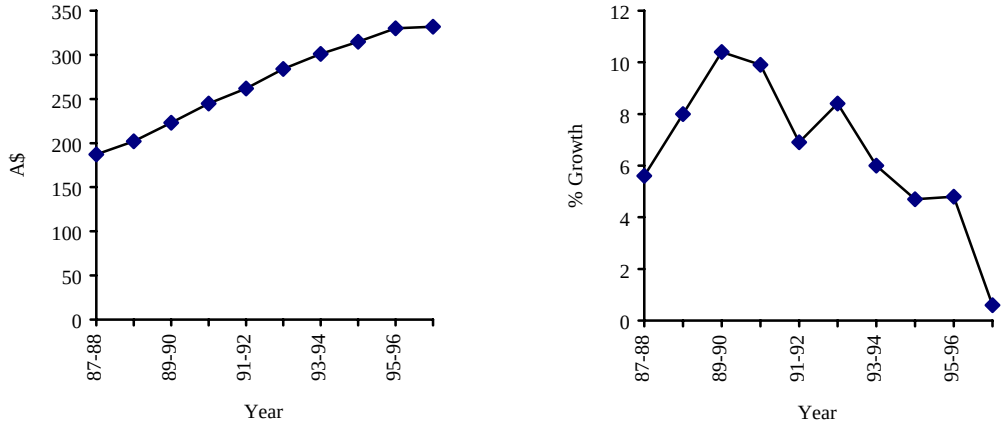
18.13 With the increasing growth in Medicare benefits and the unstable growth in tax revenue, the Commonwealth has taken some measures to constrain the growth in MBS and PBS. Table 21 and Figure 19 show Medicare benefits paid per capita during 1987-88 to 1996-97.

Table 21 - Medicare Benefits Paid Per Capita 1987-88 to 1996-97

Year	A$	% Growth
1987-88	187	+5.6
1988-89	202	+8.0
1989-90	223	+10.4
1990-91	245	+9.9
1991-92	262	+6.9
1992-93	284	+8.4
1993-94	301	+6.0
1994-95	315	+4.7
1995-96	330	+4.8
1996-97	332	+0.6

Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A4

Figure 19 - Medicare Benefits Paid Per Capita 1987-88 to 1996-97



Source: Medicare Statistics, December Quarter 1997, Commonwealth Department of Health and Family Services, Table A4

19. Evaluation on the Performance of Private Health Insurance

19.1 In Australia, private health insurance accounted for one-third of private health care expenditure, therefore the efficiency and effectiveness of this system is the main concern of the insured.

Consumer Choice

Choice of provider

19.2 Under private health insurance, patients have free choice of doctors and specialists and also have the choice of staying in either public or private hospitals.

Choice of consumer contribution

19.3 Patients must pay premiums for their hospital covers, and optional ancillary covers are available.

Adverse Selection

19.4 Community rating may dull the incentive for insurance funds to reduce costs, especially in those risk categories covered by reinsurance. It also precludes the development of some insurance products which may have high demand. Besides, it hightens 'adverse selection' whereby lower risk people will withdraw and those expecting to make claims will join.

19.5 These effects may create an inherent instability in the industry. They add to what has become a vicious circle, in which rising premiums lead to the lower risk members dropping out first. This does not only shrink the pool of insured but raises its overall risk, leading to higher pay outs and higher premiums again.

Disincentive Effects

19.6 To underpin community rating, reinsurance arrangement serves to even out differences in the burden of claims resulting from older or chronically ill members. However, it weakens the incentives in cost control and select cheaper out-of-hospital treatments.

Lack of Knowledge in Health Insurance Products

19.7 The complexity of health insurance products has meant that many consumers are unaware of the exact nature of the benefits to which they are entitled until they need to claim. Consumers also face a daunting task in deciding what level of cover to take up and in comparing the offerings of different funds.

Hidden Administration Cost

19.8 Currently, contributors face a proliferation of bills after private hospital treatment, requiring multiple claims through Medicare and their private health insurance funds. The system's inefficiencies and hidden costs to consumers are considerable.

Moral Hazard

19.9 Under Medicare and the private health insurance system, the prices of health care services are either zero or very low, people may buy more health services than they really need.

20. Medicare vs. Private Health Insurance

20.1 Table 22 compares the benefits and costs of Medicare and private health insurance. It can be seen that private health insurance provides choice of selection in surgeons, hospitals and ancillary coverage, but the cost concerned is significant. In contrast, Medicare provides free access to in-patient and out-patient treatment and the out-of-pocket cost involved is limited.

Table 22 – Comparison of Benefits Provided by Private Health Care Insurance and Medicare

Key variable	Private health insurance	Medicare
Hospitalization	Full payment	Full payment
Surgeon fee	Out-of-pocket expenses can be large if not under full cover	Full payment
Pre/post hospital doctor visits	Not available	Yes
'Hospital' in the home	Not available	Yes
Choice of surgeon	Yes	Depends on referral pattern
Choice of hospital	Public or private hospital	Public hospital only
Waiting time for electives	A few weeks	Much longer, particularly in key specialties
Ancillary cover	Full or partial payment for dental, glasses, etc.	Very limited
Cost	About A$2,000 per family in addition to Medicare levy and tax	Medicare levy and tax

Source : Private Health Insurance, Industry Commission, Report No. 57, Table 2.1, p15

21. Health Care Expenditure and Financing and Health Outcome in Australia and Hong Kong

21.1 Table 23 shows the health care expenditure in both Australia and Hong Kong. In 1995-96, total health care expenditure of Australia was 4.6 times more than that of Hong Kong, despite its population was only 3 times as many as Hong Kong. Health care expenditure per Australian was 1.5 times more than each Hong Kong resident.

21.2 Australia spent more on health care than Hong Kong. It accounted for 8.5% of GDP comparing to 5.0% of GDP in Hong Kong. Two-thirds of health care expenditure was funded by Australian Governments whereas the Hong Kong Government shouldered 44.2% of total health care expenditure.

21.3 Since Australia has a compulsory national health insurance, not many Australians joined private health insurance funds; thus, private health insurance only constituted 11.5% of total health care financing in 1994-95. Since Hong Kong does not have official statistics on private health insurance, health insurance premium is not included in total health care financing.

21.4 The leading causes of death in Australia in 1996 were disease of circulatory system, neoplasms and disease of respiratory system; in Hong Kong, the leading causes of death were malignant neoplasm, heart diseases and pneumonia.

21.5 Although Australia spends more resources on health care services, the health outcomes are similar to that of Hong Kong. Yet, one cannot conclude that the health care system in Australia is less efficient than that of Hong Kong because there are many other factors contribute to good health such as the presence of supportive social and physical environments, people's style of living, genetic endowment and other cultural, educational and economic factors.

Table 23 - Health Care Expenditure and Financing and Health Outcome in Australia and Hong Kong 1995-96

	Hong Kong[1]	Australia[2]
Health Care Expenditure		
Total health care expenditure (HK$ million)	54,895	252,957
Per capita health care expenditure (HK$)	8,698	13,902
Total health care expenditure/GDP (%)	5.0	8.5
Public expenditure on health care/GDP (%)	*2.2*	*5.6*
Private health care expenditure/GDP (%)	*2.8*	*2.8*
Health care expenditure of the insurance industry/GDP 1994-95 (%)	*n.a.*	*0.9*
Health Care Financing		
Total health care financing (HK$ million)	54,895	252,957
Public health care financing/total health care financing (%)	*44.2*	*67.7*
Private health care financing/total health care financing (%)	*55.8*	*32.3*
Health care financing of the insurance industry/total health care financing 1994-95 (%)	*n.a.*	*11.5*
Health Outcomes		
Life expectancy at birth (year) : Male Female	76.3 81.8	75.2 81.1
Infant mortality rate (per 1 000 live births)	4.1	5.8
Leading causes of death	1. Malignant neoplasm 2. Heart diseases 3. Pneumonia 4. Cerebrovascu-lar diseases 5. Injury and poisoning	1. Disease of circulatory system 2. Neoplasms 3. Disease of respiratory system 4. Accidents, poisonings & violence 5. Endocrine, nutritional & metabolic diseases & immunity disorders

Remarks :

1. Refer to RP01/PLC and RP06/PLC for detailed analysis on Hong Kong's health care delivery system and health care expenditure and financing.
2. Averaged exchange rate of Australian dollar in 1996 was A$1.00=HK$6.06.

n.a. Not available.

Sources : Long Term Health Care Policy, RP01/PLC
Health Care Expenditure and Financing in Hong Kong, RP06/PLC
Health Expenditure Bulletin No. 13, July 1997, AIHW, Table 2, 3, 5 and 17
Hong Kong Monthly Digest of Statistics, February 1998, Table 7.12, p108
Deaths, Australia 1996, ABS Catalogue No. 3302.0, ABS Statsite
Causes of Death 1996, Australia in Brief, ABS Statsite

PART 6 - CONCLUDING REMARKS

22.1 In Australia, health care services are provided by both public and private sectors, and sources of income to finance these services come from taxation revenue which includes Medicare levy, premiums contributed by individuals to private health insurance funds and by individuals' direct payments.

22.2 One main characteristic of Australia's health care system is the availability of a compulsory national insurance scheme - Medicare. Income earners pay a low percentage of their taxable income and they can enjoy universal access to free treatment in public hospitals and free or subsidized out-patient medical services.

22.3 Medicare is supplemented by voluntary insurance which is offered by registered private health funds to cover private hospital accommodation and ancillary services.

22.4 Since many services are provided free or at low cost, it may induce excess demand, which in turn leads to increase in health care expenditure. As the governments account for two-thirds of this expenditure, they have to introduce some measures to release the financial burden of the public sector. In 1997-98, anyone who does not hold private hospital cover through private health insurance has to pay additional Medicare levy. The Government also provides private health insurance incentives to encourage those who can afford to join private health insurance schemes.

22.5 It is recognized that for efficiency and equity, financing of health care should be split among different parties. However, there is no consensus on who should take the major responsibility - the Commonwealth, State and Territory Governments, or the private sector.

Appendix I

HEALTH OUTCOMES OF AUSTRALIA

Population in Australia in Selected Years 1906 to 1996 (as at 30 June)

Year	Number ('000)
1906	4 059
1916	4 943
1926	6 056
1936	6 778
1946	7 465
1956	9 426
1966 (a)	11 599
1976 (b)	14 033
1986	16 018
1996 Preliminary	18 311

Remarks:
(a) Prior to 1961, data exclude full-blooded Aboriginal people.
(b) In 1971 there was a break in series due to a change in the definition and measurement of the population.
Source: Population, Australia's States and Territories, Australia in Brief, ABS Statsite, 27/2/98

Infant Mortality Rates in Selected Years 1990 to 1996 (Deaths per 1 000 Live Births)

Year*	Mortality Rate
1990	8.2
1991	7.1
1992	7.0
1993	6.1
1994	5.9
1996	5.8

Remark: * Information of 1996 is from Deaths, Australia 1996, ABS Catalogue No. 3302.0, ABS Statsite. Information of 1995 is not available.
Source: Australia's Health 1996, AIHW, Table S6, p213
Deaths, Australia 1996, ABS Catalogue No. 3302.0, ABS Statsite

Life Expectancy at Birth by Sex 1990 to 1996 (years)

Year	Males	Females
1990	73.9	80.0
1991	74.4	80.3
1992	74.5	80.4
1993	75.0	80.9
1994	75.0	80.9
1995 (a)	75.4	81.1
1996 (b)	75.2	81.1

Remarks:
(a) Information of 1995 is from 1997 Year Book Australia, Australian Bureau of Statistics, Table 5.22, p88.
(b) Information of 1996 is from Deaths, Australia 1996, ABS Catalogue No. 3302.0, ABS Statsite.
Sources: Australia's Health 1996, AIHW, Table S13, p218
Deaths, Australia 1996, ABS Catalogue No. 3302.0, ABS Statsite
1997 Year Book Australia, Australian Bureau of Statistics, Table 5.22, p88

Causes of Death 1996
(Per 100 000 of Population at Risk)

Cause of death	No. of persons
Infectious & parasitic diseases	9
Neoplasms	193
Endocrine, nutritional & metabolic diseases & immunity disorders	21
Diseases of nervous system & sense organs	17
Diseases of circulatory system	295
Diseases of respiratory system	56
Diseases of digestive system	21
Congenital anomalies	4
All other diseases *	43
Signs, symptoms & ill-defined conditions	3
Accidents, poisonings & violence	41
All causes	703

Remark:
* Includes 700 deaths from conditions originating in the perinatal period, 2 244 deaths from diseases of the genitourinary system, and 3 560 deaths due to mental disorders.
Source: Causes of Death, 1996, Australia in Brief, ABS Statsite, 27/2/98

Appendix II

Services not covered by Medicare:

- private patient hospital costs (e.g. theatre fees or accommodation)
- dental examinations and treatment
- ambulance services
- home nursing
- physiotherapy, occupational therapy, speech and eye therapy, chiropractic, podiatry and psychology
- acupuncture (unless part of a doctor's consultation)
- glasses and contact lenses
- hearing aids and other appliances
- the cost of prostheses
- medicines
- medical and hospital costs incurred overseas
- medical costs for which someone else is responsible (e.g. a compensation insurer, an employer, a government or government authority)
- medical services which are not clinically necessary
- surgery solely for cosmetic reasons
- examinations for life insurance, superannuation or membership to a friendly society
- treatment received overseas

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