



The health dollar in Australia: 'Deal or no deal'

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In 2004–05, Australia's health expenditure was \$87.3 billion, representing 9.8% of gross domestic product (GDP). (It was 8.3% in 1993–94.) Governments provided 68.2% of this total expenditure, or \$59.6 billion. Of this, the Australian Government spent \$39.8 billion (45.6% of the overall total) and the States, Territories and local government \$19.8 billion (22.7%). The remainder was provided by individuals (\$16.5 billion; mainly in out-of-pocket expenditure on health care goods and services), private health insurance funds (\$5.7 billion) and other non-government sources (\$5.5 billion).

Australia's health to GDP ratio is comparable to Canada, Austria and Norway, is more than the UK and New Zealand, and considerably lower than the USA (15.3% in 2004).

Australia's health system

- Universal access to benefits for privately provided medical services under Medicare, funded by the Australian Government, with co-payments by users where the services are patient-billed.
- Eligibility for public hospital services, free at the point of service, funded approximately equally by the States/Territories and the Australian Government.
- Growing private hospital activity, largely funded by private health insurance, which in turn is subsidised by the Australian Government through its rebates on members' contributions to private health insurance.
- The Australian Government, through its Pharmaceutical Benefits Scheme (PBS), subsidises a wide range of drugs and medicinal preparations outside public hospitals.
- The Australian Government provides most of the funding for high-level residential care and health research, and directly funds a range of services for eligible veterans.
- State/Territory health authorities are primarily responsible for the operations of the public hospitals, mental health programs, the transport of patients, community health services, and public health services eg health promotion and illness prevention.
- The health care money spent by individuals went (2003–04) on pharmaceuticals (31%), dental services (20%), aids and appliances (14%), medical services (10%) and other professional services.
- Average real growth in individuals' out-of-pocket expenditure between 1993–94 and 2003–04 was 5.4% per year, 0.8% above the real growth in health expenditure (4.6% p.a.).
- In 2003–04, \$2.5 billion of health expenditure was funded by the Australian Government through its health insurance rebates.
- Real expenditure on pharmaceuticals grew rapidly (11.7% annually from 1997–98 to 2002–03), with growth peaking at 16.9% in 2000–01.
- Health prices increased, on average, 0.8% per year more rapidly than the general inflation rate between 1993–94 and 2003–04.
- Real health expenditure has grown more strongly than real GDP in every year since 1999–00.

In 2003–04, health expenditure averaged \$3919 per person. Western Australia (\$3653) had the lowest average level, while the Northern Territory (\$4562) had the highest. These figures do not necessarily indicate differences in health expenditure by State and Territory governments; they include

expenditure in the State/Territory by the Australian Government, private health insurance funds, individuals and providers of injury compensation cover.

Estimated expenditure on health services for Aboriginal and Torres Strait Islander people for 2001–02 was, on average, \$3901 per Indigenous person. Governments were responsible for 92.7% (\$3614 per person) of this.

In 2003–04, 59.7% (\$46.8 billion) of total national health expenditure was incurred in the most populous States, NSW and Victoria, which account for 58.3% of the total Australian population.

The Australian Government's contribution to funding for health includes:

- payments through the DVA to eligible veterans and their dependants
- specific-purpose payments (SPPs) to the States and Territories for health purposes
- direct expenditure by the Australian Government on health programs (such as Medicare, PBS, higher level residential care subsidies)
- rebates and subsidies under the Private Health Insurance Incentives Act 1997
- taxation expenditures.

In terms of the amount of expenditure involved, hospitals are the largest providers of health services in Australia. There are public (non-psychiatric) hospitals, private hospitals, and public (psychiatric) hospitals.^{1,2}

The health sector is a major employer. It accounts for 6.3% of employment in the NT, 7.2% in Queensland, 7.3% in NSW, Victoria and Western Australia, and 8.9% in South Australia and Tasmania. Its contribution to total employment declines slightly with increasing remoteness. In 2001 the health sector's share of employment was 10.2% in (ASGC's) Major Cities, 11.3% in Inner Regional, 8.8% in Outer Regional, 7.3% in Remote and Very Remote.³

Self-reported health status

In 2004–05 the majority of Australians (15+) considered their health to be very good or excellent.

Overweight

62% of men and 45% of women were classified in the overweight or obese groups. However, only 32% of men and 37% of women assessed themselves as being overweight. The proportion of adults classified as overweight or obese increased over the last ten years: for men from 52% to 62% and for women from 37% to 45%.

Alcohol

The majority of adults (71% of men and 54% of women) consumed alcohol in the week prior to (ABS) interview, and most of these (78%) had consumed alcohol at a level which would constitute a low risk to their health. The proportion of adults who had consumed alcohol at levels which, if continued, would be risky or a high risk to their health was 13% (11% in 2001).

Smoking

Approximately one in four adults (23%) were smokers in 2004–05 and in 2001. More men than women were current smokers (26% and 20% respectively) and for both men and women the prevalence of smoking was highest in the younger age groups (34% of men and 26% of women aged 18–34 years smoked).

Exercise: Two thirds of adults (66%) had exercised for recreation, sport or fitness in the two weeks prior to interview. 49% reported they had walked for exercise, 36% exercised at a moderate level and 15% did vigorous exercise.



Medical conditions

77% reported that they had at least one long-term medical condition. Among children, respiratory conditions were commonest, with asthma the most prevalent among children aged less than 15 years (15%). Hay fever and allergic rhinitis was the most prevalent long-term condition for young people aged 15 to 24 years (19%). Sight conditions, arthritis, hearing loss and high blood pressure were the most common conditions in age groups 65 years and over. In the 65 years and over age group just under half (49%) reported they had arthritis, 14% reported they had diabetes mellitus, and 18% reported a heart, stroke or vascular disease.

Distress

High or very high levels of psychological distress were recorded for 13% of the adults (similar to 2001). Of those who recorded high to very high levels of distress, 59% were female.

Doctor consults

23% of people living in private dwellings had consulted a doctor in the two weeks prior to interview, 6% had consulted a dentist and 14% another health professional, similar to results in 2001. Of those consulting a health professional other than a doctor or dentist, 29% consulted a chemist, 16% consulted a physiotherapist and 16% consulted a chiropractor.

Private health insurance

Around half of the population 15+ had private health insurance. Of those with private insurance, 75% had both hospital and ancillary cover, 17% had hospital-only cover and 7% had ancillary-only cover. The most common reason for not having private health insurance was "can't afford it/too expensive", reported by 64% of those without private cover.⁴

Mortality

The standardised death rate for males in 2004 was 770 deaths per 100 000, and for females 511 per 100 000. The Northern Territory recorded the highest standardised death rate (822 deaths per 100 000) in 2004, while the ACT recorded the lowest rate (562 per 100 000). While the NT had the highest death rate, it also experienced the largest declines of any State or Territory: from 1227 deaths per 100 000 in 1994, and 892 deaths per 100 000 in 2003.

Malignant neoplasms accounted for 28.7% of all deaths in 2004, ischaemic heart disease 18.5%. The gap between the proportion of deaths due to malignant neoplasms and Ischaemic heart disease continues to widen. Since 1994, the proportion of deaths due to Ischaemic heart disease has decreased from 24.1% to 18.5%, while the proportion of deaths due to Malignant neoplasms has increased from 26.6% to 28.7%.

Indigenous and non-Indigenous persons have the same two leading causes of death, although they are proportionally different. In 2004, Ischaemic heart diseases were the main cause of 16.3% of all Indigenous deaths compared to 18.6% of non-Indigenous deaths. Malignant neoplasms were the cause of 16.6% of all Indigenous deaths and 29.0% of all non-Indigenous deaths. Deaths due to Diabetes mellitus were higher among Indigenous persons (7.3%) than among non-Indigenous persons (2.6%). External causes accounted for 14.3% of Indigenous deaths compared with 5.8% of non-Indigenous deaths, with Intentional self-harm contributing 4.2% of all Indigenous deaths compared with 1.5% of all non-Indigenous deaths. External causes relate to deaths from accidents, poisonings and violence and in 2004 accounted for 6.0% of all registered deaths. There were 2098 deaths attributed to Intentional self-harm (suicide) in 2004 (2213 in 2003).⁵

Causes of death

The leading causes of death in Australia are circulatory diseases (41% in 1997-99; 52 230 deaths), cancers (28%; 35 604 deaths), respiratory diseases (8%; 9857 deaths) and injury (6%; 8143 deaths), with a similar pattern being observed both inside and outside Major Cities.

'Excess' deaths in rural and remote areas

The annual number of 'excess' deaths is the difference between the number of observed deaths and the number of expected deaths each year if Major Cities rates applied in all areas.

The causes of excess mortality in rural and remote areas are:

- circulatory diseases – 42%
- injury – 24%
- other (including diabetes and renal disease) – 13%
- neoplasms – 11%
- respiratory diseases – 10%

Most excess deaths occur in people over 50. Most excess deaths occur in males.⁶

Specifically, coronary heart disease (23%), 'other' cardiovascular disease (16%), chronic obstructive pulmonary disease (11%), motor vehicle accidents (11%), diabetes (6%), suicide (6%) and 'other' injuries (6%) were the main contributors to the 'excess' deaths. Prostate, colorectal and lung cancers together contribute another 10% of the 'excess' deaths.

For most causes, rates of death are higher in regional and especially remote areas. The higher rates in remote areas are affected by high overall rates for Indigenous people. For other causes (e.g. motor vehicle accidents – MVA), rates may be elevated because of high rates in the Indigenous population, but rates for the non-Indigenous population in regional and/or remote areas are still high relative to Major Cities rates. The absolute numbers of deaths in regional and especially remote areas are of course smaller than in Major Cities. The greatest disparities in death rates include respiratory diseases (such as chronic obstructive pulmonary disease – COPD), almost all injury (MVA, suicide, accidental shooting and 'other' injuries), diabetes and rheumatic heart disease. Some causes show only slightly higher rates outside Major Cities, but are responsible for large numbers of deaths. For example, rates of ischaemic heart disease are about 10% higher outside Major Cities (not dramatically higher, compared with causes such as accidental shooting), but (unlike accidental shooting) are responsible for a large proportion of deaths and 'excess' deaths. Causes that are responsible for large numbers of deaths include circulatory diseases and cancers, followed by respiratory diseases, injury and diabetes.⁶

A man born in far western NSW can expect to live 13 years less than one born in Mosman, Sydney.⁷

Summary

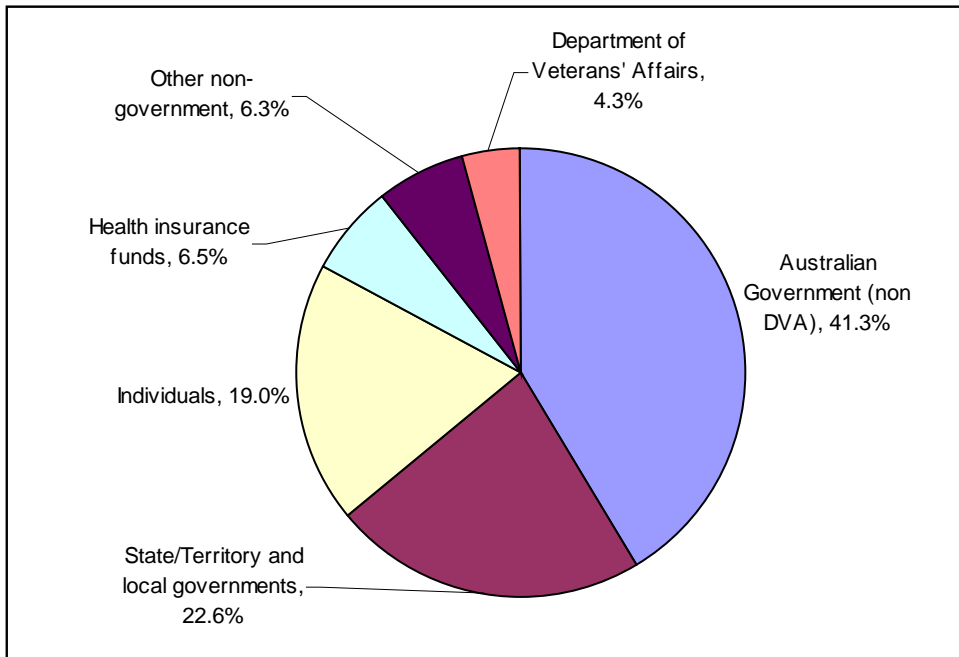
The 30 per cent who live in non-metropolitan areas receive about 20 per cent of Medicare rebates and have 15 per cent of the nation's GPs. They are more likely to be smokers; to drink alcohol in dangerous quantities; to be overweight or obese; to be physically inactive; to have lower levels of education and poorer access to work (particularly skilled work). They also have poorer access to health services, even in areas experiencing growth.⁸

Governments and communities in Australia should commit to the target of raising the health status of people in rural and remote areas to that of their urban counterparts by 2020.⁹

Rural and remote areas offer the finest quality of life – we would like our fair measure of it.

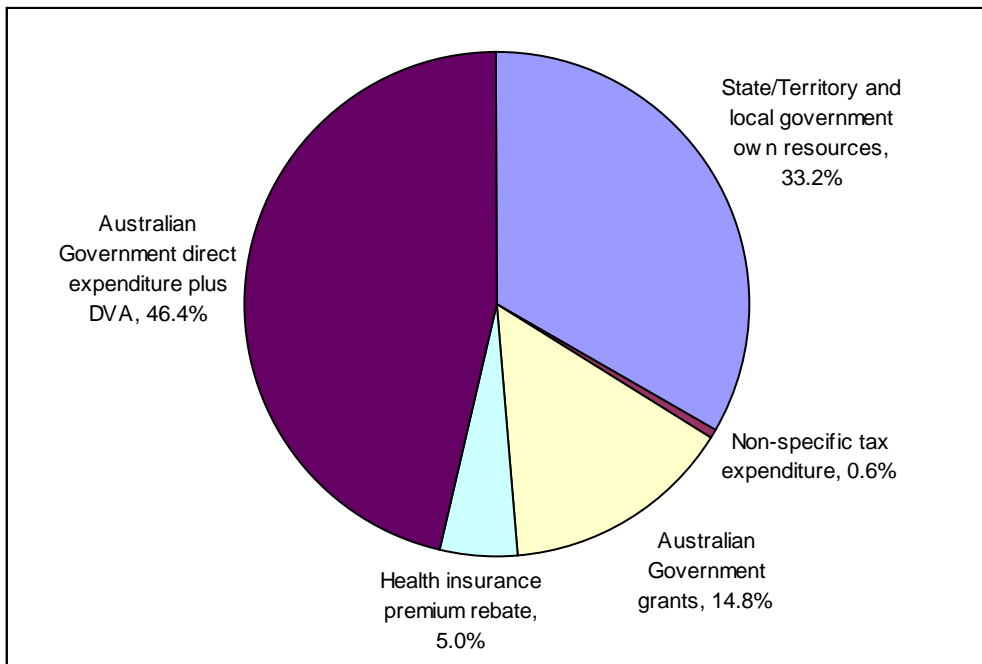


Figure 1 Total health expenditure, current prices, by source of funds, 2004–05



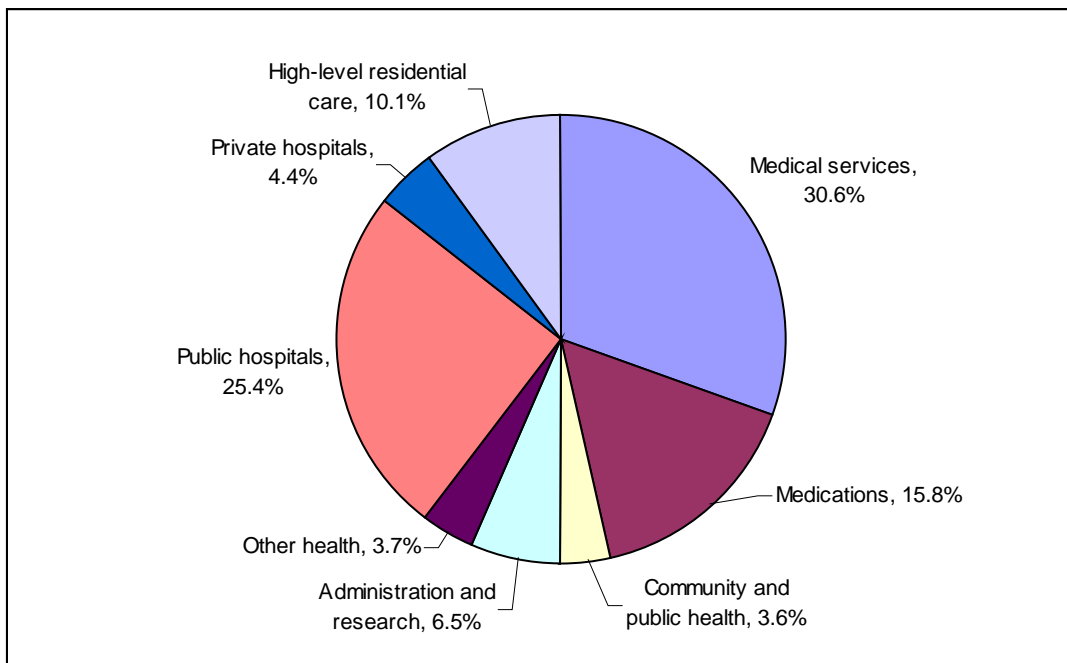
Source: *Health expenditure Australia 2004–05*, AIHW, Canberra, September 2006 (HWE 35).

Figure 2 Government funding of health expenditure, current prices, by type of expenditure, 2004–05



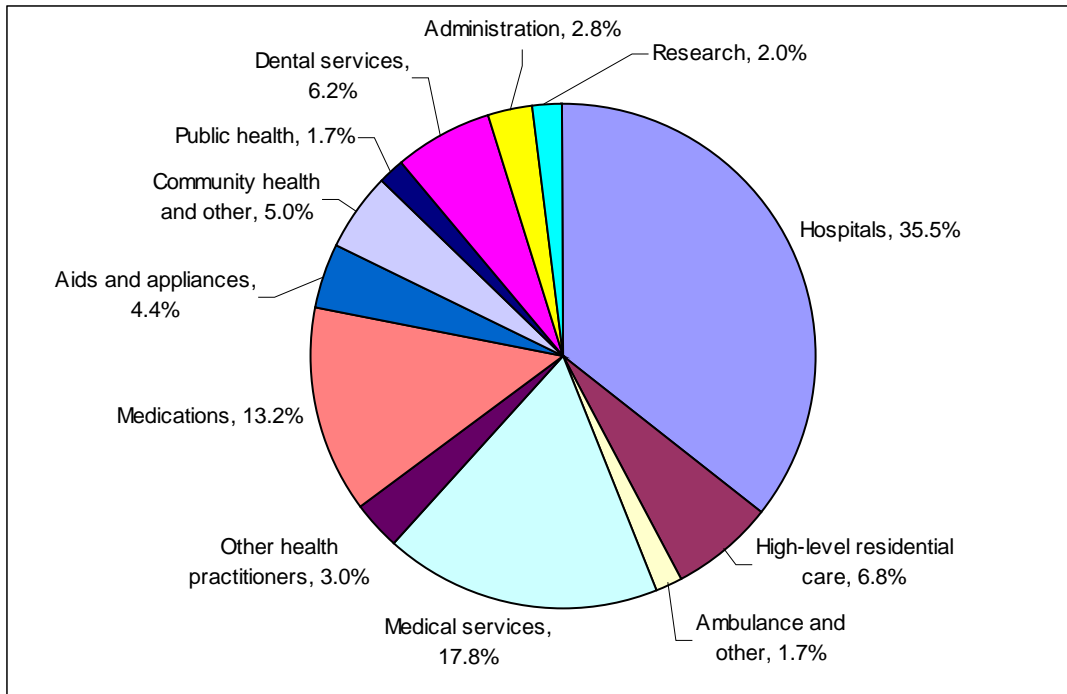
Source: *Health expenditure Australia 2004–05*, AIHW, Canberra, September 2006 (HWE 35).

Figure 3 Funding of general recurrent expenditure by the Australian Government (excluding DVA), by area of expenditure, current prices, 2004–05



Source: *Health expenditure Australia 2004–05*, AIHW, Canberra, September 2006 (HWE 35).

Figure 4 Recurrent expenditure on health goods and services, current prices, by broad area of expenditure, 2004–05



Source: *Health expenditure Australia 2004–05*, AIHW, Canberra, September 2006 (HWE 35).



References

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4. ABS, 4364.0 National Health Survey: Summary of Results 2004–05.
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6. AIHW, Rural, regional and remote health, Oct 2003 (PHE 45).
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