Caring for our health?

A report card on the Australian Government’s performance on health care

A report by state and territory health ministers

June 2007
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Caring for our health?
The Australian Government spends nearly $42 billion a year on health care. That's a lot of your money.

It supports, subsidises and pays for vital elements of the health system – general practitioners, specialists, medicines, public hospitals, private hospitals, aged care, the education of doctors and nurses … it's a long list. The Australian Government also subsidises, to a large and growing extent, private health insurance.

But where does all this taxpayers' money go?

_Caring for our health? A report card on the Australian Government’s performance on health care_ presents a snapshot on major national health funding in an easy to understand format. This report details for the first time where Canberra is spending your money. It focuses on Medicare, general practitioners, specialists, medicines, public hospitals, private health insurance and explores health funding needs into the future. It examines whether recent changes in Australian Government policy are directing money where it is most needed. Most of the information is national – there may be some variations in different parts of Australia.
We, the eight state and territory health ministers, have produced this report to keep Australians fully informed. We believe all governments should be open, transparent and accountable with taxpayer’s money. We stand committed to transparency and accountability about our own performance, and to working with the Australian Government to improve the system as a whole. We believe that the more governments are open and accountable the more effective they are. This also applies to your health system. We also believe the Australian Government should have released this information already. It has not. So we will.

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Contents

Summary ................................................................. 3

1: Introduction ......................................................... 5

2: General practitioners ............................................. 7

3: Specialists ............................................................. 15

4: Public hospitals ...................................................... 21

5: Medicines ............................................................... 29

6: Private health insurance ........................................... 33

7: The future ............................................................... 39
Caring for our health?
Summary

- People find it harder to see a GP than 10 years ago. There are not enough GPs to deal with the growth in population and they are concentrated in major cities.
- The cost of seeing a GP has risen over the past 10 years, as the Australian Government’s schedule fees have not kept pace with inflation and fewer GPs bulkbill.
- Specialists are highly concentrated in cities, and many rural people have difficulty seeing them.
- The cost of seeing a specialist is rising. Bulkbilling rates for specialists working in private practice are low and falling.
- The Australian public have almost no information on the cost of private specialist services in private hospitals.
- Australian public hospitals are seeing significant increases in patient numbers. Between 1999/00 and 2004/05 inpatient admissions increased by around 10% from 3.88 million to 4.28 million.
- The Australian Government is paying a smaller and smaller share of public hospital costs each year. In 2000 it contributed 50% of the cost of running and maintaining public hospitals. In 2005 that share had dropped to 45%.
- The Australian Government is now paying about $1.1 billion a year less than recommended by an independent arbiter. If it paid the full amount recommended, public hospitals around the country could manage an extra 350,000 admissions a year.
- If the trend continues, then in 20 years’ time the Australian Government’s share of public hospital funding will have declined to about 25%, and the states’ and territories’ share will have risen to about 75%. This would affect the states’ and territories’ ability to look after other essential services such as schools, police, public transport and roads.
The cost of the Pharmaceutical Benefits Scheme is rising rapidly. The rising costs are being shared by the Australian Government, by state and territory governments and by individuals.

The number of scripts being filled has fallen in the past year. This is due partly to the Australian Government's decision to increase out-of-pocket costs for prescription medicines.

The private health system is not always complementary to the public health system – recent changes have made it more attractive to younger and healthier people in preference to older people. These changes have done little to reduce pressure on the public hospital system.

The private health insurance premium rebates cost taxpayers more than $3 billion last year.

The Australian health workforce is ageing, which raises serious questions about how health services are to be provided in the future.

The Australian health workforce is also concentrated in cities, which means people living in rural areas often have trouble getting health care.

The costs of health care for the average person are rising rapidly. Overall, even after taking inflation into account, people are spending over 5% a year more on health care.

Health care is becoming more expensive, and more of it will be needed as the population ages. The health system was designed for people with short-term illness, yet most of its effort is now spent looking after people with chronic, long-term illnesses. On top of this, the shortage of health professionals is likely to get worse.

Is the Australian Government doing enough to care for our health, both now and in the future?
1: Introduction

States and territories welcome open and transparent analysis about the performance of the health system. We are committed to continual improvements in the health system so that it is capable of dealing with the challenges of chronic disease and population ageing.

To meet this goal, governments need to work together, each playing their part, each being transparent and accountable about the performance of the system as a whole.

The Australian health system involves a lot of people – about 230,000 nurses, 70,000 nursing assistants, 60,000 doctors, 23,000 dental assistants, 15,000 pharmacists, 14,000 physiotherapists, 9,000 dentists, 9,000 health service managers, 8,000 occupational therapists and 2,000 podiatrists, as well as others.

Some of these people work for themselves. Others work with colleagues. Some work in the public sector. Others work in the private sector. Some work to prevent health problems arising. Others deal with them once they are there. Some manage patients. Others manage services.

There are public hospitals, private hospitals, community health services, specialised health clinics and private practices.

There are programs aimed to reach everybody, like Medicare and the Pharmaceutical Benefits Scheme. There are programs aimed to reach those with special needs, such as palliative care services, dementia services and HIV services.

The Australian health system is complex. Its funding is complex too. But in very simple terms, the funding of the Australian Government’s component works like this.

The Australian government collects money from Australians through individual taxation, business taxation, the goods and services tax and the Medicare levy.

It gives the state and territory governments a certain amount of money each year for health care – some of it in general funding and some of it tied to particular areas, such as public hospitals.
The Australian Government also spends a significant amount of money on the health system, although it does not provide any services itself. It subsidises your (mainly out-of-hospital) visits to doctors through the Medicare Benefits Schedule. It subsidises a range of medicines through the Pharmaceutical Benefits Scheme. It subsidises the cost of aged care through paying some of the cost of nursing home beds and community services. It subsidises the cost of private health insurance through a rebate scheme.

The rest of this document examines the parts of the system that are funded by the Australian Government – parts of the system where information held by the Australian Government is routinely kept secret. It asks two basic questions. How is the system performing? And are all Australians getting the benefits?
2: General practitioners

General practitioners are the cornerstone of the health system. About 85% of Australians see a GP each year – they are the first and most important ongoing contact with the health system for most people.

In many cases, GPs provide the guidance and support to help people navigate their way through the health system.

The Australian Government, to a large extent, underwrites the funding of general practice. It does not negotiate fees with GPs, but sets a fee it thinks appropriate. GPs do not have to stick to this amount. However the Medicare rebate is based on that set fee. Doctors can decide to accept the Medicare rebate as the full payment for their service – this is known as bulkbilling – or they can charge their own fee. If they do so, their patients then claim back from Medicare some of the money they paid the doctor.

This approach offers incentives for GPs to see patients quickly, which is not what most GPs would like.

Following is a series of figures which lay out how many general practitioners there are in Australia, where they are, the extent of Australian Government funding of their services, the extent to which individuals pay for their services and the extent to which GPs are bulkbilling.

How many GPs are there, and where?

The number of GPs in Australia has remained fairly stable for some years, even though the population is growing and getting older. This means, on average, each GP has more people to look after, as shown in figure 1.

Where do they work? They are reasonably well spread throughout cities and rural regions, although there are shortages in some areas such as the less wealthy parts of some cities. Not nearly as many GPs work in remote regions of Australia, and the states and territories need to supply health services to fill the gap. As shown in figure 2, the further you are from a capital city, the greater the number of people each GP has to look after.
Figure 1: Number of GPs per 100,000 people

Figure 2: GPs per 100,000 people by geographical region
Who pays to see a GP, and how much?

Whether or not a GP charges a patient anything more than the Medicare rebate is a matter for the doctor to decide.

In 1996/97, more than 80% of visits to GPs were bulkbilled. Fewer than 20% of people visiting a doctor had to pay anything from their own pocket.

This figure of 80% declined rapidly over the next seven years (see figure 3), mainly because the amount the Australian Government decided to pay GPs per visit increased more slowly than inflation (see figure 4, which examines the schedule fee for the most common type of visit to a GP – item 23). In other words, if doctors kept doing the same thing each year, they went backwards financially. So some stopped or reduced their bulkbilling.

Since 2003/04, the Australian Government has introduced a number of incentives for GPs to bulkbill more people. The proportion of GP visits which are bulkbilled is rising again, but is still well below the 80% mark of a decade ago.

Figure 3: Percentage of GPs visits which are bulkbilled (%)
Figure 4: Medicare Benefits Schedule fee for the most common type of visit to a GP* ($)

Bulkbilling is not distributed evenly around the nation. It varies enormously, from 99% in some parts down to 47% in others.

In most parts of Australia, bulkbilling is less common in rural and remote areas than in cities. When added to the relative scarcity of GPs, this makes it even harder for some people in rural and remote regions of Australia to see a GP. It is not clear that the Australian Government fully appreciates the difficulties this can cause for both rural residents and overworked rural GPs.

And while bulkbilling rates are lower than 10 years ago, the out-of-pocket cost of visiting a GP for people who are not bulkbilled, has risen. It was $9.40 in 1997/98, and has jumped to $15.82 in 2005/06 (see figure 5). This is higher than the cost would have been – $11.53 – had prices simply kept pace with inflation.
The increase in out-of-pocket costs is due to a number of factors, including:

- the relative shortage of GPs (see figure 1), especially in some areas (see figure 2)
- the relative decline in the Australian Government’s schedule fee (see figure 4), which has left doctors going backwards financially and encouraged the decline in bulkbilling (figure 3).

Figure 5: Out-of-pocket costs of a visit to the GP for non bulkbilled patients, compared with inflation ($)

- Actual increase
- Increase with inflation only
How often do we see GPs?

The number of visits to the GP per person has declined over the past 10 years (see figure 6). There is no evidence that the average person’s interest in health care has declined, nor that we have less reason to see a GP, nor that GPs are being replaced by other health care practitioners for continuing health care. In fact, the incidence of many chronic diseases, such as type 2 diabetes, is rising, which indicates a need for more GP services rather than fewer.

Possible reasons to explain this decline in the average number of visits include:

- the relative shortage of GPs and their uneven geographical distribution (see figures 1 and 2), which may lead to difficulty in getting in to see a GP
- the decline in the proportion of GP services which are bulk billed (see figure 3)
- the rise in the out-of-pocket cost of seeing a GP (see figure 5)
- a decision to save up and visit a GP with several problems, rather than seeing a GP as each problem arises
- a decision to use emergency departments instead of GPs at times, partly for some of the above reasons.

Figure 6: Average number of visits to the GP per person per year
But it is also clear that people in cities see GPs far more often than people living in the country. In fact, figure 7 shows that the further you are from the city, the less often you see a GP.

Is this because people living in the country are healthier? No, people living in the country are, in general, less healthy than people living in the city for a whole range of reasons. They often need more health care, not less.

The most likely reasons for people in rural areas seeing GPs less often are:

- there are fewer GPs in remote regions (see figure 2)
- GPs outside the city are less likely to bulkbill, so the cost of seeing the GP is likely to be higher.

**Figure 7: Average number of visits to the GP per year by geographical location**
What are we not being told?

There are many important questions which are not being answered by the Australian Government. They include the following.

- What is the average waiting time between making an appointment and seeing a GP for non-urgent care in different local government areas?
- How many GPs provide after hours care in different local government areas? Does the Australian Government do enough to support GPs to provide this service?
- What is the bulkbilling rate for people who do not have a health care concession card?
- What is the average bulkbilling rate for GPs in different local government areas? Does the Australian Government do enough to support GPs to provide this service?
- What is the average number of visits to a GP in different local government areas?
- What are the average out-of-pocket costs for people seeing GPs in different local government areas?
- Does the Australian Government do enough to ensure there are sufficient GPs to provide fair access to health care for all Australians according to need?

Most of this information is already available to the Australian Government, but is not released.

Summary

People find it harder to see a GP than 10 years ago. There are not enough GPs to deal with the growth in population and they are concentrated in major cities.

The cost of seeing a GP has risen over the past 10 years, as the Australian Government’s schedule fees have not kept pace with inflation and fewer GPs bulkbill.
Specialists

Specialists are the second line of Australia’s medical system. They see people for one-off consultations or procedures, and in some cases take over the long term care of people with complex conditions.

The Australian Government subsidises the cost of seeing a private specialist. It does not negotiate fees with private specialists, but sets a fee it thinks appropriate. Private specialists do not have to stick to this amount. However the Medicare rebate is based on that set fee. Doctors can decide to accept the Medicare rebate as the full payment for their service – this is known as bulkbilling – or they can charge their own fee. Their patients then claim back from Medicare some of the money they paid the doctor.

Following is a series of figures which lay out how many specialists there are in Australia, where they are, the extent of Australian Government funding of their services and the extent to which individuals pay for their services.

Please note that these figures refer only to out-of-hospital visits to specialists. They do not refer to specialists working in hospitals, or to operations or other procedures in hospitals. We do not have adequate information on the fees charged by specialists working in private hospitals, nor on the out-of-pocket costs of seeing specialists working privately in public hospitals. The Australian Government has access to this information, but does not release it.
How many specialists are there?

In 2005 there were 23,600 specialist medical practitioners registered to work in Australia. That is a dramatic rise from the 16,000 specialists practising in 2000. In contrast to GPs, the increase in specialists has exceeded population growth (see figure 8).

How often do we see specialists?

On average, Australians see a specialist (excluding pathologists and radiologists) once a year, and that has been the case for many years.
How much do we pay specialists?

Schedule fees for specialists are much higher than schedule fees for GPs. Despite this, only 26% of visits to specialists (excluding pathologists and radiologists) are bulkbilled.

The figure of 26% is much lower than the proportion of consultations which are bulkbilled by GPs (75.6%), pathologists (85.7%) and diagnostic radiologists (60.2%). Figure 9 shows that the bulkbilling rate is low and declining further.

*Figure 9: Percentage of specialist visits* which are bulkbilled (%)

* excludes pathologists and radiologists. Refers to out-of-hospital work.*
The out-of-pocket cost of seeing a specialist, for people who are not bulkbilled, has risen from $17.99 in 1996/97 to $32.88 in 2005/06 (see figure 10). If the out-of-pocket costs had simply kept pace with inflation, the cost in 2005/06 would have been $22.07.

**Figure 10: Average out-of-pocket costs of a visit to the specialist for non bulkbilled patients ($)**


Actual increase

Increase with inflation only
Where do specialists work?

Specialists work overwhelmingly in cities. There are six times as many specialists per person in the city as in remote regions. Even areas just outside cities have half the rate of specialists as cities (see figure 11).

**Figure 11: Specialists per 100,000 people by geographical region**
Caring for our health?

What are we not being told?

There are many important questions which are not being answered by the Australian Government. They include the following.

- What is the average waiting time for a visit to a specialist for non-urgent care?
- Is this different for people in cities and people in rural and remote Australia?
- What are the average out-of-pocket costs for private patients having surgery?
- What are the average out-of-pocket costs for private patients seeing an anaesthetist in a hospital?
- What is the bulkbilling rate for specialists in different local government areas?
- What is the bulkbilling rate for different types of specialists?
- What is the average number of visits to different types of specialists in different local government areas?
- What are the average out-of-pocket costs for people seeing specialists in different local government areas?

Summary

Specialists are highly concentrated in cities, and many rural people have difficulty seeing them.

The cost of seeing a specialist is rising. Bulkbilling rates for specialists working in the community are low and falling.

We have almost no information on the cost of private specialist services in hospitals. The Australian Government needs to release this information.
Public hospitals provide essential care for sick and injured people. They are fundamentally different from private hospitals. They provide:

- care to all, not only those who can pay for it
- the most complex, specialised services for people who are critically ill
- free emergency care at all hours to all people who need it.

Public hospitals tend to treat seriously ill people with complex conditions, where private hospitals tend towards more surgical and elective work.

Public hospitals are under pressure. They continue to treat people with very complex conditions and face growing demand for their services. In just five years, the number of inpatient admissions has grown by about 400,000 people.

The states and territories are committed to improving the performance and accountability of the public hospital system. That is why we contribute data to a number of national, state and territory reports.

Public hospitals are funded by a combination of Australian Government money and money from the relevant state or territory government. Free access to public hospitals is a fundamental component of Medicare, and a continuing responsibility of the Australian Government.

Over the years, the proportion of public hospital costs paid by the Australian Government on one hand, and the states and territories on the other, has fluctuated. But that proportion has always hovered around a 50:50 share.

But since 2000, the Australian Government has gradually reduced its share of the funding of public hospitals (see figure 12). The states and territories are having to put in more and more.

In 2000, the Australian Government contributed 50% of the cost of running and maintaining public hospitals. In 2005, that share had dropped to 45%.
The states and territories have picked up the shortfall. Their share of funding of public hospitals has risen from 50% in 2000 to 55% in 2005.

If this trend continues, then in 20 years’ time the Australian Government’s share of public hospital funding will have declined to about 25%, and the states’ and territories’ share will have risen to about 75%. This would affect the states’ and territories’ ability to look after other essential services such as schools, police, public transport and roads.

**Figure 12: Share of funding for public hospitals (%)**

In 1998 the Australian Government negotiated, with the states and territories, a new round of funding for public hospital services. There was a disagreement over figures used to adjust funding for annual price rises. The parties agreed to use an independent arbiter.
The arbiter recommended that, as prices in health care rise faster than inflation, the Australian Government’s contribution to public hospital funding should be increased by 0.5% more than the inflation rate.

The Australian Government ignored that recommendation. It also ignored statements made by the Australian Institute of Health and Welfare, an expert body funded by the Australian Government, that health prices should be adjusted by a figure higher than the inflation rate.

Instead, the Australian Government has adjusted funding by a figure lower than the inflation rate. The result is that it has contributed far less to Australian public hospitals than the arbiter recommended, and than the Australian Institute of Health and Welfare would expect. That shortfall is now $1.1 billion per year (see figure 13), and growing.
What could $1.1 billion a year buy? About 350,000 admissions to public hospitals. That is quite a shortfall.

**Figure 13: Australian Government spending: actual versus recommended ($1,000M)**

The Australian Government’s contribution to public hospitals under the current funding agreement (which is different from the overall funding) has dropped to about 40%. Under this agreement, which is up for renewal next year, the states and territories pay about 60% of the costs of running public hospitals.
Emergency work

Emergency admissions are an important measure of what a hospital does. People admitted through the emergency department are the sickest people. They need the most time, staff, technology and medicines to look after.

Figure 14 shows that by far the majority of emergency admissions are through public hospitals, not private hospitals. In fact, the number of emergency admissions in private hospitals is falling while the number of emergency admissions in public hospitals is rising.

**Figure 14: Number of emergency admissions (1,000s)**
This rise in public hospital emergency admissions is partly due to difficulties people have in seeing GPs, so people might not get the care they need, when they need it. Hospitals find people attending now are more likely to be seriously ill than they were 10 years ago.

And because emergency admissions take priority, sometimes public hospitals find it difficult to admit as many people for elective surgery as they would like.

It is worth adding that public hospitals are banned by the Australian Government from charging private health insurance funds for their members who attend public hospital emergency departments (although private hospital emergency departments are allowed to charge).

Older people in public hospitals

Older people tend to need more complex care, and to spend more time in hospital, than younger people. People over 65 account for about a third of total hospital admissions, and use almost half of all beds.

In August 2006, there were about 2,300 older people in public hospitals who should have been in an aged care facility. But the aged care places, which are largely the responsibility of the Australian Government to fund, were not available.

This is a problem for both patients and hospitals. From the patient’s perspective, a busy hospital ward is not the best place to stay if they don’t need to be there. And from the hospital’s perspective, a bed used by someone who doesn’t need it is a bed that is not available to someone who does.
There are many important questions which are not being answered by the Australian Government. They include the following.

• How many residential aged care places and community-based support packages have been approved but are not yet available to the public in different local government areas?
• What are the waiting times for older Australians, once they have been assessed as requiring residential aged care placement or a community-based support package, in different local government areas?
• What is the true cost to the public health system of leaving older Australians who are waiting for a place in an aged care facility in a hospital each night?

Summary

The Australian Government is paying a smaller and smaller share of public hospital costs each year. It is now paying about $1.1 billion a year less than recommended.

If it paid the extra $1.1 billion a year as recommended, public hospitals around the country could manage an extra 350,000 admissions a year.

Many older people are waiting in acute hospital beds for places in aged care facilities because of a shortage of Australian Government funded aged care places.
Caring for our health?
5: Medicines

The Australian Government subsidises certain medicines through the Pharmaceutical Benefits Scheme (PBS). Other medicines are also available by prescription but are not subsidised by the PBS. Still other medicines, called over the counter medicines, are available from pharmacies and other outlets without prescription.

In 2005/06 the Australian Government paid more than $6 billion towards the cost of medicines on the PBS. The cost of the PBS has been rising steadily for many years, and has been increasing faster than inflation (see figure 15).

**Figure 15: Annual total spending by Australian Government on PBS versus inflation ($1,000M)**
The reasons for this include:

- new drugs are, in general, far more expensive than existing ones
- doctors tend to prescribe new drugs instead of existing ones
- new drugs are being developed for conditions which had no drug treatment before
- the number of prescriptions written per person has increased gradually until the past year (see figure 18).

The costs for individuals are rising, too (see figure 16). This is mainly because the Australian Government has gradually increased the amount people are expected to pay per prescription (see figure 17).

**Figure 16: Average annual total spending by individuals on PBS medicines ($M)**
The Australian Government has gradually increased the payment per prescription made by people holding a concession card. It cost $2.60 to fill a script in 1994/95 – now it costs $4.90. The cost is rising faster than inflation.

**Figure 17: Average concessional payment for individuals per item versus inflation ($)**

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<tr>
<th>Year</th>
<th>Actual Increase</th>
<th>Increase with inflation only</th>
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This rise in out-of-pocket costs, which is similar to the rise for people who do not pay concessional prices for medicines, may have contributed to the recent decline in the number of scripts being filled at pharmacies (see figure 18). There may be other reasons as well.

Figure 18: Average number of PBS prescriptions per person

The Australian Government has recently introduced a series of changes to PBS pricing mechanisms which will reduce the cost of the PBS to the government. It is not clear whether or not these savings will be passed on to consumers.

Summary

The cost of the Pharmaceutical Benefits Scheme is rising rapidly. The rising costs are being shared by the Australian Government, by state and territory governments and by individuals.

The number of scripts being filled has fallen in the past year. This may be due partly to the Australian Government’s decision to increase out-of-pocket costs for people getting prescribed medicines.
All Australians have health insurance. It’s called Medicare, it’s run by the Australian Government and it provides care in public hospitals and subsidies to those seeing doctors in the community, as well as a range of other health services.

Private health insurance is available outside the Medicare system. It covers part of the cost of medical expenses and accommodation in hospital for people who want to be treated as private patients. In some cases, and to varying degrees, private health insurance also covers part of the cost of seeing other health practitioners such as optometrists, dentists, physiotherapists and chiropractors.

The Australian Government has made a number of changes to private health insurance over the past decade. The government said these changes would improve the financial viability of the private health insurance funds, increase the number of people with private health insurance, support the private health sector and take the pressure off public hospitals.

As a result, the private sector now plays an important role in the Australian health system. Private hospitals undertake a large and increasing share of all surgical procedures in hospitals, although public hospitals still treat the majority of emergency and complex cases.

The Australian Government’s first significant change to private health insurance was the introduction of a 30% rebate on premiums paid to health insurance funds. That was introduced in January 1999. In 2005 the Australian Government increased private health insurance rebates to 35% for people aged between 65 and 69 years, and 40% for people over 70.

In July 2000 Lifetime Health Cover was introduced. Lifetime Health Cover penalises people who join a private health insurance fund after the age of 30. It does this by adding 2% to the premium for each year of age over the age of 30. So a person joining a health fund at age 55 will pay 50% more than a person joining at age 30 (25 years extra x 2% equals 50% extra). Further adjustments have been made since – the most recent relaxing these penalties for people who have had 10 years of continuous cover.
These changes have had the effect of enticing people to join a health insurance fund while younger, and deterring people in their 50s or older.

This year the Australian Government introduced another series of changes to private health insurance, called Broader Health Cover. As a result of these changes, private health funds are now able to cover the cost of out-of-hospital medical services as well as services designed to avoid the need for people to go into hospital in the first place. No similar changes have been made to the Australian Government’s approach to Medicare for people without private health insurance.

The Australian Government also penalises people through the taxation system. People who earn more than $50,000 a year, or couples earning more than $100,000 a year, must join a health insurance fund or they will be forced to pay an extra 1% tax, called the Medicare Levy Surcharge. These thresholds have not been indexed since they were introduced 10 years ago, meaning people on average incomes (now around $54,000 per year) are forced to take out private health insurance or pay the surcharge, even though it was originally designed to encourage high income earners to take out private health insurance.
Has private health insurance coverage increased?

Yes, private health insurance coverage has increased, as seen in figure 19. It had been in a steady decline for some time, then jumped with the introduction of Lifetime Health Cover. After that, private health insurance coverage dipped again before levelling off.

**Figure 19: The percentage of the population with private health insurance (%)**

How much does the rebate scheme cost taxpayers?

The rebate scheme costs taxpayers about $3 billion in 2006/07. This amount has grown rapidly each year since the scheme was introduced, and much faster than the Australian Government predicted (see figure 20). The rapid growth has been mainly due to increases in private health insurance premiums, which have risen by 47 percentage points since 2000.
One of the aims of the rebate is to increase the number of people with private health insurance. But while the cost is increasing rapidly, the number of people in private health insurance funds is not.

In fact, between 2000/01, when the rebate scheme settled in, and 2005/06, which are the latest figures available, the amount the Australian Government spent on the rebate rose by 58% (from $1.93 billion to $3.05 billion). But the number of people in private health insurance funds rose by only 1.5% (from 8.7 million people to 8.8 million people). The major increase in the number of people with private health insurance was prompted by the introduction of Lifetime Health Cover, and all the rebate did was arrest the slide in membership.

**Have health insurance premiums stayed stable?**

No. Health insurance premiums have continued to rise at roughly twice the rate of inflation.

In the last five years, health insurance premiums have risen by an average of 6.6% per year. The average inflation rate during this period was less than 3% (see table 1).
### Table 1: Health fund premium increase versus inflation

<table>
<thead>
<tr>
<th>Year</th>
<th>Inflation rate (%)</th>
<th>Premium increase (%)</th>
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<tbody>
<tr>
<td>2003</td>
<td>3.1</td>
<td>7.40</td>
</tr>
<tr>
<td>2004</td>
<td>2.4</td>
<td>7.58</td>
</tr>
<tr>
<td>2005</td>
<td>2.4</td>
<td>7.96</td>
</tr>
<tr>
<td>2006</td>
<td>3.2</td>
<td>5.68</td>
</tr>
<tr>
<td>2007</td>
<td>N/A</td>
<td>4.39</td>
</tr>
</tbody>
</table>

* N/A: Not applicable

It is interesting to note that these premium increases are approved each year by the Australian Government. The government justifies these higher premium increases by saying that prices in health care rise faster than prices in other areas. It seems unfair that the Australian Government does not apply the same reasoning to its share of the costs of public hospitals (see table 2).

### Table 2: Public hospital cost-related funding increases versus private health insurance fund premium increases

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost-related increase in Australian Government funding for public hospitals (%)</th>
<th>Year</th>
<th>Cost-related increase in private health insurance fund premiums (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/03</td>
<td>4.33</td>
<td>2003</td>
<td>7.40</td>
</tr>
<tr>
<td>2003/04</td>
<td>3.40</td>
<td>2004</td>
<td>7.58</td>
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<td>2006/07</td>
<td>3.30</td>
<td>2007</td>
<td>4.39</td>
</tr>
</tbody>
</table>
The $3 billion a year spent on private health insurance premiums subsidises the costs of patients who seek medical care in the private system, particularly patients admitted to private hospitals for surgery.

Figure 14 shows it has not helped take the pressure off emergency admissions to public hospitals. Public hospitals still admit 61% of all patients, and care for most of the seriously ill people. Public hospitals still care for 95% of all emergency admissions.

Australian Government funding increases for some areas of health care have not been matched with similar increases in funding for public hospitals.

This is a clear double standard which needs to be addressed through restoring appropriate levels of funding to public hospitals when such funding is next negotiated with the Australian Government.

Summary

The private health insurance premium rebates cost more than $3 billion last year.

Recent changes to the private health system have made it more attractive to younger, healthier people.

The private sector now plays an important role in the provision of hospital care in Australia. The problem is not with the Australian Government’s support for the private system, but that support for public hospitals is not provided on an equal footing.
7: The future

Health systems across Australia, and throughout the developed world, are under pressure for similar reasons.

The ageing population

Until a recent turnaround, there were fewer and fewer babies born each year. Older people are living longer (see figure 21). The result? Australia has shifted from a land of the young to one dominated by the middle-aged. And that shift will continue for decades to come.

**Figure 21: Changing age structure of the Australian population, 1925-2045**

There will be more older people, and they will use more health services. Also, the number of people of working age will decline.

So at the very time the demand for health services is increasing, the ability to supply the workforce is decreasing.
The workforce

There are shortages of doctors, nurses and other health professionals throughout the world. In countries such as Australia, Canada, the UK and the US, 20-25 per cent of doctors come from overseas.

The national workforce is growing at an annual rate of about 170,000 per year. But this will drop soon – it is predicted that in 2020, just 12,500 people will join the national workforce.

The health sector alone needs about 10,000 new workers a year just to maintain the status quo, and finding that number is a challenge. With the shrinking national workforce, it is inevitable that the number of people joining the national health workforce will shrink, also.

The health workforce we have is getting older, too. A large number of doctors and nurses will retire over the next 15 to 20 years, and will not be easy to replace.

The Australian Government is responsible for educating the majority of this health workforce. Unless it increases student numbers dramatically across all health professions, ensures education is affordable, and works with states, territories and health professionals to develop curricula that attract and prepare new generations of health workers, there will continue to be significant staff shortages in the future. This will have a serious impact on access to services and the quality of patient care.
The changing nature of illness

The nature of illness is changing. Once Australians suffered short-term diseases such as dysentery, but now the main causes of illness are long-term diseases like diabetes and cancer. Mental illness is also much more widely recognised, as are the associated issues for families. Substance abuse, too, is being recognised as a health issue, not just an issue of law and order.

These changes put enormous pressure on health services. Half a century ago people went to their local hospitals for one-off treatment. They got better, or they didn’t, but they didn’t need to keep going in and out of hospital. And if people were elderly and clearly dying, there weren’t the medications and technologies to keep them alive for long periods.

Now, people with a chronic illness may end up in hospital half a dozen times a year for the same condition. They can be treated and helped back on their feet. And people who are dying can be kept alive, often with a reasonably good quality of life, for weeks, months or even years with modern treatments.

Of course, much of this is a good thing. But it means that public hospitals are now dealing with older, sicker people, and they are dealing with them over and over again.

Public hospitals were not built to do that. If you were starting from scratch and designing a way to look after a person with diabetes, or heart failure, or recurrent anaemia, or even someone who was dying with dignity, you would not start with a hospital. You would start with providing health care in the community. Will the Australian Government work with states and territories to build up community services to deal with the change in disease patterns?
A mismatch

Although the health care system is evolving, there is still an over reliance on the acute care hospital. While the hospital’s role is important, and always will be, unless we put greater emphasis on preventive health and health promotion to reduce chronic disease, hospitals will buckle under the weight of demand. They will end up able to provide emergency care only.

Doctors, nurses and other health professionals are coming to grips with the new world of health care. As students, they need affordable, quality education to take on new roles that reflect the needs of the current and future populations.

Rising costs

Costs rise. That is the way of the world. But costs in health care are rising faster than inflation.

The cost of pharmaceuticals is rising (see chapter 5). The costs of technology are rising - new forms of testing and new treatments are usually more expensive than the ones they replace. And in some cases, the new tests and treatments are carried out as well as, not instead of, older tests and treatments.

The demands placed on health services are rising – people expect more of the health sector, and health professionals are doing more in order to meet those expectations.

One way the Australian Government has dealt with these rising costs is to shift some of them onto the individual. Ten years ago Australians spent the equivalent of $9 billion from their own pockets on health care – now it’s up to $15 billion. The rate of growth is much higher than inflation.
Summary

The costs of health care for the average person are rising rapidly. Overall, even after taking inflation into account, people are spending over 5% a year more on health care.

Health care is becoming more expensive, and more of it will be needed as the population grows and ages. The health system was designed for people with short-term illness, yet most of its effort is spent looking after people with chronic, long-term illnesses. On top of this, the shortage of health professionals is likely to get worse.

Is the Australian Government doing enough to care for our health now and in the future?