2.1 How does Australia's health system work?

Australia's health system

What do we mean by the 'health system'?

The World Health Organization says it is 'all the activities whose primary purpose is to promote, restore and/or maintain health' (WHO 2013b). A good health system is one that 'delivers quality services to all people, when and where they need them' (WHO 2013a).

While the organisation of services varies around the world, common elements include 'a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies' (WHO 2013a).

Australia's health system is a multifaceted web of public and private providers, settings, participants and supporting mechanisms.

In 2013–14, health spending was estimated at $155 billion, of which $145 billion was recurrent health expenditure (AIHW 2015b) (see 'Chapter 2.2 How much does Australia spend on health care?'). There are divided responsibilities for funding that involve all levels of government (federal, state and territory, and local) as well as non-government organisations, private health insurers, and individuals who pay for some services out of their own pockets.

Health services are provided by a variety of organisations and health professionals, including medical practitioners, nurses, allied and other health professionals, hospitals, clinics, pharmacies, and government and non-government agencies. Together, they deliver a wide range of services, from public health and preventive services in the community, to primary health care, emergency health services, hospital-based treatment in public and private hospitals, and rehabilitation and palliative care.

These health services are supported by many other agencies. For example: research and statistical bodies provide information for disease prevention, detection, monitoring, diagnosis, treatment, care and associated policy; consumer and advocacy groups contribute to public debate and policy development; and universities and health services (among others) contribute to the training of health professionals. Voluntary and community organisations and agencies also make important contributions, including raising money for health services and research, running educational and health promotion programs, coordinating voluntary care, and funding and delivering a range of health services.

Government responsibilities

Australia's federal, state and territory and local governments share responsibility for health and they have many roles (funders, policy developers, regulators and service deliverers) (PM&C 2014).

Private sector health service providers include private hospitals, medical practices and pharmacies.

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Public hospitals are funded by the state, territory and Australian governments, and managed by state and territory governments. Private hospitals are owned and operated by the private sector but licensed and regulated by governments.

The Australian Government and state and territory governments fund and deliver a range of other services, including population health programs, community health services, health and medical research, and Aboriginal and Torres Strait Islander health services. The Australian Government has responsibility for the universal public health insurance scheme, Medicare (including subsidising medical services and providing funding for primary health networks).

Local governments, in addition to providing community-based health and home care services, have a significant role in public health and health promotion activities (for example, the provision of immunisation services; smoking cessation, nutrition awareness and weight loss programs; child and maternal health services; and promoting safety and physical activity) and may also deliver environmental health-related services (including water fluoridation, sanitation services, water and food inspection and food safety monitoring) (ALGA 2010; LGNSW 2016) (see Figure 2.1.1).

Figure 2.1.1: Main roles of government in Australia's health system

Australian Government

- sets national policies
- is responsible for Medicare (including subsidising medical services and joint funding, with states and territories, of public hospital services)
- funds pharmaceuticals through the Pharmaceuticals Benefits Scheme
- funds community-controlled Aboriginal and Torres Strait Islander primary health care
- supports access to private health insurance
- regulates private health insurance
- organises health services for veterans
- is a major funder of health and medical research, including through the National Health and Medical Research Council
- regulates medicines, devices and blood

State and territory governments

- manage public hospitals
- license private hospitals
- are responsible for public community-based and primary health services (including mental health, dental health, alcohol and drug services)
- deliver preventive services such as cancer screening and immunisation programs
- are responsible for ambulance services
- are responsible for handling health complaints

Local governments

- provide environmental health-related services (for example, waste disposal, water fluoridation, water supply, food safety monitoring)
- deliver some community- and home-based health and support services
- deliver some public health and health promotion activities

Shared

- regulation of health workforce
- education and training of health professionals
- regulation of pharmaceuticals and pharmacies
- support improvements in safety and quality of health care
- funding of public health programs and services
- funding of Aboriginal and Torres Strait Islander health services

Sources: Biggs 2013; COAG 2012; Department of Health 2015b; Duckett & Willcox 2015; PM&C 2014.

Major types of health care

Primary health care

Primary health care is typically a person's first contact with the health system (Department of Health 2015f), and broadly encompasses care that is not related to a hospital visit. It includes a range of activities, such as health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions.

Services provided by primary health care vary, from prevention and health promotion activities (see 'Chapter 6.1 Prevention and health promotion' and 'Chapter 6.2 Cancer screening') to the treatment and management of illness.

The primary health care system can provide community-based, patient-centred care by a team of health professionals. Because of this, primary health care is often the 'best setting for the prevention and management of chronic and complex health conditions' (PHCAG 2015:5).

Primary health care is delivered in a variety of settings, including general practices, community health centres, allied health practices, and through communication technology such as telehealth and video consultations.

Primary health care services are delivered by various health professionals, including general practitioners, nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists, and Aboriginal and Torres Strait Islander health workers.

Primary health care accounted for around 38% ($55 billion) of the $145 billion recurrent health expenditure in 2013–14, compared with around 40% ($59 billion) spent on hospital services (see 'Chapter 2.2 How much does Australia spend on health care?'). For more information on primary health care, see 'Chapter 6.3 Primary health care'.

Primary Health Networks

On 1 July 2015, the Australian Government established 31 Primary Health Networks (PHNs). (For a map of PHNs, visit the Department of Health website.)

PHNs work directly with GPs, other primary health care providers, hospitals, and the broader community. They aim to:

- increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes
- improve coordination of care to ensure patients receive the right care in the right place at the right time (Department of Health 2015c).

The PHNs have six priorities for targeted work: mental health, Aboriginal and Torres Strait Islander health, population health, the health workforce, eHealth, and aged care (Department of Health 2015c).

Where possible, PHN boundaries align with Local Hospital Networks (LHNs) or equivalents, or clusters of LHNs. This arrangement aims to facilitate collaborative working relationships, reduce duplication of effort, and assist with the management of patients with complex or chronic conditions (Department of Health 2015c).

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Secondary health services

The primary health sector does not operate in isolation. It is part of a larger system involving other services and sectors and so can be considered the 'gateway' to the wider health system. Individuals can be directed from one primary care service to another, and from primary services into secondary and other health services, and back again.

'Secondary care' is medical care provided by a specialist or facility upon referral by a primary care physician (Merriam-Webster 2015).

Hospitals

In Australia, hospital services are provided by both public and private hospitals.

In 2013–14, there were 1,359 hospitals—747 public and 612 private. Of the 9.7 million hospital admissions that year, 59% were same-day hospitalisations (AIHW 2015a) (see 'Chapter 6.8 Overview of hospitals').

Hospital emergency departments are a critical component of hospitals and of the health system. They provide care for patients who have an urgent need for medical or surgical care. In 2014–15, almost 7.4 million emergency department presentations were reported by public hospitals—just over 20,000 each day (see 'Chapter 6.11 Emergency department care'). Australian public hospitals also provided around 18 million occasions of service for outpatient care in 2013–14 (excluding Victoria, which provided 3.7 million occasions of service in 2012–13) (AIHW 2015c).

In 2013–14, spending on public hospitals accounted for 31% of total recurrent health spending—$45.7 billion (see 'Chapter 2.2 How much does Australia spend on health care?').

For more detail on private hospital spending and services, see 'Chapter 2.2 How much does Australia spend on health care?' and 'Chapter 6.8 Overview of hospitals'.

Local Hospital Networks

LHNs are independent authorities set up by the states and territories to manage public hospital services and funding. There are more than 135 LHNs in Australia and they are directly accountable for hospital performance. (For information on LHNs, visit the health department website for your state or territory.)

Although most LHNs are responsible for the provision of public hospital services in a defined geographical area, in some jurisdictions a small number of LHNs provide services across a number of areas, for example, children's hospitals.

Jurisdictions often have their own names for LHNs. For example, in New South Wales, they are known as 'Local Health Districts'; in Queensland they are known as 'Hospital and Health Services'; in South Australia they are known as 'Local Health Networks'; and in Tasmania they are known as 'Tasmanian Health Organisations'.

How the health system is funded

In 2013–14, health expenditure in Australia was estimated at $155 billion, or 9.8% of gross domestic product, compared with $150 billion in 2012–13 and nearly $95 billion in 2003–04 (adjusted for inflation) (AIHW 2015b).

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Almost 68% of total health expenditure during 2013–14 was funded by governments, with the Australian Government contributing 41% and state and territory governments nearly 27%. The remaining 32% ($50 billion) was paid for by individuals through out-of-pocket expenses (18%), by private health insurers (8.3%) and through accident compensation schemes (6.1%) (AIHW 2015b) (see 'Chapter 2.2 How much does Australia spend on health care?').

The distribution of funding between government and the non-government sector varies, depending on the type of health goods and services being provided. Public hospitals are funded by the state and territory and Australian governments, but are largely owned and managed by the state and territory governments. Private hospitals are largely owned and operated by private (non-government) organisations—either for-profit companies, or not-for-profit organisations (AIHW 2015a).

The Australian Government provides a large amount of funding for medical services and subsidised medications, with the balance sourced from the non-government sector. The state and territory governments provide most of the funding for community health services. Non-government sources (such as private health insurers and individuals), as well as private hospitals, provide large portions of the funding for dental services, aids and appliances, some medications, and other health practitioner services.

Figure 2.1.2 provides a picture of the main services, funding responsibilities and providers. Health funding and the composition of the workforce are covered in detail in a separate article and snapshot in this chapter, but an overview is provided here to outline the main elements of Australia's health system.

The inner segments show the relative size of the recurrent expenditure in each of the main sectors of the health system: hospitals, primary health care, and other services. The 'hospitals' sector includes all services provided by public and private hospitals. 'Primary health care' includes a range of front-line health services delivered in the community (as described earlier), and also includes the cost of medications provided through the Pharmaceutical Benefits Scheme (PBS), as well as over-the counter and non-PBS prescription medications. The category 'other services' includes medical services other than those provided by GPs, medical research, health aids and appliances, patient transport services and health administration. It is important to note that these examples are not exhaustive, and each group of services consists of many types of activities.

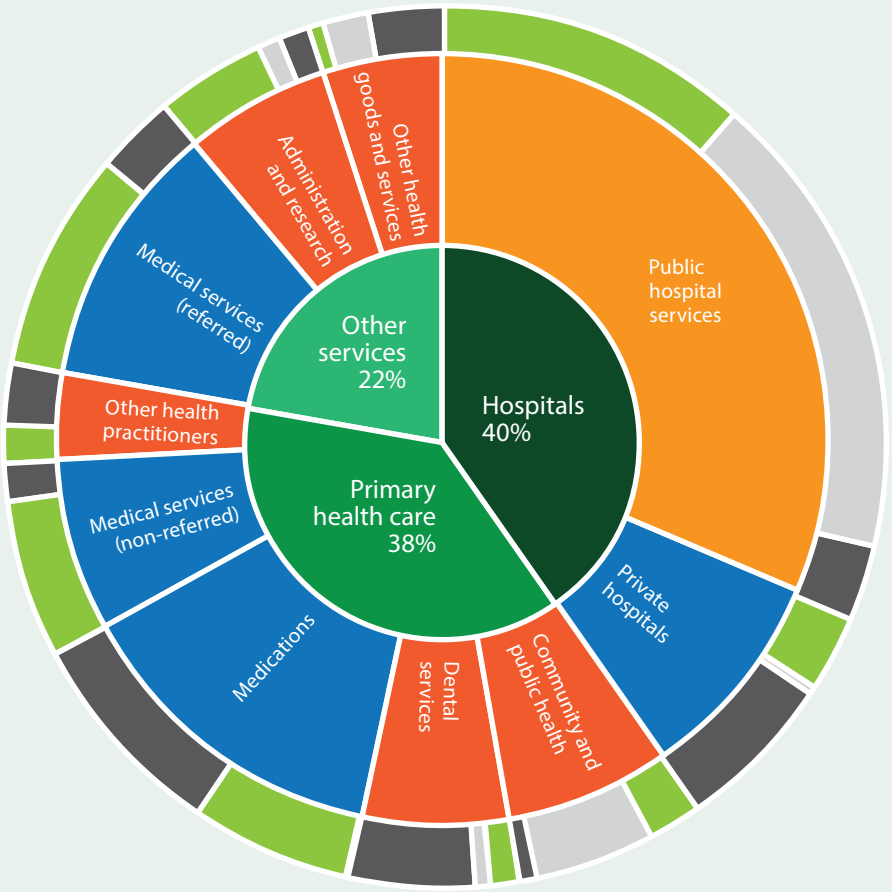
The middle ring indicates the relative expenditure on the specific service types within each sector, and who delivers the service; the colour coding shows whether the service is provided by the private sector, public sector, or both. The outer ring shows the funding source for the different services and the relative size of the funding.

Medicare

The Australian Government's funding contributions include a universal public health insurance scheme, Medicare. Medicare was introduced in 1984 to provide free or subsidised access to public hospital services and to treatment by health professionals (including doctors, optometrists and some other health professionals) (DHS 2015a).

The Medicare system has three parts: hospital, medical and pharmaceutical. Coverage of pharmaceuticals predates Medicare, with the PBS introduced in 1948.

Figure 2.1.2: Health services—funding and responsibility, 2013–14



Note: The inner segments indicate the relative size of expenditure in each of the three main sectors of the health system ('Hospitals', 'Primary health care', and 'Other services'). The middle ring indicates both the relative expenditure on each service in the sector (shown by the size of each segment) and who is responsible for delivering the service (shown by the colour code). The outer ring indicates both the relative size of the funding (shown by the size of each segment) and the funding source for the difference services (shown by the colour code). For more detail, refer to the main text.

Medicare is funded by taxpayers who, in addition to general income tax, pay a levy of 2.0% of their taxable income and a further surcharge of 1.0–1.5% of an individual taxpayer's income for a single taxpayer earning above $90,000 and for families earning over $180,000 who choose not to take out a specified level of private hospital cover (ATO 2015).

Medicare benefits are not available for medical treatment a person receives overseas. However, the Australian Government has signed Reciprocal Health Care Agreements to help cover the cost of essential medical treatment for Australians visiting certain countries: New Zealand, the United Kingdom, the Republic of Ireland, Sweden, the Netherlands, Finland, Italy, Belgium, Malta, Slovenia and Norway (DHS 2014).

Medicare and hospital treatment

Medicare offers fee-free treatment as a public patient in a public hospital, by a doctor appointed by the hospital (DHS 2015a).

It also covers 75% of the Medicare Benefits Schedule (MBS) fee for services and procedures for private patients in a public or private hospital (DHS 2015a).

Medicare and medical services

MBS fees are set by the Australian Government. Medical practitioners are not required to adhere to the recommended schedule and can charge more than the scheduled fee for private patients. If the practitioner charges more than this fee, the patient is required to pay the extra amount, which is known as a 'gap' payment.

When a person visits a doctor outside a hospital, Medicare will reimburse 100% of the MBS fee for a GP and 85% of the MBS fee for a specialist. If the doctor bills Medicare directly (bulk billing), the patient will not have to pay anything (DHS 2015b). If the doctor charges more than the MBS fee, the patient has to pay the gap.

Medical costs not usually covered by Medicare include:

- ambulance services
- most dental examinations and treatment
- most physiotherapy and other allied health services
- glasses and contact lenses.

In 2014–15, 21 million Australians (90% of the population) accessed more than 368 million individual services on the MBS—more than 1 million services a day (Department of Health 2015a).

Pharmaceutical Benefits Scheme

The Australian Government subsidises a wide range of prescription pharmaceuticals under the PBS. Under the PBS, the amount paid by the patient varies, up to a maximum of $38.30 for general patients and $6.20 for those with a concession card (Department of Health 2015e).

There are two safety net thresholds that operate on a calendar year. The general patient threshold is about $1,475. When a person and/or their family's co-payments reach this amount, they may then pay the concessional rate for prescriptions. The concessional safety net threshold is $372. When a patient and/or their family's total co-payments reach this amount, they may get their subsequent medications for free for the rest of the calendar year (Department of Health 2015e).

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

If a medicine is not listed on the PBS schedule, the consumer has to pay the full price as a private prescription (Department of Health 2015d). In some cases, these costs may be reimbursed by private insurance funds. Pharmaceuticals provided in public hospitals are generally provided to public patients for free, with the cost covered as part of the hospital treatment. Public hospitals are allowed to prescribe pharmaceuticals under the PBS to certain patients and in this situation the same co-payments apply as for pharmaceuticals prescribed in the community.

Repatriation Pharmaceutical Benefits Scheme

The Repatriation Pharmaceutical Benefits Scheme provides access to a range of pharmaceuticals and dressings at a concessional rate for the treatment of eligible war veterans, war widows/widowers and their dependants (DVA 2012).

Private health insurance

Private health insurance is available for those who wish to fully or partly cover the costs of being admitted to hospital as a private patient and/or the costs of other ancillary health services (Private Healthcare Australia 2015).

At June 2015, 11.3 million Australians (47% of the population) had some form of private patient hospital cover, and 13.3 million (56%) had some form of general treatment cover (APRA 2015).

Part of the cost of a hospital admission as a private patient is also covered by the Australian Government through Medicare.

A person can choose to be treated as a public patient in a public hospital, even if they have private health insurance. Private health insurance is not compulsory, and people can mix and match the levels and type of cover to suit their individual circumstances. The Australian Government offers a means-tested rebate for people with private health insurance.

Who governs health services?

Overall coordination of the public health care system is the responsibility of the Australian Government and state and territory government health ministers. Managing the individual national and state and territory health systems is the responsibility of the relevant health minister and health department in each jurisdiction.

The health ministers are collectively referred to as the Health Council, which comes under the auspices of the Council of Australian Governments—the peak intergovernmental forum in Australia. Membership of the Health Council also includes the Australian Government Minister for Veterans' Affairs and the New Zealand Health Minister (COAG Health Council 2014b).

The Health Council's responsibility is to 'provide a forum for cooperation on health issues, especially primary and secondary care, and consider increasing cost pressures' (COAG Health Council 2014c).

The Health Council is supported by the Australian Health Ministers' Advisory Council, which comprises the heads of the Australian Government health department, all state and territory health departments, the New Zealand health department, and the Australian Government veterans' affairs department (COAG Health Council 2014a).

Regulation

Health regulation is a government responsibility. The Australian Government's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances, while the state and territory governments license or register private hospitals, and have legislation for the operation of public hospitals.

The licensing of pharmacy premises and pharmacy ownership restrictions is also the responsibility of the states and territories. State and territory governments are also largely responsible for health-related industry regulations, such as for the sale and supply of alcohol and tobacco products.

Both levels of government jointly regulate some areas, including food standards, safety and quality of health care, and the health workforce.

Registration of health professionals

A National Registration and Accreditation Scheme for health practitioners started on 1 July 2010. Fourteen professions have joined the scheme, including medical practitioners, nurses and midwives, pharmacists and other allied health professions (AHPRA 2015a) (see 'Chapter 2.3 Who is in the health workforce?').

Each profession in the scheme is represented by a National Board that is responsible for registering practitioners and students, and for setting the standards that all registered health professionals must meet (AHPRA 2015b).

The scheme is implemented by national boards, which are supported by an independent body, the Australian Health Practitioner Regulation Agency.

One of the objectives of the scheme is to protect the public by ensuring that only health practitioners who are suitably trained and qualified are registered (AHPRA 2015a).

In 2015, health ministers approved a National Code of Conduct for the non-registered health care workers, currently operating in New South Wales, Queensland, and South Australia. Once implemented in each state and territory, the code will provide protection for the public by setting minimum standards expected of anyone who delivers a health service; and will also provide national prohibition orders.

For some health practitioner disciplines not regulated under the National Registration and Accreditation Scheme (such as dietitians, naturopaths, massage therapists and optical technicians), professional associations provide guidance on professional standards, with some associations having a formal credentialing or accreditation process that sets benchmarks for expected practice for individual practitioners.

How does Australia's health system compare internationally?

The results presented here show how Australia compares with members of the Organisation for Economic Co-operation and Development (OECD), an international organisation of 34 countries. The rankings are based on analysis that uses OECD methodology.

(For information on how Australia ranks internationally on selected health indicators, see 'Chapter 1.3 How healthy are Australians?')

Health expenditure

Using OECD calculations methods, in 2013, Australia's spending on health as a proportion of GDP was 9.4%, slightly higher than the OECD average of 9.3%. This ranked Australia in the middle (10th) of the 22 OECD countries with available data. The United States was by far the biggest spender on health care, at 17.1% of GDP (AIHW 2015b) (see also 'Chapter 2.2 How much does Australia spend on health care?').

Australia's health expenditure per person ($5,060) was higher than the OECD average ($4,561); 9th out of 22 countries. Again, the United States was the biggest spender, at $10,963 per person (AIHW 2015b). (Note: spending has been converted to Australian dollars using GDP purchasing-power parities.)

Health care resources

A substantial increase has occurred in the medical workforce in Australia since 2000 that coincided with a rise in the number of medical graduates. In 2013, Australia had 3.4 practising physicians per 1,000 population, up from 2.5 in 2000, which was slightly above the OECD average (3.3) (OECD 2015b).

Australia had 11.5 nurses per 1,000 population, up from 10.1 in 2000, which was above the OECD average (9.1) and 3.7 hospital beds per 1,000 population, down from 4.0 in 2000, and lower than the OECD average of 4.8 (OECD 2015b).

Challenges for the health system

The health system faces a number of challenges. An ageing population, increases in consumer expectations, more expensive technologies, and a growing burden of chronic conditions are among the factors driving an increased demand for services and rising health expenditure (PM&C 2014).

In a recent report, the OECD noted that this 'health shift' of ageing populations and people living longer with multiple chronic and disabling conditions had 'important implications for how care is best organised and provided; where new treatment innovations can be expected; and future cost pressures on governments' (OECD 2015a:20).

The complexity of Australia's health system also presents challenges, particularly for people with complex health conditions who may be under the care of multiple health professionals and who move from one health service to another with little or no continuity of care (PHCAG 2015; PM&C 2014).

In 2015, the Australian Government established a Primary Health Care Advisory Group to investigate possible reforms to primary health care to improve the management of people with complex and chronic disease (Department of Health 2015g).

The group noted that patients often experienced 'a fragmented system, with providers and services working in isolation'; uncoordinated care; difficulty finding services they needed; duplication of services; and 'feelings of disempowerment, frustration and disengagement' (PHCAG 2015:5).

The health sector also has strong connections to the welfare sector, which may also make integration of care, and funding responsibility, difficult (see Box 2.1.1).

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Box 2.1.1: The interface between health and welfare services

The health sector is a complex interaction of public and private service providers, settings, participants and supporting mechanisms. Many people will have experienced this complexity first hand as they have attempted to navigate the system for themselves or for someone for whom they are caring.

But the complexity doesn't end there—particularly for more vulnerable groups, such as older people, people with disability or the homeless. Not only do people need to navigate specific and separate service sectors (such as aged care), they also need to negotiate the interface between these sectors and the health sector. In many instances this is not a single transition, as they dip in and out of sectors and services as the need arises.

An example is people in residential aged care who may need treatment in a hospital. The AIHW report *Movement between hospital and residential aged care 2008–09* (AIHW 2013) showed that, of the 1.1 million hospitalisations of people aged 65 and over, 9% of the admissions were from residential aged care, and 11% of the discharges were to residential aged care—about 200,000 total movements between the hospital sector and the residential aged care sector.

The health–welfare interface has been brought into sharper relief over the course of this decade because of major national reforms in hospital services, primary care, aged care and disability support (the latter through the introduction of the National Disability Insurance Scheme). Associated with many of these reforms have been changes in the relative responsibilities in policy, program and funding between the Australian Government and state and territory governments.

Hence it is critical that robust policies, information systems and monitoring programs are in place—and are further developed—so that all Australians, and particularly those with special and complex needs, can benefit from an integrated, responsive, efficient, effective, safe health and welfare services system.

What is missing from the picture?

Currently it is not easy to profile how a person interacts with the health system—that is, the different services they use, the treatment and care provided, and the health outcome. Initiatives such as eHealth and the creation of an integrated records system for each person may provide some of this information in the future. Such information could also provide insights into the overall effectiveness and efficiency of the health system, and help prevent duplication of testing and procedures.

Where do I go for more information?

Individual aspects of the health system are discussed in more detail throughout this report.

Detailed information on health spending and the health workforce is available at www.aihw.gov.au/expenditure and www.aihw.gov.au/workforce respectively.

Detailed information on Australian hospitals is available at www.aihw.gov.au/hospitals.

More information on health reform, health practitioner registration and Australian Government health policies is available from the Department of Health website.

More information on intergovernmental arrangements and agreements is available at the COAG website.

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