1 Background and summary

1.1 Background

This publication reports on health expenditure in Australia, by area of expenditure and source of funds from 1993–94 to 2002–03. It also provides detailed preliminary estimates for 2003–04 at the national level and some selected estimates at the state and territory level. Expenditure is analysed in terms of who provides the funding for health care and what types of services attract that funding.

The bulk of funding for health expenditure is provided by the Australian Government and the state and territory governments. Therefore, as well as consideration of the whole period from 1993–94 to 2003–04, analyses of trends in expenditure have been linked to the periods covered by the major health care funding agreements between these two levels of government. These are:

- from 1993–94 to 1997–98
- from 1997–98 to 2002–03.

Australia is compared with other member countries of the Organisation for Economic Co-operation and Development (OECD). Some limited comparisons with other countries in the Asia–Pacific region are also presented.

The tables and figures in this publication detail expenditure in terms of current and constant prices. Constant price expenditure adjusts for the effects of inflation using, wherever possible, chain price indexes provided by the Australian Bureau of Statistics (ABS). Where such chain price indexes are not available, implicit price deflators are used. Because the reference year for both the chain price indexes and the implicit price deflators is 2002–03, the constant price estimates indicate what expenditure would have been had 2002–03 prices applied in all years.

Throughout this publication there are references to the general rate of inflation. These refer to changes in economy-wide prices, not just consumer prices. The general rate of inflation is calculated with reference to the implicit price deflator for gross domestic product (GDP).

Some expenditure estimates for 1997–98 to 2001–02 have been revised since the publication of *Health Expenditure Australia 2002–03*: these are detailed in Section 6.6.

1.2 The structure of the health sector and its flow of funds

The flow of money around the Australian health care system is complex and is determined by the institutional frameworks in place, both government and non-government. Australia is a federation, governed by a national government (the Australian or Commonwealth Government) and eight state and territory governments. Both these levels of government

play important roles in the provision and funding of health care. In some jurisdictions, local governments also play an important role. All of these levels of government collectively are called the public sector. What remains is the non-government sector, which in the case of funding for health care comprises individuals, private health insurers and other non-government funding sources (principally workers' compensation and compulsory motor vehicle third-party insurers). Figure 1 shows the major flows of funding between the government and non-government sectors and the providers of health goods and services.

Most non-hospital health care in Australia is delivered by non-government providers, among them private medical and dental practitioners, other health professionals (such as physiotherapists, acupuncturists and podiatrists) and pharmaceutical retailers. Delivery of health care can occur in a diverse range of settings—hospitals, residential care facilities, hospices, rehabilitation centres, community health centres, health clinics, ambulatory care services, the private consulting rooms of health professionals, patients' homes or workplaces, and so on.

In summary, the following are the main features of Australia's health system:

- Universal access to benefits for privately provided medical services under Medicare, which are 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 and 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 for health research. It also directly funds a wide range of services for eligible veterans.
- State and territory health authorities are primarily responsible for the operations of the public hospital networks, mental health programs, the transport of patients, community health services, and public health services such as health promotion and illness prevention.
- Individuals primarily spend money on pharmaceuticals, dental services, aids and appliances, medical services and other professional services.

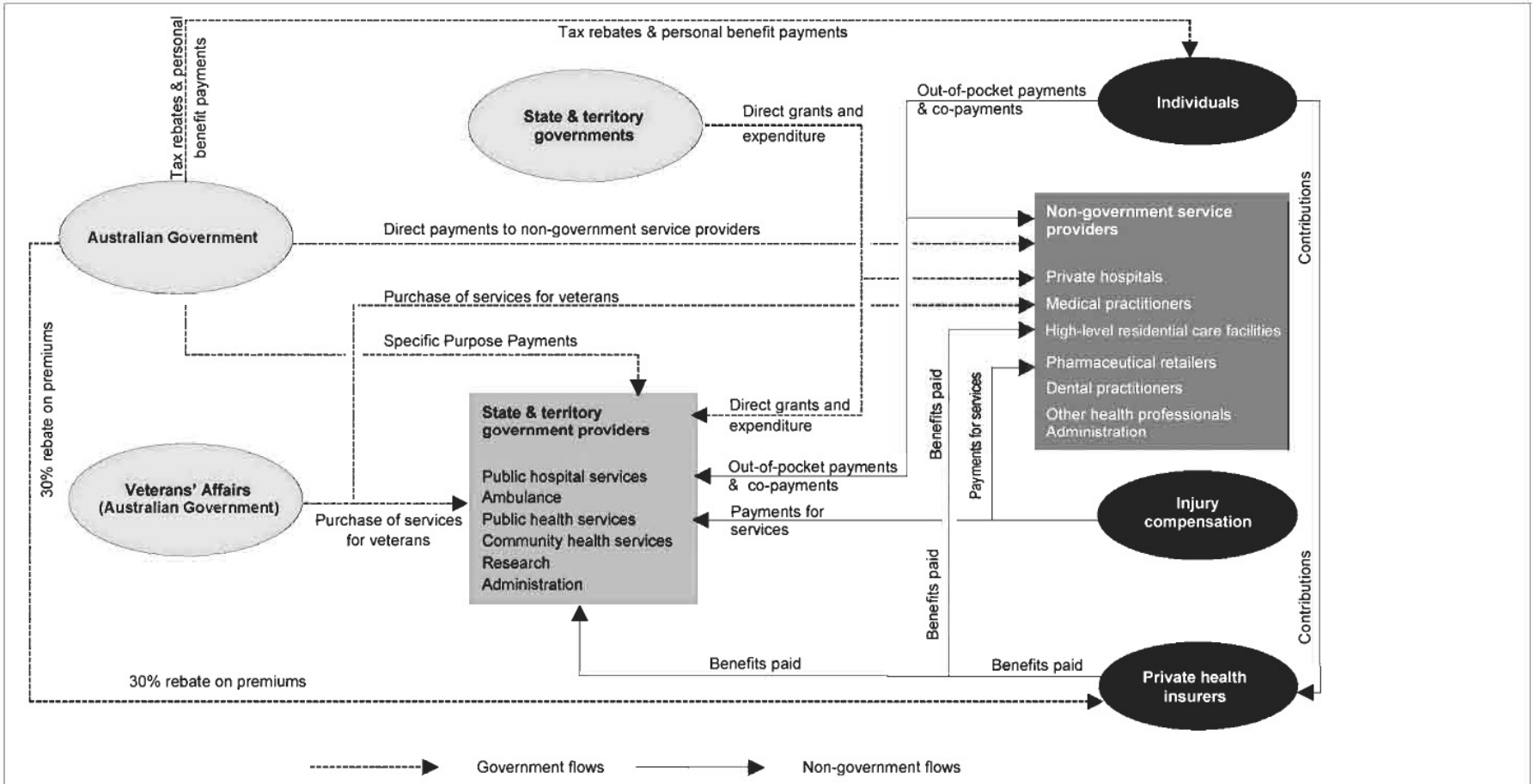

Figure 1: The structure of the Australian health care system and its major flow of funds

1.3 Summary of findings

- Total health expenditure in Australia was an estimated $78.6 billion in 2003–04 (Table 1). This is equivalent to $3,931 per person (Table 5).
- Health expenditure as a proportion of GDP was estimated at 9.7% in 2003–04, up from 9.6% ($72.5 billion) in 2002–03 (Table 2).
- Governments funded 68.0% of health expenditure in Australia in 2003–04 (Table 12), while the non-government sector funded 32.0%, an increase of 0.8 percentage points above the proportion in 2002–03.
- Average real growth in funding by individuals (out-of-pocket expenditures) between 1993–94 and 2003–04 was 5.4% per year, 0.8 percentage points above the real growth in health expenditure (4.6%) per year over the period (Tables 1 and 20).
- In 2003–04, $2.5 billion of health expenditure was funded by the Australian Government through its health insurance rebates (Table 18).
- Real growth in expenditure on health averaged 4.6% between 1993–94 and 2003–04, with the highest annual growth (7.6%) occurring in 2000–01 (Table 1).
- Real expenditure on pharmaceuticals grew rapidly (11.7% annually from 1997–98 to 2002–03), with growth peaking at 16.9% in 2000–01 (Table 16).
- Health prices increased, on average, 0.8% per year more rapidly than the general inflation rate between 1993–94 and 2003–04 (Table 4).
- Excess health inflation was around 1.0% from 2000–01 to 2002–03, after experiencing a decline of 1.3% in 2000–01 (Table 4).

1.4 Revisions to ABS estimates

Revisions to ABS estimates of GDP, household final consumption expenditure (HFCE) and Government finance statistics have affected the estimates in this publication, as in previous issues.

GDP estimates for this publication are sourced from the ABS (ABS 2005). The current price GDP estimates in that ABS publication are lower than those published in *Health Expenditure Australia 2002–03,* except for 2002–03 (which is higher than was published). For instance, the 2002–03 current price estimate of GDP was revised up in the June quarter 2005 publication by $2.0 billion, compared with the published number used in *Health Expenditure Australia 2002–03*. This resulted in a marginal increase in the proportion of GDP spent on health goods and services (the health–GDP ratio) for that year from 9.5% to 9.6%.

Estimated total HFCE has been revised down since the publication of *Health Expenditure Australia 2002–03*. The major revision related to HFCE for medicines, aids and appliances; it was revised down by $226 million in 2000–01, $519 million in 2001–02 and $748 million in 2002–03. This was offset to some extent by the combined upward revision in HFCE for doctors and other health professionals, and HFCE for hospitals and nursing homes ($253 million in 2001–02 and $194 million in 2002–03).

ABS estimates of capital formation have been revised downwards since *Health Expenditure Australia 2002–03*. This is the result of an ongoing review of all accrual time series by the

ABS, in consultation with the state Treasuries. Accrual reporting is now established in all jurisdictions and improvements in the quality of the time series data have resulted in some changes to these series. Further revisions are expected progressively over the next year.