



## 2.2 How much does Australia spend on health care?

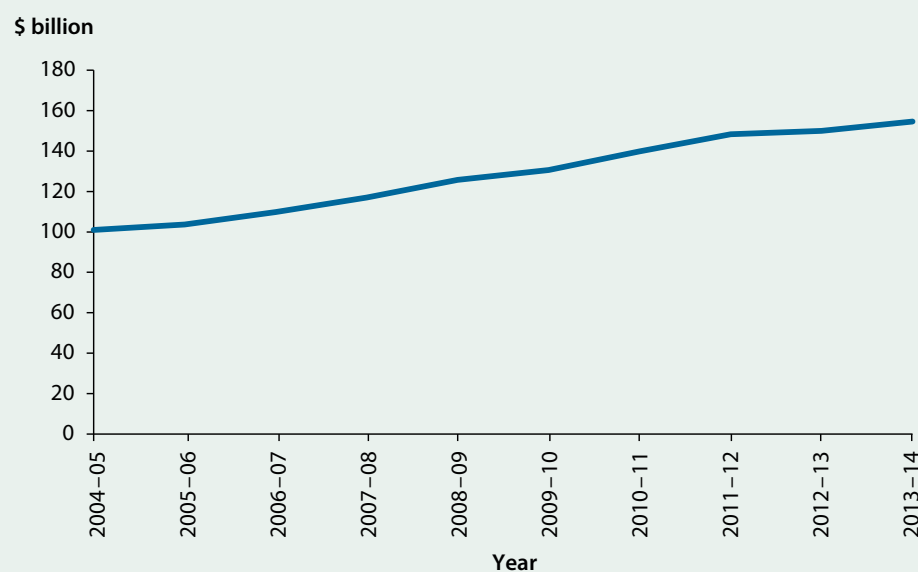
Health expenditure is money spent on health goods and services. It includes money spent by governments as well as by individuals and other non-government funders, such as private health insurers. The providers of health goods and services include hospitals, primary health care providers such as general practitioners (GPs), and other health professionals.

Over recent decades, health expenditure has grown relatively steadily from year to year. Over the decade from 2003–04 to 2013–14, health expenditure grew faster in real terms than overall gross domestic product (GDP), with an average annual real growth of 5.0%—2.2 percentage points higher than the 2.8% growth in GDP.

Using Organisation for Economic Co-operation and Development (OECD) methods, the ratio of Australia's health expenditure to GDP was 9.4% in 2013, near to the average for OECD countries (9.3%). It is a higher proportion than that of the United Kingdom (8.8%) and a lower proportion than in Canada (10.7%) and New Zealand (11.0%). The United States was by far the highest spender, with the health sector making up 17.1% of GDP in 2013.

Total expenditure on health (that is, recurrent and capital expenditure combined) has grown each year, in real terms (after adjusting for inflation) from \$95 billion in 2003–04 to an estimated \$155 billion in 2013–14 (see Figure 2.2.1).

**Figure 2.2.1: Total health expenditure 2004–05 to 2013–14, adjusted for inflation**



Note: Inflation-adjusted prices expressed in terms of 2013–14 prices.

Source: AIHW health expenditure database.



## Where is the money spent?

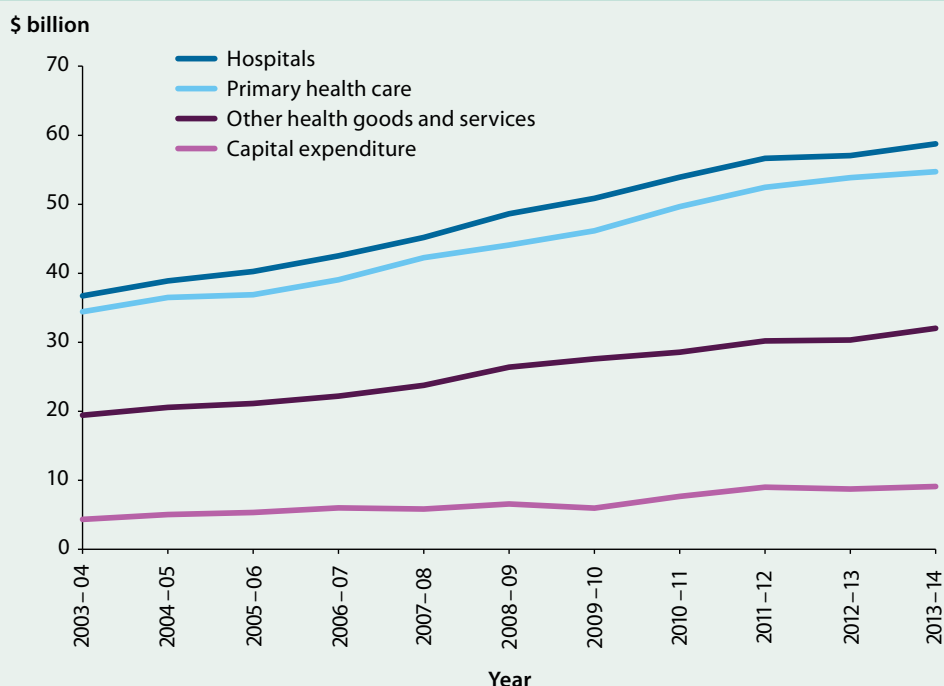
Of the \$155 billion spent in 2013–14, \$145 billion was recurrent health expenditure. In 2013–14, \$59 billion was spent on *Hospitals* in Australia, increasing in real terms from \$37 billion in 2003–04 (Figure 2.2.2). The share of recurrent expenditure accounted for by *Hospitals* remained relatively constant over the decade, at around 40%.

*Primary health care* expenditure was \$55 billion in 2013–14, around 38% of recurrent expenditure. This was an increase, adjusted for inflation, from \$34 billion in 2003–04. In 2012–13 and 2013–14, *Unreferred medical services* (largely GP services) attracted the highest share of *Primary health care* expenditure, at 19.1% and 19.3% respectively. *Unreferred medical services* cost \$10.6 billion in 2013–14, with \$8.7 billion funded by the Australian Government. Expenditure on pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS), referred to as *Benefit-paid pharmaceuticals*, and included in the *Primary health care* group, was \$10.1 billion in 2013–14.

In 2013–14, \$32 billion was spent on *Other health goods and services*, an increase in real terms from \$19 billion in 2003–04. The share of recurrent expenditure accounted for by *Other health goods and services* was around 22% in 2013–14. Around 50% of *Other health goods and services* expenditure was for *Referred medical services* (largely specialist medical services), with an expenditure of \$16 billion in 2013–14.

*Capital expenditure* increased in real terms from \$4.3 billion in 2003–04 to \$9.1 billion in 2013–14.

Figure 2.2.2: Total health expenditure, by broad area of expenditure, adjusted for inflation, 2003–04 to 2013–14



Note: Inflation-adjusted prices expressed in terms of 2013–14 prices.  
Source: AIHW health expenditure database.



## Who pays for what?

In 2013–14, governments were responsible for \$105 billion, or nearly 68% of total health expenditure of \$155 billion in Australia. Of the government contribution, the Australian Government contributed \$63.5 billion, or 41% of total health expenditure, and state and territory governments contributed \$41 billion, or nearly 27% of total health expenditure.

The Australian Government provides a large amount of the funding for medical services—\$21 billion in 2013–14, or 78% of medical services expenditure—with the balance sourced from the non-government sector. The Australian Government also spent \$8.4 billion for benefit-paid medications, covering 84% of benefit paid medication expenditure in 2013–14.

State and territory governments on the other hand provide most of the funding for community health services, contributing \$6.2 billion in 2013–14, or 79% of community health service expenditure.

Most funding provision for public hospital services is shared between Australian, state and territory governments. The Australian Government provided 37% of recurrent funding for public hospital services in 2013–14 (\$17 billion), while the state and territory governments, which have primary responsibility for operating and regulating public hospitals, provided 54% (\$25 billion).

Total non-government expenditure was nearly \$50 billion in 2013–14, or 32% of the share of total health expenditure. Funding by individuals was \$27.5 billion in 2013–14, which accounted for nearly 55% of estimated non-government funding and nearly 18% of total health expenditure. Nearly 93% of funding for non-subsidised medicines (\$9.0 billion) in 2013–14—such as over-the counter medications, private prescriptions and under co-payment level medicines—was funded by individuals. Nearly 60% of dental services expenditure in 2013–14 was funded by individuals (\$5.3 billion).

Private health insurance funds provided \$13 billion of total health expenditure in 2013–14, while the balance of \$9.4 billion came from other non-government sources, mainly in the form of payments by compulsory motor vehicle third-party and workers' compensation insurers.

The majority of private health insurance funding was for hospital services, with \$7.3 billion spent in 2013–14.

For further information on the Australian health system, including an overview of health expenditure, see 'Chapter 2.1 How does Australia's health system work?'

## Changes in expenditure over recent years

Average annual growth in health expenditure over the past decade was 5.0%, but the rate slowed in recent years. In real terms the rate from 2011–12 to 2012–13 was 1.1%, and 3.1% from 2012–13 to 2013–14.

Since *Australia's Health 2014* was released, growth in the government contribution to health expenditure also slowed and in some areas expenditure declined. The 68% of total spending sourced from governments in 2013–14 was lower than in 2011–12, when governments funded nearly 70% of total health expenditure. The areas of expenditure that most affected the slowdown in growth included *Public health, Benefit-paid pharmaceuticals, Administration* and *Patient transport* expenditure.



In real terms, adjusted for inflation, funding by the Australian Government decreased by 2.5% between 2011–12 and 2012–13. It then increased by 2.4% between 2012–13 and 2013–14. This was lower than average annual growth over the decade (4.4%) and, for the 2 years combined, there was a real decrease of 0.1% from 2011–12 to 2013–14. The main drivers of the decrease in Australian Government expenditure from 2011–12 to 2012–13 were changes to the PBS, to private health insurance premium rebates, and to the medical expenses tax rebate.

PBS expenditure followed a similar pattern to overall Australian Government expenditure, with a decline of 2.1% between 2011–12 and 2012–13 followed by a relatively small increase the following year of 1.7% (Department of Health 2015). This followed the introduction of a generic medicines initiative, which affects the negotiated price of listed pharmaceuticals through the listing of off-patent generic drugs, as well as price disclosure changes (Department of Health 2010). This decrease in expenditure did not necessarily mean fewer services provided. The number of subsidised prescriptions dispensed over this time increased from 208 million in 2011–12 to 223 million in 2013–14.

Changes to the private health insurance rebate income testing arrangements reduced the share of funding provided by the Australian Government through the rebate scheme. Coinciding with this, the proportion of expenditure funded by private health insurers increased from 7.4% in 2011–12 to 8.3% in 2013–14.

From July 2012, the medical expenses tax rebate became income tested. Expenditure on the medical expenses tax rebate declined in real terms, from \$574 million in 2011–12 to \$226 million in 2013–14.

In 2012–13 and 2013–14, growth in state and territory government spending, another major source of health expenditure funding, was also relatively slow. The state and territory government share of total health expenditure declined from 26.9% in 2011–12 to 26.6% in 2013–14.

The two fastest growing areas of expenditure between 2011–12 and 2013–14 were *All other medications* (private prescriptions, over-the-counter prescriptions and under co-payment pharmaceuticals) and *Aids and appliances*. The share of total health expenditure that related to *All other medications* increased from 5.9% in 2011–12 to 6.3% in 2013–14, with a cost of \$9.7 billion in 2013–14. The share of total health expenditure relating to *Aids and appliances* increased from 2.4% in 2011–12 to 2.6% in 2013–14 (\$4.0 billion in 2013–14).

Non-government recurrent expenditure grew in real terms, from \$41 billion in 2011–12 to nearly \$46 billion in 2013–14, and the share of total expenditure rose from 30% to 32%.

## Expenditure for admitted patients

To better understand the drivers of the expenditure trends outlined above, the AIHW periodically conducts additional studies into the purposes for the expenditure and the characteristics of the people for whom the expenditure is incurred, in terms of the diseases or conditions managed, their age, sex and Indigenous status.



The AIHW has analysed admitted patient care expenditure, for both public and private hospitals, for the years 2004–05 to 2012–13. Expenditure on admitted patient services represents around 70% of total hospital expenditure, with the remainder being for emergency departments and non-admitted care.

For each hospital stay (referred to as a hospital 'separation' or 'hospitalisation'), expenditure was allocated to the diagnoses that were likely to have influenced the cost, including diseases or conditions that the patient had on admission to hospital, and any arising after admission.

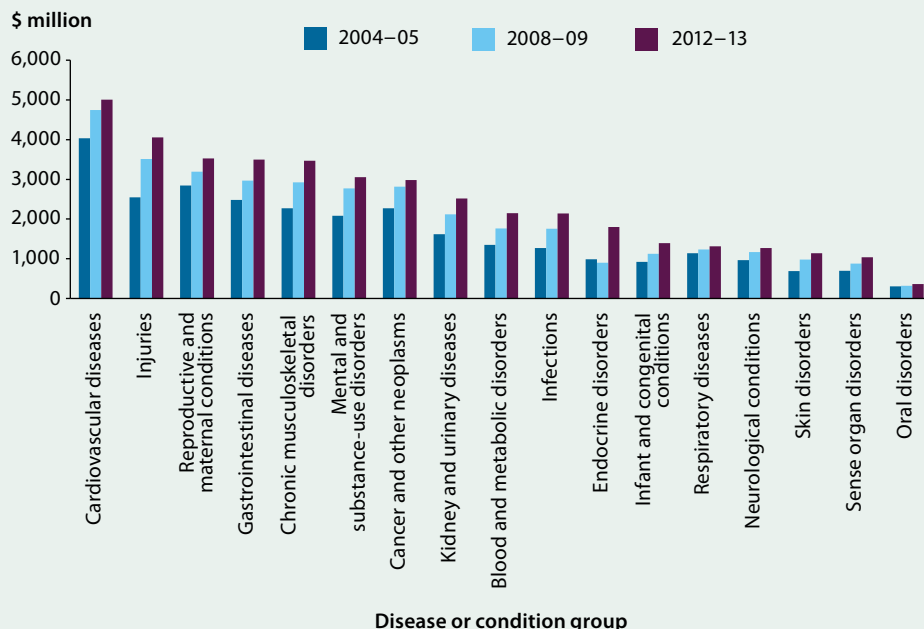
These data may be affected by different admission and data recording practices over time. The data do, however, provide significant insight into the key trends in expenditure for admitted patients over the period. A broad overview of these trends is provided in the following sections.

To assist with comparisons with the analysis presented in Chapter 3.1 'Burden of disease and injury in Australia', the data have been presented in terms of burden of disease or condition groups.

## What disease or condition groups were responsible for the most expenditure for admitted patients?

The *Cardiovascular diseases* group was responsible for the most expenditure in the years 2004–05, 2008–09 and 2012–13 (see Figure 2.2.3). In 2012–13, around \$5 billion of total admitted patient expenditure (11.1%) was related to *Cardiovascular diseases*.

**Figure 2.2.3: Disease or condition group expenditure, 2004–05, 2008–09 and 2012–13, adjusted for inflation**



**Notes**

1. Inflation adjusted prices expressed in terms of 2012–13 prices.
2. There was a large growth in expenditure on the *Endocrine disease* group, which includes diabetes, from 2008–09 to 2012–13. Changes to the Australian Coding Standard for *Diabetes mellitus* and *intermediate hyperglycaemia* (formerly *Diabetes mellitus and impaired glucose regulation*) on 1 July 2012 have affected the comparability, over time, of data reported for diabetes.

Source: AIHW disease expenditure database.



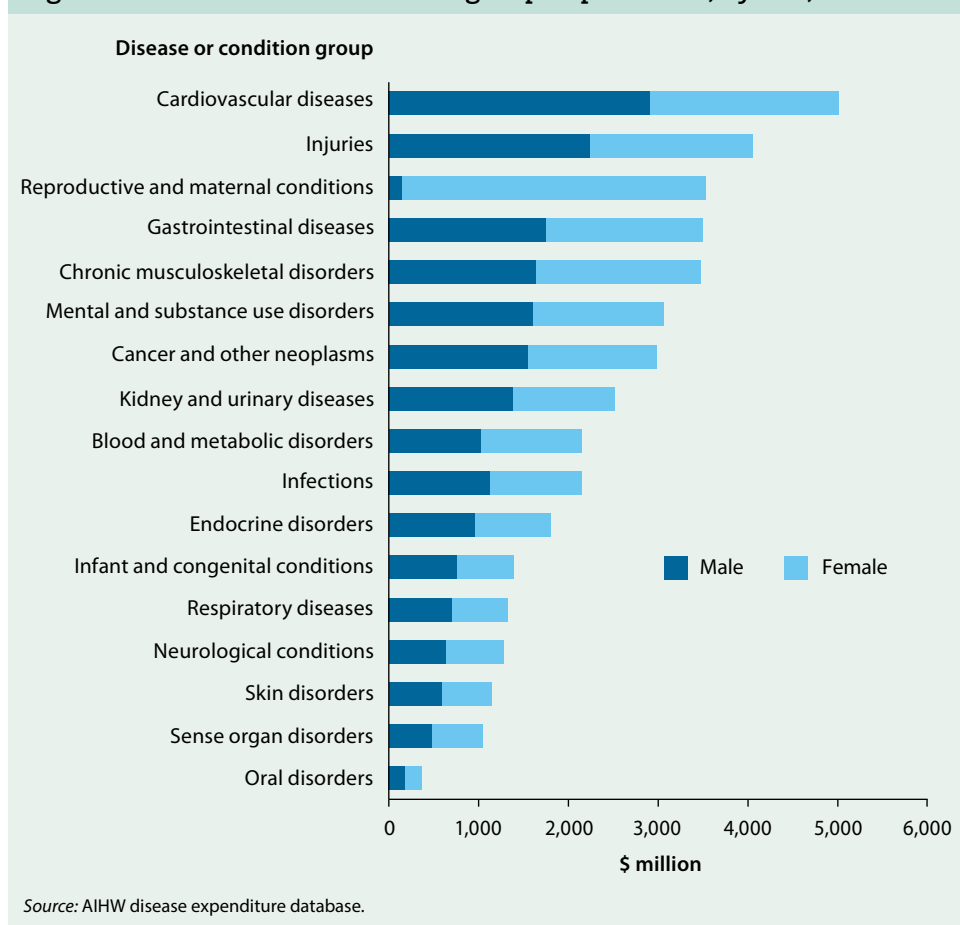
Other high-expenditure disease or condition groups included *Injuries, Reproductive and maternal conditions* and *Gastrointestinal diseases*. The *Reproductive and maternal conditions* group includes costs associated with healthy newborns as well as costs associated with the mother.

### Age and sex differences in expenditure

*Cardiovascular diseases* was a high-expenditure group for both men and women but the expenditure for men is higher, with \$2.9 billion of admitted patient expenditure spent on men in 2012–13 and \$2.1 billion on women (Figure 2.2.4). Other disease or condition groups that had higher expenditure for men were *Injuries* (with 55% of expenditure for men), *Mental and substance-use disorders* (55%), *Kidney and urinary diseases* (55%), *Endocrine disorders* (54%), *Infections* (53%) and *Cancer and other neoplasms* (52%).

As would be expected, admitted patient expenditure for *Reproductive and maternal conditions* had the highest proportion of expenditure allocated to women, at 96%, and was the group with the highest expenditure for women, with \$3.4 billion spent for admitted patient care in 2012–13. Other high-expenditure groups where there was a higher proportion of expenditure allocated to women were *Chronic musculoskeletal disorders* (53%) and *Blood and metabolic disorders*, such as anaemia (52%).

Figure 2.2.4: Disease or condition group expenditure, by sex, 2012–13



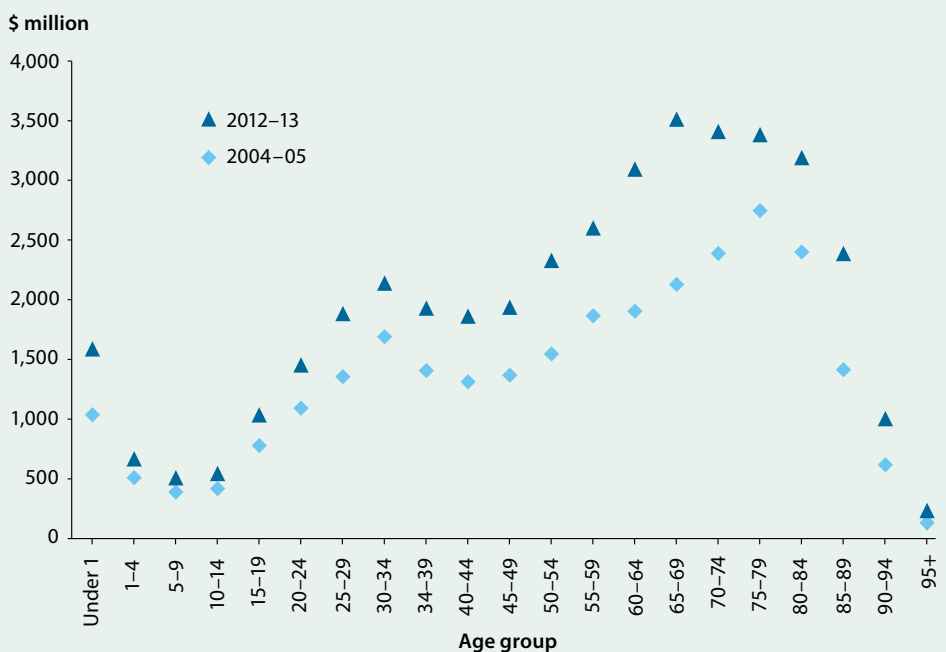


The pattern of expenditure by age group is different for males and females. For males in 2012–13, the expenditure increased from the 10–14 age group and reached a peak in the 65–69 age group (\$1,979 million). Expenditure was lower for age groups older than 65–69, with the lowest amounts for those aged 95 and over.

In 2012–13, the point of highest expenditure for women occurred in an older age group than for men. The highest expenditure was in the 80–84 age group, with expenditure of \$1,620 million. The 25–39 age group also had relatively high expenditure, due to expenditure in the *Reproductive and maternal conditions* group.

Figure 2.2.5 shows how the admitted patient expenditure by age group changed between 2004–05 and 2012–13. This change was most prominent in the 50 and older age groups, and for children aged under 1, where there was much greater expenditure in 2012–13 compared with 2004–05 (See 'Chapter 6.9 Changes in the provision of hospital care' for further information on trends in hospital care for older people).

**Figure 2.2.5: Admitted patient expenditure, by age, 2004–05 and 2012–13, adjusted for inflation**



**Notes**

1. Inflation-adjusted prices expressed in terms of 2012–13 prices.
2. The 'Under 1' age group does not include healthy newborns, whose cost is included in the cost for the mother.

Source: AIHW disease expenditure database.

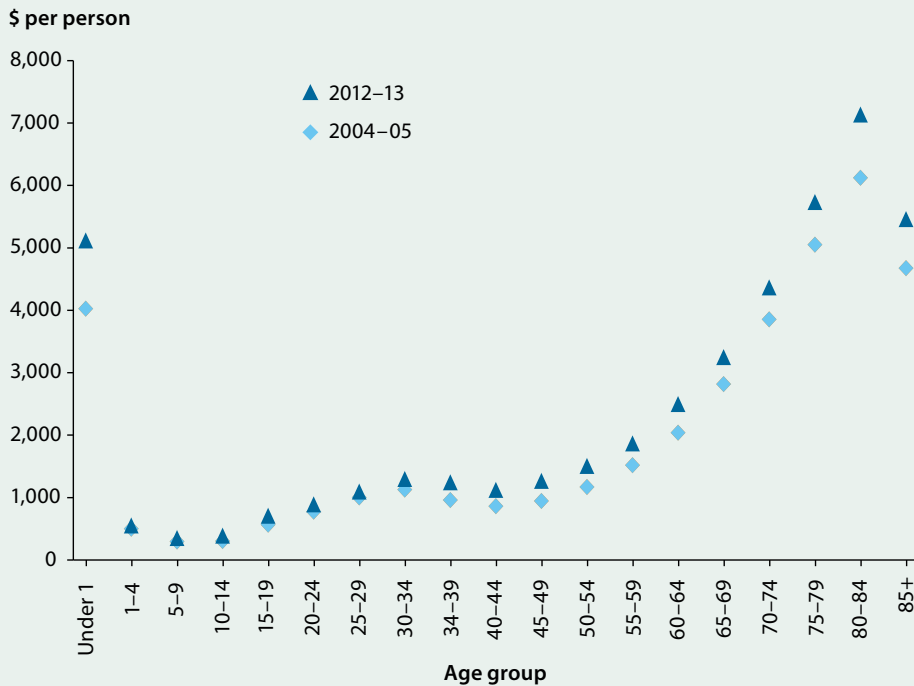
## Expenditure per person

Admitted patient expenditure per person was higher in 2012–13 than in 2004–05 in all age groups, for both men and women, with relatively large increases in the older age groups (Figure 2.2.6). The increase in expenditure in the older age groups was, therefore, related both to there being more spent per person as well as there being more people in each age group. (For further information on older Australians, see 'Chapter 6.17 Health care use by older Australians'.) This was true of the under 1 age group as well.





Figure 2.2.6: Admitted patient expenditure per person, by age group, 2004–05 and 2012–13, adjusted for inflation



Notes

1. Inflation-adjusted prices expressed in terms of 2012–13 prices.
2. The 'Under 1' age group does not include healthy newborns, whose cost is included in the cost for the mother.

Source: AIHW disease expenditure database.

## Expenditure for Indigenous Australians

Indigenous Australians have an expenditure profile that is different from that of non-Indigenous Australians. *Mental and substance-use disorders* and *Kidney and urinary diseases* were the disease or condition groups with the highest expenditure, both with an expenditure of over \$200 million in 2012–13 (see Figure 2.2.7). These disease or condition groups were ranked as the 7th and 8th highest groups, respectively, for non-Indigenous Australians.

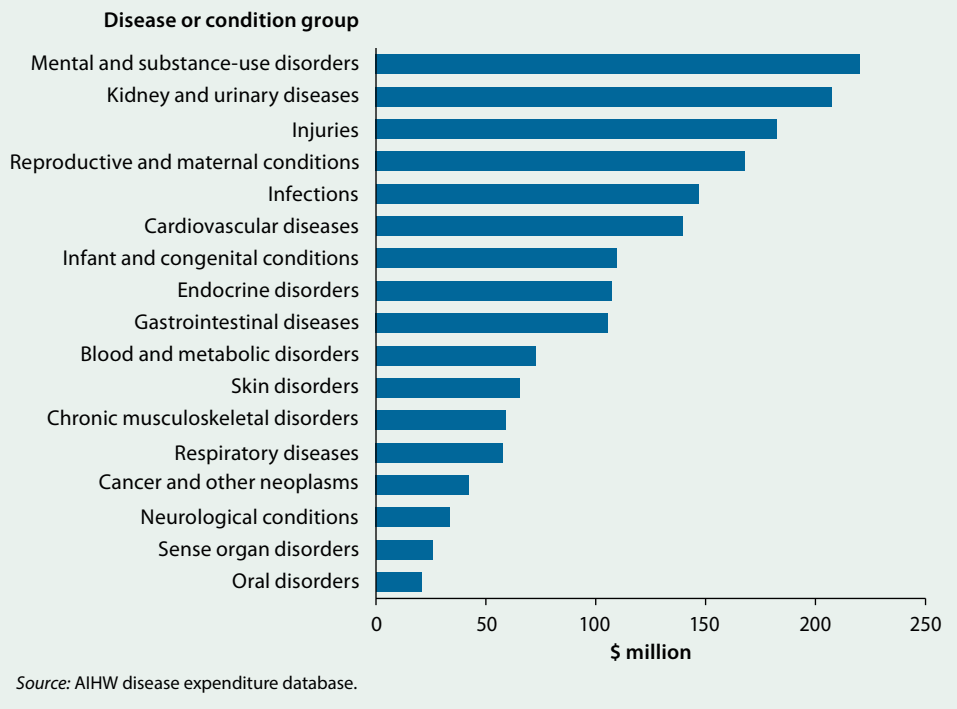
The *Infections* group ranked higher for Indigenous than for non-Indigenous Australians, but the *Chronic musculoskeletal disorders* and *Gastro-intestinal diseases* groups ranked higher for non-Indigenous than for Indigenous Australians.

*Cancer and other neoplasms* was one of the lowest expenditure groups for Indigenous people, but ranked 6th highest for non-Indigenous Australians. For further information on Indigenous Australians, see 'Chapter 5.7 How healthy are Indigenous Australians?'





**Figure 2.2.7: Disease or condition group expenditure for Indigenous Australians, 2012–13**



## What is the AIHW doing?

This detailed information on admitted patient expenditure has resulted from a redevelopment of the AIHW's health expenditure data infrastructure, which is ongoing. This work will enable the AIHW to release more detailed information on expenditure by disease, age, sex, Indigenous status and location, as well as opening these data up to researchers and policymakers more broadly.

## What is missing from the picture?

Health expenditure data do not include health data from local authorities. If local government authorities received funding for health care from a state or territory government, this expenditure was included in that jurisdiction's expenditure. Data for programs self-funded by local governments (such as public health initiatives funded and run by local authorities or councils) were not collected for inclusion in the AIHW health expenditure database. Health-related costs from the Australian Defence Force or from correctional and detention facilities are also not included in the health expenditure database collection. Not all expenditure by non-government organisations is included, such as initiatives run from private donations to the organisations.

The analysis of expenditure by disease, age, sex and Indigenous status only focuses on admitted patient expenditure data. Expenditure in non-admitted, primary care or other areas has not been included.



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## Where do I go for more information?

More information on health expenditure is available at [www.aihw.gov.au/health-expenditure/](http://www.aihw.gov.au/health-expenditure/). The report *Health expenditure Australia 2013–14* and other recent publications are available for free download.

## References

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