

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



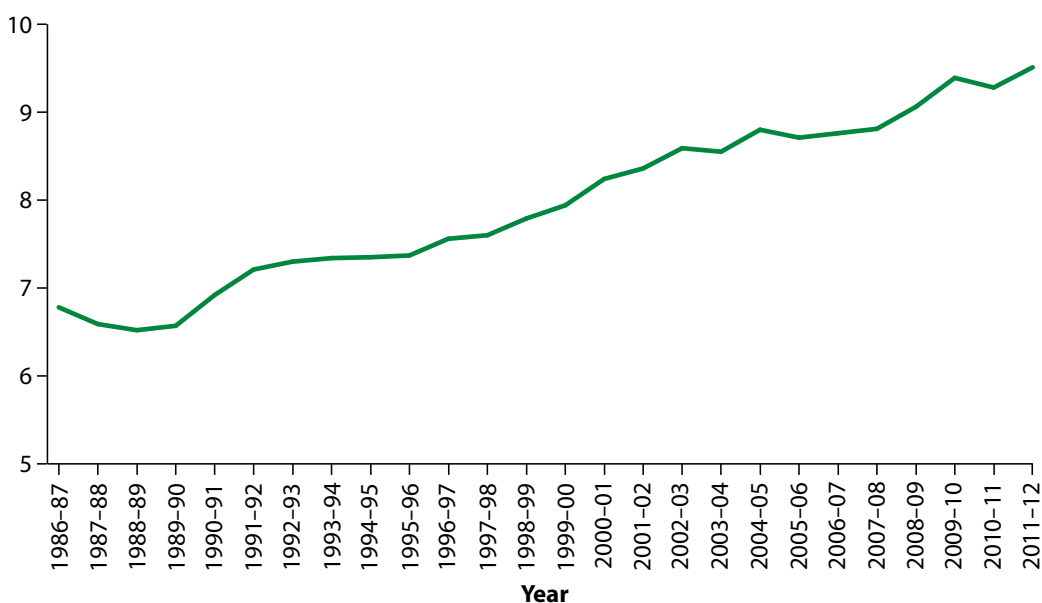
Health expenditure occurs where money is spent on health goods and services. Health expenditure data includes health expenditure by governments as well as individuals and other non-government sources such as private health insurers. The providers of health goods and services include hospitals, primary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

In 2011–12, Australia spent around \$140.2 billion on health, around 1.7 times higher in real terms (after adjusting for inflation) than in 2001–02. Health expenditure has grown faster than population growth. Expenditure increased from \$4,276 per person in 2001–02 to \$6,230 in 2011–12.

Health expenditure has also grown faster than the broader economy. The ratio of health expenditure to gross domestic product (GDP) has increased from 6.8% in 1986–87 to 9.5% in 2011–12 (Figure 2.2). Total health expenditure has grown in real terms at an average rate of 5.4% per year over the last decade, while GDP has grown at a slower rate of 3.1% per year.

**Figure 2.2**

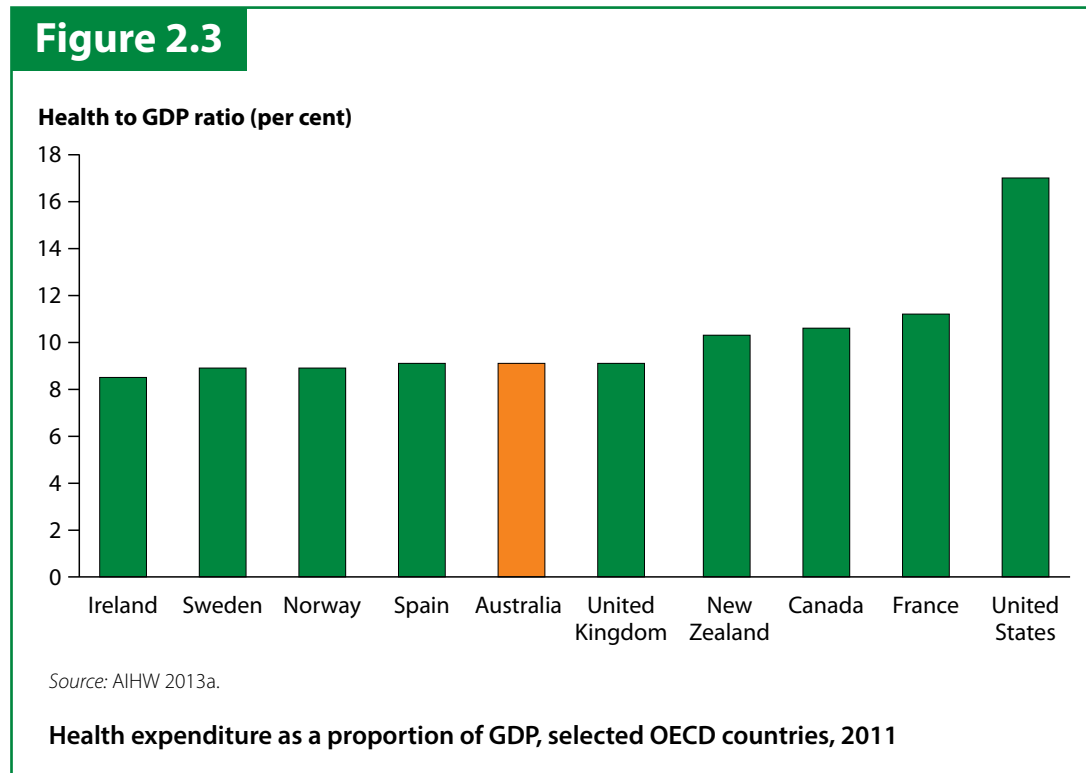
### Health expenditure to GDP ratio (per cent)



Source: AIHW health expenditure database.

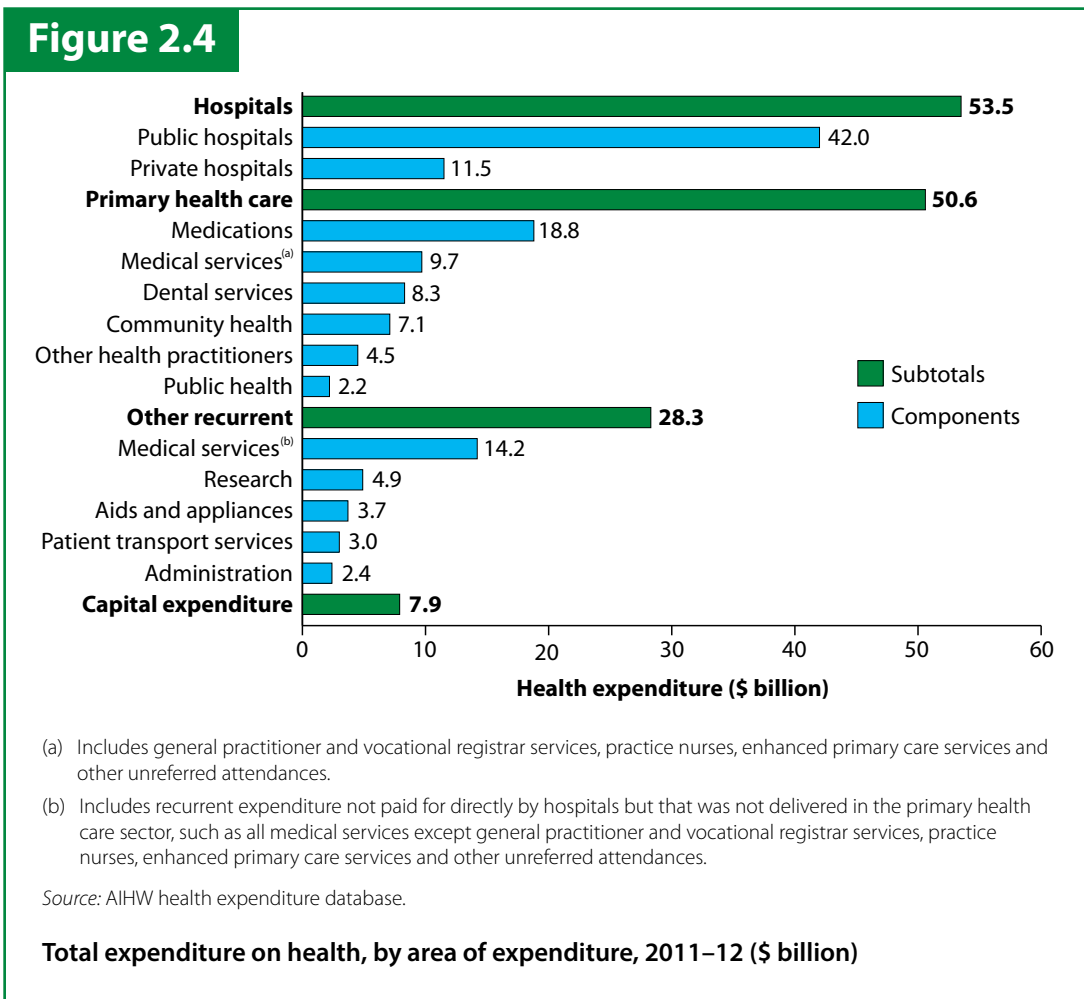
### Total health expenditure to GDP ratio, 1986–87 to 2011–12

Health has become a larger part of the economy, which is not unique to Australia. Using the Organisation for Economic Co-operation and Development's (OECD) methods, in 2011–12, Australia's health expenditure to GDP ratio was slightly above average compared with other OECD countries (Figure 2.3). Australia's position within the OECD has not changed significantly over recent years as the ratio for other countries has also increased.



## Where does the money go?

There are 4 broad areas of health spending: hospitals, primary health care, other recurrent expenditure, and capital expenditure. In 2011–12, the largest component of health spending was for hospital services (\$53.5 billion, or 38.2% of total health expenditure), delivered by both public and private providers (Figure 2.4). Hospital expenditure includes all spending incurred by hospitals and excludes expenditure on hospital-based services where the hospital did not directly incur the costs. For example, pharmaceuticals paid for by hospitals are included but pharmaceuticals purchased by patients directly from hospital-based pharmacies are excluded. Similarly, some medical services are provided by specialists in hospitals but these services are not paid for by the hospital as they may be covered by the Medicare Benefits Scheme or some other arrangement. This expenditure is also not treated as hospital expenditure.



The second largest component of health spending was for primary health care services (\$50.6 billion, or 36.1% of total health expenditure). Primary health care includes a range of front-line health services delivered in the community, such as GP services, dental services, other health practitioner services (for example, physiotherapists, optometrists), and all community and public health initiatives. It also includes the cost of medications not provided through hospital funding.

The remaining health spending was for other recurrent (\$28.3 billion, or 20.2% of total health expenditure) and capital expenditure (\$7.9 billion, or 5.6% of total health expenditure). The category 'other recurrent' includes areas of recurrent spending that were not paid for by hospitals but that were not delivered through the primary health care sector, such as medical services other than those provided by general practitioners, medical research, health aids and appliances, patient transport services and health administration.

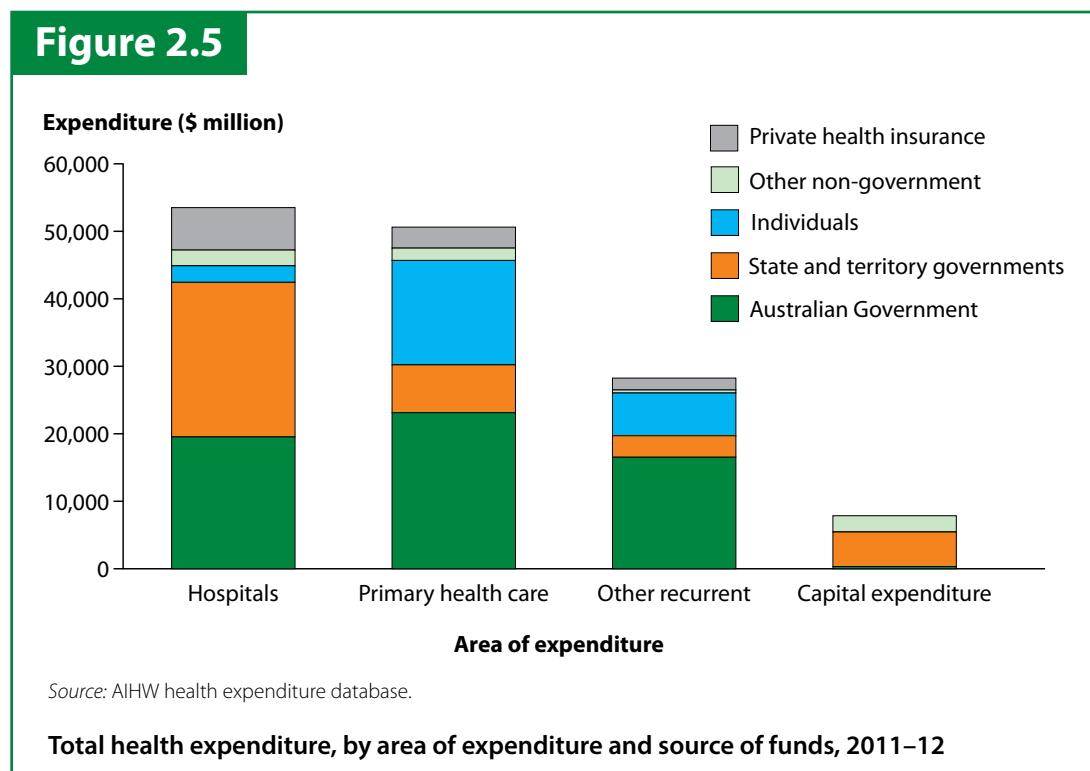
The distribution of funding by the Australian Government, state and territory governments and the non-government sector varies depending on the area of health expenditure (Figure 2.5).

**Hospital services** (both public and private) received a total of \$53.5 billion in 2011–12. The main funding sources were state and territory governments (\$22.9 billion, or 42.8% of total hospital funding) and the Australian Government (\$19.5 billion, or 36.5%). Non-government sources provided an additional \$11.1 billion (20.7%).

**Primary health care services** received \$50.6 billion in funding, slightly less than hospital services. The Australian Government was the main funder, providing \$23.1 billion (45.7% of total primary health care funding), followed by the non-government sector (\$20.4 billion, or 40.3%), and the state and territory governments (\$7.1 billion, or 14.0%).

An additional \$28.3 billion of funding was provided for **other recurrent** components of the health system while funding for health infrastructure (**capital expenditure**) was \$7.9 billion. The main source of funding for other recurrent health care goods and services was the Australian Government, providing \$16.5 billion or 58.5% of other recurrent health funding, while the non-government sources provided \$8.5 billion (30.2%) and states and territories provided the remaining \$3.2 billion (11.3%).

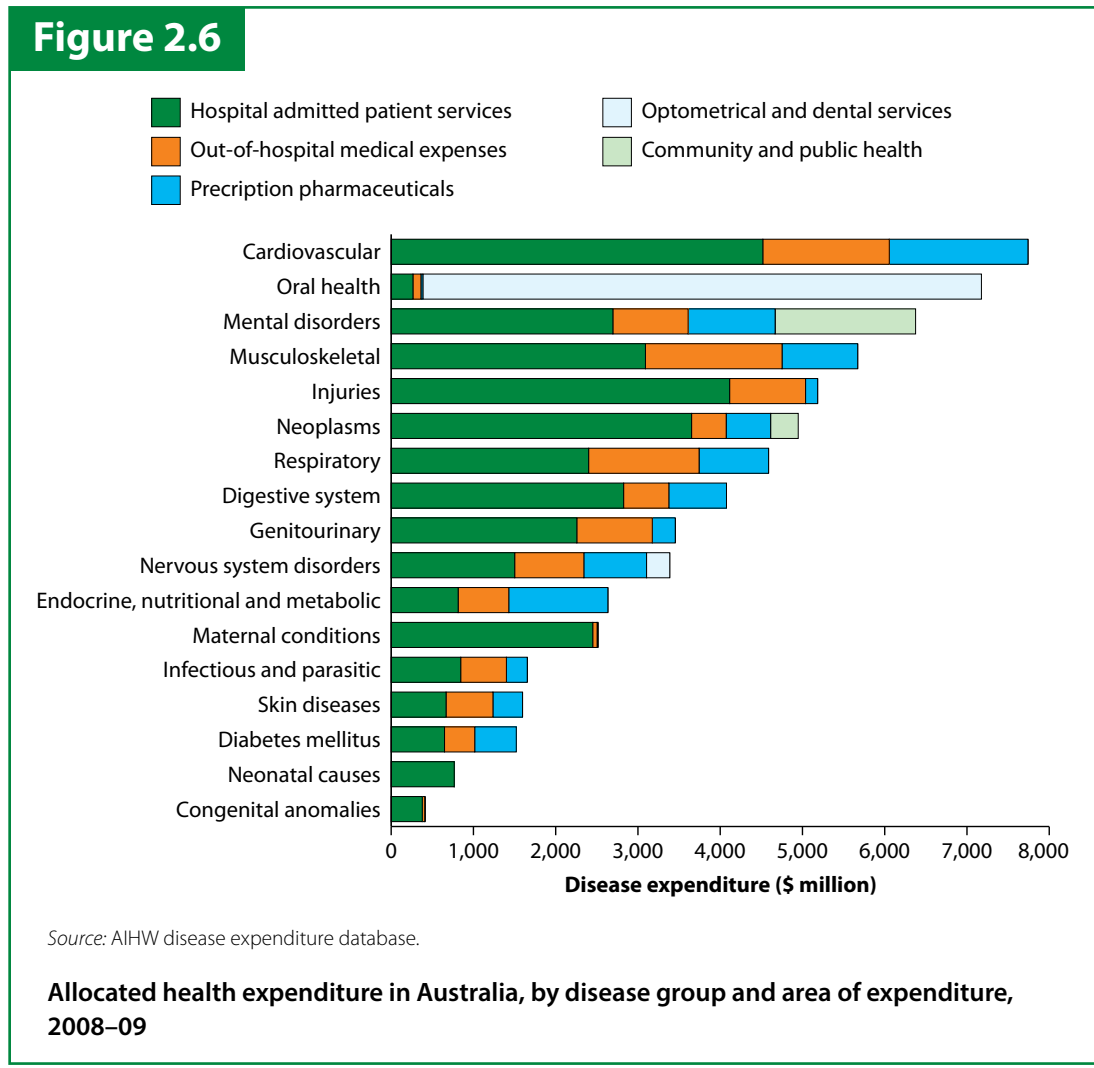
The state and territory governments provided close to two-thirds (65.1%) of the funding for capital expenditure.



### Which diseases attract the most expenditure?

For expenditure that can be allocated to individual disease groups, the group with the highest spending nationally in 2008–09 was ‘Cardiovascular disease’ (\$7.7 billion, or 10.4% of total disease expenditure), followed by ‘Oral health’ (\$7.2 billion, or 9.7%) and ‘Mental disorders’ (\$6.4 billion, or 8.6%) (Figure 2.6).

**Figure 2.6**



## Aboriginal and Torres Strait Islander health

In 2010–11, the total amount spent on health goods and services for Aboriginal and Torres Strait Islander people was estimated at \$4.6 billion, or 3.7% of Australia's total recurrent health expenditure. (Expenditure for Aboriginal and Torres Strait Islander people includes expenditure for Indigenous-specific health programs as well as a portion of the expenditure from mainstream health programs.)

This equated to \$7,995 per Indigenous person, which was around 1.5 times the \$5,437 spent per non-Indigenous Australian in the same year.

In 2010–11, publicly provided services such as public hospital and community health services were the highest expenditure areas for the Indigenous population. For example, the average per person expenditure on public hospital services for Indigenous Australians (\$3,631) was more than double that for non-Indigenous Australians (\$1,683).

For health services that have a greater proportion of the costs funded through out-of-pocket payments, such as pharmaceuticals and dental services, Indigenous expenditure is generally lower relative to the non-Indigenous population. For example, the average per person expenditure on dental services was \$149 for Indigenous Australians, compared with \$355 for non-Indigenous Australians.

A significant proportion of Aboriginal and Torres Strait Islander people live in *Remote* and *Very remote* areas and this has an effect on the cost of delivering goods and services. In 2010–11, it was estimated that \$6,625 was spent per Indigenous person in *Remote/Very remote* regions, compared with \$3,904 per Indigenous person in *Major cities*.

## Who pays for health and how has this changed over time?

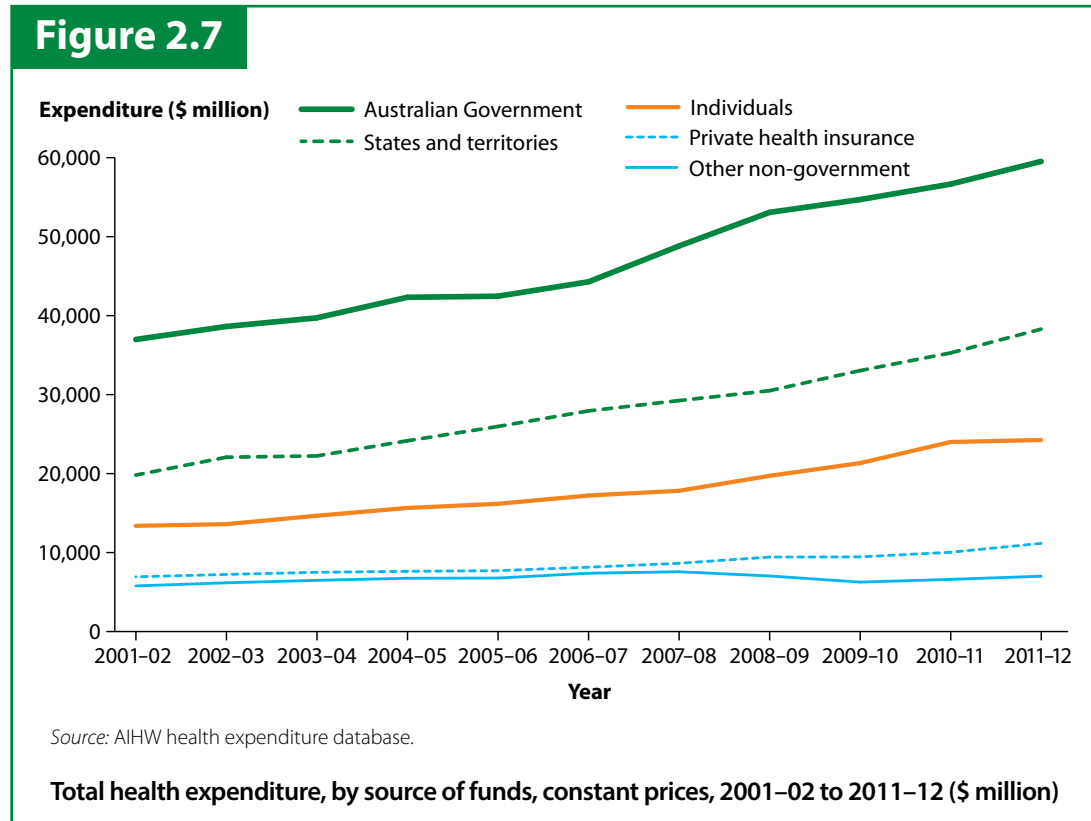
Funding for health goods and services comes from a range of sources, including the Australian Government; state, territory and local governments; and non-government sources, such as private health insurers, out-of-pocket payments by individuals and injury compensation insurers. Decisions about where and when money is spent on health often involve interactions between multiple bodies, including funders, providers and consumers.

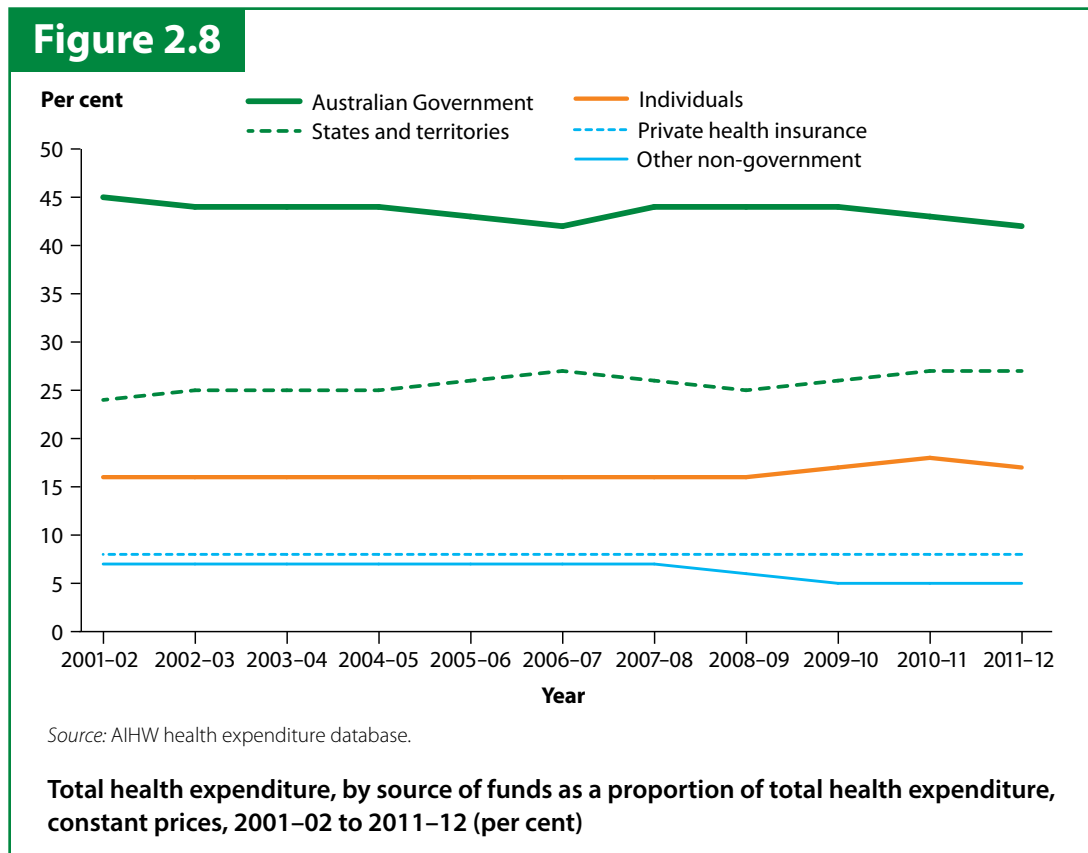
Expenditure from all sources of funds has increased over the past decade (Figure 2.7). Governments have remained the dominant source of funding for health in Australia, with the Australian Government continuing to provide the majority of health funding. The share of funding provided by the Australian Government has declined, however, and so has the share provided by non-government sources, which includes individual out-of-pocket expenditure. The share provided by state and territory governments has increased.

In 2011–12, governments funded \$97.8 billion, or 69.7% of total health expenditure (\$140.2 billion) in Australia. The Australian Government contributed \$59.5 billion, while the state and territory governments contributed \$38.3 billion (Figure 2.7 and 2.8).

The Australian Government's contribution to total health expenditure dropped from 44.0% in 2001–02 to 42.4% in 2011–12. The state and territory contribution grew steadily from 23.2% to 27.3% over the same period (Figure 2.8).

In 2011–12, non-government sources (individuals, private health insurance and other non-government sources) funded \$42.4 billion, or 30.3%, of total health expenditure in Australia. This was down from 32.8% in 2001–02.



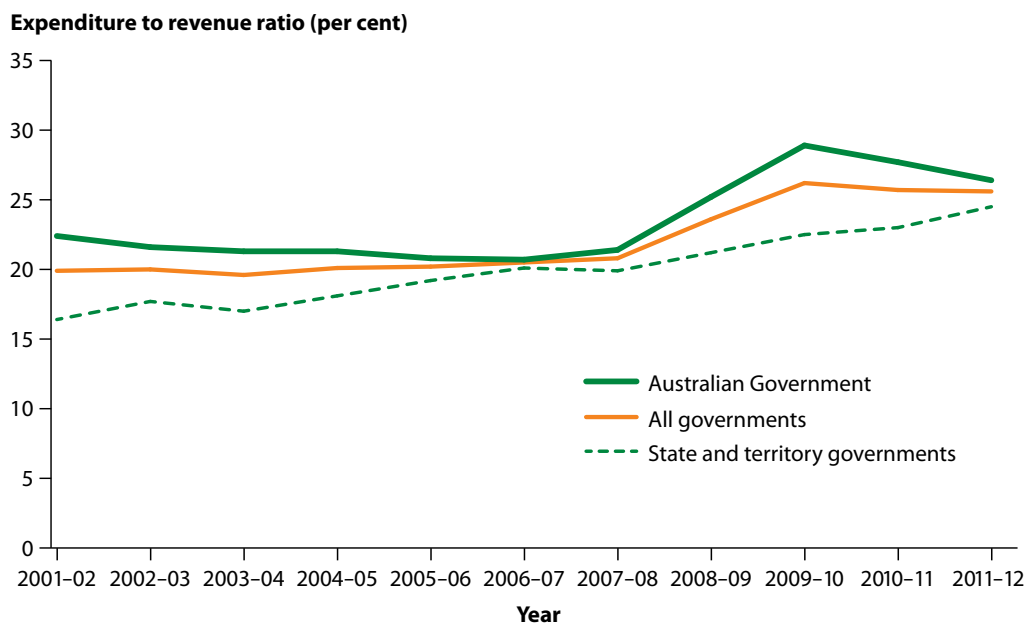


The largest share of non-government funding, \$24.3 billion, was directly from individuals. Private health insurers funded \$11.2 billion of health expenditure in 2011-12. Most of this funding was also sourced from individuals through private health insurance premiums.

Despite total expenditure growing faster than the broader economy, the main funders of health have not necessarily been spending a higher proportion of their incomes or revenues on health. Prior to the global financial crisis (GFC), which had its beginnings in 2007-08, the ratio of all government health expenditure to taxation revenue was relatively stable at around 20% (Figure 2.9). That suggests that, in broad terms, government revenues were increasing at the same rate as health expenditure. While the ratio of expenditure to GDP was increasing, the ratio to government revenues was relatively stable.

The GFC slowed government revenues without having an immediate impact on health expenditure. This increased the health to revenue ratio. The ratio has decreased slightly since 2009-10 as growth in government tax revenues has increased again. In 2011-12, the ratio of government health expenditure to taxation revenue was 25.6%.



**Figure 2.9**

Source: AIHW health expenditure database.

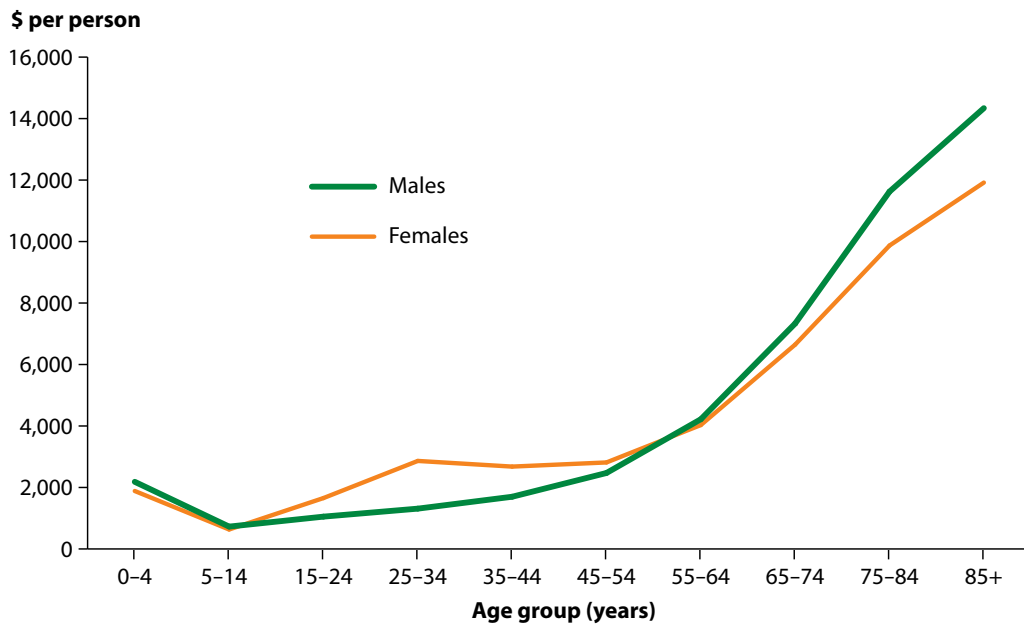
**The ratio of health expenditure to tax revenue across all governments, current prices, 2001-02 to 2011-12 (per cent)**

## Main drivers of health expenditure

Many studies have been conducted into the drivers of health expenditure over the past decade. Population ageing has attracted particular attention in this context (OECD 2013; Productivity Commission 2005, 2013; Treasury 2010). This is largely due to the fact that health care expenditure is generally higher in the older age groups. In 2008-09, expenditure in Australia on adults aged 85 and over was almost 20 times as high per person as expenditure on children aged 5 to 14 (Figure 2.10). This was true for both men and women.

On the surface this suggests that as a population ages, the number of people in the age groups where the most expenditure occurs will increase and, therefore, demand for health expenditure will increase (see Chapter 6 'Ageing and the health system').

The relationship between ageing and demand for health services is complex, however, and the extent to which current and projected growth in health expenditure can be attributed to population ageing is the subject of much debate. And in any case, over the past 25 years health expenditure in Australia has risen at a faster rate than either population growth or ageing.


**Figure 2.10**

Source: AIHW disease expenditure database.

#### Allocated health expenditure per person, by age and sex, 2008–09

Much of the growth in health expenditure can be attributed to non-demographic factors such as the development of new technologies, pharmaceuticals and diagnostic and treatment techniques—these enable a wider range of health conditions to be managed more effectively. Correspondingly, community expectations of the health system and access to such technologies and services have also increased, driving health expenditure up faster than demographic factors would predict (Coory 2004; OECD 2013; Productivity Commission 2005, 2013; Richardson & Robertson 1999; Treasury 2010).

The effect of population ageing on demand (and costs) for health services may also be mitigated by the fact that although lifetime health costs are concentrated in the last few years of life, as healthy life expectancy increases, end of life health costs are postponed (Calver et al. 2006; Karamanidis et al. 2007; OECD 2013). Some have cautioned, however, that over time an ageing population (perhaps with higher levels of chronic disease) with high expectations of access to new health technologies and quality services, will increase and compound the independent effect of population ageing on health system costs (Goss 2008; Productivity Commission 2005, 2013).



The state of the broader economy plays an important role in determining health expenditure. As shown earlier in this article, analysis of AIHW health expenditure data and international experience since the GFC suggests that while health expenditure has grown faster than the broader economy, it has tended to keep pace with growth in the revenue of governments, the key funders of health in Australia (Figure 2.9). This in turn suggests that health expenditure tends to correlate with increased revenue more strongly than increased demand for health services. Many OECD countries are experiencing a similar phenomenon (OECD 2013).

Another important and related factor in determining health expenditure is the efficiency of the health system, which is heavily influenced by government policies. In 2010, the OECD argued that life expectancy across OECD countries could be increased by 2 years if all countries had health systems as efficient as the most efficient systems across the OECD countries. They argued that this could be done without any additional expenditure. While Australia was identified as having one of the more efficient health systems, the OECD still suggested that life expectancies in Australia could be improved through improved health system efficiency (OECD 2010).


### What is missing from the picture?

The AIHW's definition of health expenditure closely follows the definitions and concepts provided by the OECD's System of Health Accounts framework (OECD 2000). It excludes:

- expenditure that may have a 'health' outcome but that is incurred outside the health sector (such as expenditure on building safer transport systems, removing lead from petrol, and educating health practitioners)
- expenditure on personal activities not directly related to maintaining or improving personal health
- expenditure that does not have health as the main area of expected benefit.

There are some data limitations in the AIHW health expenditure database, including:

- Total health expenditure excludes some sources of expenditure, including Australian Defence Force expenditure, some local government expenditure and some non-government organisation expenditure.
- There are some areas of expenditure for which data sources could be improved. For example, over-the-counter pharmaceuticals spending in Australia currently has no systemised data collection.
- Much expenditure data cannot be apportioned to specific geographic areas.
- There is a lack of comprehensive welfare expenditure information in Australia, which limits the degree to which comparisons and links can be made to this and other sectors.
- There is a lack of health outcome measures that can be linked with health expenditure to assess the effectiveness of Australia's health care system.



A particularly important gap in the available data is estimates of how much money is spent on particular diseases, with the most recent estimates being from 2008–09. Not all health expenditure can be readily allocated to disease or injury groups—in 2008–09, the figure was around 30% of recurrent health expenditure. This included capital expenditure, expenditure on non-admitted patients, over-the-counter pharmaceuticals, patient transport services, aids and appliances, administration, most community and public health services, and other health practitioner services. Disease expenditure information, while useful in its own right, does not necessarily give an indication of the loss of health due to that disease, the priority for intervention, or the need for additional expenditure.

### Where do I go for more information?

Further information on health expenditure in Australia is available on the AIHW website:

[www.aihw.gov.au/health-expenditure](http://www.aihw.gov.au/health-expenditure).

*Health expenditure Australia 2011–12* (AIHW 2013a) contains detailed information and analyses of health expenditure and funding in Australia.

*Expenditure on health for Aboriginal and Torres Strait Islander people 2010–11* (AIHW 2013b) provides estimates on health expenditure for Aboriginal and Torres Strait Islander people.

*Expenditure on health for Aboriginal and Torres Strait Islander people: an analysis by remoteness and disease* (AIHW 2013c) complements the preceding report and provides disaggregated expenditure estimates at the regional level as well as for specific disease and injury groups. These reports are available for free download. Further information on health expenditure can also be found in the online data tables and cubes.

This publication provides the most recent estimates of disease expenditure in Australia (2008–09).

Further information on disease expenditure in Australia is available on the AIHW website:

[www.aihw.gov.au/disease-expenditure](http://www.aihw.gov.au/disease-expenditure).

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