

# The Australian Health Care System, 2009

THE COMMONWEALTH FUND

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## Who is covered?

Australia's national public health insurance scheme, Medicare, provides universal health coverage for citizens, permanent residents, and visitors from countries that have reciprocal arrangements with Australia.

## What is covered?

**Services:** Medicare provides free or subsidized access to most medical and some optometry services and prescription pharmaceuticals. It also provides free public hospital care, but patients may choose private care in public or private hospitals. Some allied health services are covered if referred by a medical practitioner. The Australian government, together with state governments in most cases, also funds a wide range of other health services, including population health, mental health, limited dental health, rural and indigenous health programs, and health services for war veterans. Private insurance is optional (but encouraged with taxes and subsidies). Private treatment complements the public system and offers choice of doctors for hospital admissions, choice of hospitals (including private hospitals), and timing of procedures; services such as physiotherapy, dental, optometry, and podiatry; and complementary medicine services.

**Cost-sharing:** Medicare usually reimburses 85 percent to 100 percent of the schedule fee for ambulatory services and 75 percent of the schedule fee for in-hospital services. Doctors' fees are not regulated. Doctors are free to charge above the schedule fee, or they can treat patients for the cost of the subsidy and bill the federal government directly with no patient charge (referred to as bulk billing). Due to falling rates of bulk billing for general practice, an incentive scheme was introduced in 2004, offering additional payment for bulk billing concession card holders (low-income, elderly), children under 16 years of age, and residents of rural and remote areas, and in 2005 the Medicare payment was increased to 100 percent of the schedule fee. In mid-2009, 74 percent of all medical services and 80 percent of general practitioner visits were bulk-billed. Prescription pharmaceuticals covered by the Pharmaceutical Benefits Scheme (PBS) have a standard copayment: AUS\$32.90 (US\$30.26) in general with a reduced rate of AUS\$5.30 (US\$4.88) per item dispensed for individuals with concession cards.

**Safety nets:** Under the Original Medicare Safety Net, once an annual threshold in gap expenses for out-of-hospital Medicare services has been reached, the Medicare payment is increased to 100 percent (up from 85%) of the Medicare schedule fee for out-of-hospital services for the remainder of the calendar year. (Gap expenses represent the difference between the Medicare benefit and the schedule fee.) In 2009, the threshold was AUS\$383.90 (US\$356.00).

The Extended Medicare Safety Net, introduced in 2004, provides an additional payment for out-of-hospital Medicare services once an annual threshold in out-of-pocket costs is reached. Out-of-pocket costs represent the difference between the Medicare payment and the fee charged by the practitioner. (Out-of-pocket costs are higher than gap expenses if the provider charges above the schedule fee.) Once the out-of-pocket threshold is reached, the patient will receive 80 percent of out-of-pocket costs in addition to the standard Medicare payment for the remainder of the calendar year. (In 2009, the thresholds were AUS\$555.70 [US\$511.00] for individuals with concession cards and low-income families, and AUS\$1,111.60 [US\$1,022.00] for general patients).

Families are able to register together for the Medicare Safety Nets to have their gap expenses and out-of-pocket costs combined to reach the applicable threshold amount sooner.

## How is the health system financed?

Australia has a mixed public and private health care system. The core feature is public, taxation-funded health insurance under Medicare, which provides universal access to subsidized medical services and pharmaceuticals, and free hospital treatment as a public patient. Medicare is complemented by a private health system in which private health insurance assists with access to hospital treatment as a private patient and with access to dental services and allied health services. There is a strong reliance on out-of-pocket payments.

**National health insurance:** Compulsory national health insurance (Medicare) is administered by the Australian government. Medicare is funded mostly from general revenue and in part by a 1.5 percent levy on taxable income, though some low-income individuals are exempt or pay a reduced levy. Individuals and families with higher incomes (AUS\$73,000 [US\$67,151] and AUS\$146,000 [US\$134,299] per annum, respectively) who do not have an appropriate level of private hospital insurance coverage have to pay a Medicare levy surcharge, which is an additional 1 percent of taxable income. In 2007–08, the revenue raised from the Medicare levy (including the surcharge) funded 18 percent of total federal government health expenditure. Other federal, state, and territory government health expenditure is funded from general tax revenue, including the goods and services tax (GST), with some revenue raised from patient fees and other nongovernment sources. In 2007–2008, governments funded 69 percent of total health expenditures, with 43 percent funded by the Australian government and 26 percent funded by state and territory governments. The Department of Veterans' Affairs covers eligible veterans and their dependants by directly purchasing public and private health care services.

**Private insurance:** Private insurance contributes 7.6 percent of total health expenditure. Since 1999, 30 percent of private health insurance premiums are paid by the Australian government through a rebate. The rebate increases to 35 percent for people aged 65 to 69 years, and to 40 percent for those aged 70 and older. In mid-2009, 44.6 percent of the population had private hospital insurance, and 51.3 percent had General Treatment coverage (which includes ancillary services). Lifetime Health coverage encourages people to take out private hospital coverage early in life, and to maintain their coverage, by offering people who join a health fund before age 31 a relatively lower premium throughout their lives, regardless of their health status. People over the age of 30 face a 2 percent increase in premiums over the base rate for every year they delay joining, although fund members who have retained their private health insurance for more than 10 years are no longer subject to this penalty. Private health insurance is community-rated, and provided by both for-profit and nonprofit insurers.

**Out-of-pocket expenditure:** Out-of-pocket spending accounted for 16.8 percent of total health expenditure in 2007–08. Most of this expenditure is for medications not covered by the PBS, dental services, aids and appliances, and copayments on medical fees.

## How is the delivery system organized?

**Physicians:** Most medical and allied health practitioners are in private practice and charge a fee for service. GPs play a gatekeeping role, as Medicare will reimburse specialists only the schedule fee payment for referred consultations. Physicians in public hospitals are either salaried (though allowed to have separate private practices and additional fee-for-service income) or paid on a per-session basis for treating public patients. Generally, physicians working in private hospitals are in private practice and do not concurrently hold salaried positions in public hospitals.

**Hospitals:** The hospital sector includes a mix of public (run by the state and territory governments) and private facilities. Under Medicare the public hospital system provides free hospital care for patients electing to be treated as public patients. Public hospitals are jointly funded by the Australian government and state and territory governments through five-yearly agreements. Public hospitals also receive some revenue from services to private patients. Many salaried specialist doctors

in public hospitals are able to treat some private patients in those hospitals, to which they usually contribute a portion of the income earned from the fees. Private hospitals (including free-standing ambulatory day centers) can be either for-profit or nonprofit, and their income is chiefly derived from patients with private health insurance. Private hospitals provide a third of all hospital beds, almost 40 percent of total hospital separations, and slightly less than half of all surgical episodes requiring the use of an operating room. Most emergency surgery is provided in public hospitals, while the majority of elective surgery procedures are provided in private hospitals and day surgeries. Current policy goals include developing a new management structure for public hospitals around local area networks and increasing the federal government's contribution to public hospitals

**Pharmaceuticals:** Prescription pharmaceuticals are covered by the Australian government's Pharmaceutical Benefits Scheme (PBS), which offers payment for a comprehensive and evolving list of drugs at a negotiated fixed price. Patients have a copayment, set by the federal government. Most prescribed pharmaceuticals are dispensed by private-sector pharmacies. The Repatriation Pharmaceutical Benefits Scheme subsidizes similar access to pharmaceuticals for war veterans and dependents.

**Government:** The federal government regulates private health insurance, pharmaceuticals, and medical services and has the primary funding and regulatory responsibility for residential elderly care facilities that are government-subsidized. States are charged with operating public hospitals and regulating all hospitals and community-based health services.

### **What is being done to ensure quality of care?**

The Australian Commission on Safety and Quality in Health Care publicly reports on the state of safety and quality, including performance against national standards, while also disseminating knowledge and identifying policy directions. A new set of national indicators covering the quality and safety of clinical care has been developed. It overlaps somewhat with another set of performance indicators developed for the 2009 National Healthcare Agreement between the Australian and all state and territory governments. The Commission is currently undertaking the first stages of a new approach to accreditation, including a set of Australian health standards, a quality improvement framework, expansion of accreditation to services not currently accredited, and national coordination of quality improvement efforts. The Council of Australian Governments in 2008 signed an agreement to create a single national registration and accreditation system for nine health professions: medical practitioners; nurses and midwives; pharmacists; physiotherapists; psychologists; osteopaths; chiropractors; optometrists; and dentists. Provision of government-funded residential elder care is highly regulated, with both provider organizations and their staff being subject to stringent approval processes.

Medicare also offers financial incentives rewarding practices deemed to be working toward meeting the Royal Australian College of General Practitioners Standards for General Practices in the areas of information management, after-hours care, rural care, teaching, and quality prescribing. Attention and resources are currently being directed toward addressing the gap in health outcomes for the indigenous population.

### **What is being done to improve efficiency?**

The Medical Services Advisory Committee assesses new medical therapies for inclusion in the Medical Benefits Schedule, based on safety, cost-effectiveness and comparative effectiveness. The Pharmaceutical Benefits Advisory Committee assesses new prescription drugs on the same basis before they can be included in the PBS. The Australian government's Department of Health and Ageing then uses these assessments to negotiate prices with manufacturers. The government also offers education and incentives to general practices to encourage effective use of medicines.

The Australian government has prioritized improvement of efficiency in elder care. The recently established Ministerial Conference on Ageing—designed as a collaboration between different levels of government—is tasked with initiating,

developing, and monitoring policy reform that works toward improving elder care planning. The Australian government also plans to work with the state and territory governments to improve planning and accountability of Home and Community Care programs; it hopes to standardize the processes for entry and assessment, planning, financial reporting, quality assurance, and information management by 2011. The National Health and Hospitals Reform Commission has recommended that the responsibility for elder care be transferred to the Australian government, and that new approaches to funding be developed that are more flexible around patient needs and priorities.

### **How are costs controlled?**

Public hospitals are owned and operated by state and territory governments, although costs are shared with the Australian government. State and territory governments set annual budgets for public hospitals, with funding on the basis of case mix (proportion of diagnosis-related groups) to drive efficiency in public hospitals. Medical services and pharmaceuticals are subject to national cost controls, and any expansions in the scope of services are evidence-driven. In addition, new pharmaceuticals have to meet cost-effectiveness criteria and are subject to nationally negotiated pricing before inclusion in the formulary of publicly subsidized medicines.

Additional cost-controlling methods include: controlling the growth in cost of some large-volume diagnostic services (pathology and radiology) through industry agreements with the relevant medical specialty; controlling access to specialist services through “gatekeepers” such as general practitioners who perform an important role in promoting continuity and a “medical home”; prioritizing access to certain services according to clinical need; and limiting the number of providers that are eligible to access Medicare benefits for some high-tech services. Effective prevention and better management of chronic disease have been proposed as strategies to reduce future health care costs.

### **What recent system innovations and reforms have been introduced?**

The new Australian labor government initiated several reviews of the health system, most importantly by the Health and Hospitals Reform Commission and the National Preventive Health Taskforce, and developed a Primary Health Care Strategy, all of which have recently produced reports. Among their key recommendations are a strengthening of primary care through the development of facilities that provide multidisciplinary care and extended hours, enrollment in “health care homes” of people with chronic conditions and young families, and better integration with elder care and non-acute community services. Proposed funding changes would move all primary-care funding responsibilities to the Australian government and encourage the development of alternatives to fee-for-service. The Health and Hospitals Reform Commission has proposed immediate changes in the Commonwealth–state funding agreements to an activity-based funding model, with clear performance targets. The Commission has also proposed consideration of a change in Medicare to a managed competition model with both private and public insurers. Both the Commission and the National Preventive Health Care Strategy recommend the formation of a National Preventive Health Agency.

### **References**

- Australian Department of Health and Ageing, Medicare Statistics, June 2009.
- Australian Institute of Health and Welfare. *Towards National Indicators of Safety and Quality in Health Care*, Canberra, 2009.
- Australian Institute of Health and Welfare, *Health Expenditure Australia 2007-08*, Canberra, 2009.
- Australian Institute of Health and Welfare, *Australia's Health 2008*, Canberra, 2008.
- National Health and Hospitals Reform Commission, “A Healthier Future for All Australians,” Final Report, Canberra, June 2009.
- Private Health Insurance Administration Council, June Statistics, 2009.