# HEALTH PREFACE

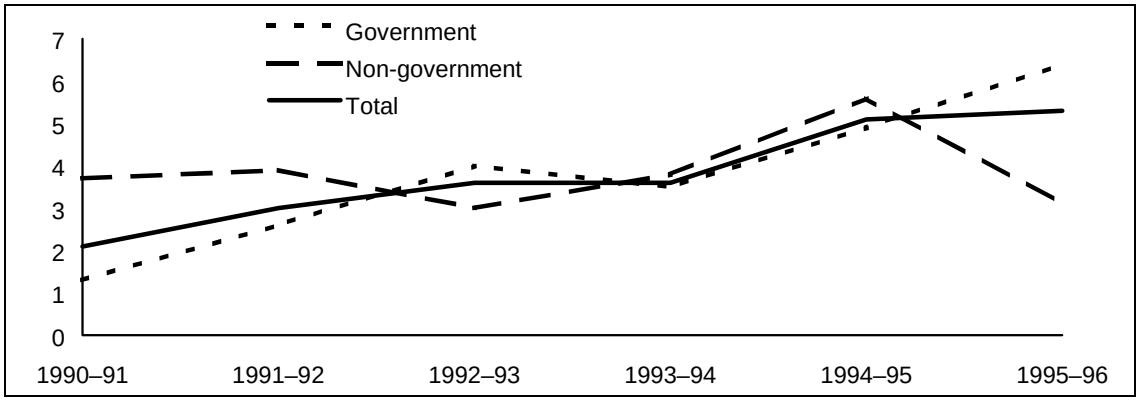
## Introduction

Government and non-government sectors provide a range of services — including general practitioners, hospitals, nursing homes and community health services — to support and promote the good health of the Australian population. Total expenditure on health services in Australia amounted to $41.7 billion in 1995–96, representing 8.5 per cent of gross domestic product. Total health expenditure rose by 5.3 per cent (in real terms) between 1994–95 and 1995–96 (AIHW 1997), compared with population growth of 1.3 per cent over the same period. The largest contribution to total health funding comes from governments, which accounted for 67.7 per cent ($28.2 million) of the total in 1995–96. Non-government providers, such as health insurance funds, individuals and workers' compensation and compulsory motor vehicle third party insurers, made up the remainder.

## Scope of the sector

Government expenditure on health services increased by 6.4 per cent in real terms in 1995–96 — more than double the growth in non-government expenditure over the same period. This higher growth rate for government expenditure went against recent trends — non-government expenditure recorded the higher rate of growth for four of the six years to 1995–96.

Growth in total health expenditure, 1989–90 to 1995–96 (per cent)



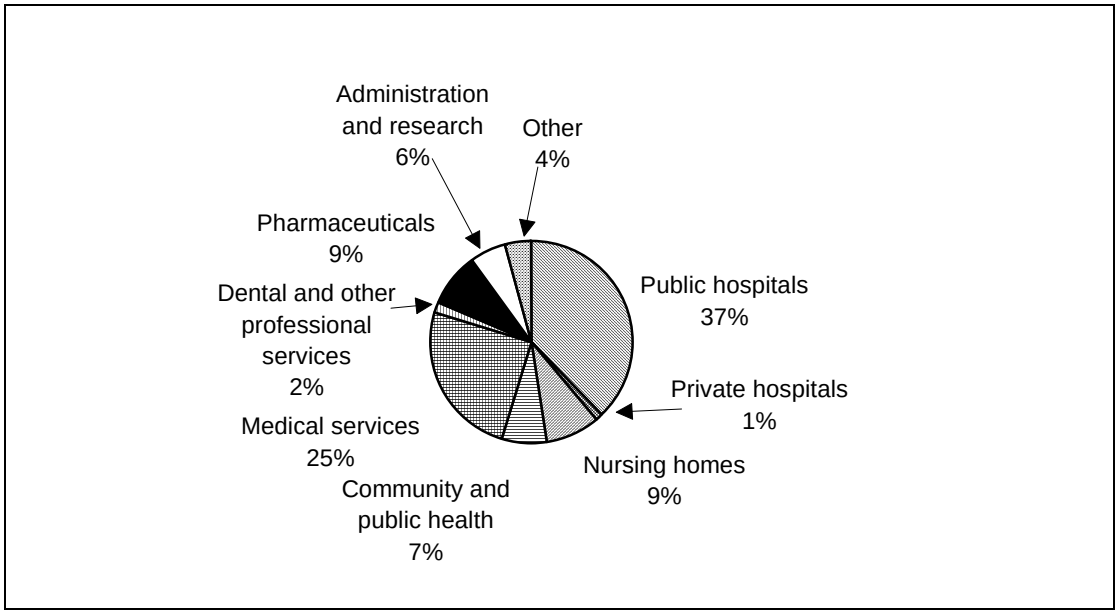

*Source*: AIHW 1997

## Components of government expenditure

Approximately 94 per cent of government expenditure on health services in 1994–95 was recurrent expenditure on the provision of government services. The largest proportion of this recurrent expenditure went to public hospitals — 37 per cent of the total in 1994–95. Fifty-five per cent of this amount was contributed by the Commonwealth Government, with State and Territory Governments supplying the remainder (AIHW 1997).

Medical services and pharmaceuticals payments (both of which are wholly funded by the Commonwealth Government) were also large expenditure items, accounting for 25 per cent and 9 per cent respectively of total government recurrent expenditure. Public and community health made up a further 7 per cent, the bulk of which was supplied by State and Territory Governments (72 per cent) (AIHW 1997).

Components of government recurrent health expenditure, 1994–95




*Source*: AIHW 1997

The scope of the health sector in this Report is public acute care hospitals and public and community health. These sectors are discussed in detail in Chapter 4. More detailed descriptions of government expenditure on medical and pharmaceuticals and other health services are outlined below.

## Some common health terms

**Acute care episode**: clinical services provided to admitted patients, including performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures.

**Acute care hospital**: an establishment which provides at least minimum medical, surgical or obstetric services for inpatient treatment and/or care, and which provides around-the-clock comprehensive qualified nursing services as well as other necessary professional services. Most patients require a relatively short stay.

**Admission:** an admission is the process by which an admitted patient commences an episode of care.

**Ambulatory care**: services provided by an acute care hospital to non-admitted patients.

**Casemix adjustment**: adjustment of data on cases treated to account for the number and type of cases. Cases are sorted into diagnosis-related groups which represent a class of patients with similar clinical conditions requiring similar hospital services.

**Community health services**: health services for individuals and groups delivered in a community setting, rather than hospitals or private facilities.

**Length of stay**: the period from admission to separation less leave days. Same-day patients are admitted and separated on the same date, and are attributed a length of stay of one day.

**Medicare Benefits Schedule:** a Commonwealth program that provides subsidised private medical services for the Australian community.

**Pharmaceutical Benefits Scheme:** a Commonwealth program that provides subsidised access to medicines for the Australian community.

**Public health**: the organised response by society to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population sub-groups.

**Public hospital**: a hospital providing free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to non-admitted patients and may provide treatment and accommodation services (for which they charge) to private patients.

**Separation**: the discharge, transfer or death of a patient from hospital.

## Medical and pharmaceutical services

The Commonwealth Government funded medical services and pharmaceuticals programs discussed above comprise a large amount of total government recurrent expenditure on health services.

The Medicare Benefits Schedule — which covers general medical and specialist services, approved dental services, diagnostic imaging services and pathology services — had expenditure of $7.1 billion in 1995–96. The Schedule provides patients with a rebate of 75 per cent of the scheduled fee for in-hospital treatments and 85 per cent of the scheduled fee for out-of-hospital services. However, if medical practitioners are willing to 'bulk bill' (that is accept the 85 per cent rebate), out-of-hospital services may be supplied at no cost to the patient. The proportion of out-of-hospital medical services bulk billed rose by 6 percentage points to 71.1 per cent between 1992–93 and 1995–96 (DHFS 1996).

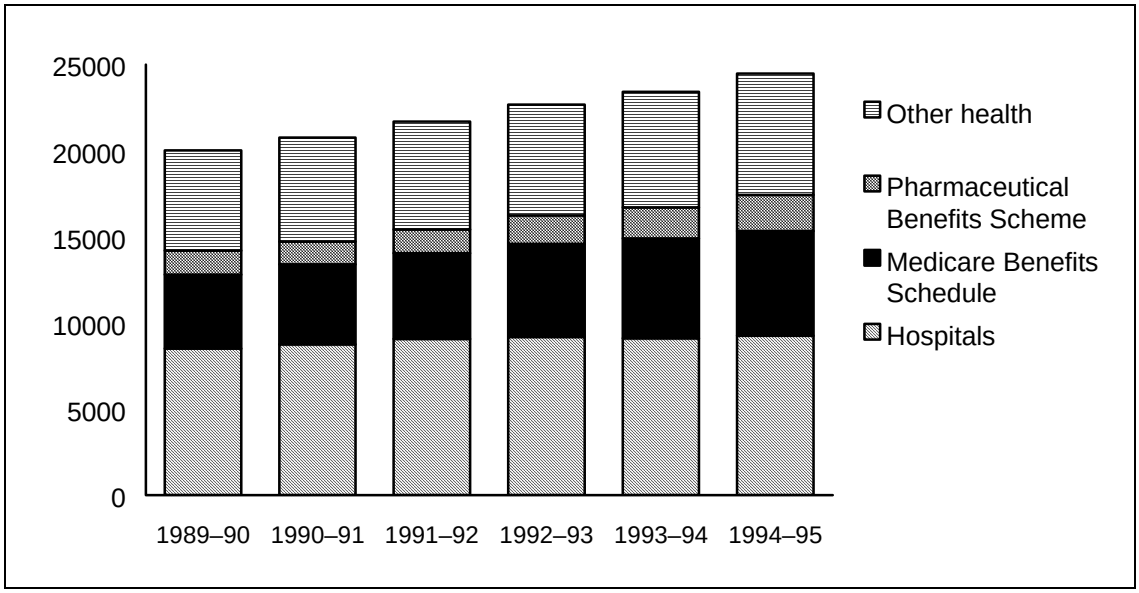
The Pharmaceutical Benefits Scheme — which limits the cost of pharmaceuticals to consumers through private capped co-payments and safety nets — had expenditure of $2.6 billion in 1995–96. Approximately 80 per cent of payments were made for supply of pharmaceuticals to concessional beneficiaries (DHFS 1996).

Unlike most other health programs, government outlays on these two programs are uncapped, with expenditure determined by the claims submitted by clients or medical practitioners. Real expenditures on both have grown rapidly in recent years — by an annual average 7.2 per cent and 8.6 per cent respectively between 1989–90 and 1994–95, compared with 3.9 per cent for total recurrent expenditure and 1.7 per cent for public hospitals over the same period (AIHW 1997). Following changes to entitlement conditions, real growth in expenditure on the Medicare Benefits Schedule slowed to 3.9 per cent in 1995–96, but growth in real expenditure on the Pharmaceutical Benefits Scheme accelerated to 16.7 per cent (DHFS 1996). Given the strong growth in expenditure on these two programs, it is not surprising that their shares of total government recurrent expenditure have risen in recent years.

## Other government expenditure on health

The remaining types of government supported health services include administration and research, dental and other professional services, private hospitals and nursing homes. Government expenditure on nursing homes is discussed in Chapter 9. Some of the other health services may be covered in future Reports.

Government recurrent health expenditure, 1989–90 to 1994–95
($'000 in 1994–95 dollars)




*Source*: AIHW 1997

## System-wide indicators

Factors such as safe food supply, clean water, sewerage services, education, employment and income, and the standard of housing influence the general health of Australians. However, causes of death and life expectancy are conventionally used as broad indicator of health expenditure effectiveness.

Cardiovascular disease was the main cause of death for men and women in 1996, accounting for 38.9 per cent of deaths in men and 45.3 per cent of deaths in women. This was followed by cancer which accounted for 29.2 per cent and 25.4 per cent of deaths for men and women respectively (ABS 1997).

Another broad indicator of health outcomes is life expectancy. In 1996, life expectancy at birth was 75.2 years for males and 81.1 years for females (ABS 1997). By contrast, life expectancy for children born between 1920 and 1922 was 59.2 years and 63.3 years for males and females respectively (AIHW 1996).

These broad indicators do not reflect significant differences between particular groups, so readers should consult the references for further information.