9th International Medical Workforce Conference

Melbourne, 17 to 19 November 2005

Session 2

Health Care Financing

Country Paper: Australia

Health Care Financing: An Agricultural Economist's Perspective

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Executive Summary

This paper seeks to emphasise the importance of demand factors, such as income, technology, prices and consumer expectations on the overall health workforce and health financing situation Australia.

Medical care and health expenses are the fastest-growing component of Australians' health expenditure.

Australia's medical workforce has more or less kept up with population growth in recent years and the current workforce shortages are largely a consequence of growth in demand driven by economic factors.

Demographic factors, such as the ageing of the population, are likely to be increasingly important in the future, but so far have had little impact.

The Australian health system is, from a financial point of view, open-ended in a number of major respects. In order to achieve the goal of universal access to health care the Australian Government heavily subsidises consumer access to medical services through Medicare insurance payments (which cover the bulk of doctors' fees), through subsidies for private health insurance and through the Pharmaceutical Benefits Scheme. In addition, the state and federal governments combine to provide free public hospital care. Thus the impact of price on decisions by consumers and doctors is relatively muted.

With some exceptions, doctors can practice where they like, when they like and in whatever field they can qualify in. The distribution of doctors, both geographically and across the fields of medicine tends to broadly reflect the earnings and lifestyle that is available in urban areas and in the better remunerated medical disciplines. The most common payment methods are fee-for-service or a mix of contract payments and fee-for-service.

This basic framework has much strength in the sense of providing access, flexibility and choice of health care for most Australians. However, the only way governments can keep a brake on expenditure is to restrict the size of health workforce and the availability of other key health resources such as hospitals but, in common with many other countries, the result is a distribution of health services to outer metropolitan areas, rural and remote regions and to some disadvantaged groups that is less than satisfactory.

For nearly two decades up to about 2002 the theme of most Australian health workforce policies was concern about oversupply of doctors and the impact that this could have on the medical workforce and health budget. Only in recent years has the Australian government sought to expand the medical workforce. For example, the annual number of medical graduates has fluctuated around 1300 for many years but is now planned to increase by 60 to 70% to over 2000 per year by early next decade.

National health expenditure has been growing strongly in real terms and at $78 billion in 2003-04 reached at 9.7% of GDP compared to 8.3% a decade earlier. The Australian government and the State governments contribute about two thirds of total health expenditure

As a consequence of continued strong growth in demand driven by income growth, new technology and subsidised prices, plus the growth and ageing of the population, expenditure could easily reach $100 billion in current dollars and 12% of GDP by the end of the decade. With the prospect of a much bigger workforce in the future and political pressures to address shortages of health services, health expenditure is likely to continue to show growth well ahead of most other components of the economy.

Preamble

Agricultural economists in developed countries are more usually faced with a surplus on the supply side than a shortage and spend much of their time concerned about relative lack of demand and low prices.

In contrast, my limited exposure to health economics indicates that, in recent years, shortages of health services and the need to train more doctors and other health workers has been the key focus. Relatively little attention appears to be paid to demand and prices and their influence on the shortage situation, particularly the effect of incomes and prices on consumer demand.

A recent econometric study of the demand for GP services in Australian indicated that income (as measured by a socio-economic index) and the GP's fee (in excess of the insurance rebate) are important factors in influencing the level of consumer demand (AMWAC,2005).

This paper seeks to emphasise the importance of demand, income and prices in the overall health workforce and health financing situation in Australia.

It is sometimes said that markets do not work in the health sector. The issue is usually raised when there is a problem matching the supply of health services with the demand in a particular sector or geographical region. A number of reasons are given for this, mostly related to the information imbalance between patient and doctor.

In practice, all markets outside the theoretical textbook model have some deficiencies and drawbacks but that does not stop the participants and stakeholders from responding to the market fundamentals. The underlying argument in this paper is that when problems arise they are not usually an indication of market failure. More often than not, they reflect the failure of interventions in market processes or indicate that the market is getting the wrong signals about what the policymakers are seeking to achieve.

Introduction

Health care financing in Australia is important because medical care and health expenses are the fastest-growing component of Australians' household expenditure. Over the five years from 1998-99 to 2003-04 the increase in average weekly expenditure on medical care and health expenses was 41% compared to 26% on all household goods and services (AIHW, 2004).

The Australian health financing system is open ended in a number of respects. The primary aim of health policy is to enable access to affordable health care for all consumers. It encourages competition and quality and provides consumers and medical practitioners with flexibility and a wide range of choice. However, matching the supply of services and infrastructure to the level of demand generated by this framework is a major challenge, which, if not met, can lead to shortages, excessive and inappropriate rationing, rising costs and consequent adverse publicity.

The focus of this paper is on the macro level, national financing framework and the broad drivers of demand, supply and costs. There is plenty of scope in the Australian health system for micro reform and for savings through streamlining decision-making, better focused training, reduction of red tape, improved communication and consultation. All of these would reduce costs and improve productivity. The fact that they receive little attention in this paper does not imply that they are unimportant but for an international meeting aimed at comparing, evaluating and contrasting different health systems, the broad approach seems to have the most relevance.

Major Features and Trends in Australian Health Care Financing

Overview of the System

The Australian Institute of Health and Welfare (AIHW, 2004) summarises the main financial features of Australia's health system as follows:

- Universal access to insurance payments for privately provided medical services under Medicare. These payments are funded by the Australian Government, with additional co-payments by users where the services are patient-billed at a rate higher than the Medicare insurance payment (rebate). (In Australia there is no "price control" as in Canada. However for around 70% of services doctors accept the Government "Medicare insurance rebate" as full payment) (These benefits are only available where the services are provided by a doctor).
- 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 insurers, which in turn, is subsidised by the Australian Government through its tax rebate (variously 30% to 40%) on members' contributions to private health insurers.
- The Australian Government, through its Pharmaceutical Benefits Scheme, subsidises a wide range of prescribed pharmaceuticals outside public hospitals.
- The Australian Government provides 74% of the funding for high-level residential care and 57%of health research funding. It also directly funds a wide range of services for eligible veterans.
- State and Territory health authorities carry the primary responsibility for mental health programs, the transport of patients, community health services, and public health services such as health promotion and disease prevention
- Individuals primarily spend money on pharmaceuticals, dental services, aids and appliances, medical services and other professional services

Key Trends in Health Expenditure

Over the decade from 1993-04 to 2003-04 total health expenditure grew by 4.6% per year in real terms to reach $78 billion. As a proportion of national GDP, health expenditure grew from 8.3% in 1993-04 to 9.7% in 2003-04 (AIHW, 2004).

A sharp rise in the use of health services occurred in the late 1990s and early 2000s. Real health expenditures grew by an average of 5% per year, compared with the real GDP growth rate of 3.7%, while average excess health inflation was 0.9%.

The quantity of health goods and services purchased by the average consumer increased by 2.6% per year between 1993-04 and 2003-04, while the average price of these items increased at 0.8% per year

The major areas of expenditure were hospitals (33.4% of total expenditure in 2002-03), medical services (16.5%) and pharmaceuticals (14.0%). In recent years expenditure on hospitals and medical services has increased at about 3% per year in real terms, while expenditure on pharmaceuticals has increased at around 10.2% per year.

International Comparisons

Australia's record over recent years has been broadly comparable with other countries with similar income levels and health systems.

In 2003 Australia's health to GDP ratio of 9.7% was above the OECD average of 8.8% but comparable with most of the higher income OECD countries. Per capita expenditure at $3919 was above the OECD average of $3240 and about the eighth highest in the OECD (AIHW, 2004).

Real growth in expenditure, after adjusting for population growth, between 1992 and 2002 averaged 3.3% per year compared to 3.8% in the United Kingdom, 3.3% in the United States and the OECD average of 3.6%.

Government health expenditure as a proportion of total health expenditure in 2003 was 67.9% compared to 83.4% in United Kingdom, 44.4% in United States and the OECD average of 72%.

The key sources of funds in 2002-03 were Australian Government 46.2%, State/Territory and local government 21.6% (total government sector 67.8%) and non-government 32.1%. This funding split has stayed fairly constant in recent years, with a slight increase in the relative contribution of the Australian Government.

Despite the significant real growth in health expenditure to the 1990s and early 2000s it seems likely that consumer demand for health services was rising even faster.

The main evidence for this is the increasing doctor shortages at a time when the per capita supply of medical practitioners was staying fairly constant.

Concern about doctor surpluses in the late 1980s and early 1990s led to restrictions on the number of medical schools, on undergraduate university medical places, on the number of general practice training places and on the intake of overseas trained doctors. General practitioners were required to undertake an additional three years training before receiving a provider number which would entitle their patients to Medicare benefits.

Around 2002 there was a paradigm shift from a philosophy of surplus and containment to concern about the doctor shortages that were showing up across many geographical areas and medical specialties. Doctor shortages in rural and remote communities were nothing new but it seemed to be getting worse and better workforce data and analyses put the spotlight on the growing shortages in outer metropolitan areas, the public hospital workforce and in many key specialty areas.

In response to the doctor shortage, doctors' fees also went up. The price index for out-of-pocket (i.e. net of the Medicare insurance rebate) household consumption expenditure on doctors and other health professionals increased by 82% between 1994 and 2003 compared to 53% for all household health expenditure and 30% for the total health price index (ABS 2003-04).

Also, over the latter part of this period the proportion of GP visits that were bulk billed (i.e. the doctor accepted the Medicare payment as a full payment for the service) fell from around 75% to below 70% (DOHA, Medicare statistics).

The bulk billing rate is used (very crudely) by politicians and the media as an index of the overall success or failure of the Australian Government's health financing policies. There was a great deal of criticism of the decline in the rate in recent years which resulted in the Government introducing range of financial bulk billing incentives into the Medicare GP insurance arrangements in 2004. As expected, these appear to have resulted in a turnaround in the declining trend in bulk billing and an increase in overall utilisation of GP services.

The demand for in-hospital medical services is also influenced by the level of private health insurance (PHI) in the community. Private health insurance in Australia is basically for in-hospital specialist care. Patients can access PHI hospital and medical benefits as a private patient in a public or private hospital. However, the overall shortages of public hospital beds have deflected demand to the private sector so that over 40% of all hospital admissions are to private hospitals. For some common procedures between 50% and 80% (eg knee procedures 77%, hip replacements 55%) of all procedures are undertaken in private hospitals

The proportion of the population with private health insurance fell through much of the 1990s to about 31% in 1998-99. Since that time the Government has introduced a range of subsidy and regulatory measures (both carrots and sticks) designed to encourage private health insurance. These have resulted in the percentage of the population taking out private insurance increasing to around 43%. Nevertheless, private health insurance premiums have continued to rise in real terms at about 5% per year as the private health insurance funds face rising costs of claims from increasing patient demands on the private health sector. This increasing demand reflects both the ageing of the population and the expectation of people with private health insurance of access to the latest health technologies.

In response to concerns about workforce shortages the Government has, over the last two to three years, substantially increased patient rebates for GP services under Medicare, provided a range of additional incentives to GPs (particularly those working in areas of workforce shortage), embarked on a program to significantly

increase the intake of overseas trained doctors, announced eight new medical schools and a substantial increase in the number of medical undergraduate places. For specialist services, in contrast, the strategy is to shift more of the burden to private health insurance (i.e. from public hospitals to private hospitals) which is, in turn, supported by the tax rebate.

In overview, the current Australian Government health budget can be characterised as growing strongly but likely to grow even faster in the future to make up for current shortages and match future demand growth.

In the following section, the main economic factors which drive health expenditure in Australia are considered followed by a discussion of the outlook for expenditure in the future and some of the policy challenges facing the health sector.

Influence of Financing Strategies on the Demand for Health Care

For the purposes of this paper the demand for health care is defined as the amount of health goods and services that consumers would like to purchase at current income and consumer price (i.e. the net cost after insurance reimbursement/Medicare rebate) levels.

This concept is not the same as the level of utilisation of health services, which is the actual amount that consumers purchase. If health services are in short supply, such as in some public hospitals, aged care homes and rural and remote regions, actual utilisation may be considerably less than the amount of services that consumers in those places would like to purchase.

Wherever demand outstrips utilisation there is, by definition, a shortage, and, in this situation, consumers, the media, politicians and local government all begin to lobby the Australian and State governments for more health services in order to satisfy demand.

Demand is also different to need. Need is related to concepts such as the appropriate level of preventative medicine for a specified population, of clinical treatment for a particular disease or condition and to models of care.

There are few, if any, operational benchmarks of health care need. Population health studies usually indicate that some groups within the community are clearly getting less health services than they need in order to achieve a reasonable health status. On the other hand, despite wide variations in the per person utilisation of health services across the community, no one has established that the higher users of the system are getting more health services than they need.

From a health expenditure perspective, the level of consumer demand is the important concept because it determines household expenditure on health services and the intensity of political pressure that will be applied to expand the health system when demand is not being met.

Demand for health services is principally a function of demographic factors such as the age, gender and geographic distribution of the population, and non-demographic factors such as income and the level of prices and changes in technology (income levels and technological change are key drivers of consumer expectations as to the quantity and quality of health care they should be able to access).

The Australian Productivity Commission argues that non-demographic factors, particularly demand and technology, have had a greater impact on health expenditure than ageing over the last 20 years and this seems to be the general consensus in the comprehensive literature review cited by the Commission (Impacts of Medical Technology, 2005).

Also, there appears to be broad agreement that, in economic terms, health is a superior good. This indicates that the demand for health products and services will increase faster than the rate of growth in real per capita incomes and, with continued national economic growth, expenditure on health will continue to rise as a proportion of GDP.

The extent to which the increased expenditure is associated with higher prices for health goods and services and/or with increased utilisation of the health system is closely linked to the health pricing policies adopted by the Australian Government.

In its Technology report (above) the Productivity Commission has expressed the link between price and consumption of health services as follows:-

The demand for virtually all goods and services is inversely related to their (relative) price. Health services are no exception. Because consumer prices for most health services are heavily subsidised, demand for health service is higher than if consumers had to pay prices reflecting costs of supply (Page 11).

While affordable, needs-based access to health care has many desirable features, it also inevitably encourages individuals to demand health services regardless of the cost because, from their private perspective, health care is a free, or relatively cheap, good (Page 12).

All the increased demand must be met, generating significantly increased health care expenditure, or rationing mechanisms inevitably must come into play (Page 12).

How governments deal with prices and non-price rationing issues will be the key determinants of health care expenditure in Australia in coming years.

At the present time the situation, broadly, is as follows:

- Public hospital services are free but heavily rationed on the basis of clinical urgency to the point where waiting times of 12 months or more are not uncommon for what are regarded as elective procedures, such as joint replacement
- Primary care services are subsidised (the patient rebate) under Medicare to the point where the patient only pays, on average, about 10% of the cost of a visit to a general practitioner, however there is a shortage of general practitioners in some outer metropolitan areas, and rural and remote regions and Indigenous communities which effectively rations their availability.

- The funding of Medicare subsidy programs has been increased substantially in the last two years
- Utilisation of primary care services tends to be relatively high in the middle to upper income areas of the major cities and relatively lower elsewhere as a consequence of low consumer prices (relative to average incomes) and relatively easy access to GPs in the former areas.
- Recent introduction of Medicare safety net arrangements which provide for the Government to pay 80% of out of pocket medical costs once a certain annual cost threshold has been reached by the patient.
- About 43% of the population now has private health insurance (up from 30% four or five years ago), with a tax rebate payable by the government (generally 30% of premiums but up to 40% for older age cohorts).

This heavily subsidised framework provides most Australians with reasonable access to affordable health care but leads to a high level of demand relative to the available health workforce and facilities. This results in complaints about shortages and rationing arrangements that are not always equitable.

In the future, as:

- consumer incomes rise,
- new technology provides an ever-increasing range of procedures, treatments and drugs, and
- consumers become better informed and have higher expectations of the health system,

demand on a health system where prices are held relatively low for all consumers can be expected to grow at a rate which will provide an ongoing challenge to governments and other health service providers to obtain the health resources to keep up.

When supply lags behind demand, media stories about the adequacy of the health system will become more frequent and prominent. Political pressure to provide more money and reform the system will increase.

<u>Supplier Induced Demand</u>

Discussion of demand would not be complete without reference to supplier induced demand (SID).

A paper by the Productivity Commission in November 2002 on SID concluded:

While inconclusive and incomplete, it is possible to make some broad observations about the empirical evidence relating to SID.

- *The findings differ - some studies find support for SID while others do not. Nevertheless, there is arguably sufficient evidence to except that SID can occur.*
- *There does not appear to be any robust and reliable evidence on the likely magnitude of SID , although most existing studies suggest that, when SID arises, it is small both in absolute terms and relative to other influences on the provision of medical services*

- *it is likely that this absence of definitive evidence will remain, as there are a number of fundamental and seemingly unresolvable methodological and data problems associated with trying to assess SID*

It could be argued that, in a situation of widespread medical workforce shortages, there is little incentive for doctors to undertake more consultations or procedures than are absolutely necessary

On the other hand, if a doctor feels there is a risk of being sued for incorrect diagnosis or inadequate treatment and the cost of additional services to the patient is zero or negligible there is little disincentive to providing a comprehensive treatment program. Many medical practitioners will say that they order more tests than are strictly medically indicated to reduce the possibility of being sued. However, defensive medicine is clearly in a different category to supplier-induced demand.

The Australian health system has a number of mechanisms for identifying, counselling and disciplining the few doctors whose patient volumes or treatment patterns are outside normal parameters and who may be over servicing.

In its submission to the Productivity Commission Study on the Health Workforce, the Australian Department of Health and Ageing commented: *If the cost to patients of drugs, services and tests is relatively low, health professionals may also feel less constrained in the procedures and treatments that they order.*

Probably the most reasonable conclusion is that there is little evidence of SID in the form of doctors generating additional treatments motivated primarily by their own financial considerations but that the Australian subsidised pricing system for most health services encourages doctors to ensure that their patients receive a comprehensive level of treatment.

Influence of Financing Strategies on Workforce Supply

The Australian Government subsidises undergraduate medical education and determines the number of medical schools and the number of undergraduate places that are offered each year. Full fee paying medical undergraduate places have been recently introduced; however, the extent that this will materially change the current system is not clear.

Graduate medical training is carried out, with exception of general practitioners; largely in State government managed public teaching hospitals although there is much discussion about shifting some training to private settings to match changing delivery patterns. This change will draw in Australian government subsidies. The Australian Government directly funds the training of GPs through a government-owned company which contracts out the training to regional training providers. For both specialist and general training, medical colleges set curricula, accredit training places, access progress and award formal certification.

In addition to Australian graduates, about 30% of the workforce is comprised of overseas trained doctors working in Australia under a wide range of permanent and temporary arrangements.

Public hospitals are funded by the State governments, assisted by a subsidy of around 50% of costs from the Australian Government. Private hospitals and aged care facilities are provided by the private sector but subsidised to varying degrees by the Government.

The division of responsibilities between the Australian and State governments for health financing and administration leads to added costs, coordination problems and to "cost shifting" and "blame shifting" between the levels of government. From time to time it is suggested that the Australian Government should take over all aspects of health financing and administration.

And as noted earlier, through much of the 1990s, the Australian Government maintained a policy of limiting the number of entrants to the medical workforce in response to concerns about oversupply of doctors and the impact this could have on the health budget. Only in recent years has there been a major change in the focus of health policy to concern about doctor shortages and a new emphasis on expanding the medical workforce accompanied by substantial additional budget allocations.

The number of medical school graduates has stayed fairly constant and around 1200 to 1300 per year from the early 1990s until the present time but is projected to steadily increase over the next few years to reach 2200 early in the next decade.

The number of doctors has grown steadily but, as a consequence of declining working hours, the number of full-time equivalent doctors has been about constant in recent years. A general trend in the medical workforce towards shorter working hours and the relative increase in the female proportion of the workforce have contributed to the lower average weekly hours. Female doctors are more likely to work part-time than their male counterparts and, on average, work 10 to 15 hours per week less than male doctors.

Postgraduate Medical (GME) Training

The medical colleges have primary responsibility for GME standards and requirements and the size of the annual intake of trainees, although this is influenced by the

The structure and distribution of the Australian medical workforce is significantly influenced by the financing arrangements.

Of 52,000 clinicians in 2003, 42% were GPs, 46% specialists or specialists in training and 11% or hospital non-specialists. GPs are paid on a fee-for-service basis, specialists on a mix of fee-for-service and sessional fees from hospitals and hospital non-specialists are primarily on a salary.

Medical graduates can exercise wide discretion about where, when and for how long they will practise medicine. Some overseas trained doctors and some bonded medical students are required to serve in areas of doctor shortage for varying lengths of time but the majority can practice where they like and choose whatever field of medicine they can qualify to train in.

A result of these arrangements is that the distribution of the medical workforce is weighted towards the more remunerative fields of medicine and disproportionately located in the middle to upper income urban areas of the major capital cities.

Doctors, not surprisingly, chose to live and, mostly, practice among other professional groups and in areas where family needs and lifestyle goals can be met.

The result, however, of these arrangements has been an increasingly severe shortage of doctors in outer metropolitan areas, rural and remote regions and indigenous communities. For example, the number of GPs per hundred thousand population varies from less than 100 in rural and remote areas to over 300 in some of the inner-city regions.

Without the availability of those overseas trained doctors who are required under the terms of their immigration arrangements to work in areas of doctor shortage, the health workforce situation in rural hospitals and in rural general practice would be very acute.

It is occasionally argued that, if the medical workforce is increased sufficiently, competition among doctors will result in a reasonably equitable distribution of medical services both between fields of medicine and in terms of geographical spread across the country. However, this hypothesis would be very expensive to test. Current indications are that there is sufficient demand for medical services, given the current level of Medicare subsidies, in middle to upper socioeconomic urban areas to absorb further increases in the medical workforce in these areas. The trickle down effect could be a long time coming.

Furthermore, this argument ignores a series of financial and non-financial influences. Costs of practice are higher in rural areas, and policy settings have been slow to recognise and adjust the pricing and remuneration framework. Family and lifestyle issues carry considerable weight also. Monaco and Liechtenstein may be the only principalities in the world without a rural medical workforce issue.

The Government has chosen instead, one suspects wisely, to provide a wide range of incentive payments and subsidies to doctors prepared to locate in areas of workforce shortage. While it is too early to conclude whether these will achieve an adequate response, there are signs that, in conjunction with the overseas trained doctor intake, they will lead to some easing of the shortage in some areas. Also, arrangements to subsidise the employment of practice nurses by rural GPs appear to be assisting the situation.

More recently there has been discussion of further developing the roles of nurses and allied health workers to supplement the role of medical practitioners. However, doctors' organisations oppose this approach unless the allied health worker is under the broad supervision of a doctor. There is an acceptance, at least from some general practice organisations, that some care, particularly for chronic illnesses may be more effectively delivered by "multidisciplinary teams" and there are some new government programs supporting such arrangements, delivered through general practices.

Financial Trade-offs and Containing Costs

The state of the health system is always a high priority for voters and never far from the front page of the newspapers; hence it receives a great deal of political attention, which, in turn, often leaves little scope for explicit trade-offs.

The major Australian political parties broadly share the goals of access and affordability of health care for all Australians but differ, to some extent, on how they should be achieved. The conservative parties prefer to give relatively more emphasis to the private sector while the Labor Party gives higher priority to the public sector components of the system. In practice, the differences are not very marked.

The division of responsibility for various aspects of health education, administration and funding between national and state levels of government and between government departments also limits the capacity of any single government or minister for health to take a holistic approach to health priorities and funding at a macro level.

In addition, the broadly subsidised and largely open ended approach to consumer demand for health services and the market-based framework allowing doctors to choose how and where they practice, limits the capacity of governments to directly influence the system. The indirect financial and regulatory policy levers that are available to governments do not allow for fine tuning or short-term policy adjustments.

At the local and regional levels health administrators have to juggle priorities and the various components of their budget but at the state and national levels major changes usually occur in response to crises such as the recent national doctor shortage, a current severe crisis in the Queensland Health Department and a medical indemnity crisis in 2003.

Cost containment is influenced by gatekeeper arrangements, price and regulatory mechanisms and rationing, principally through waiting lists.

Gatekeeping arrangements include:-

- Access to public hospitals is subject to a priority assessment system
- A referral is normally required from a GP in order to see a specialist.
- Rebates for investigations (pathology and diagnostic imaging) only apply if the test has been ordered by a medical practitioner;
- Medicare rebates for some diagnostic tests are only available if the tests are ordered by a specialist.
- There are a range of explicit limitations and bureaucratic hurdles on the ordering of subsidised pharmaceuticals

Access to the private health sector tends to be expensive if the patient is not among the 43% of Australians who have taken out private health insurance.

Waiting lists for elective procedures in public hospitals and for appointments with specialists and some GPs have tended to put a brake on the utilisation of these resources.

The size of the medical workforce has been regarded as the key to containing overall medical costs, however, at times, lack of infrastructure, such as operating theatres, is a limiting factor.

It will be very interesting to observe the impact of the planned 60% to 70% increase in the number of new medical graduates every year over the next few years on the overall costs of health system.

Outlook for Healthcare Spending

A recent study of the demand for health services in Australia has concluded that real demand is likely to increase by 3% to 4% in the future as a consequence of the demographic and non-demographic factors discussed earlier (AHWOC, April,2005).

This seems to be consistent with recent trends but does not take into account the current level of unmet demand, such as shortages of workforce, aged care beds and public hospital capacity.

If workforce growth expenditure keeps up with the rate of growth in demand, health expenditure as a proportion of GDP will increase from its 2003-04 level of 9.7% to around 12% by the end of the decade. In current dollar terms, this would mean an increase in total health expenditure from $78 billion to nearly $100 billion and all government sector expenditure on health from $52 billion to $65 billion by 2010.

However, as recent new policies designed to address current shortages to boost Medicare rebates, to redistribute the workforce and to increase the number of medical schools and students begin to take full effect it would not be surprising to observe even faster growth.

There are regular calls for “fundamental reform” of Australia’s health workforce and financing arrangements. It is probable that if such reform did occur it would have little effect on the underlying real factors driving demand and, therefore, on these likely trends in aggregate expenditure.

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