AUSTRALIA'S HEALTH SYSTEM

Some Background Information

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History is our parents' experiences, current affairs is ours, and the future we are engaged in creating.

In a walk down the street in a country town seventy years ago it would have been commonplace to meet a woman with a gross swelling on her neck—goitre.

It would have been commonplace to meet a man with withered limbs in a wheelchair—the results of poliomyelitis.

The children's ward at the local hospital might well have contained children battling rheumatic fever.

The milkman who came in the small hours in his horse-drawn cart delivered bottled milk, but milk which had been pasteurised, because the nation was still struggling to detect and contain tuberculosis. However, unpasteurised milk continued to be delivered in some cities, for instance Brisbane, into the 1950s.

By and large, the passers-by conformed to the rangy physical stereotype—Chips Rafferty Aussie.

Back then, the States were the major providers of public health programs, long-term institutional care of the aged and the mentally ill, and acute hospital care. Doctors were, as now, mostly independent self-employed professionals. Specialists served as 'honoraries' in public hospitals. Local government bodies performed a public health role by being responsible for water supply and its purity, sanitation, and maintenance of pure food standards.

This reflected both practice since colonisation, and the fact that the Commonwealth Constitution adopted in 1901 did not give the new Federal Government relevant powers in health, beyond quarantine.

It was in 1956 that the Commonwealth moved beyond its role in quarantine to establish the first Federal health insurance system, supporting and expanding the existing State-based and registered voluntary medical and hospital health insurance organisations. The constitutional power to do this rested on the power related to Commonwealth regulation of insurance. Even so, a constitutional referendum had been necessary to amend the Constitution to confirm this capacity.

More recently the Commonwealth has expanded into supporting a wider range of health programs, using such tools as Specific Purpose Grants to the State and Territory governments, and its powers (again established by a Constitutional referendum) to make laws relating to Australia's Aboriginal population.

Today some of the successes of public health programs mean we rarely see the sequelae of earlier childhood diseases; polio has virtually been defeated, as has tuberculosis in mainstream communities. The addition, from the late 1940s, of iodine to table salt controlled goitre, not unlike the more recent addition of fluoride to domestic water supply to control dental caries. That dental health achievement of singular importance is now being undermined by the fashion for consumption of bottled water. We have been less successful in achieving improvements in the health of Australia's Indigenous peoples.

But there are new challenges. Professor Fiona Stanley of Western Australia worries about the breakdown of parenting skills and the consequences for childhood development and the future mental health of the population. Obesity has become an issue, along with other diseases linked with life-style—diabetes, cardio-vascular illness and cancer of the lower bowel.

The Commonwealth has become the major player in health care financing by providing: direct grants to States for their hospitals and health services; subsidies to individuals through a compulsory national health insurance scheme to enable them to purchase health care from doctors, and a range of allied health professionals (but not dentists); subsidies for individuals' long-term care in not-for-profit or private nursing homes; and subsidies to individuals for the costs of certain medicines (the Pharmaceutical Benefits Scheme).

The Commonwealth is also directly responsible for a wide range of health services for Veterans.

Commonwealth education funding determines the numbers of doctors and nurses and other health professionals our (State-registered) universities can produce.

States are still largely responsibly for the day-to-day provision and administration of mental health services, public health and community health education programs, public hospitals; and it is the States which register health professionals. The States provide domiciliary nursing services and other forms of ambulatory care which support frail elderly and disabled people in the community. Both Commonwealth and States contribute to the cost of post-acute care for people discharged earlier and earlier from acute hospitals.

Private enterprise has become a big player in the provision of acute hospitals, as well as of long-term nursing care settings.

Major public health challenges, such as that posed by HIV-AIDS have required significant Commonwealth-State cooperation. It is interesting to note that it was not until the Commonwealth wished to promote the use of condoms as a preventive tool against infection that the States were persuaded to repeal their legislation preventing public advertising of contraceptive devices (a relic of a scare about slow population growth in the1920s).

So, it is clear that just as health challenges change and evolve, so too does Australia's health system.

The components of Australia's health services are very varied, the system overall is complex, and coordination is through the Council of Australian Government Health Ministers.

The Australian Institute of Health and Welfare (AIHW) is the statutory body which produces data on health status, on health and welfare systems. The following data are from their recent publication, *Australia's Health 2004*.

Spending on health, broadly defined, accounts for around 9.3% of Gross Domestic Product (GDP) in 2001–02, and this compares with that of France. The total sum in that year was $66.6 billion, compared to $55.8 billion in 1999–2000.

About 70% of total expenditure on this system is made by governments, and of this the Commonwealth contributes about two-thirds, and States, Territories and local governments one third. The balance is contributed from private sector sources.

- Health expenditure per person was $3,292 in 2001, up from $3,034 in 1999.
- Spending on hospital services accounted for more than one-third (35.4%) of recurrent expenditure in 2001–02, compared with 36.6% in 1999.
- Real growth in recurrent expenditure averaged 5.7% per year between 1999 and 2001–02. The major drivers of this growth were expenditures on pharmaceuticals, which averaged growth of 13.9% per year and private hospitals (5.1% per year).
- The Australian Government provided 46.3% of total funding in 2000–02 compared with 46.9% in 1999–2000, while the States, Territories and local governments provided 22.3%, compared with 23.0% in the earlier year. Funding from the non-government sector increased from 30.1% to 31.4%.
- In 2001, there were 2,322 health workers for every 100,000 people living in Australia. This was an increase from 2,206 in 1996.
- Nursing workers per 100,000 population decreased from 1,267 in 1996 to 1,259 in 2001.
- The health workforce is ageing. About 39% of people employed in health occupations were aged 45 years or more, up from 31% in 1996. The proportion of workers aged 45 increased faster for females (from 29% to 37%) than for males (from 38% to 43%), reflecting the rapid ageing of the female nursing labour force.
- The oldest health occupations were medical workers, complementary therapy workers and pharmacists.
- In the 2001 Census, 3,742 people reported being Indigenous and employed in a health occupation. Half of these were employed in nursing.
- Nearly half (47%) of medical workers reported working 49 or more hours per week, far higher than any other broad health occupational group. Conversely, more than half (51%) of nursing workers worked less than 35 hours per week.
- In most health industries there were decreasing rates of employment with increasing remoteness in 2001. For example, there were 1147 per 100,000 head of population employed in hospitals in major cities, compared with 601 in very remote areas. Small industries, in particular, were not as well represented in more remote regions. For example, in the optometry and optical dispensing industry, the ratios were 53 per 100,000 population in major cities compared to 14 and 2 in remote and very remote areas, respectively.

These are some of the facts about total and relative spending, about Constitutional powers, and about the health workforce, which must be taken into account in consideration of proposals for change.

Readers are encouraged to go to the AIHW site for further authoritative data.
http://www.aihw.gov.au/