ICU MANAGEMENT & PRACTICE

ICU Volume 7 - Issue 1 - Spring 2007 - Country Focus: Australia

An Overview of the Healthcare System in Australia

Author

Jeffrey Braithwaite, *PhD*

Director

Centre for Clinical Governance Research,

Faculty of Medicine, University of New South Wales, Sydney, Australia

Professor

School of Public Health and Community Medicine,

Faculty of Medicine, University of New South, Wales, Sydney, Australia

j.braithwaite@unsw.edu.au

Introduction

To understand the Australian healthcare system requires a consideration of core problems facing every healthcare system – the financial and structural arrangements, perceived weaknesses and strengths, how performance compares internationally, what future challenges are likely to be faced and how challenges can be tackled. Australia is a large, federated country of nine jurisdictions. It occupies a continent, has a population of 20 million and a developed economy with a gross domestic product (GDP) per capita of US $34,660 in 2006. This places Australia in the world's wealthiest fifteen countries (World Bank 2006).

Australia's healthcare system is a mixed public-private model, lying somewhere between the largely monolithic public systems exemplified by the National Health Service (NHS) of England on the one hand and the more privatized arrangements characterizing healthcare in the United States of America (USA) on the other. Beneath that over-simplification lies considerable detail that needs to be filled in to provide an adequate description of the unique Australian healthcare configuration.

Financing and Structural Arrangements

Expenditure on healthcare in Australia, at 9.7% of GDP, is above the Organisation for Economic Cooperation and Development (OECD) average. Health expenditure has tended to rise in recent decades in OECD countries, including Australia, driven primarily by the costs of population ageing and of advancing, and increasingly expensive, medical technology (OECD 2006). Around twothirds (68%) of the GDP consumed by Australian healthcare is public expenditure, and the remainder (32%) is non-government, private expenditure. The Australian government contributes 45% of total funding, principally through taxation, and directly funds pharmaceuticals, general practitioners and medical services. States and territories provide funding in conjunction with the Australian government and directly manage public hospital services and various community, prevention, public health, health education and health promotion programs. Local governments have responsibility for environmental issues such as garbage disposal, health inspections and some home-care and preventive services.

The generic term for the main policy instrument to achieve these service arrangements is Medicare. The vehicle used to contract the jurisdictions to their part of the bargain in sharing federal, state and territory responsibilities for public hospitals are called the Australian Health Care Agreements (Department of Health and Ageing 2006). The states and territories manage services via area, district or regional health service arrangements, which are geographically-based administrative units responsible for the health of a population of perhaps half a million people. Medicare enshrines the principle that all resident Australians are entitled to free public hospital care if they exercise the choice to be public patients.

Private patients meet their costs via private health insurance or personal contributions. The Australian government has recently encouraged increased membership in private health insurance funds. About half the population is covered by elective, government-subsidized private health insurance. Most out-of-hospital medical services are provided by private doctors, and, alongside salaried medical practitioners, these doctors perform a considerable proportion of hospital services (Department of Foreign Affairs and Trade 2006).

Weaknesses and Strengths

Commentators have bemoaned the poor integration between general practice and hospitals and the apparent administrative and policy duplication attributed to the split responsibilities between thefederal government and the states and territories (Leeder 1999; Duckett 2004). A bigger issue is whether we can call the health industry a system at all, given the various levels of divided responsibilities, fragmentation and its pluralist nature. Australian consumers and providers have considerable discretion and autonomy, and there is a complex mix of public-private concerns, state-federal politics and other intermittently strained, dichotomous interests, such as those representing clinicians and managers, the acute and community sectors, and medicine and nursing. Someone once likened the health system of the USA to "primordial ooze." The Australian healthcare system is not quite so unstructured, but there are many species of provider, policy and lobbyist running around in the healthcare soup. Some of these are collaborators with other agents, others are isolates, while yet others compete vigorously for resources.

The other major weakness is the deplorable state of indigenous health, with extremely high prevalence of diabetes, obesity, alcohol abuse and drug problems amongst the Aboriginal population. Overall, life expectancy of Aboriginal people is 17 years below that of other Australians. Everyone wants this fixed, but progress has been painfully slow.

The strengths of the system are considerable. All in all, the Australian population, measured by the usual morbidity and mortality indicators, is relatively healthy and enjoys good life expectancy. Healthcare in Australia is well funded; clinicians, managers and policymakers are suitably trained; and equipment, buildings and technology are modern and well-resourced. The health policy settings are underpinned by effective research and are internationally well regarded, despite the fragmentation and difficulties in promoting integration at some points in the system. Plurality and diversity, though contributing to system fragmentation, can also bring strengths, particularly when they offer a wide range of different types of services, thereby creating choice for consumers. Having multiple perspectives and actors in a system tends to lead to greater innovation and improved results (Surowiecki 2004).

International Comparisons

Internationally, Australia compares favorably with other countries on many measures of health system performance. Table 1 provides some selected comparative data, drawn from the Commonwealth Fund, a private, international research foundation (Commonwealth Fund 2006; Schoen, Osborn et al. 2004; Schoen, Osborn et al. 2005).

Future Challenges

Braithwaite and Cormack (2003) have listed some of the major challenges facing Australian healthcare (see table 2). Improved quality of care, patient safety, efficiency and equity, better coordination of services and the search for new models of care are likely to be issues of concern to every health system.

But these are distal issues. Summarized, the proximal problems, not confined to Australia, seem to be affordability of new technology and funding the rapidly increasing treatment capabilities against a backdrop of population ageing and workforce shortages. A current debate (Braithwaite 2006; Podger 2006a; Podger 2006b) is whether structural responses are needed to address some of these challenges. For example, is it warranted to encourage greater competition, e.g. by separating the purchaser from the provider of health services and allocating healthcare funding through a competitive bidding process? Some economists prefer competitive models, but others are not convinced that structural-financial change, designed to induce more competition, will lead to a fundamental response to system deficits. Such structural debates, while important, do not guarantee any detectable change in patient outcomes. Time will tell, but the struggle to provide excellent services within limited resources is not likely to be resolved soon.

Published on : Thu, 15 Aug 2013