Attachment A

Australia and the International Context

Current Approach and Performance

Australia's approach to health service delivery is underpinned by a universal health care system. This includes access under the Medicare Benefits Schedule (Medicare) to free or subsidised essential health services, benefits for privately provided medical and pharmaceutical services including and access to affordable medicines through the Pharmaceutical Benefits Scheme (PBS), and free public hospital treatment as a public patient. Complementing Medicare is a private health care system that allows individuals to make a greater financial contribution towards their health care in return for greater choice about the care they receive.

Compared with other countries, Australia has an efficient health system that delivers strong health outcomes at a reasonable level of expenditure. According to OECD figures, our average life expectancy of 82 years is better than all but a handful of countries, while our level of health expenditure is below the average for comparable economies. Bloomberg recently found that Australia had the seventh most efficient health system in the world. The relative efficiency of Australia's health care system was also confirmed by the most recent Global Burden of Disease Study by the Institute for Health Metrics and Evaluation (IHME), which found that of the top 15 countries ranked by income per capita, Australia has the 12th lowest total health spending per capita (private and public expenditure) but ranks 2nd in terms life expectancy and 4th in terms of preventing premature mortality.

In 2011, Australia's total expenditure on health was 9.1 per cent of GDP. This compares with the USA's total expenditure on health, which was 17.0 per cent of GDP in 2011, and the OECD median total expenditure on health, which was 9.0 per cent of GDP in 2011.

Comparison of Health Systems

There are a variety of health systems currently operating across the world for lessons that could be learned for Australia. In general, governments seek to achieve three main goals in their approach to health policy: better health, fairness in financial protection and responsiveness to people's expectations. Across the world, different advanced economies have sought to achieve these goals through a variety of approaches to the four main functions of health systems: delivering services (provision), financing (collecting, pooling and purchasing), creating resources (investment and training) and stewardship (oversight). An analysis of 30 OECD countries shows that half place a heavy reliance on market mechanisms in service provision while the other half rely mainly upon public provision. Each arm of this bifurcation has three subgroups.

Among the countries that place a heavy reliance on market mechanisms in service provision, four (the USA, Germany, the Slovak Republic and Switzerland) rely almost entirely on private insurance for health financing, including for basic services. In these countries, government assistance with health costs is generally available on the basis of a strict means test. In general, these arrangements offer most users substantial choice, and the government some budget control, but at the cost of a deal of inequality and lower quality.

Other OECD countries also place a heavy reliance on market mechanisms in service provision but have public insurance arrangements in place for basic services. Of these countries, six (Austria, the Czech Republic, Greece, Japan, Korea and Luxembourg) have few gatekeeping arrangements with respect to access to basic services and have little private insurance beyond the basic coverage. By contrast, four countries (Australia, Belgium, Canada and France) that place a heavy reliance on market mechanisms in service provision have gatekeeping arrangements that seek to control access to some basic services and private insurance arrangements for non-basic services.

Of the eight countries that rely mostly on public provision and public insurance, three (Iceland, Sweden and Turkey) have no gatekeeping arrangements and provide consumers with an ample choice of providers, and five (Denmark, Finland, Mexico, Portugal and Spain) have gatekeeping arrangements in place for basic services and seek to control costs by limiting the choice of providers. The final group of seven countries (Hungary, Ireland, Italy, New Zealand, Poland and the United Kingdom) have gatekeeping arrangements in place for basic services and seek to control costs through budget caps.

There is little evidence that any of the six groups of health systems are superior to others in achieving the goals of government. Efficiency analysis shows that there are efficient and inefficient health systems in each of the six groups discussed above. However, it should be noted that overall health costs per capita tend to be higher in countries with the greatest reliance on private insurance for basic care and market mechanisms, although the share of costs borne by government in these countries tends to lower. In the case of the USA, the effect of the higher per capita health costs outweighs the lower share met by government, so that the net effect is that government expenditure on health in the USA is higher than in many other countries.

Attachment B

Australian Health Expenditure

Current and Future Expenditure on Health

Health has been, and will continue to be, one of the fastest growing areas of expenditure for the Australian Government. This is driven by population ageing and by the higher costs that are sometimes associated with newer, more complex, and more effective treatments. Between now and 2052, the proportion of Australians aged over 65 years or more will almost quadruple. Older people tend to be higher consumers of health services and are more likely to suffer from chronic diseases such as arthritis, dementia and cancer. Advances in medical technology have resulted in, and will continue to result in, new treatments, which more successfully treat disease but sometimes at a higher cost. Australians have also increased their consumption of health services over time.

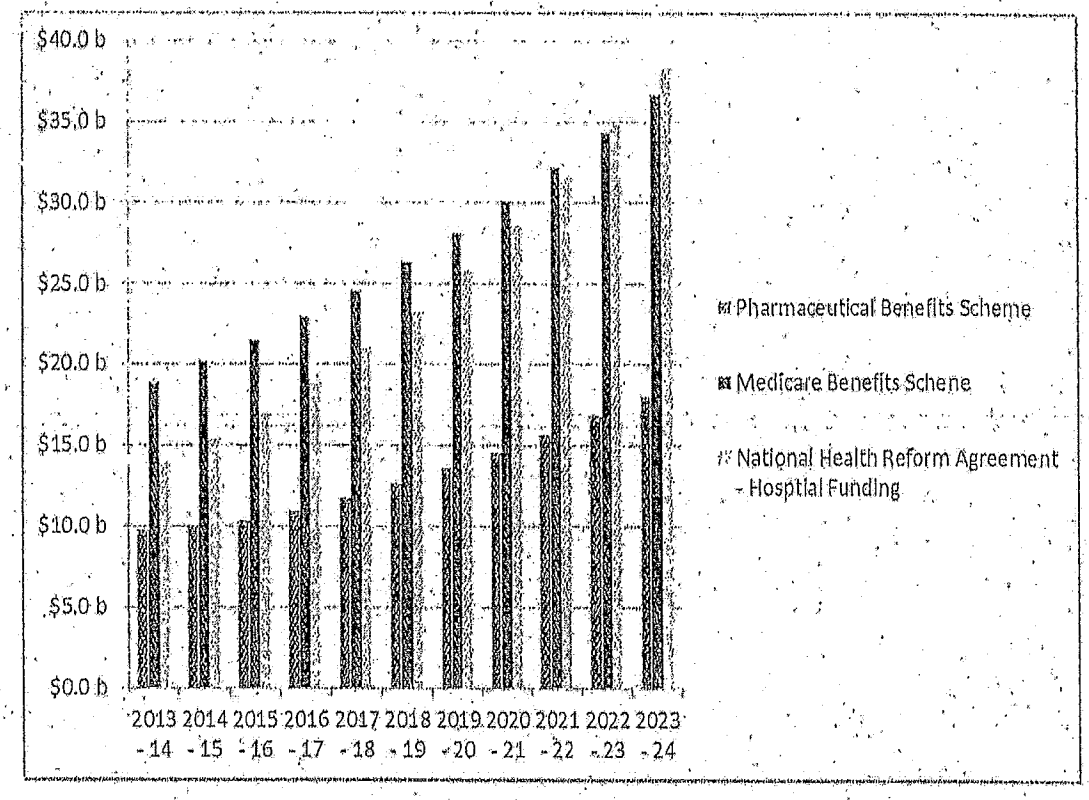
In 2013-14, the Commonwealth will spend about $64.8 billion on health. This is projected to (nominally) increase to $75.2 billion by 2016-17. As a share of GDP, Australian Government expenditure on health is projected to increase slightly from around 4.1 per cent in 2012-13 to around 4.2 per cent in 2016-17. Over the longer term, the real rate of growth in Commonwealth expenditure on health is projected to be higher. Expenditure on the three major programs (excluding the private health insurance rebates) will account for around 2.7 per cent of GDP in 2013-14, increasing to around 3.8 per cent by 2023-24.

The largest growth area for the Commonwealth will be in expenditure for public hospitals, which is currently estimated to grow by 174 per cent over the decade, partly as a result of the Commonwealth taking on an increasing share of expenditure rather than just underlying cost and service growth. This is double the projected rate of growth in expenditure for the PBS, and almost double the projected rate of growth for Medicare. By the end of the next decade, transfers that are made to the States for public hospitals will be the largest of the four major programs (private health insurance rebates, PBS and Medicare being the other three), and will account for 33 per cent of expenditure on those programs, compared with 25 per cent currently.

Between 2001-02 and 2011-12, funding by individuals grew by an average of 6.1 per cent a year in real terms, compared with an average of 5.4 per cent for total funding of health expenditure.

The share of health costs met by individuals in Australia is higher than the OECD average, although much of the costs paid by individuals can be attributed to spending on non-essential health services, or 'discretionary' health care. One category of health expenditure that could be classified as 'discretionary' is the 'all other medications' category, which excludes drugs subsidised under the PBS. Such medicines are frequently not evidence based and have not been evaluated for public funding through a health technology process. In 2011-12, 'all other medications' accounted for 32.5 per cent of all funding by individuals. That is, as much as a third of current spending by consumers on health can be considered to be discretionary. Higher user contributions for subsidised health services would not therefore, necessarily increase overall costs to consumers by the same amount, as consumers might substitute out some of their current discretionary spending on health.

Figure 1: Projected expenditure on the three major health programs, 2013-14 to 2023-24, nominal $, based on current policy settings



Attachment D

Commonwealth and State – Roles and Responsibilities

Context

Under the Constitution, all health-related powers (except quarantine) were held by the States until 1946 when it was amended to give the Commonwealth Parliament legislative power with respect to 'pharmaceutical, sickness and hospital benefits, medical and dental services'. Other sources of Commonwealth power within the Constitution include: Section 96 - the power to make special purpose grants; and Section 51 – insurance, the corporations power, the defence power, and the power to make laws for the benefit of Indigenous Australians.

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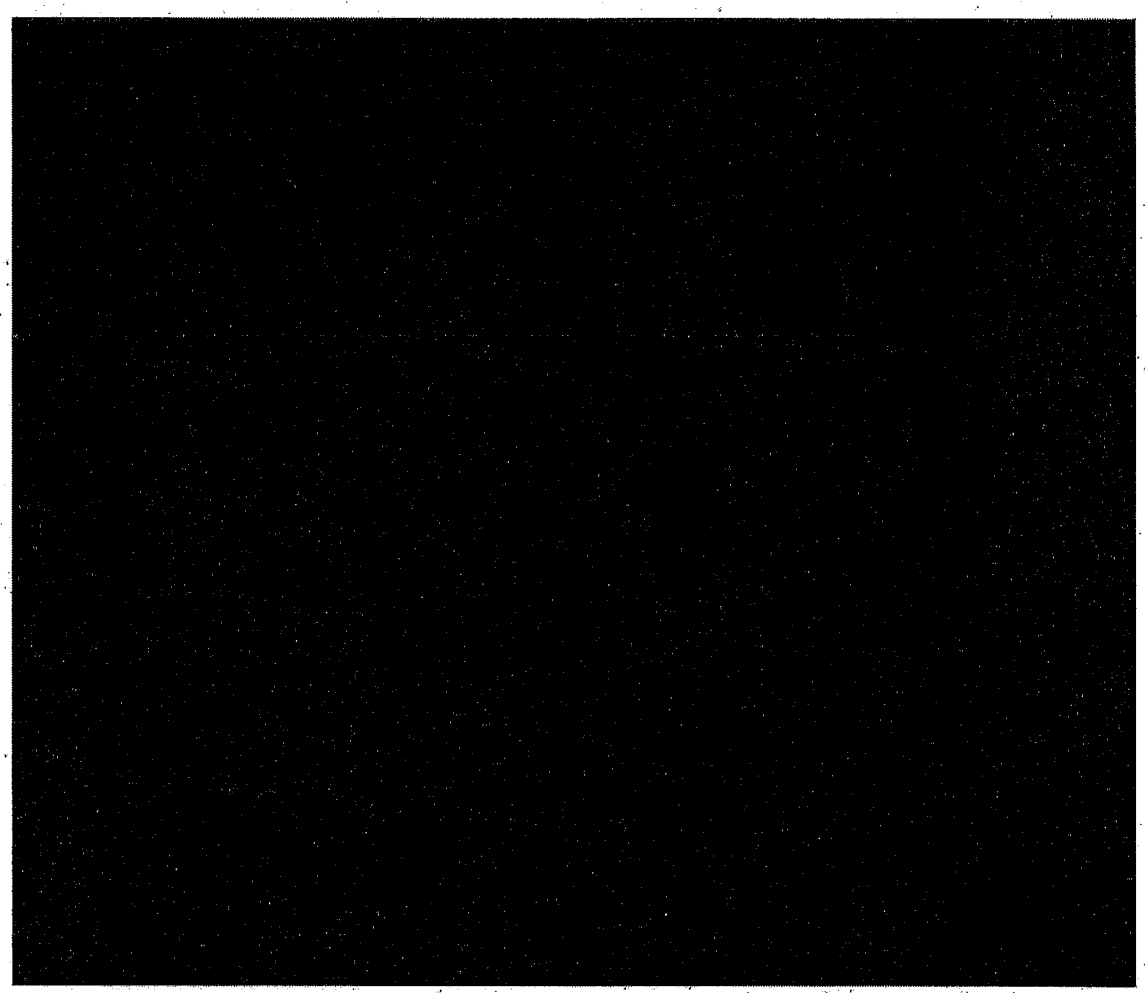

Aboriginal and Torres Strait Islander Health

A critical role for government is in addressing health inequalities as not all population sub-groups enjoy the same high quality health outcomes. Aboriginal and Torres Strait Islander peoples experience particularly poorer health outcomes, with life expectancy of Indigenous Australians well below that of the non-Indigenous population (11.5 years lower for males and 9.7 years lower for females), and the rate of Indigenous child deaths is more than double that for non-Indigenous children. Indigenous Australians experience more than double the burden of disease (taking into account ill health and disability as well as mortality). Chronic diseases, such as circulatory disease, cancer, diabetes and respiratory disease, contribute two thirds of the gap in mortality rates.

There continue to be disparities between Indigenous and non-Indigenous Australians throughout the patient journey. In 2008, 26 per cent of Aboriginal and Torres Strait Islander peoples aged 15 years and over reported problems with accessing health services, with access issues higher in remote areas. Selected potentially preventable hospitalisation rates for Aboriginal and Torres Strait Islander peoples were five times the non-Indigenous rate during the period July 2008 to June 2010. Aboriginal and Torres Strait Islander peoples have lower rates of hospital procedures, lower rates of elective surgery, and discharge from hospital against medical advice was five times the rate compared with non-Indigenous Australians.

[redacted]

2010 Strategic Review of the Health Portfolio

A strategic review of the administrative arrangements within the Health Portfolio was undertaken in 2010. The focus of the subsequent Departmental National Alignment (DNA) program was to create a more efficient organisation and to enable resources to be directed to support government's health priorities.

The strategic review bought investment for much needed internal reform with net savings of $53.5 million over 4 years, becoming an ongoing reduction of $50 million per annum (or 8 per cent of total Departmental resources).

Achievements to date include:

- *Grants Procurement and Funding* – Centralisation of grant administration into a single Division; to streamline our processes, achieve consistency and cut red tape for service providers. Consistent policies and processes, a single grant agreement, and a single grant management system ('FOFMS' – FaHCSIA's Online Funds Management System) are also being rolled out. Benefits for service providers include a single point of contact in the department for their business relationship, and having (over time) a single agreement with the department with simplified reporting.

- *Flexible Funds* – Consolidation of 159 separate grant programs into 18 flexible funds, with new program guidelines. This resulted in reduced red tape, increased flexibility to respond to emerging issues, and delivered better efficiency to the Department.

- *Enterprise Data Warehouse* – An enterprise data warehouse is being established to increase productivity of staff by improving access to information and better data analysis and reporting. This is being supported by improved data management and governance.

- *Portfolio Shared Services Centre* – A shared services centre has been established and provides a full range of corporate services to eight portfolio agencies and a more limited range to a further 12 agencies.

- *Measurement and Monitoring* – the Department implemented a Departmental Activity Survey to monitor how staff spend their time. This helps the Department measure benefits realisation from corporate change projects, as well as helping understand where to target further efficiency measures.

Other achievements include:

- Implementation of the whole of government parliamentary workflow system to improve consistency. Correspondence in the department has also been streamlined; 63 per cent of correspondence is now a single page response (as of 30 June 2013).

- A new enterprise desktop has been successfully rolled out, resulting in improved energy efficiency and reduced greenhouse emissions. The department has also deployed an electronic document management system, with a 68 per cent reduction in the creation of new paper files this financial year compared to last year (to date).
- The Department has increased its APS:EL ratio by aligning positions with APS work level standards.