

## 2004 Chief Health Officer Seminar Series

### Seminar Five – 15 September 2004

Dr Richard Madden, Director, Australian Institute of Health and Welfare

#### Abstract:

#### *Australian Health Expenditure: of course it still matters*

A casual observer might say that cost containment is no longer a priority in the Australian health system. But some spending by one sector is sometimes offset by reductions in others.

This presentation will start with a short review of the framework for discussion of Australian Health Expenditure, as well as some of the key numbers. Topics will include who pays, for what, and what have been the long term trends. Sometime will then be spent examining some of the drivers of health expenditure, from both the demand and the supply side.

#### Transcript:

In the front of the Australian Health Expenditure Bulletin that the Australian Institute of Health and Welfare puts out is a diagram of figures from 2001-02.

The diagram explains a little about the flows of money around the system. It starts with the people who are simply funders and goes over to the people who provide services or consume services. The States and Territories sit between these groups of people because they both fund and provide services.

For the purpose of completeness the Department of Veterans Affairs is in there too because there are two Commonwealth systems, one through Health and Ageing and the other one through Veterans Affairs, which makes up about 10 per cent of the Health and Ageing one.

It's quite a big sector. The Commonwealth pays funds to the States, which pay rebates to health insurers, and principally it pays benefits to private providers.

The States provide services. They also buy services from private providers and the individuals make payments to the insurers and to the States for some services and to private providers.

The percentage of GDP spent on health rose in 2001-02 to 9.3 per cent to give total spending of \$66.5 billion.

It's risen gradually over the decade of the nineties and accelerated a bit in the last three or four years when it's been going up by 2 percentage points of GDP. However, you've got to allow for inflation in the process so that puts the overall figures in some context.

In real terms the growth has also been accelerating and has averaged 5.4 per cent in real terms over the period 97-98 to 2001-02, which is the period of the last health care agreement that was available when the figures were done. Things have been going up rather more quickly than in the previous period.

Let's look at the shares of different sectors. The non-government figure is just over 30 per cent. It's pretty constant over a long period of time. One of the issues around all health expenditure numbers is people can get very excited over movements from time to time, but there is remarkable stability over time in most of the aggregates and things that go up tend to come down again in terms of shares.

The Commonwealth share has risen over the period '91-'92 to 2001-'02 (from 42.8 per cent to 46.1 per cent). You've got to be careful in interpreting that because the Commonwealth share includes the private health insurance rebate, which is now over \$2 billion. About 3 per cent of that share is due to the private health insurance rebate.

The State and Territory share is also fairly constant over the period at an average of about 23 per cent.

We'll look next at a breakdown of total health spending in 2001-'02, breaking up the non-government sharing to health insurance, individuals and other non-government sectors. Individuals represent 18.6 per cent, health insurance funds 7.6 per cent and other non-government sectors 5.5 per cent. Interestingly the individual (non government) sector in Australia has been growing more rapidly than any other sector which really does make you wonder as to what the targets of a lot of the public programs, and particularly the health insurance programs, are.

What about spending per person by the States and Territories? At \$3562 (in 2001-'02) the ACT's expenditure is a bit above the average of the other States, especially the big States. Compare it with NSW with \$3316, though their respective figures for the previous year (\$3090 and \$3084) shows them about the same.

It's a bit difficult to interpret this and I must hasten to say that in the ACT's case the nominator would simply be the population, so the expenditure on NSW people would get rolled up in that.

You'd expect those figures to be going up across the States and Territories, particularly you'd expect the Northern Territory to be quite high. In fact, it's surprising it's not much higher, though it is the highest at \$3733 per person.

The main thing is how close all those figures are to the national average of \$3397. I think that's the big story. This includes expenditure by all players so Commonwealth, State and private sectors source back to the jurisdiction where it's spent. However, you wouldn't want to swear to the last dollar in any of those numbers, given my estimation process.

So what did the Commonwealth spend its \$25.4 billion on in 2000-'01? Medical services 30.7 per cent, public hospitals (27.3 per cent) and pharmaceuticals (16 per cent) are the big areas. High residential aged care (9.7 per cent), that's what most people call nursing homes, is included in health expenditure, low level residential aged care and community care is not – that's following an OECD convention.

Private hospitals are fairly small in terms of Commonwealth funding with 3.6 per cent of the share and that's the private health insurance rebate share that goes to private hospitals.

How does Australia compare in terms of health spending as a percentage of GDP with other OECD countries? The United States has actually taken off since 2000 and in 2001 had 14.6 per cent, the last figure that's come from the OECD.

And that's occurred during a near recession in the US over that period so the denominators are also important. Australia is in the middle of the pack. Probably now it's right in the average. The low countries are Japan, New Zealand and the United Kingdom, but Australia's pretty much in the OECD pack.

Let's now deal with the important topic of inflation in relation to the cost of health services. Health services tend to rise in cost more quickly than other services.

If you look at general inflation across a select group of OECD countries, excess health inflation is the element of price increase above other countries. In the 10 years to 2001 Australia does quite well with 0.7 per cent excess health inflation, not as well as Canada (0.1 per cent) and France (zero per cent), but traditionally it's done quite well.

You'll find over time if you look at the US, their excess inflation is quite high (1.4 per cent). I wouldn't state this as a firm conclusion, but I think one of the issues around their very high proportion of GDP spent on health is the remuneration to labour, the people who work in the health industry, which I think is way above what it is in other countries, particularly here.

If we look at a time series in Australia of excess health inflation from 1991 to 2001 there's nothing too much in it. The numbers jump around overall – they were 2.2 per cent between 1997-98 and 1998-99 and minus 1.0 in 1999-00 to 2000-01 but by and large the figures on an international scale are not too bad.

At this point I should mention capital. I won't say much about it but this is important. I think the crucial thing here is the total capital investment in the health sector - \$2.84 billion. Remember the total expenditure's \$66 billion so \$2.8 billion is a remarkably low percentage of capital expenditure in the system, that's about 4 per cent of health expenditure.

Look at any other industry, far more is spent on capital. I think the argument about the under-capitalisation of the system in Australia, though probably not as extreme as it might have been a few years ago because there has been some expansion – of course this is cumulative – there is very low level of capital expenditure. When you think about the cost of the equipment in the health system and the increasing technology, the fact that it's all sourced from overseas, these numbers I think are really of great interest and probably I can say of concern.

The next topic is the famous one that gets all the political heat – funding of public non-psychiatric hospital expenditure. Depending on whether you're in the Liberal Party or the Labor Party, in the Federal Government or State and Territory Governments, you've got your own interpretation of this. I must say last year the Prime Minister quoted these sorts of figures with the approval of the Institute which immediately had us checking our numbers because clearly Mr Howard liked them.

I think his point is that the Commonwealth share of public hospital expenditure tends to be above that in the States. To me the main story is how they are lock-step. The shares move around a bit, but over time they've gone very much along together.

Interestingly, if you're familiar with the health care agreement years, you'll see a big leap in the Commonwealth share and a big drop in the State and Territory share in the first year of the second last health care agreement, which coincides with the Liberal premierships of Mr Kennett and Mr Olsen.

Over the period of that agreement things came back up again. Over the next health care agreement the Commonwealth share went up again, but the State share hasn't caught up as much over the period. So there is a bit of a change there, although again I think you've got to be cautious in drawing too much from those numbers.

Meanwhile the non-government share wanders along at a pretty constant figure and probably drops as a share. I've already commented on non-government expenditure so I won't labour it. I normally observe that health insurance, given it's 7 per cent of health expenditure, 24 per cent of non-government expenditure, gets perhaps undue attention in the public debate. I don't know. I will leave that to you to ponder upon.

Let's turn to the subject of drugs - always an interesting topic in health expenditure - specifically the Pharmaceutical Benefits Scheme, which had a total cost \$4.5 billion in 2000-01. In the PBS the government spends most of its money on concessional patients, a much smaller amount on general patients, and the patient contributions are there as well. With the recent changes in co-payments, those shares will probably shift around a little bit, but not too dramatically.

If we look at movement in health expenditure on pharmaceuticals over a period of time, the most recent figures show the very high growth of expenditure both from individuals and from the Australian Government. For example, in 2000-01 spending grew by more than 22 per cent.

Let's now look at a specific socio-economic issue - spending on indigenous people. The crucial number is that for indigenous people about \$1.22 is spent for every dollar spent on non-indigenous people, in spite of their very large health differentials.

State spending is much higher on indigenous people. Commonwealth spending is much lower, despite the fact that they have indigenous specific programs. The share of Medicare, the PBS in particular, going to indigenous people is very low and that's worth considering because I don't think it's just a geographical issue of there not being private doctors in a lot of remote areas.

There also are important cultural issues around the willingness of Aboriginal people to access mainstream services so those numbers are certainly worth contemplating. I think probably as a headline number, the first report we put out showed \$1.08 spent for every dollar spent on non-indigenous people; in 1998-99 it was \$1.22. I don't know what the next one's going to be, but it certainly does focus the mind on the issue.

Before closing I want to talk a bit about what's driving health expenditure. The topic of my talk by the way was to raise the issue of cost containment because we used to hear a lot about cost containment in the health sector. But remarkably in the last few years we haven't heard that term used at all. In fact it's quite the reverse.

Ministers of all persuasions seem to be competing to ladle out more money towards the health system, more rebates to those who insure and so on. So it's interesting that there's been that change in the debate.

So what are some of the drivers of health care demand? It's interesting to speculate about their relative importance. The first one is ageing of the population, though I think it's generally accepted that it's not such a big driver of demand of itself.

The next one is incidence of major diseases. Things like cardio-vascular disease have been dropping at a substantial rate for both sexes. For men, cancer incidence has been dropping, cancer mortality has certainly been dropping. For women cancer rates have reached a plateau.

Hopefully with the decline in smoking the incidence for women will turn down too like the men's. Diabetes on the other hand has been going up substantially, but each of these diseases has a big impact on the demand for health services.

The next one is new technology and its spread. It's probably where ageing does play a confounding role because a lot of the new technologies that are being introduced are aimed at older people and the diseases that older people get. There's been a very high take-up of technology for those diseases, the cardiac surgery and angiography, which illustrate that very well.

When cardiac surgery was introduced 25 years ago old people were essentially excluded from it. Not any more. Though in the UK interestingly they have been dramatically excluded from it. At an OECD seminar I was at a few years ago the UK was referred to as 'that little island off the coast of Europe with the poor health service' because they excluded old people from a whole lot of services that were a lot more widely available elsewhere. Interestingly the place where they are most available to old people is the US because Medicare in the US is essentially a barrier system for people over 65.

In Australia those technologies have spread. You can imagine that those who want to make a few bob out of the health system are going to try to introduce new technologies, be they surgical, implants, drugs, whatever, that are used by old people. If old people are targeted for new technologies that will make the impact of ageing a confounding issue in the health system.

The impact of public health measures is very important here. I've talked about capital outlays. Our accounting systems don't treat public health expenditures as investment, but they are investment of course. We spend about \$1.2 billion (1.7 per cent) of health expenditure of \$66 billion on investment. These are remarkably small levels of investment with remarkably high potential pay-offs in terms of the impact on risk factors, the impact on early diagnosis of disease.

But people who try to argue for these things find it very difficult when waiting lists and all these things get so much of the headlines, even in a rational newspaper like *The Canberra Times*.

Evidence-based medicine, you would hope, would create a downward pressure on demand, that we'll stop doing stupid things, things that don't have a lot of utility to them. We live in hope.

The National Institute of Clinical Services in Australia is I think a good step in the right direction. It's building on an equivalent organisation in the UK, to try to get evidence not only of what works known about publicly, but to make it available at the point of decision making and service.

That could hopefully have a decrease in demand, particularly if the patients can be persuaded to demand that sort of evidence base in what is being done to them. People themselves are able to access better health information through the web and so on, so hopefully people will become more rational in what they demand. On the other hand, they may become more aware of the latest technology even more quickly and demand it to be applied to them. It can cut both ways, but it's certainly a very important influence for change.

My own view on supplier induced demand - the moral hazard issues, the information and balance between providers and patients - is that it is still an important issue. This is so particularly if there is downward pressure on doctor's incomes, which of course there hasn't been in recent years, but the fundamentals of health economics I think can't be wished away.

The determinant of demand is the overall social and economic health of the country, particularly with regard to the inequality within the country. Essentially, though, wealthier countries have healthier people.

Finally I'll deal very quickly with some supply side issues. I've talked about health service inflation already, but labour force has come to the fore in the last few years. We've been doing labour force collections in the Institute since we started. I must say they are a real backwater. That's no disrespect to the guy who ran them, but nobody much was interested in labour force until the last four or five years when that's all changed.

We have a substantial body of data on the medical and nursing labour force because questionnaires are sent to doctors and nurses when they register and we get remarkably good response rates from those professions, for which we are very grateful, so we do know quite a lot about them.

Now I've already mentioned the possible low increase in costs of labour in Australia so I'd like to discuss the relative wage levels in Australia compared to the overall wage levels.

Nurses earn very slightly more than average weekly earnings, doctors earn about twice average weekly earnings. They're not overly well paid. You might be able to afford a BMW if you're a doctor, but it won't be the top of the line. Nurses will probably be more into the Corollas.

So that's an issue. If we don't get that supply side right, the labour force itself is not going to be growing very quickly in future years so the health professions will have to compete for labour. The clear impact on prices, if there is a shortage, you don't have to imagine.

We've now got a policy, at least on doctors, where we're very prepared to import doctors from anywhere without much regard to what happens to the countries we're importing from.

That's turned around dramatically in five years since we brought in the bans on provider numbers for doctors from New Zealand in '96 or '97. They're really important issues. There are very long lead times in training doctors and nurses, particularly doctors, and we really have to get those policies right.

Voluntary labour is also very important. The carer group needs to be nurtured because most of it is in the non-market sector, most of it's provided within families. We need a set of policies and social attitudes importantly that respect voluntary labour. If that goes wrong, the market sector has to fill in more, creating substantial drivers on supply.

Health spending - it's a complex issue and of course it matters very much.