

SELECTED FACTS AND STATISTICS ON AUSTRALIA'S HEALTHCARE SECTOR

**Engaging and empowering
citizens and patients is the
key to better health outcomes**

**THIS PAPER SHOULD BE READ WITH ITS COMPANION PAPER –
USING MICROECONOMIC REFORM TO DELIVER PATIENT-CENTRED
HEALTH CARE**

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The Business Council of Australia paper, *Using Microeconomic Reform to Deliver Patient-Centred Health Care*, argues for using a microeconomic reform perspective to add to the current health reform debate. This companion paper, *Selected Facts and Statistics on Australia's Healthcare Sector*, contains key financial and resource-related facts about the healthcare sector that have been used to support this argument. Both papers were prepared with assistance from Port Jackson Partners Limited.

The Business Council of Australia (BCA) works to achieve economic, social and environmental goals that will benefit Australians now and into the future. Our vision is to help make Australia the best place in the world in which to live, learn, work and do business.

The health of a nation is one of the most critical elements that determine its wellbeing and prosperity. The BCA is calling for action to ensure the health of all Australians is as strong as it can be and that the healthcare system delivers good value for the nation.

Our objectives for health reform are to:

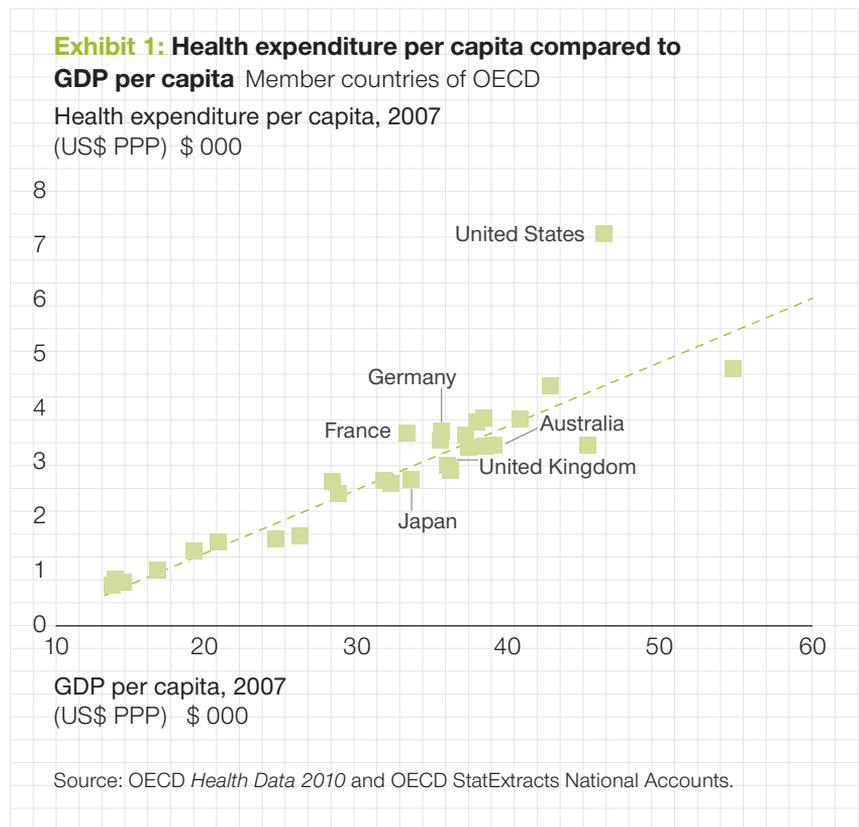
- **Improve the health of all Australians.**
- **Improve the effectiveness, efficiency and patient-centricity of our healthcare sector.**

SECTION 1

THE RELATIONSHIP BETWEEN HEALTH AND THE ECONOMY

The correlation between health, health expenditure and GDP

Health improves as GDP rises; health expenditures rise as GDP rises but faster.



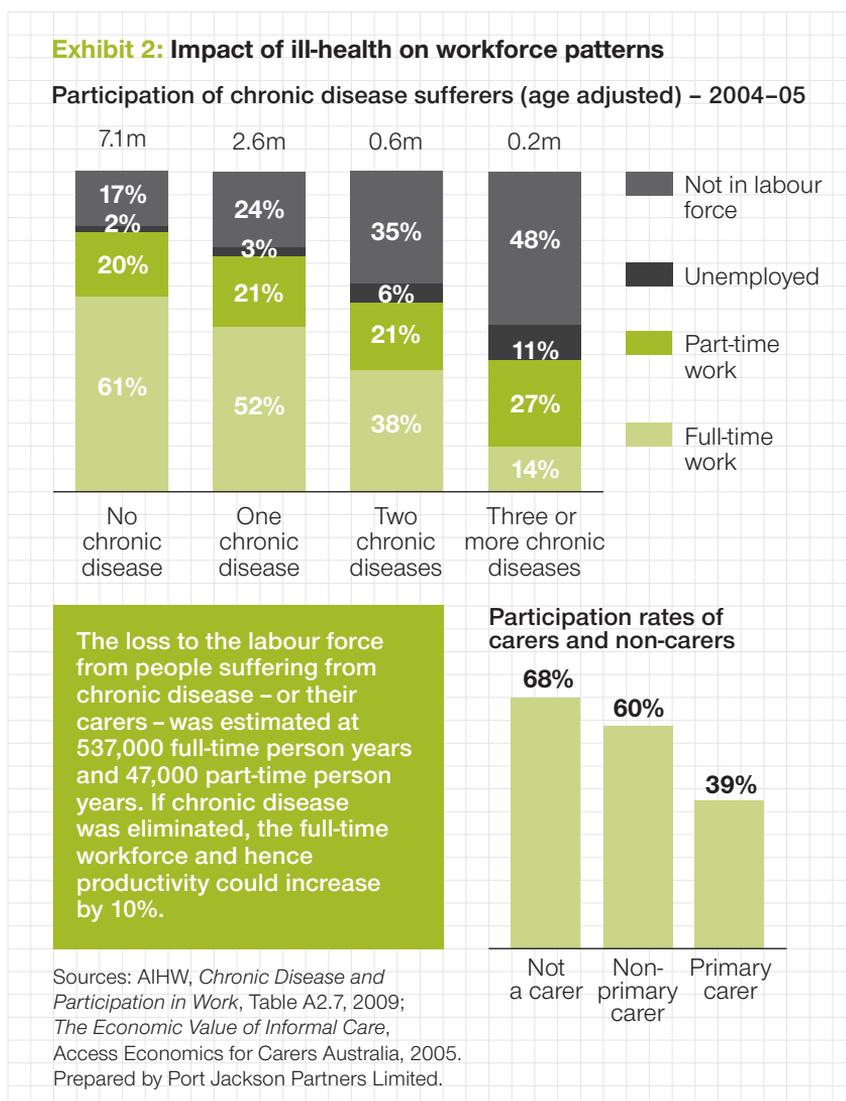
Health, productivity and workforce participation

Health affects participation and productivity.

Absenteeism:
\$7b per annum

Presenteeism:
\$18–25b per annum

Potential increase
in workforce
participation:
+0.6 per cent



Benefits of prevention

The benefits of prevention are potentially significant when about one-third of the current disease burden arises from avoidable behaviours.

Exhibit 3: Estimates available from prevention

Financial benefits available from achieving 'realistic' reductions in disease risk factors in the lifetime of the 2008 Australian adult population.

Financial outcomes	\$ million
Production gains/(losses)	473
Recruitment/training costs	79
Leisure-based production	110
Home-based production	248
Total production	830
Health sector offsets	1,504
Total opportunity cost savings	2,334

Source: Cadilhac et al., 2009.

Exhibit 4: Medibank Private: interventions on reducing obesity

The facts:

- 24.8 per cent of people aged 18 years and over were obese in 2007–08, up 8.4 per cent from 2004–05.
- 4.4 million Australians aged 5+ are obese.
- In 2008–09 an estimated 7,200 deaths could be attributed to obesity.
- Obesity leads to higher risk of mortality from cardiovascular diseases, such as coronary heart disease, stroke, heart failure and peripheral vascular disease, and greater risk of developing Type 2 diabetes, gall bladder disease, osteoporosis, sleep apnoea, and certain kinds of cancer.

Assessing the impact of obesity intervention programs:

Program	Expected benefit/ person(\$)	Expected cost/ person(\$)	Net benefit (cost)(\$)
Lifestyle intervention	2,846	1,081	1,764
Pharmacological	2,174	1,566	608
Bariatric surgery	7,567	10,935	(3,366)

The potential:

Based on current success rates of 11 per cent, if just a quarter of obese Australians undertook a lifestyle intervention it would create a net benefit to the Australian economy of \$1.92 billion through lower direct medical costs and increased productivity.

Source: Medibank Private 2010 Fact Sheet, 'Obesity in Australia: The Financial Impacts and Cost-Benefits of Intervention'.

The healthcare sector is large compared to other sectors**The healthcare sector is 9 per cent of GDP and rising**

Total health expenditure of \$112.8 billion in 2008–09 represented 9 per cent of Australia's GDP and is projected to increase to between 12 and 15 per cent of GDP over the next 30 years, on an unchanged policy basis.

The healthcare and social assistance sector is the largest employing sector in Australia. It employs more than the retail, construction and manufacturing sectors. Healthcare alone is the sixth largest employment sector.

The annual growth alone in health spending of \$9.2 billion from 2007–08 to 2008–09 was about the same as was allocated to economic infrastructure in the May 2009 Commonwealth Budget (\$8.5 billion).

The growth is almost three times the amount to be spent on water buybacks by the Commonwealth Government over 10 years (\$3.1 billion).

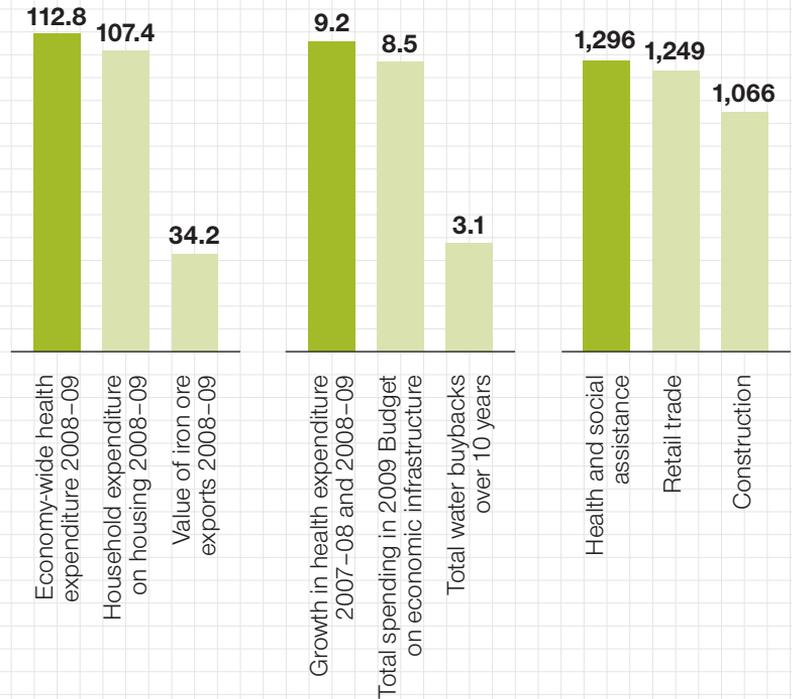
Total health expenditure was almost three times as much as income from iron ore exports in 2008–09 (\$34.2 billion).

Exhibit 5: Putting the health industry in context

Expenditure in context
\$ billion
(2009 dollars)

Expenditure growth in context
\$ billion
(2009 dollars)

2010 workforce in context
Thousand employees
(seasonally adjusted)



Source: Prepared by Port Jackson Partners Limited.

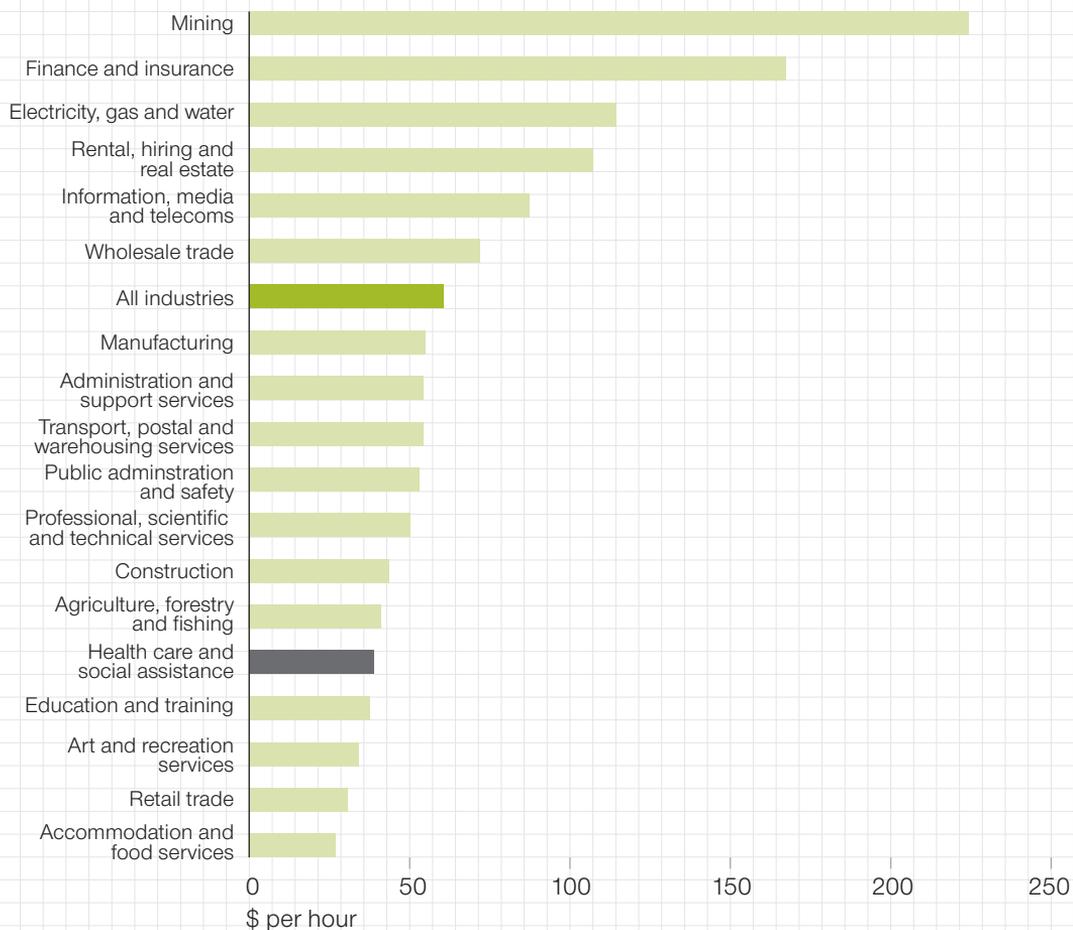
Healthcare sector performance lags behind other sectors

- Productivity in the healthcare sector is low compared with other sectors of the economy, and costs are rising faster than CPI. Yet the sector competes for scarce resources with other sectors of the economy.
- There has been plenty of technological innovation, but it has been applied to procedures and diagnostic tests. The sector typically invests about 1.5 per cent per annum in IT systems compared with 2.5 per cent in other sectors.
- Health expenditure has been growing faster than GDP with a compound annual growth rate of 5.4 per cent in real terms over the last 10 years.
- Nominal costs have been growing at between 9 and 10 per cent. For seven of the 10 years, most of this growth was driven by an increase in volume of health goods and services consumed.
- This compares with 3.2 per cent real growth in GDP over the same period. This expenditure does not include direct spending on aged care or preventative/wellness expenditures by organisations or individuals.

Exhibit 6: Labour productivity by sector

Dollar-value labour productivity estimates can be derived from industry value added and rough estimates of hours worked.

Estimates of the dollar value of output per hour worked, 2008–09

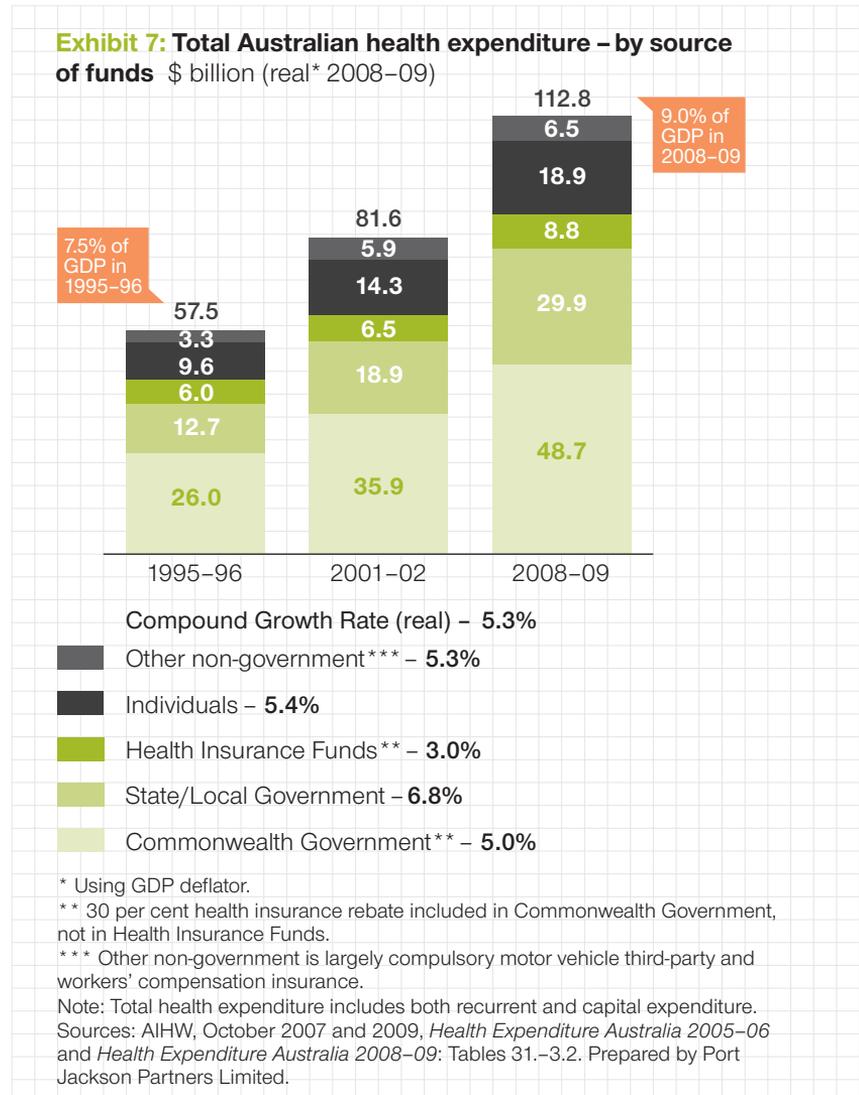


Note: Aggregate hours worked for each sector derived by 'grossing up' estimates of average hours worked in the survey week for the middle month of each quarter in 2008–09. Output is gross value added.

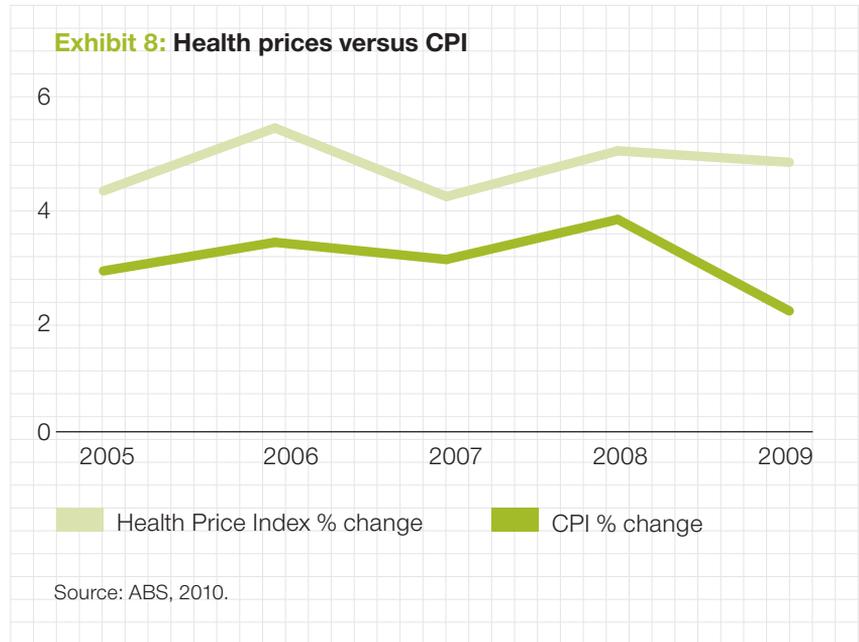
Source: Grattan Institute, 2010.

SECTION 1

THE RELATIONSHIP BETWEEN HEALTH AND THE ECONOMY



Health care is consuming more of GDP by the year and costs are rising faster than CPI

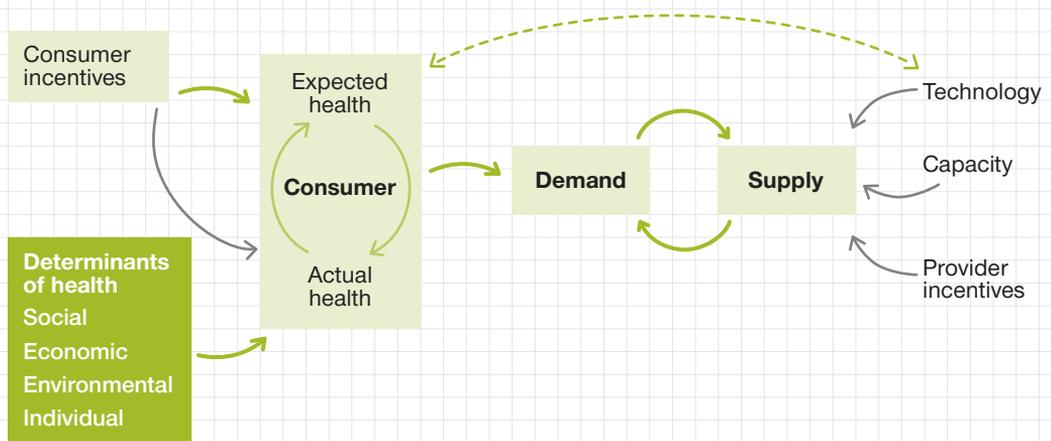


THE MARKET FOR HEALTH CARE

The supply of, and demand for, health care

The supply and demand for health care is a complex interplay of health/illness patterns, and social, economic, environmental and technological variables.

Exhibit 9: A supply–demand model for health care



Source: Adapted from *The McKinsey Quarterly*, September 2008.

Demand is driven by:

- The pattern of illness and long-term conditions in the population. Estimates of future demand can be deduced from patterns and prevalence of risk factors, such as obesity, smoking, risky alcohol consumption, high cholesterol and high blood pressure.
- Expectations of what is possible and normal.
- Wealth.

Supply is a function of:

- The number of health professionals.
- Facilities (including beds).
- Technologies (drugs, equipment and devices).

Supply capacity reflects how these three types of resources are combined in processes.

Market failures in health care

The weaknesses in both health and the healthcare sector identified by the National Health and Hospitals Reform Commission (NHHRC) can be seen as market failures as well as social failings.

Exhibit 10: The causes of failures in healthcare service provision

Observed failure (NHHRC)	Source/cause
<p>1. Lack of adequate response to changing pattern of disease and treatment:</p> <ul style="list-style-type: none"> - inadequate focus on preventative health - uncoordinated patient journeys (i.e. coordination of necessary services) - inappropriate balance, configuration of services 	<p>Incentives for providers and individuals based on old patterns of disease; emphasis on curative health care and episodic fee for activity.</p> <p>Dispersed nature of provision relies on market signals which have been slow to change. Still no widely understood statement of need and strategy; few system connectors.</p> <p>Government investment is in catch-up mode; private sector investment hampered by lack of change to fee rebates.</p>
<p>2. Uneven distribution of health outcomes (linked to inadequate access to services)</p>	<p>Choice of clinician location implicit in private practice; lack of effective incentives for redistribution.</p>
<p>3. Static error rates and continuing quality issues</p>	<p>Greater policy attention to throughput and quantity of demand; lack of outcome data and reluctance to publish; federal structure has divided improvement efforts; continued reliance on self-regulation; lack of patient/citizen focus. Inadequate incentives, penalties for poor outcomes.</p>
<p>4. Costs growing faster than CPI and threatening financial sustainability of the system and creation of two-tier system</p>	<p>Result of previous constraints on supply; rising technology costs and expectations. Few incentives to efficiency. Administrative burden growing with low investment in business systems. Lack of treatment options data – costs and outcomes – for end-users and/or advisers.</p>
<p>5. Growing shortages of health professionals threaten the sustainability of care delivery</p>	<p>Restrictions on training places for many years; rigidity in roles and failure to invest in business systems and communication systems leading to administrative work. High turnover, especially in nursing. Poor morale and workplace stress in public systems leading to greater availability in private system. Reward systems favour specialists.</p>

DEMAND FOR HEALTH CARE

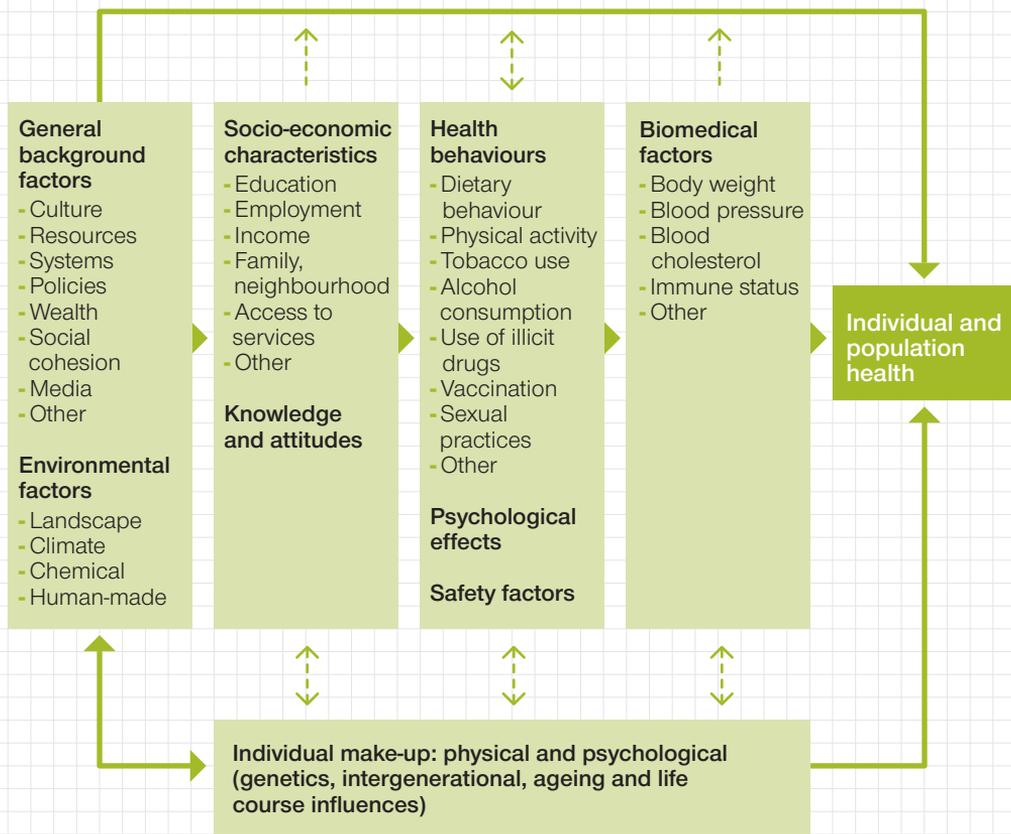
Determinants of health

We know what causes much of chronic disease. This means that we can prevent or predict, detect and diagnose earlier and so intervene earlier.

Roughly 32 per cent of current illness, or disease burden, is attributed to known risk factors or behaviours. The most significant risk behaviours include smoking, excessive alcohol consumption and obesity. The most significant risk factors include high cholesterol and high blood pressure.

Seventy-five per cent of deaths before the age of 75 years are deemed preventable.

Exhibit 11: A conceptual framework for the determinants of health



Source: AIHW, 2010.

Demand is driven by the pattern of illness

Exhibit 12: The pattern of illness and risk

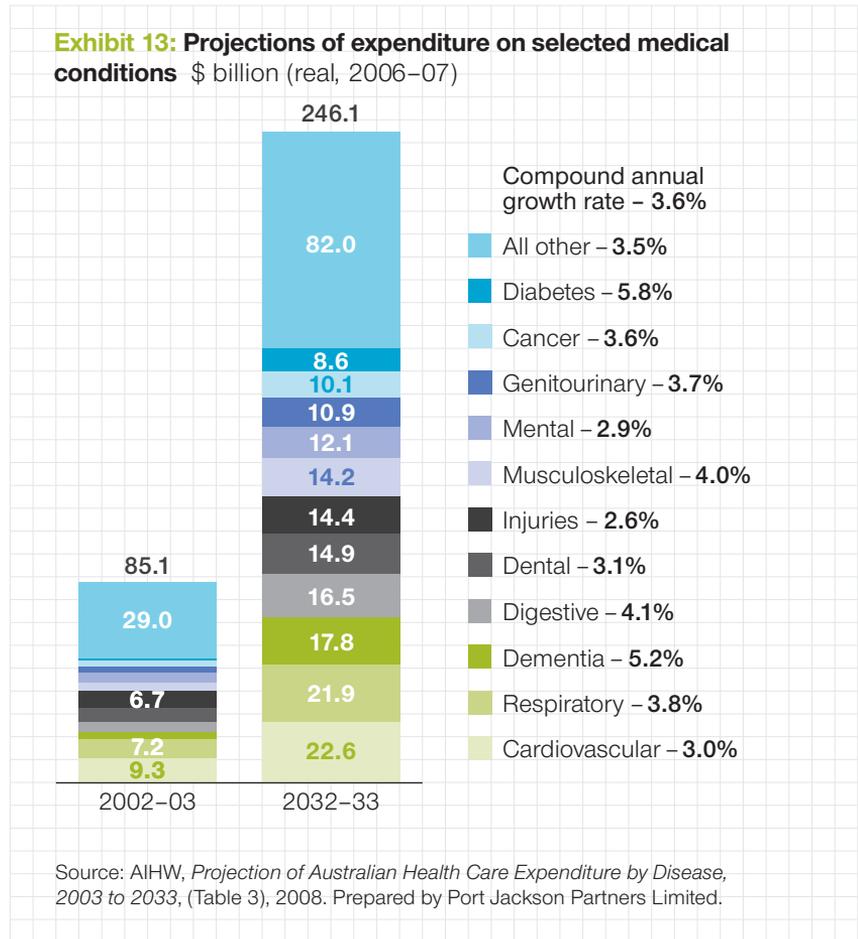
Leading causes of death	<ul style="list-style-type: none">- Coronary disease, strokes and other heart conditions (about 30 per cent)- Cancers: lung, prostate/breast, colorectal (14.9 per cent)- Respiratory diseases- Injury remains highest cause in first half of life- 55 per cent of premature deaths in males and 60 per cent in females
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Leading causes of illness	<ul style="list-style-type: none">- Cancers: 19 per cent- Cardiovascular: 17 per cent- Mental illness: 13 per cent- Neurological and sensory: 12 per cent- Chronic respiratory: 7 per cent- Injuries (road, work, home) around 7 per cent
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Source: AIHW, 2010.

Where does the money go?

- Chronic disease accounts for 70 per cent of total healthcare expenditure and affects all age groups. Two examples:
 - Respiratory diseases are the second highest driver of health spending. More than 20 per cent of Australian children under the age of 16 have been diagnosed with asthma.
 - Alzheimer's disease affects older people and is projected to grow by 50 per cent between 2003 and 2023. (PwC Health Research Institute, 2010).
- In 2005, 77 per cent of Australians were reported as having at least one long-term condition.
- Eight major disease groups are predicted to make up 50 per cent of future healthcare costs.
- Diabetes and dementia are projected to have the highest rates of growth in expenditure, at 5.9 per cent and 5.8 per cent respectively.



Consumers pay, but their contribution varies by service

- Analysis of the co-payments currently made by health consumers shows high variability between the extent of payment and the service.
- Out-of-pocket expenditure per person (A\$889) is higher than the weighted average expenditure for OECD countries (A\$860) and as a proportion of total health expenditure (17.7 per cent compared with 14.4 per cent). As a share of household consumption, Australians' health expenditure has increased from 2.3 per cent to 2.8 per cent, although this proportion was and is the OECD average. Australian governments' share of health expenditure (67 per cent) continues to be below the OECD average of 75 per cent.
- In 2010, Medicare fee observance was 78.5 per cent and the bulk billing rate was at 74.3 per cent (source: Medicare Statistics).
- Consumers pay 97 cents in every dollar for non-prescribed medicines. Expenditure in total on complementary medicines is estimated at \$3 billion per annum.
- Eight per cent of Australians are members of gyms or fitness centres.
- Forty-five per cent of Australians have private health insurance.
- The ABS Patient Experience Survey shows that cost is a barrier to some in accessing required services.

Exhibit 14: The contribution of individual consumers to the cost of their health care

Area of expenditure	Individual payments \$m	Total payments \$m	Individual payments as % of total
Non-PBS/RPBS medications	4,036	4,216	97
Aids and appliances	2,072	2,787	74.3
Dental	3,573	5,337	66.9
Other health practitioners	1,653	3,035	54.5
RBS/RPBS medications	1,240	7,286	17
Medical services	1,745	15,499	11.3

Source: Doggett, 2009, citing AIHW, *Australia's Health 2008*.

What consumers want from their health system

While the disease pattern shapes the type of services required, consumer preferences about the price, quality and service attributes of healthcare services are less well understood. A consumer survey undertaken in seven countries showed that individual preferences for 15 different healthcare system attributes vary markedly by age and gender.

Respondents aged 50 years and older valued high-quality and personal attention, whereas younger people valued low-cost services, health education and wellness.

Women desired good access and low-cost health care, whereas men sought high-quality and personal attention.

As a result, many healthcare systems are experimenting with segmentation of consumers by health status or disease group.

Source: PwC Health Research Institute, 2010.

There has been relatively little segmentation of market research on what citizens want from their healthcare system.

Part of the transformation of the system will involve getting more detailed understanding of what matters 'beyond the headlines'.

Patient experience surveys are giving clues to what is important once citizens are within the system.

Consumer engagement in health reform is limited

Consumer engagement in health reform

Not only are consumer preferences not well understood, the process for engagement of health consumers is also lacking.

Exhibit 15: Consumer engagement: emerging key themes

- Consumer engagement in Australian health policy is poorly understood, inconsistently practised and under-theorised.
- Consumer engagement is poorly defined.
- Consumer engagement is a mindset, not a technique.
- Consumer engagement requires organisational commitment and a high-level champion.
- Consumer engagement is an ongoing process, not a fixed-time event.
- Consumers need to be confident that their input will be valued and considered.
- Consumers usually need background information to contribute at the policy level.

Source: Gregory, 2008.

THE SUPPLY OF HEALTH CARE: FINANCE, PEOPLE AND SYSTEMS

Finance: who pays what?

Australia's dual public and private health sector is unique, balancing government-provided universal health care with individual choice in health care.

However, the large number of payer types for each service leads to fragmentation and complexity. This makes navigation around the system harder for patients, communication between providers more unwieldy, and drives higher administrative costs.

Governments directly fund almost 70 per cent of the nation's healthcare bill. Health has represented the largest increase in total government expenses (state and Commonwealth) over the last nine years. State government contributions were the fastest-growing component of health expenditure, followed by individual payments.

The Commonwealth funds 43 per cent (\$48.7 billion) – the largest component. This proportion has remained fairly consistent through time and represents 16 per cent of overall budget expenditures. The Medicare Levy raises 16 per cent (\$8 billion) of this amount.

State governments contribute an additional 26 per cent of health expenditure, which has until recently represented a growing proportion.

Individual payments make up about 17 per cent of spending on health.

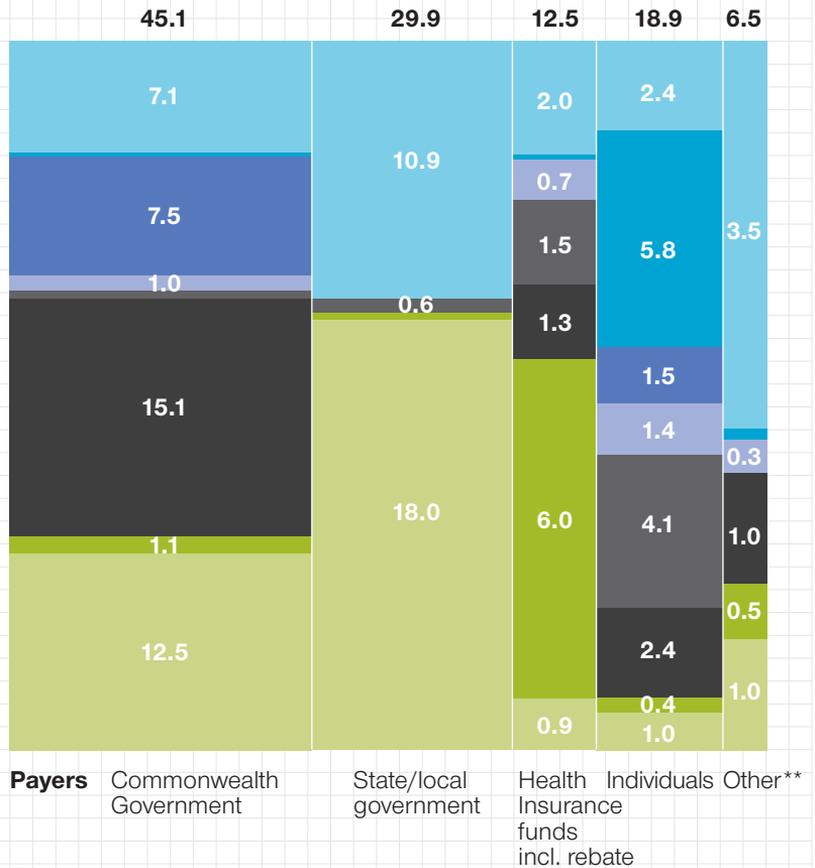
Total spending by payers = \$112.8b

Total spending by Commonwealth = \$45.1b

Commonwealth Government spent \$15.1b on medical services

Total spent on public hospitals by all payers = \$33.4b

Exhibit 16: Australia's total health expenditure by payer and service – 2008–09 \$ billion



Services

- Public hospitals – \$33.4b
- Private hospitals – \$8.4b
- Medical services – \$19.8b
- Dental – \$6.7b
- Other health practitioners – \$3.4b
- PBS pharmaceuticals – \$8.9b
- Other pharmaceuticals – \$6.3b
- Other* – \$25.9b

*Other services include community health, aids and appliances, capital expenditure, public health, research, administration and transport.

**Other payers are largely compulsory motor vehicle third-party and workers' compensation insurance.

Source: AIHW, *Health Expenditure Australia 2008–09*, Table A3. Prepared by Port Jackson Partners Limited.

SECTION 4

THE SUPPLY OF HEALTH CARE: FINANCE, PEOPLE AND SYSTEMS

People: The health workforce

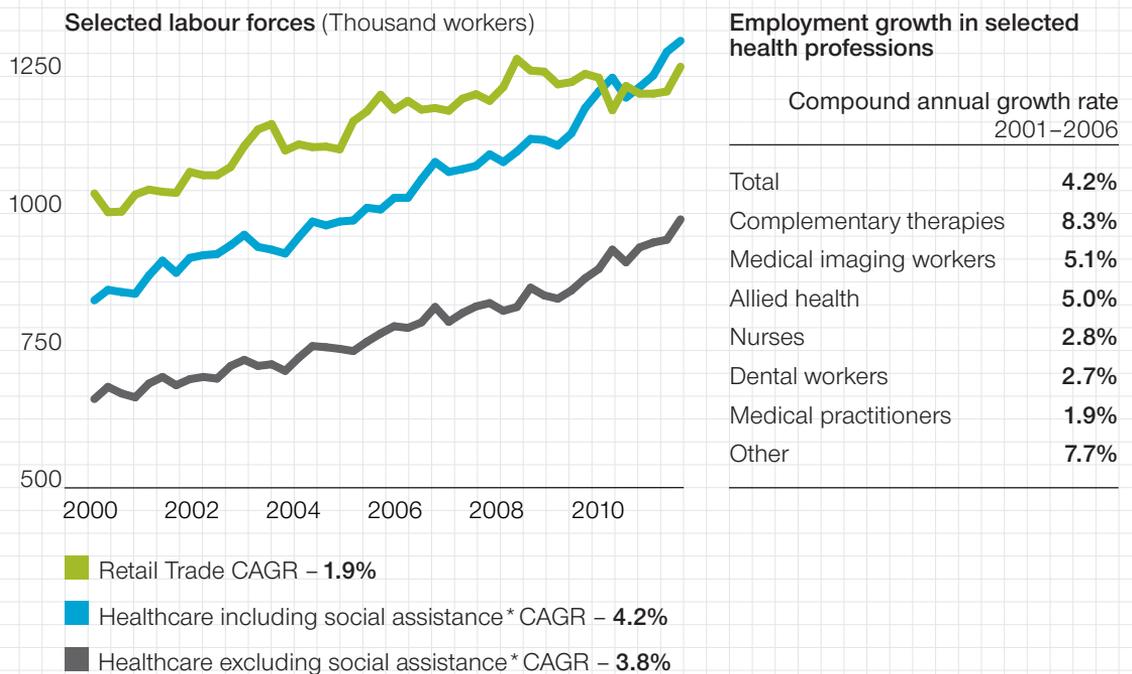
As a knowledge- and labour-intensive sector, the healthcare sector's largest expense is wages and fees. The sector employed 1.3 million people as at December 2010, representing 11.4 per cent of the overall workforce. We supplement Australian professionals with immigrants.

The National Health and Hospitals Reform Commission estimated that without changes to existing models of care, the healthcare sector will need to employ 20 per cent of the overall workforce.

Despite the growth, health professional shortages are projected, particularly in some areas.

Comparative data shows Australia has slightly fewer practising physicians per thousand population than the OECD average and about average for nurses per thousand population.

Exhibit 17: Australia's health labour force



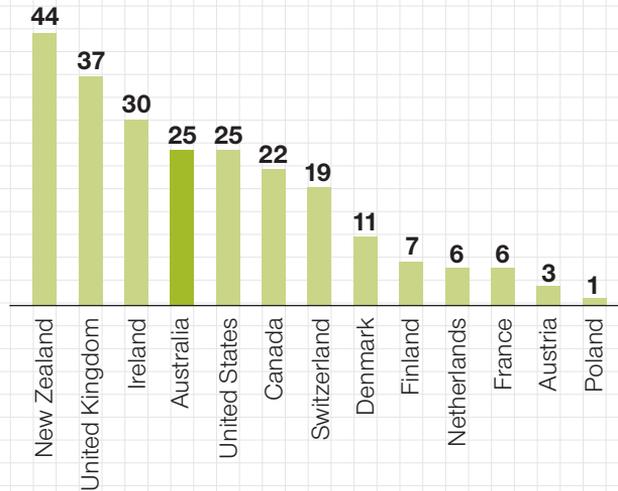
* Includes residential care services

Source: AIHW, Labour Force – Health: <http://www.aihw.gov.au/labourforce/health.cfm> and ABS. Prepared by Port Jackson Partners Limited.

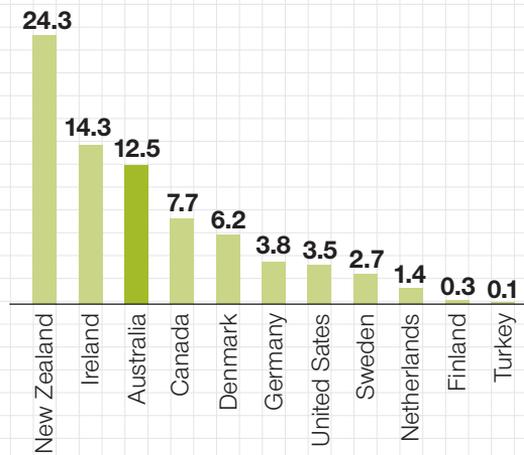
Exhibit 18: Foreign-trained clinicians are common

% of clinicians in each country who were trained in another country

Doctors



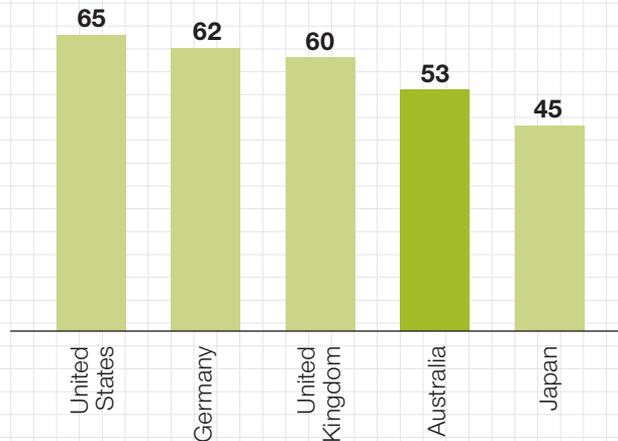
Nurses



Source: *The McKinsey Quarterly*, December 2009.

Exhibit 19: Clinical workforce spending as a percentage of all healthcare spending

In most developed countries, the clinical workforce is by far the largest expense for the health system.

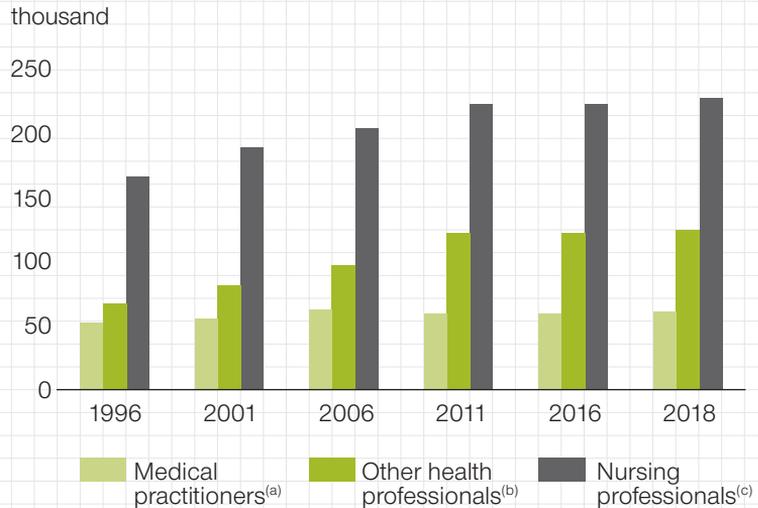


Source: *The McKinsey Quarterly*, December 2009.

Several factors affect the future supply of health professionals. They include:

- The lag between commencement of training, graduation and subsequent practice. Recent increases in university places have not been matched by adequate clinical placements.
- Reduced hours per person: increased numbers of trained professionals are not translating into increases in available working hours, because of ageing of the medical workforce and more women, juggling work and family commitments. This has meant fewer available for after-hours service.
- High turnover and burnout, particularly in nursing. Some 40,000 trained nurses are not working as nurses. Programs to attract trained nurses back to the workforce have been relatively unsuccessful.
- International competition for health professionals.
- Informal carer workforce: this invisible workforce that supports key parts of our healthcare system, including aged care and disability services, is one that is often taken for granted by policymakers. However, studies clearly show (e.g. the Productivity Commission Inquiry into Aged Care), that such an assumption cannot be relied upon as the carer 'workforce' ages or faces pressures to (re-)enter the paid workforce.

Exhibit 20: Number of Australians employed in health workforce occupations, 1996–2018



Source: Access Economics, 2007 (unpublished data).

Note: Access Economics developed the forecasts using a complex model which models changes in components of investment and consumption in relation to employment. It takes into account things such as exports/imports, public investment, private consumption, and government spending consumption. For example, an increase in spending on the construction of housing will lead to a surge in the number of construction jobs.

Note: Definitions for health workforce occupations (the reference numbers refer to category reference number assigned by the Australian Bureau of Statistics):

(a) **Medical practitioners** include: Specialist Medical Practitioners (2312) and Generalist Medical Practitioners (2311).

(b) **Other health professionals** include: Dental Practitioners (2381), Pharmacists (2382), Occupational Therapists (2383), Optometrists (2384), Physiotherapists (2385), Speech Pathologists (2386), Chiropractors and Osteopaths (2387), Podiatrists (2388), Medical Imaging Professionals (2391), Veterinarians (2392), Dieticians (2393), Natural Therapy Professionals (2399), Other Health Professionals (2399).

(c) **Nursing professionals** include: Nurse Managers (2321), Nurse Educators and Researchers (2322), Registered Nurses (2323), Registered Midwives (2324), Registered Mental Health Nurses (2325) and Registered Developmental Disability Nurses (2326).

Source: National Health Workforce Taskforce, April 2009, Figure 3.3.

**Investments in system connectivity
and business systems has been relatively
low compared with other sectors**

Systems: Investment in ICT

Investment in information technology and communication systems in the healthcare system has typically been lower (1.5 per cent of revenue) than in other sectors (2.5 per cent). According to the Productivity Commission, the spread of these systems has been linked to increased productivity.

Electronic collection, storage and sharing are seen as critical in streamlining patient 'journeys' and improving quality and safety.

Without investment in national infrastructure to support e-health, investment is likely to continue to be less than optimum.

Exhibit 21: Benefits and costs of a national e-health system

A number of studies have estimated the potential costs and benefits of introducing a national e-health system:

- The estimated costs of e-health investment are \$6.3 billion over five years, which is around one per cent of total health expenditure over the period.
- Potential benefits could be \$27.8 billion over the first eight years.
- Implementation of the national e-health record system could allow an increase of 4.8 to 6 per cent in real output from the hospital and medical services sector, and could provide an increase of \$7.5 to \$8.7 billion in GDP by 2019.
- Investment in an integrated national e-health record system could increase the net present value of GDP by \$6 billion to \$13 billion over 10 years and create 12,000 new jobs.

Source: Booz & Company, October 2008.

Capital facilities: Health care can be capital-intensive

Hospital bed numbers have declined over the past 20 years and are slightly below the OECD average.

- Rising demand has been met through higher occupancy rates (85 per cent plus), the trend to day surgeries (now 50 per cent plus) and shorter stays (down from an average stay of 4.1 days to 3.3 days over 10 years to 2006).
- Demand is higher than necessary because of lack of investment in sub-acute and high care residential aged care places and because of the failure to treat conditions earlier.
- Approximately 10 per cent of hospital admissions could be prevented.
- Capacity could be increased through improved management of flows of patients (e.g. the Victorian Auditor-General suggests that 10 per cent more capacity could be achieved through better management).
- Australia's hospitalisation rates are relatively high by OECD standards.
- The private sector treats 40 per cent of all patients, provides 33 per cent of all hospital beds and undertakes 64 per cent of all elective surgeries.
- Rates of investment in diagnostic technology, based on Medicare eligibility, suggests Australia has a lower than average rate of CT and MRI investment than the OECD average.

Sources: OECD, 2010; Sammut, 2009; AIHW, 2010.

Structure of the healthcare sector

The structure of the healthcare sector is generally categorised by purpose and setting of care: primary, secondary, acute, sub-acute and community. It also spans for-profit, not-for-profit and public sectors.

Exhibit 22: Key facts about the structure of the health sector

	Suppliers/Providers	Payers/Buyers
Public hospitals	<ul style="list-style-type: none"> - 756 public hospitals provided by the states and area/regional health services - 72 per cent of public hospitals have fewer than 50 beds 	<ul style="list-style-type: none"> - Paid for by state and Commonwealth governments
Private hospitals	<ul style="list-style-type: none"> - 561 private hospitals including 285 day hospitals - Consists of a small number of large chains, and a large number of often not-for-profit individual hospitals 	<ul style="list-style-type: none"> - Private hospital services largely bought by private health insurers and individuals - Private health insurance industry continuing to consolidate
Medical services	<ul style="list-style-type: none"> - Largely provided by private medical practitioners, including approximately 24,000 GPs and approximately 22,000 specialists, generally operating as sole traders or in small groups. Twenty per cent of GP practices have <2 FTEs and 43 per cent have 2 to 5 FTEs. However, the trend is to larger (10+ GPs) practices with 20 per cent of all practices. At the same time, there has been a significant reduction in the number offering after-hours care (from 46 per cent to 29 per cent). - Concentrated pathology sector, with three national private firms doing 80 per cent of community pathology - Radiology is also highly concentrated, with three companies accounting for about 70 per cent of the market. 	<ul style="list-style-type: none"> - Commonwealth Government is primary payer and approximately 73 per cent of medical services are bulk-billed

Exhibit 22: Key facts about the structure of the health sector (continued)

	Suppliers/Providers	Payers/Buyers
Dental	<ul style="list-style-type: none">- Approximately 10,000 practising dentists, 83 per cent working in the private sector	<ul style="list-style-type: none">- Purchased by individuals and private health insurers
Allied health	<ul style="list-style-type: none">- 65,000 allied health workers, largely in private practice	<ul style="list-style-type: none">- Purchased largely by individuals and private health insurers
PBS pharmaceuticals	<ul style="list-style-type: none">- Concentrated pharmaceutical supplier base of large, mainly multinational firms- Pharmacy ownership is highly regulated and therefore very fragmented	<ul style="list-style-type: none">- Commonwealth Government is sole purchaser of PBS pharmaceuticals

Source: Prepared by Port Jackson Partners Limited using AIHW (2010).

There are several features to note about the healthcare sector that are distinctive:

- **Dominance of providers:** Providers are numerous, dispersed but well represented in negotiations with government funders and individual institutions. Because consumers view health care as a critical service, the political importance of health is high, adding to provider power.
- **Most of the health workforce is not employed directly by government,** even though health care is perceived as both a responsibility of government and a government service. This means that the levers of policy for government are necessarily indirect; for example, access to fee schedules; license to operate; provision of training and clinical places; regulation.
- **The service providers range in size from very large to very small and many service providers are effectively small businesses.** This affects the capacity and desire to invest in new technologies and business systems, although this has been redressed through incentive payments in some segments.
- **Entry into key markets (labour and products) is made difficult by high barriers to entry (funding/fee schedules; accreditation and extent of specialisation of these; availability of subsidised university and clinical training places for all key health professionals; or for pharmaceutical companies, high R&D costs).**
- **Substitutes are rare because of regulatory structures and the Medicare rebate schedule but there is a growing alternative healthcare sector.**
- **Citizens and health consumers (22 million) are numerous but not well represented except through governments.** They are only indirectly involved in many purchasing decisions as a result of the mandated referral system and the asymmetry of information that flows from low levels of health literacy and a lack of publicly available outcomes data. As a result it is difficult for them to form judgements about options or overall system performance.

-
- All funders also face inadequate information on quality, price and availability of healthcare services; government as single buyer exerts large market pressure but with lagged and inconsistent data. The flow of funding by the dominant payers – governments – to providers directly means that there is greater focus on that interaction than on the end-user.
 - The sources of capital for new facilities and technology are either budget-limited or private. The latter can mean that all the benefits of new technologies are captured by investors, due to the way in which payments flow and because of the lack of caps on out-of-pocket expenses. Regulatory uncertainty arises from the dependence on government as major funder.
 - Notwithstanding that service provision spans the for-profit, not-for-profit and public sectors, there are no overarching system institutions that oversee market performance in the way in which other sectors are overseen. Instead, oversight is undertaken through a myriad of governmental and professional bodies that are responsible for various aspects of the system.
 - System management is also limited. The lack of a clear national health strategy as the basis of a national purchasing system has meant that market-shaping behaviours have been disjointed and often contradictory. The dispersed nature of service providers means that there is limited, inconsistent and untimely data on the extent to which health needs are being met.
 - There is little electronic connectivity within the sector, despite the 90 per cent take-up of computerisation within some segments of providers. The current e-health strategy seeks to establish unique identifiers, standard definitions and interoperability protocols.
 - Competition/reward is focused on number of episodes/procedures.

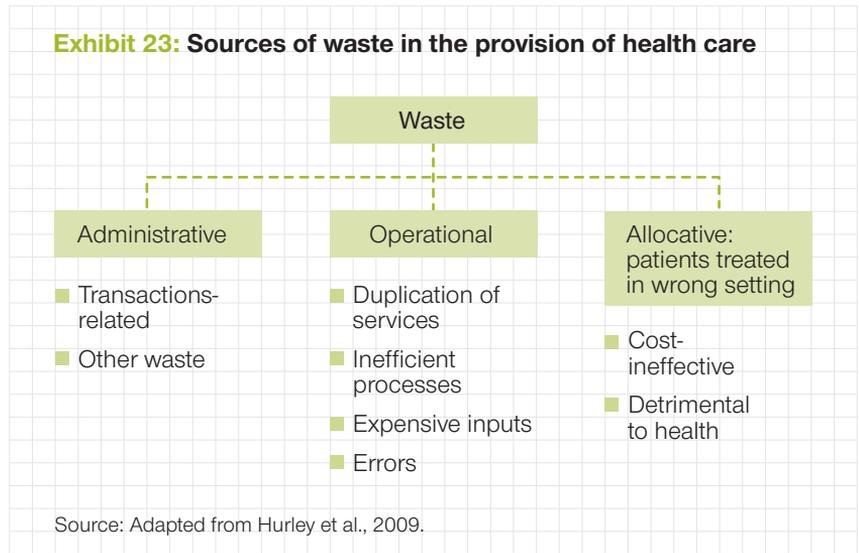
Scope for efficiency gains in the healthcare sector

Despite OECD data showing that Australia achieves relatively good value for its health dollar in comparison with other health systems, several national studies have identified potential efficiency gains of up to 20 per cent in the healthcare sector.

These gains are across all sub-sectors of the sector – hospitals, primary and residential care – and would derive from less duplication; improved business and communication systems; improved clinical process design; economies of scale and reduced errors. The diagram shows that efficiency could be improved through all facets of operation. However, blunt budget reductions will not necessarily deliver efficiency improvements. These will come from ensuring that institutions have the flexibility and capability to redesign processes and take advantage of new technologies.

The Productivity Commission's reviews of the relative efficiency of private and public hospitals suggest that there is a 25 per cent variation in costs between the best- and worst-performing hospitals.

Exhibit 23: Sources of waste in the provision of health care



Finally, while OECD data suggests that Australia's administrative costs are relatively low, we have found it difficult to substantiate this, as much of the administrative cost is allocated to programs. A clearer picture is provided by headcount.

FUTURE TRENDS THAT WILL RESHAPE HEALTH CARE

The healthcare sector is a knowledge-intensive sector and the way in which that knowledge has been generated, stored, shared and used has shaped the way in which it has been structured. However, three major trends are poised to transform health care and the structure of the sector:

- the growing dominance of chronic disease
- digitisation
- the increasing acceptance of the genetic, social, environmental and economic determinants of health.

Source: PwC Health Research Institute, 2010.

Together they will enable personalised and mobile health management. The more that is understood about the causes and courses of chronic disease, the more that can be done to prevent it, detect and manage it earlier. Increasingly, this will be done in community settings, enabled through mobile communication and monitoring devices and with the patient responsible for day-to-day management of routine care, supported by a team of professionals. This does not mean that the need for acute services disappears – it does not. But it does mean the evolution of many more community-based or remote care services. The regulatory framework must enable such adaptation.

‘Technology is leading health care into a new era of mass customisation, following other industries such as auto manufacturing, media and entertainment.’ – PwC Health Research Institute, 2010

The process of health care: knowledge, judgement and procurement

The core resource of health care – knowledge, mediated by professional judgement and experience – is subject to enormous advances. Current healthcare services reflect not only past patterns of disease and treatment, but also the way in which knowledge has been generated, stored and applied. Digitisation and the development of new communication technologies, including the smart phone, electronic medical records and home health monitoring, will facilitate changes to the way in which information flows and the settings in which treatment can be managed. This combined with rising expectations about what, how and when health care can be delivered will drive the evolution of new business models and patterns of service delivery.

The core process of health care is procurement – the procurement of additional specialist advice and/or treatment; of residential and nursing care; of supplies; or drugs and access to diagnostic and monitoring services. As technology changes so too do the patterns and nature of procurements.

The increasingly accurate identification of individuals at risk, early detection, treatment and management of illnesses will mean that different patterns of illness and wellness will prevail, enabling and requiring changed patterns of healthcare services.

Translating new knowledge and technologies into improved health and health care involves considerable challenges. For example, the sheer logistical difficulty of health professionals keeping abreast of fast-changing bodies of knowledge and their translation into best practice treatments is vast, as the frequently observed gap between best and actual practice attests.

‘The sad fact is that science has far outstripped the ability of delivery organisations to apply it. Most are not configured to rapidly disseminate and use new knowledge. This is ... why care known to be beneficial is not consistently administered, care of uncertain value is overprescribed and avoidable harm abounds.’ – Bohmer, April 2010

Health organisations worldwide are seeking to build synthesising knowledge management and decision support systems for health professionals and in many cases, instituting treatment protocols as a basis for standardising practice. The value of these is evident from the improved outcomes reported.

Sources: PwC Health Research Institute, 2010; Bohmer, April 2010.

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