The australian health care system

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Australia is a highlydeveloped countryand one of the wealthiest in the world, with theworld’s 12th-largest economy, the population is 21 million and the life expectancy in Australia in 2010 was 79. 5 years for males and 84. 0 years for females [1] , total expenditure on health (including private sector spending) is around 9. 8% of GDP [2] . Health care in Australia is provided by private and government, the current health care system known asMedicare, was established in 1984. It coexists with a private health system; Medicare is funded partly by a 1. 5%income tax(with exceptions for low-income earners). An additional tax of 1% is imposed on high-income earners without privatehealth insurance. As well as Medicare, there is a separatePharmaceutical Benefits Schemethat considerably subsidies a range of prescription medications.

In 2005-06 Australia had about 1 doctor per 322 people and 1 hospital bed per 244 people [5] . And the life expectancyis among the highest in the world, which in 2013Global burden of diseasestudy Australia was ranked 3rd highest in life expectancy [7] . The leading causes of death in Australia in 2011 wereischaemic heart disease, cerebrovascular disease, dementia, alzheimer disease, bronchus andlung cancersandchronic obstructive pulmonary disease [6] .

The Australian Government is improving primary health care by establishingMedicare Locals, building over 60GP Super Clinics; increasing access to afterhours services through the availability of theafter hours GP helplineand by tasking Medicare Locals with a range ofafter hours primary

care responsibilities; and funding approximately 425primary care infrastructure upgradesto general practices, primary care and community health services, and Aboriginal Medical Services to improve access to integrated GP and primary health care. In February 2011, the Australian Government released the publicationImproving Primary Health Care for All Australians.

The reforms of the health system in Australia are prepared for many points, since August 2011, the Australian government signed the National Health Reform Agreement; this agreement led to a new change in government policy about funding the new health system, and this will result in a new financial problem for the government because they have to support the hospitals and all health care services by money to meet the needs of people for health services. The funding plan was called ‘’Activity based funding ‘’ it will give motivations for hospitals to treat the patients more efficiently, and funding the public hospitals will be based on the services and effectiveness that provided by each hospital , and this will determined by Independent Hospital Pricing Authority (IHPA) .

The Classifications begun in 1980s, and the first classification system was used in Australia is the Australian National Diagnosis Related Groups (AN-DRGs) which released in 1992. In 2008 the Council of Australian Government (COAG) agreed to change the funding of public hospital to ABF (Activity based funding) . In 2011, COAG agreed to the establishment of IHPA as a national agency to develop and maintain the classification systems. IHPA develops cost and pricing models that explain the expenditure of Local Hospital Networks nationally, to determine the National Efficient Price (NEP),

IHPA first develops a cost model based on cost and activity data from three years before. IHPA converts the cost model to a pricing model. This is developed by removing the out-of-scope costs and indexing the costs to best reflect costs in the year of the NEP. Price weights and adjustments are combined to define the National Weighted Activity Unit (NWAU).

The NWAU is a measure of activity expressed as a common unit, against which the NEP is paid. It is a point of relativity for pricing of hospital services, which are weighted for clinical complexity. The price of a hospital service can then be defined by multiplying the NEP (which is a reference cost) by the number of NWAU. The NWAU allows comparison between hospital activities; the pricing model ensures a good access to public hospital services, quality, efficiency and effectiveness.

Costing plays a main role in the ABF process. Hospital patient costing is the process of identifying the inputs used in a hospital and applying the costs of those inputs to the delivery of patient care (outputs) by the various categories, costing requires a wide range of skills in identifying inputs and outputs. To help with the costing process IHPA works with stakeholders to develop and implement theNational Costing Standards for Australian Hospitals.

IHPA is focused on improving data quality wherever possible to ensure that the NEP and NEC are robust, transparent and as accurate as possible. IHPA aims to improve the collection each round and has recently undertaken significant improvements in standards, the collection structure and the validation and reporting tools. IHPA has also recently completed a Strategic

Review of the NHCDC (National Hospital Cost Data Collection) which provided 20 key deliverables to guide IHPA in improving the processes, transparency and the quality of the collection into future years.

Classification systems enable clinical information to be converted into data. The rules for gathering information and clinical data need to be the same across Australia to ensure that all providing information the same way. IHPA uses the classification systems to determine the amount of funding a hospital requires providing treatments and care to calculate the national efficient price, all the classifications for patient service categories have specific name. The main role of IHPA is to update the classifications or introduce new classifications and it will develop and specify the national classifications to be used to classify activity in public hospitals for the purposes of ABF in the following categories:

- Admitted acute care
- Emergency care
- Non-admitted care
- Sub-acute care

In the Admitted acute care a different price is paid for each patient class and that price depends on what each patient class typically costs, it measuring the productivity of the components of hospital care, while in the Emergency care a wide range of facilities and providers from general practices, ambulance services, through to Emergency Departments (EDs). The Government is investing $750 million to improve performance in public hospital Emergency Departments (EDs), 90% of all patients presenting to a

public hospital ED will either physically leave the ED for admission to hospital or transferred to another hospital for treatment. This is to be completed by 2015 [4] . The third category is Non-admitted care which provided to patients who do not undergo a formal admission process and do not occupy a hospital bed, and the last one is Sub-acute care which the primary need for care is optimization of the patient's functioning and quality of life.

Sub-acute care includes the following care types:

- Rehabilitation care
- Palliative care
- Geriatric evaluation and management care
- Psycho-geriatric care

Non-acute care includes the following care type:

- Maintenance care

Many older Australians are unable to access sub-acute care services in their community, but Sub-acute care can play an important role in improving health outcomes for many patients. Under National Health Reform, the Australian Government will provide $1. 6 billion in funding for the state and territory governments to operate 1, 316 new sub-acute care beds nationally by 2013-2014 [4] . This will improve access to sub-acute care for patients in need, and reduce the pressure on public hospitals.

The Australian healthcare system is the site of one the nation's most intense battles against inequality, rural communities continue to struggle with a lack of access to quality healthcare services as compared to Australia's urban communities, leaving them marginalized by comparatively poorer health

outcomes. Health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of environmental factors, including macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors. Gross health inequities have been certified between developed, transitional and developing countries across a range of health indicators.

The measure of inequality most commonly used is the Gini coefficient, which varies between zero (when all households have exactly the same income) and one (when one household has all the income) Preferred because it’s calculated for everyone in the population.

In 2003 the Gini coefficient for Australia was 0. 301 to 1, health inequalities are most marked between Indigenous and non-Indigenous Australians. Aboriginal men and women have a life expectancy that is 17 years lower than the national average (3) .

Tax and transfer systems play a key role in lowering overall income inequality; the redistributive impact of cash transfers varies widely across countries, reflecting both the size and progressivity of these transfers. In Australia cash transfers are small in size but highly targeted on those in need. Of the various types of taxes, the personal income tax tends to be progressive, while social security contributions, consumption taxes and real estate taxes tend to be regressive. In addition, removing other tax reliefs such as reduced taxation of capital gains from the sale of a principal or

secondary residence, stock options and carried interest would increase equity and allow a growth-enhancing cut in marginal labor income tax rates. It would also reduce tax avoidance instruments for top-income earners.

I think one of the best ways to reduce inequality is to reduce poverty and social inequity, including by addressing social determinants of health, policy responses in the areas of income, welfare, employment, education, housing, infrastructure, transport, and environmental sustainability.

The Australian Government promotes the sustainability of private health insurance and support consumer choice in health care. The Government is committed to ensuring that Australians have access to private health insurance through a viable and cost-effective private health industry. With incentives such as the Australian Government rebate on private health insurance, a fair and equitable reimbursement framework for surgically implanted prostheses, the Medicare levy surcharge and Lifetime Health Cover, the Government will continue to encourage and support individuals and families to purchase private health insurance. The Australian Government will maintain the regulatory framework that includes obligations around community rating, default hospital benefit payments, maximum waiting periods, and portability. 2The Government will ensure health providers benefiting from private health insurance payments meet quality requirements, including accreditation.

In my opinion the advantages of the Australian health care system is more than the disadvantages, which are the limitations of choices (choice of doctor in a hospital) and the citizens of Australia are encouraged to use the

private insurance system because the public hospitals may have long waiting lists, whereas that you can get your treatment faster in the private system like if you want to do a hip replacement surgery the it will a good advantage to have a private insurance , further more you can chose the doctor and the hospital , one of the disadvantages also for the public health care system is the additional cost for the patient (dental examinations and treatment, glasses and contact lenses, ambulance services) also administrative duplication and a lack of coordination at the national level have led to Australia's health policy being described as slow [8] , and the advantages of this health care system that the quality of care are very high, there's no limit on the amount of medical services for the patient , all the public hospitals and GP's are free to users, and increasing equity because all the Australian people are covered by this health care system.

I think the main objectives of the Australian have been to build a high performing and sustainable health care system, cost effective health care system and improve the health outcomes for all the Australian, three basic goals of the Australian health care system are equity (fair payment and fair access to the medical services), efficiency (perfect services comparing with money) and quality (high quality of outcome), now Australia enjoy a wide healthy quality of life, the reforms of the health care system in Australia is ongoing to meet the needs of the patients and the health outcomes for the population are positive because of long life expectancies and falling in mortality rates.

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