Understanding the Australian Health Care System
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A suite of video interviews with practitioners and thought leaders have been created for this edition and are available on the Evolve site: http://evolve.elsevier.com/AU/Willis/understanding/

The videos further explore the themes and content within the chapters, as well as outlining challenges of the profession and advice for new graduates.

- Public health in Australia (Chapter 5)
- Organising care for the mentally ill in Australia (Chapter 12)
- People living with disability: navigating support and health systems (Chapter 13)
- The complementary and alternative health care system in Australia (Chapter 15)
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- Health care managers in a changing system (Chapter 25)
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CHAPTER 2

The public health sector and Medicare

Lindsay Krassnitzer and Eileen Willis

Key learning outcomes
By the end of this chapter you will be able to:
♦ understand how the public health care sector in Australia is organised, funded and delivered
♦ describe the purpose and function of Medicare and its role in the Australian health care system
♦ recognise the role of public hospitals within the Australian health care system, and how they are funded and administered
♦ articulate and critique the roles of local, state and federal governments in funding and managing the public health care sector in Australia
♦ understand the drivers and impacts of perpetual health reform in Australia.

Key terms and abbreviations
activity-based funding
bed block
blame game
bulk-billing
Consumer Price Index (CPI)
co-payment/gap payment
Council of Australian Governments (COAG)
elective surgery
gate-keeper
general practitioner (GP)
gross domestic product (GDP)
hospital separation
inpatient
Local Health Network (LHN)
market failure
market-based
Medicare
Medicare Benefits Schedule (MBS)
National Disability Insurance Scheme (NDIS)
Organisation for Economic Co-operation and Development (OECD)
outpatient
perverse incentives
Pharmaceutical Benefits Scheme (PBS)
population-based funding (PBF)
universal access
welfare state
Introduction to the public health sector in Australia

The Australian health care system is a mixed model of public and private health services. This chapter addresses the major features of the public health care sector: the Medicare system and public hospital services. The overarching (public) health system in Australia is based on the principle of universal access; this means that all citizens (and permanent residents) have equal access to medical services. However, in practice universal access takes a variety of forms. In some cases free medical care is provided (such as in public hospitals), while in others health consumers are expected to contribute to the cost of the services they receive; this may be known as a co-payment or gap payment. The feature of gap payments in the Australian health care system has some commentators questioning whether it is a truly universal system. This is a philosophical debate as to whether universality means universal access, or universal free access (Elliot 2003; Gray 2004).

A universal health care system is one feature of a welfare state; ‘welfare state’ means a society in which the government provides for the welfare of citizens in terms of health care and other social services. In general terms, Australian society can be described as a modern market-based economy, with the country supporting the welfare state in many forms. Another feature of the Australian health care system is that the government does not control the fees charged by private health practitioners (such as general practitioners [GPs], private medical specialists and allied health professionals); they are able to set their own fees. Constitutionally, the government cannot force doctors to charge certain prices (you can read more about this in Chapter 27) (Elliot 2003). From these brief examples we can see that the welfare state and the market-based economy are both features of the Australian health care system, and this can cause tensions in how the system is administered given that the system goes beyond medicine to include other health professions, consumer lobby groups, the evidence informing policy, and the realities of funding health care. The relationship between the private health and public health sectors has been described as an ‘uneasy compromise’ (Gray 2004), and Boxall and Gillespie state that ‘attempts to find a sustainable balance between the two sectors have been a major driver of reform’ (2013, p. 182). It is also noted that the mixed public and private system represents a problem as a result of the undefined roles of each sector (Boxall 2010; Boxall & Gillespie 2013).

Health is to be considered a fundamental human right and every country of the world supports this notion, although achieving it is another question (World Health Organization 2008a). Health is also highly political (Duckett & Willcox 2011). Gray (2004) suggests that health policy has been a major issue at every Australian election since the 1940s. One of the driving forces for a universal access system, such as Medicare in Australia (discussed in detail later in this chapter), is the idea that a market-based economy will not provide for those unable to purchase health services for themselves. This is known as market failure and can be considered a legitimate instance in a market-based society where government intervention is required to ensure that all citizens have access to a service such as health care (Podger & Hagan 1999; Duckett & Willcox 2011).

Prior to 1975, Australians needed to purchase health insurance to provide for their own health care needs. Many people could not afford to do so and were therefore disadvantaged by the failure of the market and the government to provide health services for them, which is considered unjust and a driving factor for the operation of the welfare state. In 1975, the Whitlam Labor Government established an Australian health insurance scheme known as Medibank. In 1984, Medibank was
re-introduced by the Hawke Labor Government as Medicare, which, with modifications, operates today. Australia is joined by countries such as Canada, Sweden, Singapore, New Zealand and the United Kingdom in providing a taxpayer-funded national health system accessible by all (Organisation for Economic Co-operation and Development 2013). The path to a universal insurance scheme was certainly not easy; it was contentious and vehemently opposed by the medical profession at the time Medibank was introduced (Gray 2004; Boall & Gillespie 2013). The medical profession, through the Australian Medical Association, is now highly supportive of Medicare and has been instrumental in protecting it against various government attempts to erode services and funding (Australian Medical Association 2015c). The USA has been experiencing similar disunity over plans to implement a fairer health package over recent years; Chapter 4 explores the US system in further detail.

The Australian health care system delivers some of the best health outcomes in the world, with one of the highest life expectancies and one of the lowest mortality rates under competitive expenditure levels in comparison with other similar countries (Australian Institute of Health and Welfare 2014d). It is important to remember this when discussing and debating the problems within the health care system: the system is certainly not perfect, but it does perform well when compared globally; although we should remember that the health care system is certainly not the only contributor to health status (Ross et al. 1999). Challenges facing the health system at present include the ageing of the population and concomitant increases in chronic disease and complex comorbidity management, increasing costs of health care technologies and other advances, increased consumer expectations, and inequalities in health status and inequitable access to health care services for some population groups (National Health and Hospitals Reform Commission 2009; Department of the Prime Minister and Cabinet 2014).

Table 2.1, from the Australian Institute of Health and Welfare, provides data on life expectancy at birth by sex for the top 10 OECD countries. Did you get any surprises with these figures? What countries are missing? Consider whether the type of health service is the explanation. What else might explain mortality rates?

**Administration of the Australian health care system**

The administration of the Australian health care system is complex and involves all (three) levels of government as well as other stakeholders, including private and public service providers. This leaves the system vulnerable to a range of tensions between levels of government, as well as those between external stakeholders who have varying levels of interest and influence in how the system functions. For example, Chapter 1 of this book introduced the concept of medical dominance – the medical profession is a powerful interest group and exerts considerable influence over how the health system is organised and funded (Palmer & Short 2010). Multiple stakeholders have vested interests in the Australian health care system. Gray (2004) puts it this way:

- Service providers are concerned with profit, income and clinical autonomy.
- Citizens are concerned with affordable access to quality services.
- Governments are concerned with ideology, electoral popularity and budgets.
health insurance for purchase by individuals. Figures 2.1 and 2.2 provide detailed overviews of the roles and responsibilities of the different levels of government in funding, policy, regulation and service delivery, and where these overlap. We can see that the organisation of the Australian health care system is complex, with multiple layers of administration, service delivery and financing. It is considered fragmented and bureaucratic (National Health and Hospitals Reform Commission 2009).

One of the outcomes of this fragmented health care system is the phenomenon of cost-shifting (see Box 2.1). Dwyer and Eagar (2008 p. 5) suggest that “The current split of responsibilities sets up perverse financial incentives for governments and other providers, whereby one level can “win” financially through measures that cause the other level to “lose” financially.”

Debates about the problems associated with cost-shifting and the division of responsibilities (the blame game) in terms of financing and administering the health care system drive most health system reforms. One of these debates centres on whether one level of government should assume total responsibility for the funding and management of specific aspects of the health system, rather than sharing funding and management responsibilities. This issue was explored recently under the federal Rudd Labor Government (2007–2010) by the National Health and Hospitals Reform Commission, whose terms of reference included that they ‘reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing’ and ‘address overlap and duplication … between the Commonwealth and states’ (National Health and Hospitals Reform Commission 2008b). One of the 123 recommendations of the Commission was that the Commonwealth should take over total responsibility for primary health care in Australia. Effecting macro reforms like these is difficult due to the vested interests of various interest groups, such as doctors, private health groups and consumers; indeed, some recommendations were never implemented while others were implemented and subsequently dismantled. Ross et al. (1999) remark that the objectives of reducing duplication and overlap were also addressed by a National Commission of Audit in 1996 – the pace of reform can be slow.

This section has briefly introduced you to the bureaucracy behind the Australian health care system. As noted, there are many levels of government involved in administering and funding this system. Thinking about the health care system as a whole, what types of groups and individuals are important stakeholders in this space? Are some more powerful than others?

Drawing on the ideas outlined by Tuohy in Chapter 1, reflect on why the Rudd reforms could not be achieved. What are your conclusions?

Financing the Australian health care system

Funding for the Australian health care system has received intense scrutiny over the past decades, although it is noted that this scrutiny is often based on ideological rather than economic perspectives (Duckett & Willcox 2011). Government expenditure in the health sector has been increasing over the past decade at approximately 5% per annum (Australian Institute of Health and Welfare 2014g).
FIGURE 2.1 MAP OF GOVERNMENT ROLES AND RESPONSIBILITIES IN HEALTH

Australia’s Health Care Arrangements

Prevention
Preventive health measures, including health promotion, food safety, immunisation, cancer screening

Primary care
The initial services received by patients, including from general practitioners, dentists and allied health professionals

Specialist care outside hospitals
Care delivered by specialists outside of hospital settings, including managing long-term chronic illness

Emergency care
Care provided in an emergency, including ambulance services, retrieval services, and emergency departments in hospitals

Hospital services
Care provided by hospitals, including admitted patients, non-admitted patients, rehabilitation, and nursing-home type care

Community care
Care to avoid hospital (re)admissions and other complex post-hospital care, including rehabilitation and palliative care

Funding
Policy
Regulation
Service delivery

<table>
<thead>
<tr>
<th></th>
<th>Funding</th>
<th>Policy</th>
<th>Regulation</th>
<th>Service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Shared*</td>
<td>Shared</td>
<td>Shared</td>
<td>Shared*</td>
</tr>
<tr>
<td>Primary care</td>
<td>Commonwealth lead, state and territory role*</td>
<td>Shared</td>
<td>Shared</td>
<td>States and territories*</td>
</tr>
<tr>
<td>Specialist care outside hospitals</td>
<td>Commonwealth</td>
<td>Commonwealth</td>
<td>Commonwealth lead, state and territory role</td>
<td>States and territories*</td>
</tr>
<tr>
<td>Emergency care</td>
<td>States and territories lead, Commonwealth role*</td>
<td>States and territories</td>
<td>States and territories</td>
<td>States and territories*</td>
</tr>
<tr>
<td>Hospital services</td>
<td>Shared*</td>
<td>States and territories lead, Commonwealth role</td>
<td>States and territories</td>
<td>States and territories**</td>
</tr>
<tr>
<td>Community care</td>
<td>States and territories lead, Commonwealth role*</td>
<td>Shared</td>
<td>Shared</td>
<td>States and territories*</td>
</tr>
</tbody>
</table>

*non-government sector also plays a role  **elective surgery is also delivered in private hospitals

Source: Department of the Prime Minister and Cabinet (2014, p. 26)
### FIGURE 2.2 MAP OF CROSS-CUTTING AREAS OF HEALTH CARE RESPONSIBILITY

<table>
<thead>
<tr>
<th>Cross-cutting areas of health care responsibility</th>
<th>Funding</th>
<th>Policy</th>
<th>Regulation</th>
<th>Service delivery</th>
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<tr>
<td><strong>Health workforce</strong></td>
<td></td>
<td></td>
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<tr>
<td>The funding, training and regulation of health professionals</td>
<td>Shared</td>
<td>Shared</td>
<td>Shared</td>
<td>States and territories*</td>
</tr>
<tr>
<td><strong>Therapeutic goods</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Regulation of therapeutic goods, standard-setting and enforcement</td>
<td>Commonwealth</td>
<td>Commonwealth lead, state and territory role</td>
<td>Commonwealth lead, state and territory role</td>
<td>N/A*</td>
</tr>
<tr>
<td><strong>Indigenous health</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Aboriginal community health organisations</td>
<td>Shared*</td>
<td>Shared</td>
<td>Shared</td>
<td>States and territories**</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Specialised care in public hospitals, private psychiatric hospitals, community services</td>
<td>Shared*</td>
<td>Shared</td>
<td>Shared</td>
<td>States and territories*</td>
</tr>
<tr>
<td><strong>Private health insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulation of the private health insurance industry and provision of subsidies</td>
<td>Commonwealth*</td>
<td>Commonwealth</td>
<td>Commonwealth</td>
<td>N/A*</td>
</tr>
<tr>
<td><strong>E-health</strong></td>
<td></td>
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</tr>
<tr>
<td>Personally Controlled Electronic Health records, standards, terminology, telehealth</td>
<td>Commonwealth lead, state and territory role</td>
<td>Shared</td>
<td>Shared</td>
<td>Shared</td>
</tr>
<tr>
<td><strong>Health research and information</strong></td>
<td></td>
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<tr>
<td>AIHW, NHMRC, other Commonwealth and state and territory information bodies</td>
<td>Shared</td>
<td>Shared</td>
<td>Shared</td>
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</tr>
</tbody>
</table>

*non-government sector also plays a role

**Aboriginal Community Controlled Health Organisations also play a significant role

Source: Department of the Prime Minister and Cabinet (2014, p. 27)
Governments have a vested interest in containing costs for political and budgetary reasons; however, Gray (2004) argues that health service providers naturally resist government efforts to contain costs (and by default constrain their incomes), and goes on to say that there is ‘an absence of sufficient political will to confront a powerful medical establishment’ in relation to capping fees and gap payments (Gray 2004, p. 22). At present there is no cap on funding available through Medicare benefits, except for access to benefits paid to consumers under the Extended Medicare Gap, and therefore expenditure increases as service use increases (Duckett & Willcox 2011).

Overall expenditure on health in Australia in 2012–2013 was in excess of $147 billion, of which $101 billion was funded by governments and $46 billion by non-government sources, including individuals (Australian Institute of Health and Welfare 2014g). Figure 2.3 demonstrates how this funding was spent in 2012–2013. The Australian government provided 68% of the total government health expenditure and state governments funded the remaining government expenditure. Approximately 18% of non-government expenditure was paid by individuals. In 2014–2015, total funding for health services by the Australian government comprised 16% of its overall budget, at approximately $67 billion (Commonwealth of Australia 2014c). While the health sector consumes considerable resources, it is also an important component of the Australian economy because it is the largest employing industry (12% of the total Australian workforce is employed in the health and

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**BOX 2.1 COST-SHIFTING IN PRACTICE**

There are multiple ways that governments in Australia can shift costs between each other. Here are some examples:

- State governments have an incentive to shift people away from expensive in-hospital care (which they largely fund and are responsible for) towards out-of-hospital care funded through Medicare. As Medicare funding comes from the federal government, this shifts the costs to that level of government.
- State governments have an interest in improving out-of-hours GP services; however, they have no control over these services as they are funded by the federal government. Increasing access to affordable out-of-hours GP services would reduce the burden on public hospital emergency departments and shift the cost of service provision to the federal government.
- Public hospital outpatient departments may be funded within the hospital budget (state government responsibility) or may be billed as medical services to Medicare (federal government responsibility).
- Public hospitals will provide medications to inpatients during their stay as part of their package of care, but will often discharge patients with prescriptions for any further medication required, which attracts federal government funding.

This constant shifting between the two levels of government is referred to as the **blame game**.

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social assistance industry), with well over a million Australians employed overall, including over half a million specific registered health practitioners (Australian Bureau of Statistics 2014a; Health Workforce Australia 2014f).

While the level of health expenditure is under constant scrutiny, in Australia it represents 9.67% of Australian gross domestic product (GDP) (Australian Institute of Health and Welfare 2014g), which is roughly in line with other OECD countries (Organisation for Economic Co-operation and Development 2013). The country with the highest health expenditure in relation to GDP is the USA, where health expenditure consumes over 17% of GDP – markedly higher than any other OECD country (although the quality of health outcomes achieved for this level of expenditure is certainly questionable) and, as you would have noticed from Table 2.1, this does not equate to low morbidity for either males or females. Health expenditure as a percentage of GDP has increased in the 10-year period 2002–2003 to 2012–2013 from 8.59% to 9.67% (Australian Institute of Health and Welfare 2014g). So while the Australian health care system may be considered reasonably efficient at providing a high-quality universal health system, it is clear that the long-term trend is increasing costs which contributes to the level of scrutiny placed on the health budget.
Health care system reform

Arguments about the sustainability of the health system prompt reform and efficiency programs. The Australian health care system may be considered to be in a state of perpetual reform; indeed, there is a fixation on reform and on frequent restructuring of how health is organised (Hall & Viney 2000; Duckett & Willcox 2011) (Box 2.2). Palmer and Short (2010) question whether this frequent restructuring has actually improved the efficiency of the health system or the health status of the population.

As an example of reform at the edges of the health system, the Australian government Department of Health has been known under nine different names as a result of mergers, de-mergers and other alterations to its structure and operation since its establishment in 1921 (Department of Health 2015b). In conjunction with changes to government and ministerial appointments there have been 46 health ministers in the 93 years between 1921 and 2014 (Department of Health 2015b). While these reforms may sound like name changes and the movement of chess pieces, they absorb considerable resources from the health system and the frequency of change creates instability among the health workforce and uncertainty regarding the sustainability of programs.

In Australia, health reform generally focuses on two main issues: the relationship and responsibilities of the different levels of government in the health system, and the relationship between the private and the public health sectors (Palmer & Short 2010). Analysing the role of government in the Australian health care system is not new. In reality this matter has been debated continuously since before the establishment of the modern health care system. Two recent examples of this debate can be found in the National Commission of Audit report released in February 2014 (National Commission of Audit 2014) and the Reform of the Federation White Paper on roles and responsibilities in health released in December 2014 (Department of the Prime Minister and Cabinet 2014). Both of these reports discuss the role and scope of government involvement in health financing,

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**Box 2.2 Health Reform in Practice: The Case of Medicare Locals**

As an example of the speed of reform in the Australian health care system at a national level in recent years, 2011 saw the abolition of the Divisions of General Practice (which had been in place since 1992 as a way to coordinate GP-based primary health care services) to make way for the establishment of Medicare Locals under the National Health Reform Agreement (Council of Australian Governments 2011b). The intention of Medicare Locals was to reduce the fragmentation of health services and provide improved primary health care at the community level. In 2014, it was announced that the 61 Medicare Local organisations would be abolished after only three years of operation and Primary Health Networks would be established in their place from 1 July 2015 – in another attempt to reduce service fragmentation and improve patient outcomes (Department of Health 2014d; Horvath 2014). In both cases there was an extensive, timely and costly tender process for groups wishing to provide the services.
Case Study 2.1

Joining the dots of public and private health insurance

Leanne is 45 years old, single, and earns $95,000 a year. She pays the Medicare levy of 2% of her taxable income, which amounts to $1,900 per year. Leanne has purchased private health insurance; otherwise she would be liable to pay a Medicare levy surcharge of an additional 1% of her taxable income (an extra $950 in tax per year), as she earns in excess of $88,000 a year. Her private health insurance costs $1,500 per year and provides private hospital cover as well as cover for ancillary services such as travel vaccinations, dental services, physiotherapy and massage. As part of her health insurance, Leanne must pay a $500 excess if she goes to hospital; Leanne chose to include this in her policy to reduce the cost of her premiums.

Leanne visits her GP as she has been experiencing ongoing gastric reflux for which she has seen her GP before. She has a consultation with her GP lasting 15 minutes and her GP bulk-bills her for this. The Medicare Benefits Schedule (January 2015) pays a GP $37.05 for a standard consultation of up to 20 minutes (not inclusive of any bulk-billing incentive payments that are in operation). At the end of this consultation Leanne does not have to pay anything; she signs a form and her GP receives the payment of $37.05 from Medicare. If Leanne’s GP chose to charge more than $37.05 for a standard consultation, then Leanne would need to pay the difference between $37.05 and the fee charged – the gap fee, or co-payment. This gap is not covered by private health insurance.

Leanne’s GP is concerned about her condition and has referred her to a private specialist gastroenterologist that she believes provides excellent-quality care. Leanne visits the gastroenterologist’s private consulting rooms three weeks later. The gastroenterologist charges $140.90 for this consultation. The Medicare schedule fee for this type of consultation is $85.55; however, Medicare only covers 85% of this cost (which equals $72.75). Leanne has to pay the difference of $68.15 ($140.90 consultation charge minus $72.75 Medicare rebate). Even though Leanne is accessing a private medical service, this gap fee is not covered by her private health insurance as it is not provided in hospital.

The private gastroenterologist suggests that Leanne needs to have an endoscopy for further investigation of her gastric problems and books her in for this procedure in a private hospital the following week. Leanne’s private health insurance covers the cost of this procedure; however, she must pay the $500 excess on her health insurance as well as a small gap for the assisting anaesthetist.

An alternative option that Leanne’s GP could have pursued would have been to refer her to a public gastroenterologist at the local public hospital outpatient clinic as a public patient. This service would have been provided to Leanne at no charge; however, she might have had to wait several months for an appointment and she would have had no choice about which doctor she would see. If it had then been decided that Leanne needed an endoscopy for further investigation, she would have been placed on an elective surgery waiting list and could have waited several months or longer for the procedure to be done. The procedure would have been carried out in the public hospital and Leanne would have received no bill for the procedure.
private forms of health care such as physiotherapy, dental services, etc., but they must pay for these services.

There are various checks and balances in place to support the administration of Medicare. Medicare benefits are only payable for services that are deemed to be clinically relevant. If a patient requests a service that is not considered clinically relevant, then no benefit is paid towards that service; an example would be cosmetic surgery. In addition, under the Health Insurance Amendment (Compliance) Act 2011 Medicare uses a number of strategies to monitor the billing practices of practitioners to ensure that ‘over-servicing’ or fraudulent activities are minimised. However, the level of scrutiny applied here has been criticised (Palmer & Short 2010; Webber 2012).

**Australia’s hospital system**

In 2012–2013, there were 1338 hospitals in Australia, of which 746 were public hospitals and 592 were private hospitals (Australian Institute of Health and Welfare 2014b). Collectively, these hospitals provided approximately 86,000 hospital beds (58,300 public and 27,800 private). Public hospitals provided 5.5 million separations in 2012–2013; a hospital separation is an episode of specific care which ends at discharge, death or transfer to another service/care type. Almost 7 million public hospital emergency department attendances occurred in 2012–2013; there were 2.5 million admissions to Australian hospitals for surgery, of which only 300,000 were considered emergencies (required within 24 hours) with the remainder being considered ‘elective’ surgery, which is surgery that needs to occur but not within 24 hours. The use of the term ‘elective’ may imply the surgery is not necessary; however, this is not the case (Duckett & Willcox 2011). All medical conditions requiring surgery are categorised into categories of urgency. While these differ from state to state, generally they are organised around the time the patient can wait before the condition deteriorates (Australian Institute of Health and Welfare 2013f). The majority of elective surgery (67%) occurs in the private hospital system rather than in public hospitals (Australian Institute of Health and Welfare 2014b). In 2012–2013, approximately half of all admissions to public hospitals involved admission overnight or longer, whereas in private hospitals only a third of admissions required overnight admission, indicating a different service mix (a higher rate of day procedures).

To understand the relationship between waiting times for elective surgery and categories of urgency, go to the website for South Australian public hospitals (elective surgery dashboard), provided in the Online Resources section of this chapter, or find the dashboard for your own state or territory.

In excess of $42 billion in funding was provided to Australian public hospitals in 2012–2013, and the sector employed almost 275,000 Australians with the largest employee group being nursing staff (Australian Institute of Health and Welfare 2014b). Over $38 billion of funding for public hospitals came from government, with the remainder being funded through non-government sources such as private patients electing to have their surgery in a public hospital.
Demand for hospital services is continually increasing. In the five-year period 2008–2009 to 2012–2013, public hospital separations increased by more than 3% every year (Australian Institute of Health and Welfare 2014b). Challenges currently facing public hospitals include elective surgery waiting times, emergency department waiting times, ‘bed block’ (where patients in emergency cannot be admitted to a ward due to lack of beds) and ambulance bypass and ramping issues when emergency departments are overloaded. A section in Chapter 17 on the profession of nursing touches on one of the negative outcomes of these productivity issues: missed nursing care. Safety and quality in health care is guided by the Australian Commission on Safety and Quality in Health Care, and rationed or missed care is on its agenda.

In 2011, as part of the National Health Reform Agreement, Australia moved to a nationalised system of activity-based funding for public hospital services. Activity-based funding means that hospitals are paid for the specific services and procedures they provide and each service and procedure has a set price based on its characteristics (Eagar 2010). It is assumed that activity-based funding promotes efficiency because service providers are paid a set price – if a procedure payment includes a three-day hospital stay and the patient is discharged at two days, then the service provider makes a ‘profit’ on this service (Solomon 2014). This funding agreement is in place until 2017, at which time it is planned to move back to a population-based block-payment funding model with growth payments linked only to the Consumer Price Index (CPI; the measure at which the prices of goods and services increase) (Biggs 2014) as well as activity-based funding. The potential impact of linking public hospital funding to the CPI is that often health care costs increase at a greater rate than this, leading to a cumulative shortfall in funding (Biggs 2014). The planned return to population-based funding (PBF) is another example of reform being explored, implemented and dismantled in a very short space of time.

Public hospitals provide services to inpatients who are admitted to hospital for surgery, investigations, medical management and other issues, and they also provide services on an outpatient basis to people who need medical treatment but do not require admission to hospital. An outpatient service might be where after being discharged from an acute episode (for example heart surgery), a patient would need to visit a public hospital several times a year to see a specialist (in this case a cardiologist) to manage their condition on an ongoing basis. In 2012–2013, there were 54 million non-admitted patient services provided in Australian public hospitals (Australian Institute of Health and Welfare 2014b). For patients admitted to hospital, the average length of stay (excluding same-day patients and psychiatric patients) declined to 5.6 days per person in 2012–2013. Reducing the average length of stay is one mechanism used to reduce the cost of public hospital services, as each day in hospital can be very costly. It is possible to monitor individual patient lengths of stay and determine whether a patient has required more time in hospital than expected. This information can then be used by service planners to determine where improvements to services and patient care can be made to reduce days in hospital.

All public hospitals across Australia are governed through entities known as Local Hospital Networks (LHNs). LHNs were established in 2011–2012 under the National Health Reform Agreement as part of the national health reform process that commenced in 2008. The establishment of LHNs was designed to increase local accountability in an effort to improve public hospital services (Council of Australian Governments 2011b). Governance of local hospitals is provided through each LHN and its Governing Council, which is responsible for the budget and overall performance.
of all hospitals within the LHN. LHNs have relationships with the federal government as well as the relevant state government and consumers.

Visit the ‘myhospitals’ website (www.myhospitals.gov.au/) and search for your local hospital. Explore the data provided about your hospital – how many beds does the hospital have, what services are provided and what are the waiting times? Investigate how your local hospital compares with other hospitals.

Summary

This chapter has introduced you to the basics of the Australian health care system. As you will have read, the system is complex and beset with problems, but is still a well-functioning service. Major issues discussed include:

- Governance of the Australian health care system is shared across federal, state and local governments, with each sector of government responsible for different aspects in isolation or through shared ventures. This shared system contributes to tensions and issues such as cost-shifting and blame-shifting between sectors of government.
- There are tensions between the private and the public health sectors, and debates about which model of service delivery is optimal and equitable.
- Health expenditure in Australia has been rising year on year, which presents concerns and challenges for health policy makers. Despite this, the level of expenditure in Australia is competitive when compared with similar countries.
- The Australian health care system performs well in comparison to health care systems in similar countries. Australia has enviable health outcomes and high life expectancy.
- Continual reform of the health care system places strain on all components of the system for ambiguous outcomes.
- Medicare provides universal access to free public hospital care for all Australian citizens and subsidised access to other medical services. A range of measures has been explored and/or implemented to contain the cost of providing Medicare; however, the principle of universal access remains.
- Public hospitals provide a large amount of high-quality specialist medical care in Australia, and are also vulnerable to funding and governance reform.

Review Questions

1. Describe how cost-shifting might have impacts on public hospitals.
2. Considering the perpetual state of reform in the Australian health care system, what are some of the potential impacts on the health professional workforce?
3 Given the overlap in funding and responsibility for the management of various parts of the Australian health care system, what do you see as the potential problems arising here?

4 Following on from identifying the problems in question 3, what do you think is the appropriate role for different levels of governments in this space?

5 The Standing Council on Health, under the Council of Australian Governments, is responsible at a national level for the operation of the health system. What difficulties might arise based on the membership of this group?

Further Reading


Online Resources

Australian Institute of Health and Welfare – provides comprehensive information, publications and statistics about most aspects of the Australian health care system, population groups and specific diseases: www.aihw.gov.au

Department of Human Services – administers Medicare Australia: www.humanservices.gov.au

Elective surgery dashboard SA Health: www.sahealth.sa.gov.au and click on ‘About us’, then ‘Our performance’ in the left-hand menu, then the ‘elective surgery dashboard’ link on that page.

Medicare Benefits Schedule: www.mbsonline.gov.au

Key learning outcomes

When you finish this chapter you should be able to:

♦ describe occupation and its relationship to health and well-being
♦ describe the scope and organisation of occupational therapy in Australia
♦ describe the application of occupational therapy across the life-span and in different contexts
♦ describe the range of roles that occupational therapists may undertake within the Australian health care system
♦ reflect on the likely impact of contemporary trends and health issues on the future profile of occupational therapy.

Key terms and abbreviations

- Alzheimer's disease
- American Occupational Therapy Association (AOTA)
- Australian Health Practitioner Regulation Agency (AHPRA)
- client-centred practice
- continuing professional development (CPD)
- Department of Veterans' Affairs (DVA)
- National Disability Insurance Scheme (NDIS)
- occupation
- occupational engagement
- occupational justice
- occupational therapist (OT)
- Occupational Therapy Board of Australia (OTBA)
- speech pathologist (SP)
- spinal cord injury
- World Federation of Occupational Therapists (WFOT)

Introduction

This chapter will introduce the concepts and practice of occupational therapy in Australia. There are two key terms reflected in the profession's title, namely 'occupational' and 'therapy'. The initial section of this chapter will outline what is meant by the term 'occupational' by examining the concept of occupation. The second part will then outline how occupation is related to health and well-being and therefore applied as therapy, particularly in an Australian context.
Occupation and occupational engagement

To be able to understand what occupational therapy is, you first need to understand the meaning of the term ‘occupation’. It is this that most clearly differentiates occupational therapists (OTs) from other members of an interprofessional health care team. **Occupation** is defined as ‘daily life activities in which people engage’ (American Occupational Therapy Association 2014, p. S43). You can see by this definition that it is much broader than ‘work’, which is so often what people associate with occupation. Occupation in this context encompasses everything we do. What we do, how effectively and why we do these things, has a significant impact on our health, satisfaction and well-being.

Occupational therapy is about ‘achieving health, well-being, and participation in life through engagement in occupation’ (American Occupational Therapy Association 2014, p. S4). Occupational therapy intervention focuses on supporting clients, who may be individuals, groups or organisations, to engage in the occupations of everyday life that they need and want to be able to do to live meaningful lives (World Federation of Occupational Therapists 2012a). It is important to keep in mind that what is ‘meaningful’ needs to be defined by the individual, group or organisation. To do this, OTs need to be able to understand the barriers and facilitators to occupational engagement. **Occupational engagement** is the ‘performance of occupations as the result of choice, motivation, and meaning within a supportive context and environment’ (American Occupational Therapy Association 2014, p. S42).

**Occupational therapists** use occupation as a therapeutic tool. The occupations people choose to undertake often reflect and shape their identity (Unruh 2004). Think about an occupation you enjoy and how you feel when you do it. Think about how that occupation reflects your sense of yourself. Occupations are central to a person’s sense of competence and have particular value and meaning to that individual (American Occupational Therapy Association 2014). Engaging in occupations can influence mood, emotion, physical and cognitive capacities (see Case Study 22.1 for an example of how an occupation can influence some of these aspects).

Occupational engagement is highly individualised. One person may categorise ironing as work, another as a domestic chore, and yet another may find it relaxing and calming. When OTs work with clients they identify and analyse the individual elements of each occupation and consider how these support or hinder occupational engagement, the impact this has on the client’s health and well-being and their ability to participate in life as they would wish to. They match this with their understanding of the client as a whole and the factors that may impact on that person’s occupational choices. These factors may include their values, beliefs and spirituality, their body functions and their body structures. The final element that OTs consider is the environmental factors that influence occupational engagement. These include cultural, personal, physical, social, temporal and virtual contexts (American Occupational Therapy Association 2014). Context and environment influence how and when an occupation is carried out. As a simple example, think of planning a picnic. How does the time of year influence this? How does a picnic differ from having a meal at home?

Impact of occupation on health and well-being

As well as the definitions of health already considered in this book, occupational therapy considers health as a resource to allow people to engage in meaningful occupation.
Case Study 22.1
The effect of engaging in an occupation

Picture Maggie, a 76-year-old woman with Alzheimer’s disease who has been living in a nursing home for three months following the death of her husband. She has become less and less responsive to her children, the staff and her surroundings. They have tried to include her in the general activities in the nursing home, with no success. She sits day after day slumped over in her wheelchair.

The occupational therapist (OT) talks with Maggie’s children to see what occupations have been important in her life, and discovers that Maggie used to love music and dancing. She danced as a young child right through to her 30s, and then was involved in teaching children. She loved musicals and was always singing, listening to music, working on routines and sewing costumes.

The OT suggests they bring in some examples of her former interest and start talking with Maggie about this. The OT talks about how we experience our occupations through a range of our senses and how this may help Maggie access her memories. Her children bring in photos, trophies, music, ballet costumes, Maggie’s old sewing box and, becoming very creative, a pair of old, smelly tap shoes. They spread this around Maggie and gently talk to her about what they have found, showing her the items and allowing her to feel them and experience them. Slowly but surely, Maggie begins to respond and starts to talk about her dancing days as she handles the costumes and shoes. She shows interest in her environment and notices the photos and starts to smile. She then looks up at her daughter and smiles at her.

Active engagement in meaningful occupation generally promotes, facilitates and maintains health and well-being. There are cases, however, where active engagement in occupation can be harmful to health and well-being, for example addictive occupations such as gambling. Another example is professional musicianship. The occupation of rehearsing and performing with a violin at a professional level requires the musician to hold certain parts of their body (trunk, neck, shoulders) in sustained and often awkward positions while other body parts (fingers, wrists) are engaged in fast and repetitive movements for long periods of time. The focus and concentration required to play at this level means that musicians often become so engrossed that they do not notice how long they have been participating. They enter a state of flow which has been defined as a rare focused state of consciousness (Csikszentmihalyi 1993). This is usually considered to be a health-enhancing state, but a study of professional musicians by Guptill (2012) draws attention to the negative effects...
that flow can have on health. Despite the fact that these musicians experienced pain and physical injury as a result of their playing, many of them still reported an enhanced sense of well-being because the occupation was so valued, reflected their sense of identity and positively influenced their mood and emotional state (Guptill 2012). This study highlights the importance of understanding an occupation and taking into consideration the person’s perspective, particularly around the value or meaning of the occupation.

Occupational therapists consider that people thrive when they are able to participate in a range of occupations that match their needs, interests and capacities. A state of occupational imbalance occurs when excessive time is spent in one or more areas of life at the expense of others (Backman 2010). For example, a high school student could spend much of their time playing computer games at the expense of schoolwork, which impacts negatively on their goal of wanting to obtain high grades to enter a particular university course.

Supportive environments also play a crucial role in maximising participation, health and well-being. Occupational therapists consider the social determinants of health and understand that these influence opportunities to participate in occupations. This applies across all ages, but can be highlighted when considering learning and development outcomes for young children. Children learn and develop from a context of safe and secure relationships and opportunities to engage in core occupations such as playing. When working with a child presenting with a developmental delay, an OT will strive to understand the broader social, cultural and environmental influences that may be impacting on this child and family, such as access to safety, adequate shelter and food, parental well-being and mental health, and financial security. The OT will be mindful of these when planning therapeutic interventions; see Case Study 22.3 later in the chapter as an example of this.

**Occupational science**

Occupational science is an evolving interdisciplinary research field involving contributors from a range of disciplines that include occupational therapy, anthropology, economics, geography, political science, psychology, sociology, physiology and neuroscience. The field originated in the 1980s, and aims to study the complex nature of human occupation using a range of methods and approaches. Occupational science is interested in understanding human occupation in context with the ultimate aim of supporting ‘equitable participation in [the] everyday life of a society by all its citizens’ (Molineux 2010, p. 370). It is important for OTs to understand people as occupational beings and to understand how occupation can influence a person’s life both positively and negatively. Occupational science offers a knowledge base that supports occupational therapy practice with a focus on analysing and optimising knowledge about occupation (Wright-St Clair & Hocking 2014). As already discussed in this book, efficiency, effectiveness and equity are core drivers for health system performance, and in challenging economic environments there is increasing pressure from health services and other employers to demonstrate value and results.

**Occupational justice**

Occupational therapists also focus on the social justice agenda previously discussed in this book by considering human rights from an occupational perspective. The World Federation of Occupational Therapists (WFOT; 2006) *Position statement on human rights* endorses the United Nations’
Universal Declaration of Human Rights and adds a perspective in relation to human occupation and participation that recognises people’s rights to participate in meaningful occupations consistent with their culture, context and values.

A model of occupational justice described by Townsend and Wilcock (2004) considers occupational opportunities in light of the issues of rights, equity, fairness, empowerment and enablement, and highlights the need to consider and protect people’s different priorities, needs and capacities and how they are expressed through what they do. Occupational rights include the right to:

♦ participate in a range of occupations for health, development and social inclusion
♦ make choices and share decision-making in daily life
♦ experience meaning and enrichment in one’s occupations
♦ receive fair privileges for diverse participation in occupations (Wilcock & Hocking 2015, p. 407).

This approach expands possible occupational therapy intervention from an individual clinical role to one of working with populations, organisations and communities to advocate for and enact change at a policy or program level to address issues of occupational injustice. Occupational deprivation is an outcome of occupational injustice, and is defined as ‘a state of prolonged preclusion from engagement in occupations of necessity and/or meaning due to factors which stand outside of the control of the individual’ (Whiteford 2000, p. 201). Alex’s situation as described in the Pause for reflection is an example of occupational deprivation.

Alex is a 23-year-old man who has experienced significant brain damage as a result of a car accident and requires high-level care. The only residential option that could provide 24-hour nursing care at the level he requires is an aged-care facility. He has lived in this facility for the past three years. Imagine how Alex’s daily life and the occupations he wants and needs to do are affected by living in this environment. How are his occupational rights being upheld?

This is an example of occupational injustice. In this case, an occupational therapist could work as part of a team to advocate for Alex’s occupational rights, could work with the aged-care facility to consider environmental and program modifications to address issues of occupational deprivation, and could support submissions to the National Disability Insurance Scheme to consider better funding options.

- Refer to the Young People in Nursing Homes National Alliance (www.ypinh.org.au) for further information on this issue.
- See also Occupational Therapy Australia’s submission Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia, available through their website (www.otaus.com.au/news-events/id/311).
Case Study 22.3

Providing occupational therapy in an interdisciplinary context

Jacob is 2 years 6 months old and has been referred to an early childhood development team by his mother, Ruth, because he is not yet talking. His first contact with the health service is with two members of the interdisciplinary team, an occupational therapist (OT) and a speech pathologist (SP). After a brief time where Jacob and Ruth play and interact together, getting comfortable in the play space, the role of the service and the purpose of this initial meeting are explained.

The OT talks with Ruth and takes an in-depth developmental, medical and occupational history of Jacob and his family. She gains a sense of what has happened in this little boy’s life to date, and how this might be impacting on his learning and development. She establishes a relationship with Ruth that honours and respects Ruth’s role as the expert in Jacob’s life, and begins to build a therapeutic partnership that will underpin any intervention. She also gains a sense of the environments in which Jacob is living, and how these may be influencing his outcomes. Key environments she explores include home, family, child care, and other key relationships in Jacob’s life. The questions she asks help to establish a sense of how considerations of safety, employment and financial security, nutrition, physical activity and sleep may be influencing health and well-being for this boy and his family. She also gains a sense of how Jacob’s mother is feeling and what support or challenges she has in her role as his mother and in any other key roles she plays.
During this time, the SP plays with Jacob and gains a sense of his capacities and challenges. The OT and SP then swap and the SP develops her connection with Ruth, explaining what she has noticed about Jacob's play and communication and checking whether this is typical for him. She then asks specific questions that may shed more light on Jacob's speech and language development while the OT interacts with Jacob and gains a sense of his fine and gross motor skills, play styles and preferences and sensory responses.

Once the initial information is gathered, the OT and SP summarise their observations, discuss any recommendations that could be put into action straight away, and make a plan with Ruth for the next step in therapy. Following the session, the SP and OT jointly write a summary which captures the family's circumstances as well as their combined assessment of Jacob's speech and language skills, fine and gross motor skills, concentration and attention, sensory responses, play styles and skills, and how he responds to his mother, the therapists and the therapy environment. This information is discussed at the weekly interdisciplinary team meeting, which includes the OT, the SP, a child psychologist, a social worker, the crèche manager and a dietitian. Jacob and his family's needs are prioritised and a service plan is agreed on. A copy of this is sent to Ruth.

Case study questions
1. What are the advantages for Ruth and Jacob of this interdisciplinary approach?
2. How does this interdisciplinary approach strengthen the occupational therapy approach and reduce costs and waiting times for occupational therapy specifically and the health service as a whole?
3. How does this assessment process reflect an understanding of how the social determinants of health impact on children's learning and development?

Summary
This chapter has provided information on the occupational therapy profession, in particular:

- An in-depth understanding of occupation and how its therapeutic use underpins occupational therapy. Occupations are activities in which people engage, and they form the fabric of our daily life. Occupations hold individualised meaning and value for people. Occupation influences people's health and well-being and shapes our identity.
- Occupational science is the study of human occupation and all its complexity.
- Occupational justice considers issues of rights, equity and justice from an occupational point of view, and contributes another perspective to contemporary local and global health issues.
- Occupational therapy has developed from its early days in large mental health asylums to a progressive profession working across many sectors and undertaking many roles. These include clinical, academic, managerial, advocacy and support roles.
- Educational programs within Australia are at Bachelor's or Master's degree level.