Health Service Delivery Profile

Australia

2012

Compiled in collaboration between
WHO and Australian Institute of Health and Welfare

Australia health service delivery profile

A. Health Service Delivery Profile

National context

Demographics and health situation

In 2011, Australia had a population of 21.5 million people; the median age was 37 years and is projected to increase to between 38 and 4 years in 2026. The majority (64%) live in the seven state capital cities. Approximately 2.5% of the population are Indigenous and 25% of the population are born overseas, with close to 79% of the population speaking only English at home. The two major Indigenous groups are Aboriginal and Torres Strait Islander peoples, within and between which there is much diversity in origin, culture and world-views. Indigenous Australians have a younger population than the total Australian population.

Table 1. Key development indicators for Australia

Key development indicators	Measure	Year
Human development index	0.929	2011
Gini coefficient	0.331	2007-08
Total health expenditure	8.5% GDP	2009
Incidence of poverty		
Literacy rate (male/female) (%)	99/99	2003
Life expectancy at birth	81.9 years	2011
Infant mortality rate	4.2 per 1,000 live births	2007
Indigenous infant mortality rate	9.6 per 1,000 live births	2011
Maternal mortality rate	8.4 per 100,000 live births	2003-05

Australia currently enjoys a high level of health status. The health care system is a partnership between the federal, state and territory governments. Self-perception of health and wellbeing is generally good to excellent. However, not all Australians share this good health and there are clear discrepancies between the health of Indigenous populations, those living outside the capital cities and those of low socio-economic status compared to the health status of other Australian residents. In 2010, coronary heart disease was the leading cause of death in both sexes, accounting for more than one-sixth of all deaths. Cerebrovascular disease, cancers, chronic obstructive pulmonary disease, dementia and Alzheimer disease were also leading causes of death in 2010. Cancers with an unknown primary site, and dementia and Alzheimer disease have increased in prevalence as causes of death in recent years.

Health strategies, objectives, and legislation

The *National Health Agreement (2011)* is signed by the federal and state governments and outlines the goals of the health system and specific roles and responsibilities for each government in managing and providing health services. It ensures the policy of providing a range of free or subsidized services to Australian citizens meeting Medicare eligibility. The *National Partnership Agreements* are specific agreements between the Commonwealth of Australia and states and territories on programs for preventive health, Indigenous health reform, and improving public hospitals, and they include indicators and benchmarks. *Closing the Gap (2009)* is a commitment by federal and state governments to reduce Indigenous disadvantage within 25 years. It is a national integrated strategy with national agreements and partnerships in areas of health and social determinants of health, such as education, housing and economic participation.

Service delivery model

Australia has a complex health service package with a variety of funding, management and regulatory mechanisms. Adding to this complexity, services are provided by a number of levels of government, including federal, state and local governments, as well as private and not-for-profit organisations. The federal government health insurance system is Medicare. The objective of Medicare is to make health care affordable through free or highly subsidised health care, and therefore accessible, for all Australians regardless of their ability to pay. The Medicare Benefits Schedule (MBS) lists all services covered, including services provided by medical practitioners and hospitals at primary and secondary levels, but also eligible dentists, allied health professionals, optometrists, health prevention and promotion, and long-term care services. Necessary pharmaceuticals are subsidised through the Pharmaceuticals Benefits Scheme (PBS). Federal and state governments directly fund health promotion and disease prevention services, and 2.3% of total health expenditure was spent on these in 2007-08.

The provider network

Table 2. Summary of health services and providers in Australia, 2012

Health promotion and disease prevention	
Communicable diseases surveillance	Communicable Diseases Network Australia coordinates surveillance, responds to outbreaks, develops policy and trains communicable disease epidemiologists.
Immunisation	National Immunisation Program Schedule provides free immunisations to children, adolescents and adults. Delivered in general practices, by local governments, and community health centres.
Screening	Primarily focus on breast, cervical and bowel cancers, each managed by separate national programmes
Tobacco, alcohol and obesity Heath promotion (other)	Australian National Preventive Health Agency (ANPHA), established in 2010, is focused on a systematic, evidence-based and comprehensive approach. National health surveys and strategies for these issues. Each state also has an active health promotion program based on the needs of the population. The Australian Government Department of Health and Ageing (DoHA) develops and manages anti-smoking campaigns for high risk and hard to reach groups. NGOs are also (increasingly) active in health promotion, advocacy, campaigns, research and communicating information.
Mental health	Promotion, prevention and early intervention services through national action plan.
Family planning	Family planning organisations provide contraceptive services, counselling and information services, early intervention and health promotion services and the management of sexual and reproductive health.
Primary care and community services	
Primary care GP services	7,151 GP private practices. Commonly manage respiratory, cardiovascular, and musculoskeletal problems, problems of a general and unspecified nature, such as check-ups, and skin problems Services funded through Medicare.
Other primary services	In private practice, hospitals, and community services. Accredited counsellors, acupuncturists, chemists (for advice only), chiropractors, dentists, dieticians, naturopaths, nurses, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, psychologists, social and welfare workers and others. Some are eligible for Medicare rebates. 46% of Australians used these health professionals in 2007.
Community health services	Usually consist of multi-disciplinary teams of health and allied health professionals that serve their particular community. Funded by the state government, local health services or community organizations.

Primary care services coordination and collaboration	19 'Medicare Locals' (the 2010 health reforms will establish 38 in total) Networks of independent primary care organisations that work with GPs, aged care, allied health and community care providers. These aim to improve integration, access to care and quality of services. Focus on management of chronic conditions, primary care access, and continuity of care. These will also deliver ANPHA health promotion and preventive health programs.
Primary services for Indigenous Australians	Provided through hospitals, community clinics, Aboriginal Community Controlled Health Services, and specific primary health care and substance misuse services in community-based settings. Aboriginal communities operate over 150 of these services, including large multi-functional services and smaller mostly preventive ones. Medicare Liaison Officers encourage access to these services and pharmaceuticals.
Dentists	Mostly private practice dentists. Primary dental care for children and adolescents in schools. State funding for public dental health programmes and some dental care for adults (the elderly, disabled, single parents with health care cards and the unemployed) in community clinics or hospital clinics.
Remote emergency and transport services	The Royal Flying Doctors Service provides primary and community health care clinics, consultations by radio, telephone and video, pharmaceutical supplies and emergency air transport to and from hospitals for those in regional, remote and remote Indigenous communities from a number of bases around the country.
Secondary and tertiary services	
Inpatient, and outpatient services	752 Public hospitals in 2010-11 (AIHW Australian Hospital Statistics 2010-11) Most commonly provide acute care, newborn care and rehabilitation, palliative care, geriatric care, maintenance care, outpatient services including radiology, pathology, pharmacy, and community health services. Specialised health services for inpatients include pathology, specialist attendances, diagnostic imaging, operations, anaesthetics, obstetrics, radiotherapy and therapeutic nuclear medicine. Specialised public hospital outpatients clinics provide allied health, obstetrics, and oncology, dental, orthopaedic and other medical services. Treat a larger proportion of Indigenous patients and patients of relatively low socioeconomic status compared to private hospitals. Services are funded through Medicare.
	17 Public psychiatric hospitals in 2010-11
	581 Private hospitals including 302 free standing day hospitals in 2009-10 Often specialise in a limited range of surgical procedures, although there are a number of full service private hospitals delivering the same categories of care as public hospitals. 279 Acute and private psychiatric hospitals in 2009-10. Medicare subsidizes a proportion of private hospital services that are listed on the Medicare Benefits Scheme. Around 60% of private hospitals operate on a for-profit basis.
Ambulance services	Funded and delivered by six states and territories, two states and territories contract this service out. Includes transport, acute care, and coordinating emergency services.
Mental health services	Delivered through GPs, psychiatrists, psychologists, community based mental health services, psychiatric hospitals, psychiatric units within hospitals, and residential care facilities.
Alcohol and drug treatment	Provided in both residential and non-residential settings and include services such as detoxification, rehabilitation, information and education courses, pharmacotherapy and counselling treatments.
Hearing services	Private and public practitioners provide a range of hearing services, including assessments and screenings, regular checks, the supply and fitting of hearing devices and training to improve listening and communication skills.

Long-term and continuing care services	
Aged care services	Aged care services are primarily funded by the Australian Government. Services including assistance with everyday living, personal care and nursing care are delivered in the community and in residential care settings. Mainstream residential services are delivered through: 296 Public long-term facilities 2464 Private long-term facilities (1648 not-for-profit, 816 for-profit)
	Day care centres provide physiotherapy, speech therapy and occupational therapy
Disability care services	Programs similar to elderly care programs are available to Australians with a disability. These assist people to live at home and in the community, and support carers.
Palliative care	Provided in the patient's home, residential settings such as aged care homes, in palliative care units and in hospitals.

In 2010-11 there were a total of 85,520 beds in public and private hospitals, totalling 3.9 beds per 1,000 population. Public and private hospitals provided 5.3 and 3.6 million inpatient episodes of care respectively, and public hospital outpatients provided 16.7 million occasions of service for admitted patients and an additional 25.89 million for non-admitted patients. In 2008-09 an average of 7.1 specialist services were provided per Australian, as measured and rebated through Medicare.

Health financing

In 2009-10, the majority of public health expenditure was paid for by the government (69.9%), which is financed mainly by a combination of Specific Purpose Payments from the Australian Government, and funding by the states and territories from their fiscal resources. In 2009-10, non-government funding for health was 30.1% of total funding. The largest component of non-government funding came from out-of-pocket payments by individuals (17.5% of total funding). Private insurance copayments also contribute, and almost 45% of the population are covered by private insurance. A large share of the government's funding is directed to three national subsidy schemes: the Medicare Benefits Scheme, the Pharmaceuticals Benefits Scheme and the Private Health Insurance Rebate (a 30% rebate from the federal government). The Government also provides significant funding ($13.9 billion in 2009-10) to public hospitals. Medicare is funded by general government taxation plus individual contributions through a Medicare levy on taxable income (1.5%) above a certain threshold. Low-income groups are not required to contribute a Medicare levy. Medicare usually pays, through reimbursement to providers, the full Medicare Benefits Scheme fee for GP services and provides free public hospital care for Australian residents, as an admitted patient, out-patient or emergency department patient. Medicare will provide 85% rebate to patients for out-of-hospital services by a specialist, and subsidize 75% of specialists' fees for inpatients with private insurance. Limited reimbursement is also provided to other eligible health professionals. Medicare also provides a financial safety net for residents that accumulate out-of-pocket expenses for out-of-hospital treatments and medicines that exceed a certain annual threshold.

If patients are charged at the time of receiving GP services, they may be reimbursed by Medicare up to the Medicare Benefits Scheme fee, or they may lodge their account with Medicare and payment is made directly to the practitioner. In this way, patients do not necessarily have to pay at the time of service. Some GPs choose to charge fees in addition to the cost of services as set out in the Medicare Benefits Scheme. Private sector providers also receive Medicare Benefits Scheme funding for services delivered, but may include other charges to the patient. Private hospitals are not bound by the same service obligations as public hospitals and have greater scope for raising revenue through fees. In 2012, general patients will pay up to $35.40 for each item covered under Pharmaceuticals Benefits Scheme, while concessional patients will pay $5.80. Private health insurance covers a proportion of dentistry costs, but there are still relatively high out-of-pocket payments required.

Human Resources

Major cities have a greater number of medical practitioners (392 per 100,000 population) than remote areas 246 per 100,000). The majority of employed nurses work in hospitals, followed by aged care (10.9%). Few nurses are employed by GPs, community health centres, women's health and Aboriginal health services.

Table 3. Selected health professional numbers in Australia

Registered Healthcare Professional	Total No.	Year	Other information
Employed medical practitioners	72,739	2009	93% were clinicians and, of these, 38% were primary care practitioners or GPs
Full time equivalent salaried medical officers (in public hospitals)	32,514	2010-11	In public hospitals
Nurses (in public hospitals)	119,126	2011	65.2% of nurses work in a hospital (not including psychiatric/mental health hospitals)
Nurses (aged care)	40,443	2011	10.9% of nurses work in aged care. There are more nurses working in aged care than any other single clinical area.
Diagnostic and allied health professionals (in public hospitals)	36,993	2010-11	
Practicing dentists	10,404	2006	50.3 per 100,000 population 83% worked in the private sector

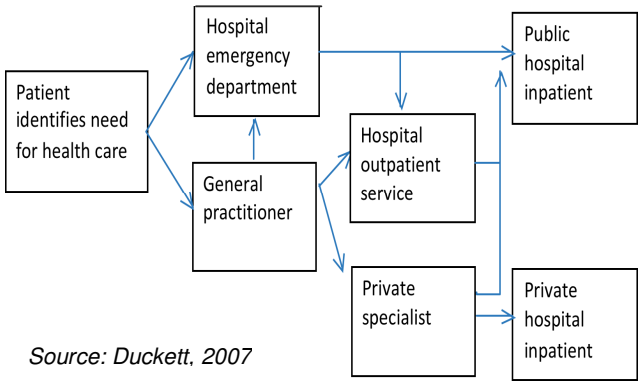
Medicines and therapeutic goods

Medicines accounted for $13.7 billion or 13% of the recurrent health expenditure in 2006-07. Medicines are mostly obtained by patients through prescription or obtained over-the-counter in pharmacies without a prescription. Prescription medicines are primarily provided by community pharmacies and hospitals. The Pharmaceutical Benefits Scheme (PBS) provides the Australian community with reliable, timely and affordable access to necessary and cost-effective medicines at a cost that individuals and the community can afford. This is achieved through the careful assessment, by the Pharmaceutical Benefits Advisory Committee (PBAC), of a medicine's efficacy and cost-effectiveness, including comparisons with other treatments where appropriate. If a medicine is found to be acceptably cost-effective, then the government negotiates its price with the supplier.

The PBAC is an independent expert body appointed by the Australian Government. Members include doctors, health professionals, health economists and consumer representatives. Its primary role is to recommend new medicines for listing on the PBS. No new medicine can be listed unless the committee makes a positive recommendation.

Referrals and linkages through the provider network

Figure 1. Typical sequence and referral pathways to hospital



Source: Duckett, 2007

Many pathways exist into the health service system. GPs and hospital emergency departments are the primary ways into hospital care, as shown in Figure 1.

Incentives are provided for GPs to improve assessments, referrals and ensure coordinated care. For example the Chronic Disease Management item on the Medical Benefits Scheme provides rebates for activities such as undertaking a health assessment, developing a GP management plan and coordinating care with other relevant health professionals. In general though, there is concern over the lack of integration across primary care services and with the acute sector.

Implementation of the service delivery model and package

The primary role of the federal government is to set national health policies and subsidize health services provided by state and territory governments and the private sector. The federal government also funds universal medical services and pharmaceuticals, provides leadership in policy, regulation and funding for public hospitals, and assists funding services for the elderly. It also regulates pharmaceutical and therapeutic goods and appliances, food safety and labelling, and the private health insurance industry. The Department of Health and Ageing manages Medicare and the Pharmaceutical Benefits Scheme. State and Territory governments provide a variety of direct health services including psychiatric and promotive and preventive services. The main health responsibilities of local government are in environmental control, such as garbage disposal, clean water and health inspections. Local governments also provide home care and personal preventive services, such as immunisation and health promotion activities. The Therapeutic Goods Administration, a government agency, is responsible for regulating medicines, including traditional/complementary medicines, medical devices, and other products. The Australian Private Hospitals Association is the industry body for private hospitals and day surgeries in Australia, and other health professionals all have membership bodies representing their interests. The Consumers Health Forum of Australia (CHF) is the national body representing the interests of Australian healthcare consumers through a consultative process.

The Australian health service package is comprehensive and well established, and the implementation has been reasonably stable over the previous five years, with small alterations and improvements being made at a variety of service levels. The health system reforms have been based on broad consultation and evidence. These are only beginning to be implemented and progress and impacts will take time to be realised.

Equity

Universal coverage to health services through Medicare aims to improve equity of access and contribute to health equity. However, one clear and ongoing pattern across all health service sectors, outlined in the *National Health Performance Framework*, is the discrepancies in health between Indigenous and non-Indigenous populations and those living in rural and remote areas. There are also strong inequities in the health status between low and high socioeconomic groups. For example, Indigenous Australians have a life expectancy 10 to 12 years lower than non-Indigenous Australians, more disability and a lower quality of life. Rural people have higher levels of disease risk factors than those living in cities, and disadvantaged Australians are more likely to have shorter lives compared with those who have social and economic advantages. Factors for this include availability and access to services, cultural appropriateness of health services, and affordability.

Although there is targeted support to improve access to primary and community services for those in rural areas and Indigenous Australians, the discrepancies in health status, the determinants of health, and health system performance between population groups raises the question of whether Australia's health system is accessible and equitable for all.

The Commonwealth Government has committed to closing the gap in life expectancy and health outcomes between Indigenous and non-Indigenous Australians within a generation. The National Healthcare Agreement between the Commonwealth and State and Territory Governments includes the following targets:

- to close the gap in life expectancy within a generation;
- to halve the gap in mortality rates for Indigenous children under five within a decade;
- to ensure all Indigenous four year olds in remote communities have access to early childhood education within five years;
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

Quality

Quality and safety of general practice is ensured through the Royal Australian College of General Practitioners Standards, and many practices choose to be formally accredited to these. Improving quality is also a key aim of the Medicare Locals. All public hospitals and health services in Australia are required to be accredited, and this is regarded as a performance indicator relevant to effectiveness of services. The quality of federal funded residential aged care facilities is monitored by the Aged Care Standards and Accreditation Agency. In addition, under the guidance of the Australian Commission of Safety and Quality in Health Care, work is underway to ensure that monitoring of safety and quality are undertaken in all levels of health service delivery, including primary care and community health, and developed at a national level.

Demands and constraints on the service delivery model

A strong economy and a stable, democratically elected government that has a commitment to achieving good health and equity of access to health services provides support for the health of Australians. The recent health reforms have addressed a number of key areas, including:

- A commitment to prevention, the establishment of the ANPHA which complements the good participation in surveillance, screening, immunization and public health risk-based campaign. Further policy commitment may be necessary in areas such as obesity and alcohol to achieve significant improvements in health status.
- Primary health fragmentation and lack of integration as a result of numerous funding bodies involved, and shortfalls in leadership, policy, accountability, and information sharing between services. This is particularly an issue for coordinating care for those with chronic or complex conditions. Although the MBS provides chronic disease-focussed programs, these can be difficult to negotiate and administer for GPs. Primary care reform focuses on Medicare Locals, GP Super Clinics in areas of high demand or poor access to services, and a national call centre network staffed by nurses and GPs to address these issues.
- Increased federal funding and consistent governance and performance reporting of hospitals through local hospital networks. This will also increase local autonomy and flexibility so that services are more responsive to local needs.
- The Australian Government is rolling out a national eHealth record system and people seeking healthcare in Australia can now register for an eHealth record. This is the first step in the development of the eHealth record system, which will continue to be built up in carefully managed stages.

Indicators of progress

The *National Healthcare Agreement 2011* committed federal and state governments to report on a range of performance indicators and benchmarks. The specific *National Partnership Agreements* also include a number of agreed indicators and benchmarks. *The National Health Performance Framework* is agreed to by governments and includes 42 indicators in three domains that provide a broad perspective of Australia's health and health system performance. These will be reported against by the Australian Institute of Health and Welfare in their biennial health report – *Australia's Health*. Considerable data gathering and collection efforts are underway to match data and indicators for future reporting.

- Health status indicators – show that mortality is reducing, levels of certain illnesses and diseases have decreased and life expectancy is one of the highest in the world.
- Determinants of health indicators – show a mixed picture. For example while smoking-related indicators have improved, rates of overweight and obesity have increased.
- Health system performance indicators – present an overall mixed picture. This is partly due to difficulties in establishing trends using available data and the inclusion of some recently developed indicators. Indicators include effectiveness, safety, and responsiveness, continuity of care, accessibility, efficiency and sustainability across each level of health service: population health, primary care, acute care and continuing care.

OECD Health Data 2012 How Does Australia Compare

Total health spending accounted for 9.1% of GDP in Australia in 2009-10, slightly lower than the average of 9.5% in OECD countries in 2010. Health spending as a share of GDP is lower in Australia than in the United States (which spent 17.6% of its GDP on health in 2010) and in a number of European countries including the Netherlands (12.0%), France and Germany (11.6%), and Switzerland (11.4%).

Australia ranks above the OECD average in terms of total health spending per capita, with spending of 3670 USD in 2009-10 (adjusted for purchasing power parity), compared with an OECD average of 3268 USD. Nonetheless, health spending per capita in Australia remains lower than in the United States (which spent 8233 USD per capita in 2010) and a number of other OECD countries including Norway, Switzerland and the Netherlands.

Between 2000 and 2009, total health spending in Australia increased in real terms by 4.6% per year on average, a growth rate similar to the OECD average of 4.7%. Data for 2010 are not yet available for Australia, but the average for other OECD countries with available information was zero growth (i.e. no increase), with several countries (including Ireland, Iceland, Estonia and Greece) seeing substantial negative growth.

The public sector is the main source of health funding in all OECD countries, except Chile, Mexico and the United States. In Australia, 68.5% of health spending was funded by public sources in financial year 2009-10, below the average of 72.2% in OECD countries.

Resources in the health sector (human, physical, technological)

In 2009, Australia had 3.1 practising physicians per 1000 population, the same as the OECD average. Australia has maintained a balance between general practitioners and specialists, each at around 1.5 per 1000 population. There were 10.1 nurses per 1000 population in Australia in 2009, a figure higher than the OECD average of 8.7.

The number of acute care hospital beds in Australia was 3.4 per 1000 population in 2008-09, which was also the OECD average in 2009. As in most OECD countries, the number of hospital beds per capita in Australia has fallen over time. This decline has coincided with a reduction of average length of stays in hospitals and an increase in the number of same-day surgical procedures.
During the past two decades, there has been rapid growth in diagnostic technologies such as CT scanners and magnetic resonance imaging (MRI) units in most OECD countries. In Australia, the number of MRIs increased from 0.6 per million population in 1990 to 5.6 in 2009, although these are only machines eligible for Medicare reimbursement. The OECD average was 12.5 in 2010. Australia had 42.8 CT scanners per million population, well above the average of 22.6.

Health status and risk factors

Most OECD countries have seen substantial gains in life expectancy over past decades, largely due to improvements in living conditions, public health interventions and progress in medical care. In 2010, life expectancy at birth in Australia stood at 81.8 years, two years higher than the OECD average of 79.8. Australia has the fifth highest life expectancy among OECD countries, following Japan, Switzerland, Spain and Italy.

The proportion of adults smoking daily has declined markedly over the past two decades in most OECD countries. Australia has achieved remarkable progress in reducing tobacco consumption, cutting by more than half the percentage of adults who smoke (from 35.4% in 1983 to 15.1% in in 2010). The smoking rate in Australia is now one of the lowest in OECD countries, among a small group of countries including Sweden, Iceland, and the United States. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation.

Obesity rates have increased in recent decades in all OECD countries, although notable differences remain. In Australia, the adult obesity rate, based on measures of height and weight, was 24.6% in 2007. This is lower than in the United States (33.8% in 2008) and Mexico (30.0% in 2006) and about the same as Canada (24.2% in 2008). The average for the 15 OECD countries with recent measured data was 22.2%. Obesity's growing prevalence foreshadows increases in the occurrence of health problems (such as diabetes and cardiovascular diseases), and higher health care costs in the future.

Traditional medicine

Traditional or complementary and alternative medicines (CAM), including Australian indigenous medicine, exist alongside western medicine and contribute to health care.

Traditional/complementary medicine goods and services are widely used in Australia, with a survey of Australian adults showing 68.9% of respondents had used at least one form of traditional/complementary medicine and 44.1% had visited a practitioner in the previous 12 months. Seventeen different types of complementary medicine are used in Australia.

Alternative Medical Systems	1. Acupuncture 2. Homeopathy 3. Naturopathy
Mind-Body Interventions	4. Meditation 5. Yoga
Biologically-based Therapies	6. Aromatherapy 7. Chinese herbal medicine 8. Chinese medicine dietary medicine 9. Clinical nutrition including multivitamins and minerals 10. Western herbal medicine
Manipulative and Body-Based Methods	11. Chinese therapeutic massage 12. Chiropractic 13. Osteopathy 14. Reflexology 15. Western therapeutic massage
Energy Therapies	16. Energy healing (e.g. Reiki) 17. Qi Gong, martial arts and Tai Chi

Australian Indigenous medicine

Aboriginal indigenous medicine is also called “bush medicine”, and uses a range of remedies including wild herbs, animal products, steam baths, clay pits, charcoal and mud, massages, string amulets, secret chants and ceremonies to treat a person’s mind, body, and spirit. Unfortunately, much of the knowledge of traditional Aboriginal medicine has been lost. In recent years there have been attempts to record and test some of the medicinal uses in central and northern Australia - the most notable example being a project called the Aboriginal Pharmacopoeia in the Northern Territory.

National policy and control

Australia has no national policy on TM/CAM. However, the *National Medicines Policy 2000* includes complementary healthcare products. A key component of this policy is the appropriate use of medicines. The *Therapeutic Goods Act (1989)* has been responsible for the regulation of herbal medicines since 1989.

The Therapeutic Goods Administration, a government agency, is responsible for regulating medicines, including traditional/complementary medicines. The Advisory Committee on Complementary Medicines is a national expert committee on traditional/complementary medicines that advises and makes recommendations on the inclusion, variation or retention of complementary medicine products in the Australian Register of Therapeutic Goods. The National Prescribing Service is an independent body that provides prescription, non-prescription, and traditional/complementary medicines information and resources for health practitioners and consumers on improving quality use of medicines. The Australian National Institute of Complementary Medicine is a non-Government organization and hosted by the University of Western Sydney. Traditional/complementary medicines research is also undertaken at other Australian research institutes.

Private health insurance ancillary or 'extras’ cover often includes complementary therapies, particularly chiropractic and osteopathy services. Health insurers are free to determine the nature of TM/CAM services that attract general treatment benefits, and are increasingly including TM/CAM options among their coverage.

Providers of traditional medicine

The federal government recognises the role played by traditional medicine and includes some forms of traditional medicine in its mainstream health services. However, most CAM practitioners deliver services in the private sector, often in their own private clinics. No data is available on the provision of CAM at the primary care level.

There are a number of TM/CAM practitioners registered in the National Registration and Accreditation Scheme for health practitioners.

Furthermore, a number of university and vocational level courses in Australia are available for TM/CAM practitioners including Bachelor and master degrees. These qualifications are shown in Table 5, below.

Table 4. Selected health professionals numbers in Australia

Registered Healthcare Professional	Total No.	Year
Registered acupuncture practitioners	950	2008
Registered chiropractic practitioners	2486	2008
Registered homeopathic medicine practitioners	235	2008
Registered naturopathic medicine practitioners	2982	2008
Registered osteopathic therapy practitioners	776	2008
Registered traditional Chinese medicine practitioners	481	2008
Registered massage therapists	8199	2008
Registered natural remedy consultants	2631	2008
Other registered complementary health therapists	561	2008

Table 5. Traditional and complementary therapy qualifications available in Australia, 2012

Type of CAM Therapy	Qualification
Chinese medicine/acupuncture	Bachelor of Health Science in Traditional Chinese Medicine Bachelor of Health Science (Acupuncture) Diploma of Traditional Chinese Massage
Osteopathy	Currently 3 universities in Australia offer 5-year courses (combined Bachelor and Masters degrees) accredited by the Australian and New Zealand Osteopathic Council.
Chiropractic	3 Australian universities offer generalist chiropractic courses (Bachelor degrees) accredited by the Council on Chiropractic Education Australasia
Naturopathy/Homeopathy/ massage/other complementary therapy	A wide range of vocational level courses for other types of TM/CAM are offered in Australia, including Bachelor degrees, Diplomas, and advanced Diplomas

The Australian Health Practitioner Regulation Agency supports four national health practitioner boards covering TM/CAM practitioners; these are the Chiropractic Board, the Osteopathy Board, the Aboriginal and Torres Strait Islander Health Practice Board, and the Chinese Medicine Board. Currently osteopaths and chiropractors are registered under the National Registration and Accreditation Scheme, and Aboriginal and Torres Strait Islander health practitioners and Chinese medicine practitioners will also be included in this scheme in 2012.

Herbal medicines are sold in pharmacies as over-the-counter drugs, in special outlets, by licensed practitioners, and without restriction.

Research suggests that there is a large market for traditional and complementary medicine in Australia, with an estimated value of US$1.67 billion per annum in 2001.

A 2002 study found that alternative practitioners were used significantly more by people aged 35–54 years compared to other age groups; by those with higher education levels and higher incomes, and women more than men. The main driver of the increasing use of CAM is a desire for improved health and disease resolution, particularly in those with chronic diseases. Other reasons include: high levels of satisfaction with CAM practitioners and how they communicate with clients; inability of orthodox medicine

to treat some chronic conditions; ability of patients to be more involved in their own health care and to take steps to prevent illness; and a desire to avoid the side effects associated with use of conventional medicines.

Quality and safety of complementary medicines

The Therapeutic Goods Administration carries out a range of assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard with the aim of ensuring that the Australian community has access, within a reasonable time, to therapeutic advances. It maintains a database that includes details of all therapeutic goods that are imported into, supplied in, or exported from Australia – the Australian Register of Therapeutic Goods. It is a legal requirement that, unless specifically exempt or excluded, all therapeutic goods are included on this register prior to supply. Complementary medicines may be listed or registered based on low risk. There are 28 registered complementary medicines and more than 14,000 listed medicines on the Australian Register of Therapeutic Goods.

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