

A big future for Australian health services

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Key points

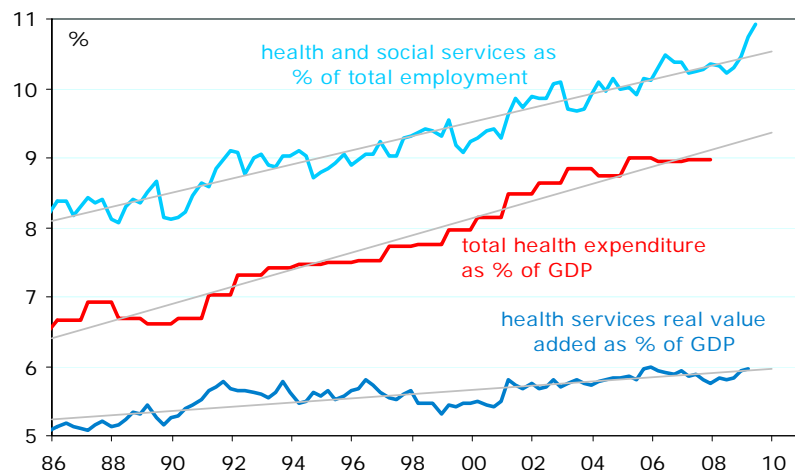
Health services is often singled out as the most 'recession-proof' industry in Australia and elsewhere because it has direct support from government and strong underlying demand based on demographics as well as income. Over two-thirds of our total national health expenditure (currently around \$100 bn) is paid directly by federal, state and local governments. Households directly pay for 17% and the remainder is covered by insurers and non-government agencies. Of these sources, government spending has been growing the fastest due to very large, uncapped healthcare programs such as Medicare (for GP services) and Pharmaceutical Benefits.

So how has health performed in past recessions? Certainly, health services activity and employment have kept rising during recessions (and have even displayed some counter-cyclical characteristics), but evidence from the Australian and US equities markets indicates the performance of health stocks during recessions is not so easily assured.

In Australia, the constant growth of health services, even when other industries have been flat or declining, has seen health services grow as a share of total employment and of the economy more generally (figure 1). Health (inc. aged and community) services is now our second-largest employing industry after retail. In our 'oldest' state, South Australia, it is already the largest employer. On current growth trends, it will become Australia's single largest employing industry within the next few years.

Total health expenditure already accounts for around 9% of GDP and 15% of federal government expenditure. These shares are set to keep rising in coming decades, as Australia's population grows larger, older and wealthier. It is projected to reach 12.4% of GDP within the next 25 years. The latest government report (released on 27 July) to examine the challenges facing our health system recommended major reforms to reduce duplication, fragmentation and adverse events, plus big spending boosts for public hospitals, dental, preventative and community health. The Government will respond to this report and then commence negotiations with the states (through COAG) in 2010, with a view to introducing any agreed healthcare reforms by 2015.

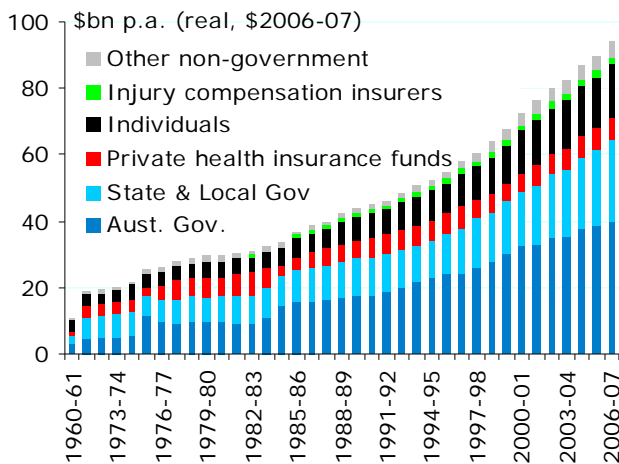
1. The rising economic importance of health services: it is now our second largest area of government expenditure and second largest employer



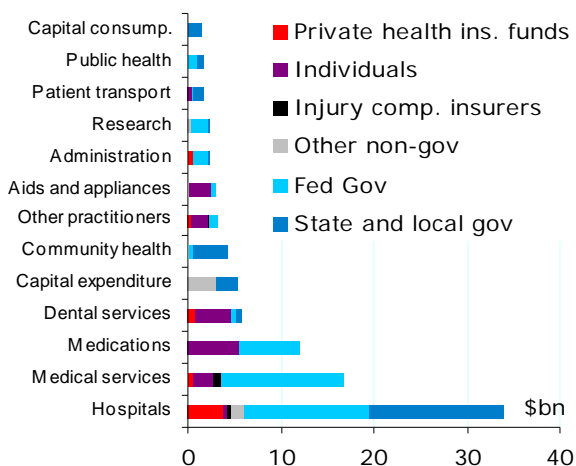
Sources: Australian Institute of Health and Welfare (AIHW), ABS.

Australian health funding

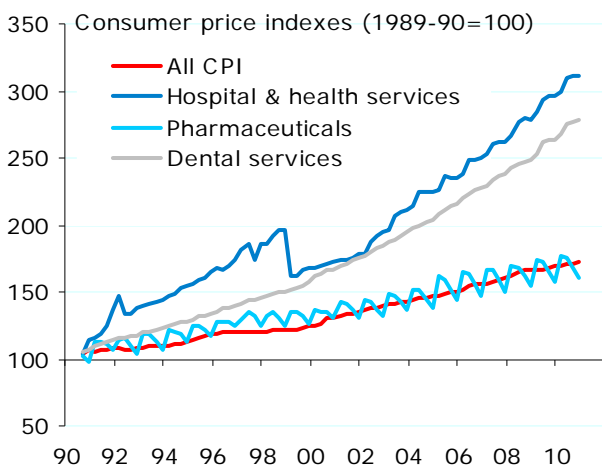
2. Total health expenditure has trebled in the last 25 years, in real terms. Now almost \$100 bn p.a.



3. Hospitals, doctors and medicines dominate our national health spending profile (2006-07 data)



4. Prices for dental, hospital and medical services have risen more strongly than all CPI this decade



Sources: ABS 6401.0, *Consumer Price Index*; AIHW 2008, *Health Expenditure Australia, 2006-07*.

Australian health services are provided by a mix of private (profit and non-profit) and public sector organisations. The majority are located in and/or funded by government. The Australian constitution allocates responsibility for health services to the States, but the Federal Government provides most of the funding, directly or indirectly (figure 2).

The total amount spent on health has been climbing steadily for decades, both absolutely and as a proportion of GDP. In 1961 we spent 3.8% of GDP on healthcare, in 1971 we spent 5% and by 1991 we were spending 7.3%. Both state and federal governments have attempted to reign in this growth in recent years. Measures to tighten Medicare and pharmaceutical benefits costs helped stabilise total health costs at just under 9% of GDP by 2005-06. The AIHW estimates that nationally, we spent \$94bn on health services (excluding community and welfare services) in 2006-07, equal to 8.9% of GDP.

The federal government directly funds 42% of all health expenditure, with another 26% coming from state and local government budgets. A third of direct federal government spending goes on hospitals, a third goes to medical (mainly GP) services and 16% goes on pharmaceuticals. State governments spend most of their health dollars on hospitals (around 60%), with another 15% spent on community health services and 5% on transport.

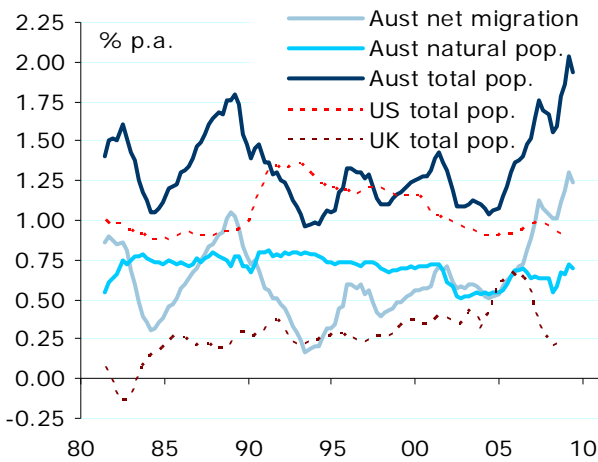
Individuals and householders' direct spending on health services has been very stable since the 1970s, at about 17% of all healthcare spending (and well down from the 30%+ paid by individuals in the 1960s). Household dollars for direct health services (excluding health insurance premiums) are spent mainly on medications (34%), dental services (24%), aids and appliances (14%), out-of-pocket fees for medical (GP) services (12%) and for other (non-GP) medical practitioners (11%) (figure 3).

Despite their high visibility, health insurance funds contribute a surprisingly small share to total health costs (net of government subsidies), at around 7.3%. Their share of total health expenditure has actually fallen in the long-term, reflecting changes in government policy, from around 17% in the 1970s and early 1980s (peaking at 23% in 1982-83) to 11-13% from 1984 to 1996, to 7 to 8% today. The current federal government is reducing the subsidies it pays for private health insurance, but in 2009-10, it will still spend \$4.1bn on health insurance. Over half of health insurers' health spending goes to hospitals and a quarter goes to dental and medical services. Insurers spend 10% on administration, compared with 2.5% of government expenditure.

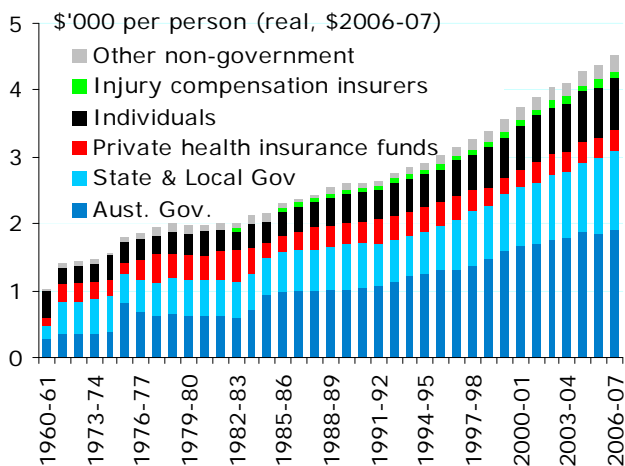
Health expenditure has been rising strongly over the years for both quantity and pricing reasons. As well as buying more health services, many services have also become more expensive relative to other goods and services. Prices for hospital and health services (including health insurance) have grown by over 170% since 1990, compared with 60% for all CPI and 69% for pharmaceuticals (figure 4).

Demand for health services

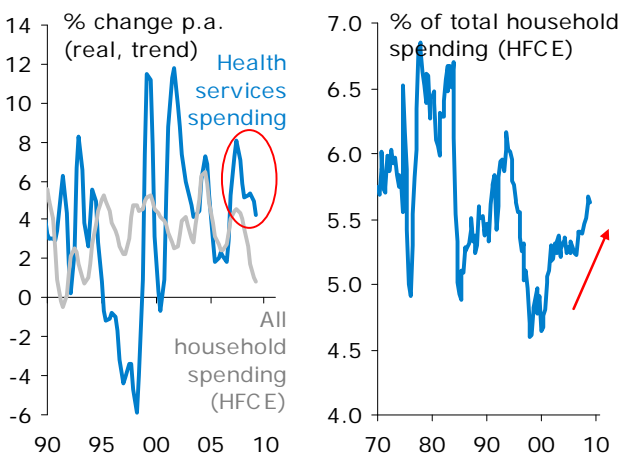
5. Australian population growth is relatively strong, from both net migration and natural pop. sources



6. Not just pop. growth: spending per person rising, as population gets older and wealthier



7. Government pays the lions' share, but health spending* by households is also rising again



* direct spending on health services, exc. health insurance.
Sources: ABS 3101.0, *Demographics Statistics*, ABS 5206.0, *National Accounts*; AIHW 2008, *Health Expenditure Australia, 2006-07*; Thomson Datastream.

Health services are not a 'normal' good or service in economics terms, in that demand for health services is driven less by incomes, wealth and economic cycles and more by demographics, social trends, medical technologies, disease trends and public policy. As noted above, the majority of Australian health expenditure is sourced from government, so government health policy is crucial (see p. 5 below). The total market for healthcare, the population, has been growing strongly in recent years, due to higher immigration and local birthrates (figure 5).

The other key demographic trend for this industry is ageing (i.e. longer life expectancies), since demand for health services rises as people age, absolutely and relative to other goods. In the last national health expenditure survey (2003-04), average direct expenditure by individuals on health services per person was 47% higher for those aged 65 and over than for younger people. And health services took 7.2% of their total spending, compared to 3.7% of for younger people. People tend to have a lower income after retirement, but even when compared to younger people on similar incomes, a higher share of older people's spending went on health.

At the other end of the age scale, children also tend to be high-volume users of health services, from birth through to the teen years. The services they use differ greatly from those for elderly people, including obstetrics, paediatrics, vaccinations, and community and mental health. These services are all seeing a spike in demand as a result of the recent (and possibly temporary) uptick in birth rates.

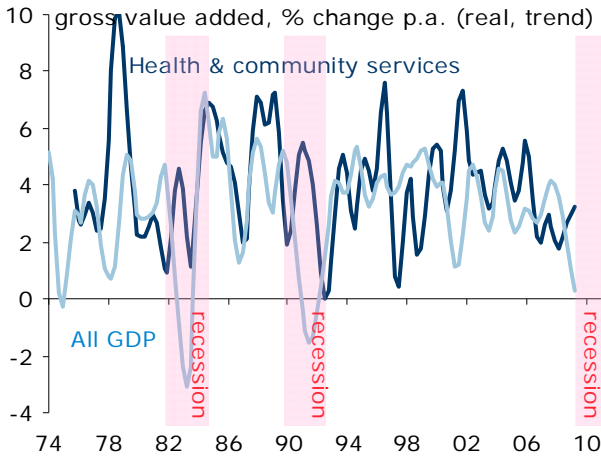
The effects of income and wealth on demand for health services are complex. On average and in aggregate, higher income earners spend more on health services than do lower income earners of the same age (as for most other goods and services). Unusually, health also accounts for a higher share of total expenditure for higher income earners (except for very high income earners). This is mainly due to greater (means-tested) direct government support for health services for those on low incomes.

Although they spend more, national health surveys indicate higher income earners tend to be healthier than lower income earners of the same age, and thus buy different types of health services. There is an element of 'chicken and egg' in any comparison between health status and income however, because illness and disability often reduce a person's ability to work, so low income earners have higher rates of illness and disability, and *vice versa*.

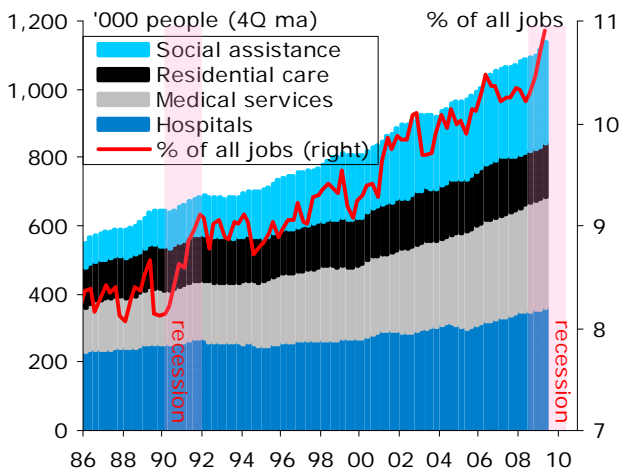
Social trends are another important driver of health demand, on several levels. Social behaviours such as smoking, alcohol consumption, violence, obesity, diet, fitness, and even personal hygiene all affect the need for health interventions. But social trends also affect the health treatments and outcomes that people expect. Health expectations have been rising over time, in line with ongoing advances in medical knowledge and treatments, but also in line with rises in general incomes and social awareness.

Performance in previous Australian recessions

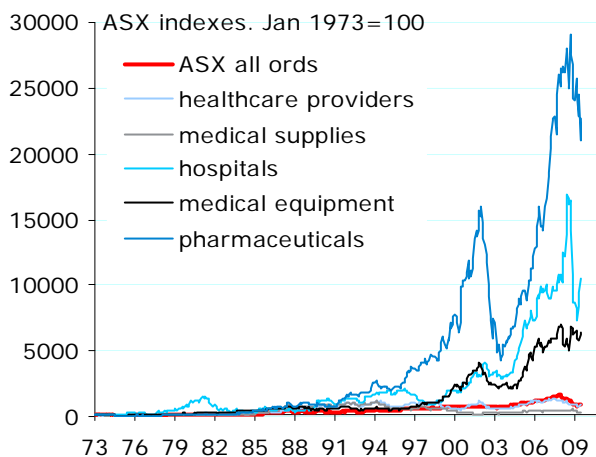
8. Health services has counter-cyclical characteristics; activity *accelerated* in past recessions



9. Healthcare jobs grew absolutely and relatively in the last recession. Repeating this pattern in 2009?



10. Equities: great long-term performance for med. equipment, hospitals and especially pharmaceuticals



Sources: ABS 5206.0, *National Accounts*; ABS 6291.055, *Labour Force Detailed Quarterly*; Thomson Datastream.

While Australian health services are not totally 'recession-proof' (as is sometimes claimed), their solid government support means they are less affected by recessions than other sectors, in terms of both the severity and length of the downturn. Indeed, their large government funding base gives health services some reassuringly counter-cyclical characteristics, because demand is not as directly affected by falling household or private business spending. Less positively, counter-cyclical demand is also supported because more people tend to require health (and related social and community) services during downturns; there is evidence that some physical and mental health conditions become more prevalent due to increased stress and poverty.

These counter-cyclical characteristics can be seen in the 1980s and 1990s recessions in data for activity and employment (figures 8 and 9). From Dec 1981 to Jun 1983, Australian GDP fell in 6 quarters and showed a negative annual growth rate in 4 quarters. In contrast, value added in health services fell in 3 quarters, but showed no negative annual growth. Indeed, annual growth for health accelerated in the middle of this recession. A similar pattern emerged in 1991, and appears to be re-emerging now.

There are no aggregate data that directly measure the profitability of private sector health providers, but Australian stock exchange (ASX) indexes provide an indication of the fortunes of larger, listed operators. In the long-term, 'medical equipment', 'hospitals' and especially 'pharmaceuticals' strongly outperformed the ASX All Ordinaries Index. 'Healthcare providers' tracked more closely to the rest of the market, while 'medical supplies' have under-performed since the late 1990s (figure 10).

But how do health-related equities perform during market downturns? A basic peak-to-trough analysis shows health-related equities performed better than the market average (the All Ords) during 5 of the 6 ASX crashes over the last 30 years (see p. 7). In 1973-74, 1981-82, 1987-88, 1994-95 and most recently 2007-2009, healthcare equities fell by a lower proportion (peak to trough) than the market average. In 2002-03 however, they fell by more, with the normally bullet-proof pharmaceuticals stocks falling the most, at -67% compared to -30% for all healthcare stocks and -18% for the All Ords. So although healthcare equities do, on average, outperform the ASX market average during downturns, they are not guaranteed to do so. Some of these results may of course reflect non-market events, such as concurrent changes in government health policy (e.g. the privatisation and ASX listing of CSL Ltd in 1994) or health scares (e.g. avian flu).

Internationally, McKinsey and Co have found similar recession experiences for healthcare in the US, with no measurable effect on sales and earnings for healthcare in 1990 or 2001, and only a short, weak effect in 1973-75 and 1980-82. In those recessions, healthcare was one of the first sectors to recover. McKinsey found US share price performances tended to converge to the average during recessions.

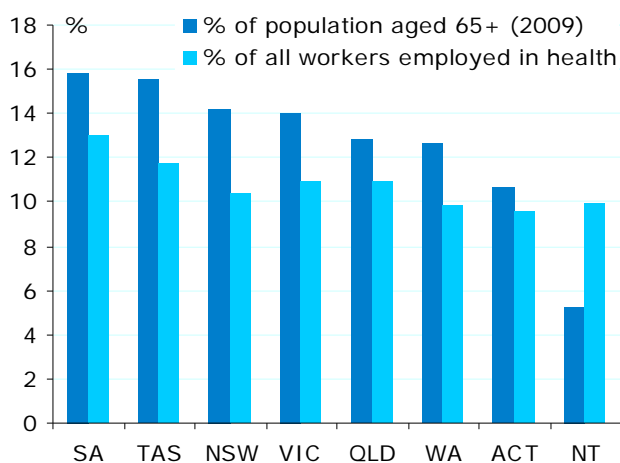
Short-term outlook: current policy and economy

11. Australian government health budget allocations

expenses, \$mn	2009-10	2010-11	2011-12	2012-13
Medical services & benefits	21,221	21,000	21,975	22,801
- Medicare benefits	15,003	15,649	16,498	17,311
- health insurance	4,115	3,264	3,355	3,313
- veterans	959	974	987	1,000
Hospital services	1,689	1,687	1,742	1,780
States' healthcare agreements/specific purpose payments	11,530	12,404	13,033	13,910
Pharmaceuticals	9,873	10,440	10,926	11,092
- PBS concessional	5,442	5,794	6,142	6,498
- PBS general	1,549	1,652	1,745	1,840
- PBS specialised	879	954	1,026	1,039
- PBS vaccines	328	332	338	343
- Other PBS	1,225	1,277	1,261	976
ATSI health	634	682	687	661
Other health services	4,598	5,174	5,382	5,470
Administration	1,677	1,814	1,874	1,914
Total expenses	51,223	53,201	55,619	57,628
% of total gov. exp.	15.1	15.4	15.6	15.4
Net cap. investment	153	-22	-34	-18
Purchase of non-financial assets	149	51	61	62

Source: *Federal Budget 2009-10*, Budget Paper No. 1, Statement 6: Expenses and Net Capital Investment.

12. Sign of things to come: SA has the 'oldest' populations AND the largest health workforce



Source: ABS 3222.0, *Population projections 2006-2101*; ABS 6291.055, *Labour Force Detailed Quarterly*.

In this year's Federal Budget, health services will take 15.1% of all government expenses, second only to social security and welfare payments (32.8%). Health spending will grow by 2% p.a. in real terms over the next 4 years and its share of government spending will continue to drift up (in contrast to the 2% 'efficiency dividend' being sought from most other government programs). The single largest area of expenditure, Medicare benefits for GP services, will grow by 2.8% p.a. in real terms. Payments to the states for hospital, dental and other services is projected to grow by 4.9% p.a. Pharmaceuticals spending will grow by 1.9% p.a. in real terms due to 'new high cost drug listings' on the PBS and 'increased use of drugs associated with an ageing population'. Health insurance is one of the few areas of government spending projected to shrink during the Budget outlook period (figure 11).

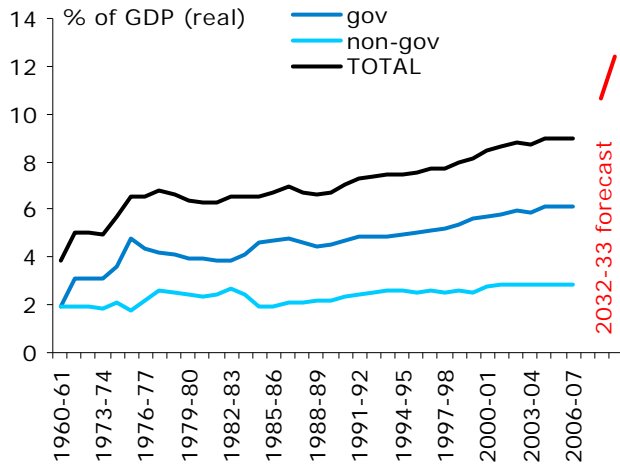
The effect of population ageing on health spending is most apparent in South Australia and Tasmania, which currently have the 'oldest' age profiles of Australia's states (figure 12). In SA, health services (including aged care and welfare services) has been the single largest employer since 2003. In Tasmania, health has been the second largest employer since 2003, and is set to overtake retail trade as the state's top employer during 2010. Nationally, health services overtook manufacturing as our second largest employer in 2006. And on current growth trends, health is likely to overtake retail trade as our single largest employing industry within the next two years — possibly sooner if retail loses more jobs during this recession, as expected.

The latest government report to examine ageing, skills shortages, funding, coordination and a myriad of other health system challenges was released in July by the National Health and Hospitals Reform Commission (NHHRC). The NHHRC made over 120 recommendations to improve the effectiveness and efficiency of the national health system. Foremost among these is that the federal government should take direct responsibility for all primary healthcare and should introduce a universal dental service by 2015. National electronic health records should be introduced by 2012 and more resources should be directed to preventative and community health, especially for chronic diseases. A federal take-over of acute hospital care is also to be considered. The NHHRC costed its recommendations at up to \$5.7bn p.a. (11% of the current federal health budget), plus \$3.6bn p.a. for a new national dental service, plus up to \$7bn in one-off capital expenditure. It anticipates savings of \$4bn p.a. would be recouped by 2032, by reducing hospital admissions, reducing adverse events and improving services' efficiency.

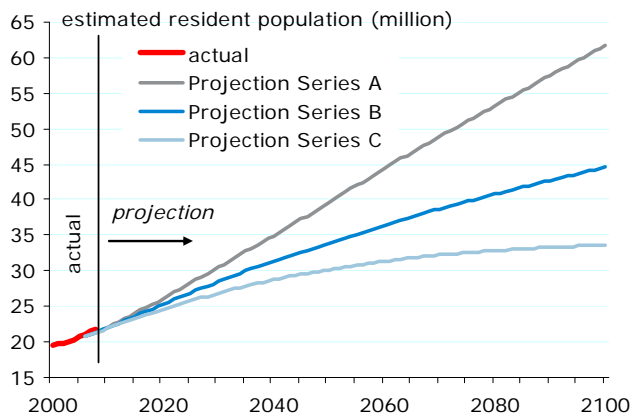
Prime Minister Rudd announced the government will hold public consultations and will then negotiate a national health reform agenda with the States (through the COAG) in 2010. If that process fails, then a referendum asking Australia to cede control of most health services from the states to the Commonwealth may be considered as a final option.

Long-term outlook: demographic and other trends

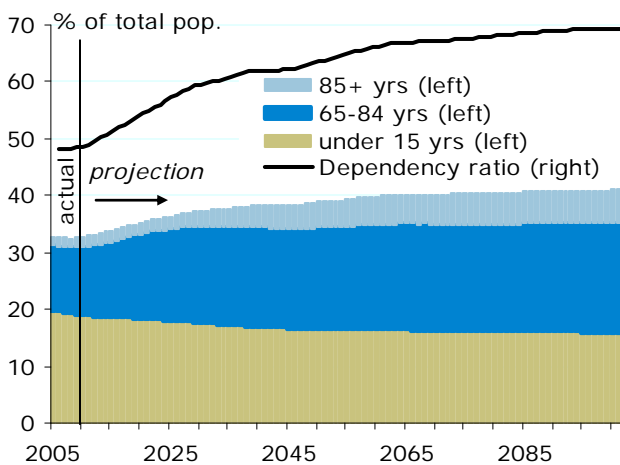
13. Total health & aged care spending will climb from 9% of GDP today, to 12.4% by 2032-33



14. Australian population projections



15. Australian age projections (series B)



Sources: ABS 3222.0, *Population projections 2006-2101*; AIHW 2008, *Projections of Aust health care expenditure*.

The long-term drivers of demand for health services are demographics, incomes and medical technology. Social and environmental changes will also play a role, but their likely effects are difficult to quantify.

The AIHW expects real health (including aged care) expenditure will grow more strongly than all GDP growth, taking total expenditure from its current 9% of GDP to 12.4% by 2033. The AIHW expects half of this growth will come from more medical treatments *per patient*, with a quarter of the increase coming from ageing and a fifth from population growth. That is, almost half of the growth in spending will be driven by demographics, and half will be driven by rising incomes and greater expectations and use of medical technologies and treatments. Improvements in diagnostic accuracy and timing for example, will see increased proportions of people with each disease being diagnosed and treated. All of this will outweigh the benefits of a small projected improvement in disease prevalence rates (see p. 8).

Several scenarios are possible for future population growth (figure 14). Of the scenarios analysed in detail by the ABS, series B most closely reflects current trends in fertility, life expectancy and net migration. Series A and C are based on higher and lower assumptions for these variables respectively.

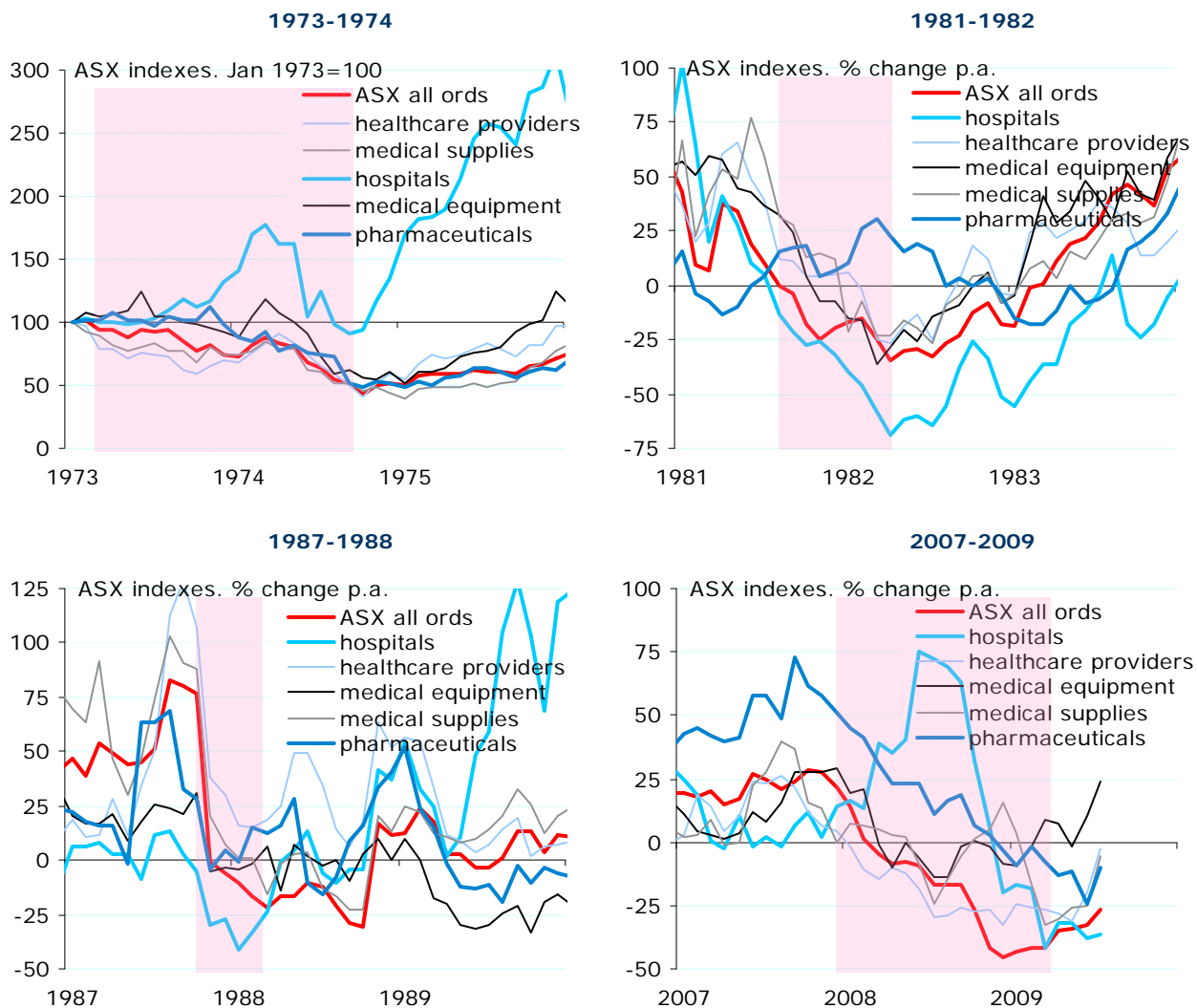
The recent spike in Australian population growth has pushed actual growth rates above even the highest scenario, series A. Population growth is, however, likely to fall from these recent peaks due to the recession, as net migration and birth rates tend to wane during such downturns. Series B therefore remains the most plausible projection. It implies a total population of 25 mn in 2020, 34 mn in 2050 and 40 mn (double our current population) by 2080. (Series A would see our population double by 2055).

The second long-term demographic trend is of course ageing. This has been a significant trend for some time, and is set to continue. In 2008, 13% of the population were aged over 65 years. This is expected to rise to 17% by 2020 and 22% by 2050. At the other end of the age scale, despite the recent mini baby-boom, the proportion of children (aged under 15 years) is projected to ease from 19% in 2008 to 16% by the end of the century (figure 15).

Ageing affects not only total health expenditure, but also the type of conditions that need to be treated and the type of services that need to be provided. For example, the AIHW estimates that ageing will cause a large increase in cardiovascular, neurological and musculoskeletal conditions, but a (smaller) decrease in demand for maternal, neonatal, dental and mental services. Rising prevalence rates for diabetes (especially type II) will also be a major contributor to growth (see p. 8).

Other, less quantifiable factors that will affect long-term health demand and spending include social changes and climate change. Local climate change may, for example, see demand for respiratory treatments grow by more than is currently forecast.

Australian health-related equities indexes, 1973 to 2009



All Ord's and health related ASX indexes, % change from peaks to troughs (Jan 1973 = 100. Monthly data)

Downturn event	peak/trough month	All Ords Index*	All health services	Hospital services	Healthcare providers	Medical equipment	Medical supplies	Pharmaceuticals
1973-74	Feb '73							
% fall	Oct '74	-58.24	-55.47	-9.10	-57.43	-47.73	-51.20	-51.94
1981-82	June '81							
% fall	Apr '82	-35.44	-11.96	-66.13	-20.69	-29.42	-29.23	22.31
1987-88	Oct '87							
% fall	Feb '88	-44.19	-39.71	-34.62	-27.10	-17.19	-33.22	-13.80
1994-95	Feb '94							
% fall	Feb '95	-20.65	-19.40	7.89	-35.78	-31.49	-46.50	-23.70
2002-03	Feb '02							
% fall	Mar '03	-17.55	-29.94	-6.20	-48.18	-35.35	2.33	-67.21
2007-09	Nov '07							
% fall	Mar '09	-53.25	-17.42	-28.76	-36.60	-12.68	-33.53	-5.69

*All Ordinaries Index, Jan 1971 = 100 (rebased for comparison purposes to Jan 1973). All medical indexes, Jan 1973 = 100. A red entry indicates the index fell by more than the all ordinaries index over the same period.

Sources: Thomson Datastream, ANZ Economics and Markets Research.

Expected growth in total Australian health and residential aged care expenditure*, 2002–03 to 2032–33

By:	2002-03	2032-33	Growth	Contributions to growth (%)					
Condition	real \$mn	real \$mn	%	Age-ing	Pop. growth	Disease rate	Volume per case	Treatment advances	Price
Cardiovascular	9,329	22559	141.8	48.3	28.0	-24.0	31.4	5.1	11.3
Respiratory	7,188	21947	205.3	3.3	-0.2	3.9	84.2	0.0	8.8
Injuries	6,650	14353	115.8	15.4	31.9	-21.6	60.9	0.0	13.4
Dental	5,888	14925	153.5	-1.5	30.9	-1.2	66.9	0.0	4.9
Mental	5,147	12109	135.3	-0.9	31.6	2.6	63.1	0.0	3.7
Digestive	4,877	16488	238.1	13.3	23.7	3.1	58.1	0.0	1.6
Neurological	4,727	21560	356.1	48.1	17.7	3.7	25.4	0.0	5.1
- Dementia	3,847	17837	363.7	55.1	17.2	3.6	19.9	0.0	4.3
- Parkinson's	323	1399	333.1	46.5	16.7	1.9	36.2	0.0	-1.9
- Other neurol.	557	2325	317.4	-6.8	22.6	6.2	62.2	0.0	15.3
Sense disorders	2,636	8859	236.1	56.9	33.3	4.2	52.9	0.0	10.8
Musculoskeletal	4,411	14234	222.7	24.4	13.5	2.0	32.0	0.0	1.1
Genitourinary	3,678	10857	195.2	33.8	19.9	-16.7	51.3	0.1	3.8
Cancer	3,487	10112	190.0	48.9	12.2	-0.5	34.4	0.0	-1.1
Endocrine, etc	2,584	6395	147.5	-5.2	29.1	3.1	83.4	0.0	-10.8
Skin	2,373	7767	227.3	5.9	27.1	5.2	50.6	0.0	11.3
Maternal	2,150	3953	83.9	-30.0	39.9	0.0	78.8	0.0	11.1
Infectious	1,890	4673	147.2	2.5	29.5	2.5	57.9	0.0	8.3
Diabetes	1,607	8610	435.8	21.0	15.3	25.7	36.4	1.7	0.1
- Type 2 diab.	1,296	8041	520.4	21.3	14.2	26.2	37.4	1.8	-1.0
Neonatal	631	1185	87.8	-32.5	39.7	0.0	81.2	0.0	10.8
Congenital	310	633	104.2	-18.6	37.2	0.0	71.2	0.0	12.4
Other#	15,500	44,837	189.3	26.5	21.7	-0.2	47.8	0.8	5.4
Total	85,063	246,056	189.3	23.4	21.4	-1.4	50.5	0.6	5.5
Service	2002-03	2032-33	Growth	Top 5 disorders contributing to growth (% growth)					
	Real \$mn	Real \$mn	%	1	2	3	4	5	
Admitted patients	25,926	81,425	214	Diabetes (508%)	Neurolog (383%)	Senses (334%)	Skin (285%)	Respir (264%)	
Out of hospital medical	10,859	27,952	157	Diabetes (451%)	Neurolog (270%)	Senses (228%)	Digestive (187%)	Skin (175%)	
Pharmac.	10,865	28,544	163	Neurological (394%)	Diabetes (376%)	Senses (307%)	Musculoske (307%)	Cancer (244%)	
Residential aged care	7,528	29,725	295	Diabetes (519%)	Senses (408%)	Neurolog (360%)	Musculoske (307%)	Skin (293%)	
Other health	29,885	78,410	162	-	-	-	-	-	
Total	85,063	246,056	189	Diabetes 435% (type 2: 520%)	Neurolog 356%	Digestive 238%	Sense dis. 236%	Skin 227%	

* real expenditure, in 2006-07 dollars. Includes all expenditure for direct health services and residential aged care (high care).

"Other" includes expenditures which cannot be allocated by disease. It includes signs, symptoms and ill-defined conditions where the cause of the problem is unknown, such as fertility control, reproduction and development; elective plastic surgery; general prevention, screening and health examination; and treatment and aftercare for unspecified disease.

Source: AIHW 2008, *Projections of Australian health care expenditure*.

International comparison of selected health indicators, 2006

Country	Health resources				Health outcomes			
	Total health expenditure	Total health expenditure	Practicing physicians	Hospital beds	Life expectancy at birth	Infant mortality rate	Potential years of life lost *	Potential years of life lost *
	% of GDP	US\$ PPP per person	per 1,000 people	per 1,000 people	years	per 1,000 live births	per 100,000 females aged 0-69	per 100,000 males aged 0-69
Australia	8.7	3,141	2.8 (2005)	3.9 (2005)	81.1	4.7	2,362 (2003)	4,082 (2003)
Austria	10.1	3,606	3.6	7.6	79.9	3.6	2,127	4,221
Belgium	10.3	3,462	4.0	6.7	79.5	3.7 (2005)	na	na
Canada	10.0	3,678	2.1	3.4 (2005)	80.4(2005)	5.4 (2005)	2,554 (2004)	4,168 (2004)
Czech R.	6.8	1,509	3.6	8.2	76.7	3.3	2,686 (2005)	5,791 (2005)
Denmark	9.5	3,362	3.3 (2005)	3.6	78.4	3.8	3,081 (2001)	4,723 (2001)
Finland	8.2	2,668	2.7	6.9	79.5	2.8	2,195	5,037
France	11.0	3,449	3.4	7.2	80.9	3.8	2,292 (2005)	4,805 (2005)
Germany	10.6	3,371	3.5	8.3	79.8	3.8	2,226	4,062
Greece	9.1	2,483	5.0 (2005)	4.7 (2005)	79.6	3.7	1,957	4,332
Hungary	8.3	1,504	3.0	7.9	73.2	5.7	4,032 (2005)	9,235 (2005)
Iceland	9.1	3,340	3.7	na	81.2	1.4	1,724 (2005)	2,946 (2005)
Ireland	7.5	3,082	2.9	5.6 (2005)	79.7	3.7	2,289	3,848
Italy	9.0	2,614	3.7	4.0	80.9(2004)	3.9 (2004)	2,126 (2003)	4,018 (2003)
Japan	8.1	2,578	2.1	14.0	82.4	2.6	1,880	3,483
Korea	6.4	1,464	1.7	8.5	79.1	5.3 (2002)	2,227	4,568
Mexico	6.6	794	1.9	1.7	75.7	18.1	5,206 (2005)	8,669 (2005)
Netherlands	9.5 (2004)	3,156 (2004)	3.8	4.5	79.8	4.4	2,377	3,402
New Zealand	8.0 (2004)	1,856 (2003)	2.3	na	80.2	5.2	3,008 (2004)	4,529 (2004)
Norway	8.7	4,520	3.7	3.6	80.6	3.2	2,210 (2005)	3,720 (2005)
Poland	6.2	910	2.2	6.5	75.3	6.0	3,211	7,962
Portugal	10.2	2,120	3.4 (2005)	3.6 (2005)	78.9	3.3	2,858 (2003)	6,024 (2003)
Slovak R.	7.4	1,308	3.1 (2004)	6.7	74.3	6.6	3,343 (2005)	7,732 (2005)
Spain	8.4	2,458	3.6	3.4 (2005)	81.1	3.8	2,000 (2005)	4,399 (2005)
Sweden	9.2	3,202	3.5 (2005)	na	80.8	2.8	2,306 (2004)	3,535 (2004)
Switz.	11.3	4,311	3.8	3.5	81.7	4.4	2,058 (2005)	3,630 (2005)
Turkey	5.7 (2005)	591 (2005)	1.6	2.7	71.6	22.6	na	na
UK	8.4	2,760	2.5	3.6	79.1(2005)	5.0	2,649 (2005)	4,326 (2005)
US	15.3	6,714	2.4	3.2	77.8(2005)	6.9 (2005)	3,633 (2005)	6,291 (2005)
Average	9.0	2,915	3.0	5.7	78.7	5.4	2,552	4,962

Notes: all data are for 2006 unless otherwise stated. Averages are for all countries reporting data in 2005 and/or 2006.

* estimated years of healthy life 'lost' due to accident, injury, illness, disability and all other causes. For definitions, see OECD.

Source: OECD 2008, *OECD Health Data 2008: Statistics and Indicators for 30 Countries* (released Dec 2008). www.oecd.org.

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