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The Australian Health Care System

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1. INTRODUCTION

Australia is a federation of states, which provides its residents with universal access to health care and has managed to control total health care expenditure to around 8.4% of GDP in 1996/97. Unlike other countries that have managed to contain health care expenditure through a strong centrally funded health care system, Australia also has substantial private financing and provision of health care services, being second only to the United States in the OECD in terms of private financing of health care.

The federal nature of government in Australia has resulted in a somewhat unequal division of responsibility for different aspects of service funding and delivery through different levels of government. This is no less the case in terms of health care services, in which funding is largely the responsibility of the Commonwealth government but service provision and coordination is largely the responsibility of the state governments (see Table 1).[1]

The result is that the Australian health care system is a multi-faceted system, characterised by a complex interaction between governments on the one hand, and public and private purchase and delivery of health care services on the other. The question remains as to the capacity of such a mixed system of financing and provision to achieve some level of technical and allocative efficiency, whilst ensuring that universality and equity of access are maintained.

In discussing these tensions we should not only consider the relationship between the various levels of governments, but also between the public and private systems, and the tenuous balance that exists in striving to achieve the broader objectives of efficiency and equity. Exploring these issues requires that we have some understanding of the history of the Australian system, its current organisation and the tensions that exist within. This is the focus of the following paper.

The paper begins with an overview of the Australian Health care system. The remainder of the paper expands on this overview to provide a more detailed account of the Australian health care system, starting with the history of the current system. The following section details the nature of financing in both the public and private sectors, with specific attention to the financing of hospital services. Provision of health care services is subsequently discussed. In each of these sections a vignette is offered to illustrate the machinations of the system that come into play when an individual accesses health care. More specialised health care initiatives are discussed in the penultimate section, the closing section offering some discussion on the implications of the current system.

[1] States refers to all the states and territories that comprise the Australian federation: New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory.

2. OVERVIEW OF THE AUSTRALIAN SYSTEM

Perhaps the most notable feature of the Australian health care system is the fact that it offers a dual system of public and private health care financing and delivery (see Diagram 1). Overall the public system accounted for 68.6% of total health care expenditure in 1995/96, with 10.5% funded by private health insurance and the remainder through individuals self funding (AIHW,1998a).

The basic tenet driving the public system is universal access to needed health care irrespective of ability to pay. Medicare, the compulsory income tax based system of public health care insurance, covers ambulatory medical services and provides that all residents are entitled to treatment in public hospitals without charge.

Private health insurance covers treatment as a private patient in a public hospital, and private hospital care. The latter has resulted in the growth of a significant private hospital sector, accounting for 30% of all hospital admissions and 25% of all bed-days.

Although the use of private hospitals has increased over the last ten years, the proportion of the population covered by private health insurance has fallen from 50% to just over 30% in 1997/98. This anomaly is explained by the structure of private health insurance, with basic insurance covering private treatment in a public hospital, supplementary insurance, and private hospital care. Basic hospital cover and the proportion of public hospital admissions of private patients have fallen but supplementary cover has remained stable.

The fall in population coverage by private health insurance can be attributed to a number of factors:

- premiums have risen faster than general inflation;
- premiums must be community rated, that is an insurance company must offer the same premium to all, irrespective of risk; and

- there are often large copayments for patients as insurance does not meet all the expenses associated with health care.

The result has been an insurance market beset by problems of adverse selection and a declining customer base.

Recent policy initiatives have sought to address the issue of maintaining private insurance cover while preserving the universality of the public system and community rating premiums. These initiatives have taken the form of a rebate on insurance premiums for lower income earners and a tax surcharge for higher income earners who do not have private insurance. This has been replaced by a non-means tested 30% rebate on insurance costs. Furthermore, new legislation has facilitated the development of preferred provider arrangements, boosting the services private health insurers may offer to customers and reducing copayments. The development of lifetime community rating, to address problems of adverse selection, is being investigated.

Although the growth of private health care and market systems is seen by some as the best means to contain health care expenditure (Moran, 1998), Australia has had reasonable success at cost containment with a predominantly public system. This has been achieved through controls in both pharmaceutical and medical services expenditure.

Public funding of pharmaceutical products in Australia provides patients with access to products listed under the Pharmaceutical Benefits Schedule (PBS) at a subsidised cost to the patient. These products may be obtained in a hospital setting, in which case there is no cost to the patient, or through community pharmacies requiring some patient payment.

The Commonwealth government heavily regulates the listing of products on the PBS. Australia is the world leader in requiring manufacturers of pharmaceutical products to submit economic evaluations prior to listing a product on the PBS, thereby restricting its supply. This strategy was not aimed at cost containment per se but rather at ensuring value for money

in pharmaceutical products. However it is not clear whether this will translate into lower pharmaceutical costs in practical terms.

In any event, such regulation must be seen in the context of a series of supply side initiatives, which are more clearly aimed at controlling total costs. These include the introduction of consumer copayments and generic prescribing to allow cheaper equivalent brands to be substituted.

Medical services are also remunerated under fee for service, and potentially an open-ended budget commitment. The Commonwealth government has an important influence on medical prices by setting fees for the payment of Medicare rebates under the Medicare Benefits Schedule (MBS). This acts as a price floor in that providers are permitted to charge above the Medicare scheduled fee. However, the increase in the number of providers over the last decade has led to increased price competition, at least in the cities. This has resulted in many providers billing services directly to Medicare, thereby eliminating patient copayments.

Other strategies that have been employed to contain medical services budgets are the development of an organisational structure for primary care doctors, alternatives to fee for service income and a restriction on the number of new doctors eligible to receive Medicare rebates.

Perhaps more important in terms of containing total health care expenditure is the control of hospital based spending. In Australia, state governments fund public hospitals and their budgets can and have been capped. The need to manage public hospital budgets has led to substantial variations in funding mechanisms across the states. All states have moved away from historical deficit funding. One approach is to fund hospitals according to their case-mix (a DRG based payment system), as is the case in Victoria.

The alternative approach, adopted by New South Wales (NSW), is to fund health services through a geographically based administration. These are areas funded according to

population need and are responsible for matching services to need. Technical efficiency has been improved under both funding approaches but there have been different results in terms of changing patterns of resource allocation. This is not surprising given that substantial variation is possible within the parameters of universal access.

Australia provides an interesting case study in terms of two aspects of its health system. First, it has achieved universal cover and total cost control with mixed public and private financing. Second, although the basic structure of the system has remained unchanged, substantial reform has been achieved through incremental and piecemeal approaches. Cost control has been achieved in the fee for service components of the system through the government's role in price setting. Many of the strategies employed have been part of a broader approach to quality, safety and appropriateness of care.

More important in terms of cost control is the capacity to cap hospital spending through the states. The Commonwealth government is able to exert considerable leverage on the states through its funding mechanism, and that has assured the universal right to free hospital treatment. A significant private sector continues to co-exist with the public sector, providing an alternative for those who wish to buy more than the public sector can provide.

However, private health insurance faces adverse selection problems and substantial government support has been provided in an attempt to overcome this. The result is a complex system in which the Commonwealth government, state governments, and the private sector all share in the funding and provision of health care services.

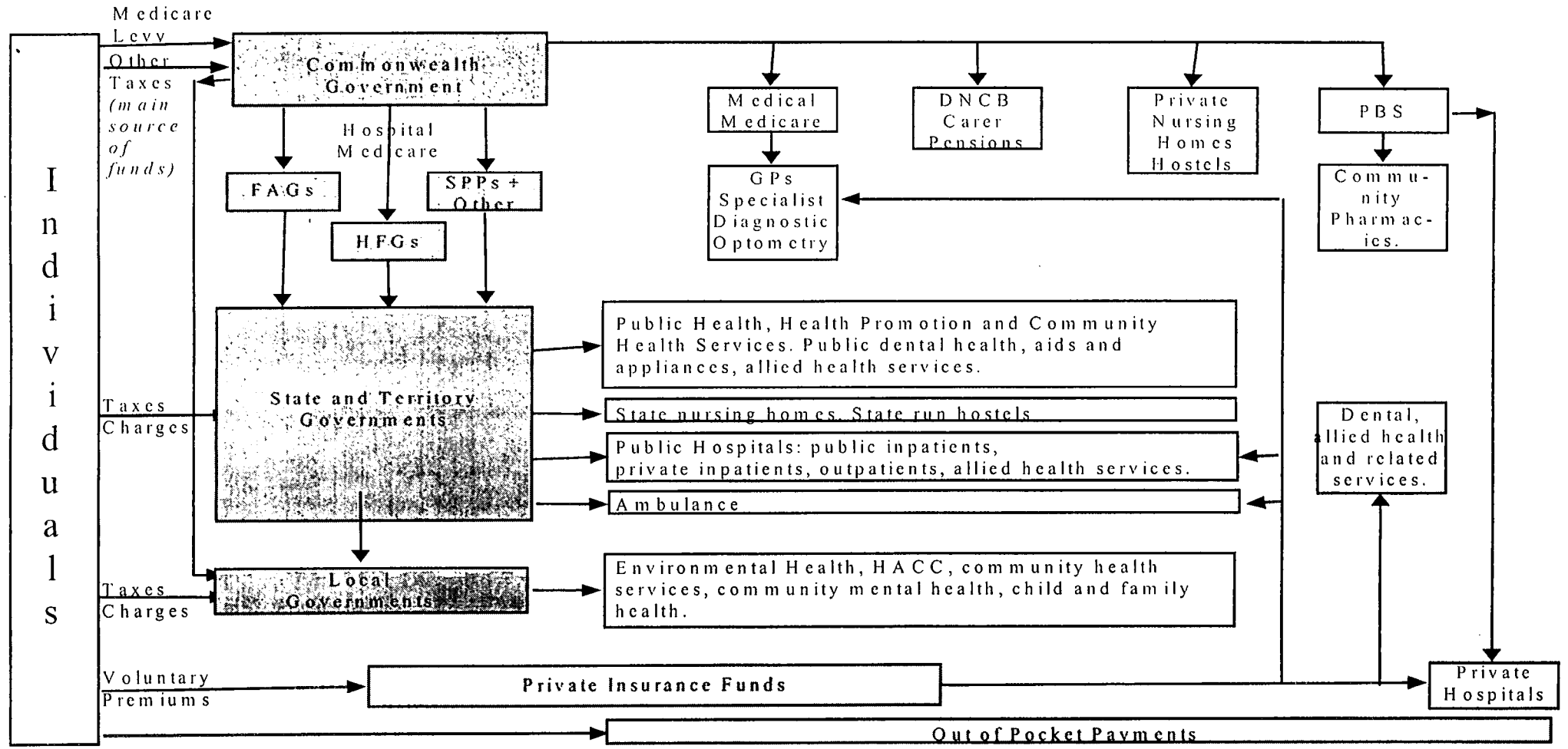
TABLE 1: SUMMARY OF CURRENT DIVISION OF GOVERNMENT HEALTH CARE RESPONSIBILITIES

	Commonwealth	States	Local	Mixed
Public Hospitals	• provision of medical benefits to private patients in public hospitals.	• responsible for administration of public hospitals and for determining mix and location of services.		• public hospitals are funded by Commonwealth, States and private payments.
Private Hospitals	• provision of medical benefits for patients in private hospitals. • Regulation of health funds. • Reimbursing veterans' stays in hospital.	• regulation of private hospital ownership and location.		• various private patient fees are set following Commonwealth and State consultation.
Pharmaceutical Services	• funding and administration of pharmaceutical services provided in community pharmacies through the PBS • partial funding of pharmaceutical costs in private hospitals.	• administration of pharmaceutical services provided in public hospitals. • regulation of ownership, standards etc. of community pharmacists and pharmacies.		• joint funding between Commonwealth and States of public hospital pharmacies.
Medical Services	• provides funding for all, or part of fees charged to individuals through MBS.	• funding of medical services provided in community-based services. • determines the service level and administers.		• joint Commonwealth and State funding of non-inpatient medical services in public hospitals.
Aged Care and Community	• partial funding of residential care for the aged through	• partial funding of residential care through State nursing	• provision of community health	• joint Commonwealth

Health Services	nursing homes and hostels. • partial funding of variety of respite care programs. • provision of employment and related services through the CSDA. • partial funding of Community Aged Care Packages.	homes. • provision of accommodation, respite and other support services under CSDA. • funding of respite care services.	centres, centres for handicapped, baby health centres, home care services, school health services, education services etc. • provision and funding of Home and Community Care (HACC) services.	and State funding of CSDA services. • joint Commonwealth and State funding of HACC services
Dental Health Services	• dental services to veterans.	• funds and administers various dental schemes: school dental, dental hospital, pensioner dental, low income dental		
Mental Health Services	• funding of mental health services under MBS and PBS, and for veterans.	• planning and delivery of mental health services.		• joint Commonwealth and State funding of mental health services.
Public Health Services	• responsible for quarantine. • responsible for the Public Health Outcome Funding Agreement (PHOFA).	• administration and supplementary funding of PHOFA services and other public health services.	• provision of immunisation, hygiene and sanitation services.	• funding of public health by both Commonwealth and States.

Source: National Health Strategy, 1991; Commonwealth Government, 1998.

DIAGRAM 1: THE AUSTRALIAN HEALTH CARE SYSTEM



3. HISTORY

The complexities of the Australian health care system stem largely from the historical arrangements that underpin the current system. More precisely, health care in Australia has been subject to a myriad of piecemeal and ad hoc changes throughout most of the last century. These changes, which have occurred at all levels of service provision and funding, have resulted in a lack of clear direction and consistency between the states and Commonwealth in regard to the organisation and delivery of health care (NHS, 1991a).

From the turn of the century until the 1940s, health care in Australia was based on a system of medical philanthropy. Medical practitioners operated through solo private practice, with charitable hospitals providing free medical services to the poor. Individuals able to contribute toward health care insurance could join friendly societies. These purchased medical services from private practitioners and public hospitals, on behalf of their members (mainly low and middle-income earners) (Scotton & Macdonald, 1993).

Labor governments in 1938, 1944 and 1948 all attempted to introduce a national public health care system, including the provision of free medical services. However, these attempts failed, largely due to the strength of the medical association and its desire to maintain control over the provision of medical services (Crichton, 1990).

In the early 1950s, the Menzies government succeeded in implementing the Page plan, a voluntary national health insurance scheme (Gardner, 1997; Crichton, 1990). This divided the population into three distinct groups for the purposes of health care funding.

Firstly, pensioner groups received fully subsidised hospital and medical care. Secondly, low to middle income earners, as specified by the government determined income cut off (income of 550 pounds per year at that time) received some public cover but this was subsidised by private cover. Membership to friendly societies provided up to a 50% subsidy on capitation fees and patient copayments of 10 to 20%. Thirdly, those with income above the prespecified

threshold also received subsidised treatment if they joined a friendly society, or medical benefits fund, that offered such benefits (Scotton & Macdonald, 1993; Gardner, 1997).

The nature of this system was such that public cover could be subsidised by private cover. This led to an increase in the rate of private insurance coverage, increasing up to 70% of the population covered in the 1960s (Scotton & Macdonald, 1993). However, by the mid 1960s the inequities promulgated by the three tiered system of insurance had become obvious, with 17% of the Australian population having no insurance and no access to public benefits (Gardner, 1997).

To address this situation, the Governor General formed the Nimmo Committee in 1968 to inquire into the state of the Australian health care system (Gardner, 1997). The Committee found that many Australians were unable to meet the costs of insurance, resulting in them being uninsured. Others were dropping out because of the complex nature of insurance, or low benefits relative to the costs of medical care (Scotton & Macdonald, 1993). The inquiry found that insurance organisations were absorbing an 'unduly high proportion of the contributions' and overall the scheme of voluntary insurance was 'unnecessarily complex and beyond the comprehension of many' (Scotton & Macdonald, 1993).

At the same time, dissatisfaction with the system of voluntary insurance led Scotton and Deeble to propose a more universal, public approach to health care insurance (Sax, 1984). Their scheme focused on the provision of services to users free of charge, with a centralised or nationalised health care organisation. Payments to practitioners and hospitals would be prespecified, private health care arrangements would be curtailed and there would be the restriction of freedom of choice of doctor (Sax, 1984). Funding for the scheme would be raised through a combination of a levy on personal taxable income, a matching Commonwealth subsidy and a levy on Worker's Compensation and Third Party Motor insurance (Sax, 1984).

In 1974 a scheme similar to that proposed by Scotton and Deeble was put into effect. Medibank, as it was called, was a public, non-contributory, national health insurance scheme which aimed to ensure universal access to basic medical and hospital care, regardless of individuals' income (Gardner, 1997). The scheme was administered by the Health Insurance Commission (HIC), which was responsible for the payment of fees to medical practitioners and state hospitals (Gardner, 1997).

Under this scheme, the payment of medical fees for services provided was according to an agreed schedule of fees. The HIC funded 85% of the scheduled medical fee on behalf of the individual receiving that service. The practice of 'bulk billing', allowing practitioners to bill the HIC directly for services provided, was also introduced at this time, effectively eliminating the need for patient copayments on some services (Sax, 1984).

Funding for Medibank was raised via a 1.35% levy on taxable income (with an exemption for low income earners), matched by a Commonwealth subsidy and a levy on worker's compensation and automobile third party insurance. However, in order that private insurance remain viable, relieving some pressure on the public system, those with private health insurance received tax concessions in respect of the insurance premiums paid (Sax, 1984).

The socialist nature of this scheme meant that its life was short lived with the return to power of a conservative Liberal government in 1975. Although there was a stated commitment to keeping Medibank, it was subject to a number of changes over the following seven years, to the extent that there was a *"faltering and confusing return to the basic Page plan"* (Gardner, 1997).

Under the amended scheme, individuals had the option of voluntarily contributing to the public system through a levy on taxable income or taking out private health insurance. For those who chose not to contribute to the income levy, the Commonwealth subsidised their hospital and medical services by 40% of the scheduled fee. Subsidies to pensioners and the disadvantaged were considerably higher at 75% of the scheduled fee.

The system of private insurance also underwent major reforms during this period, in particular the introduction of community rating for all insurance memberships, regulations preventing the discrimination against potential members and requirements to contribute to a state based reinsurance pool – effectively risk pooling.

The voluntary nature of the public system meant that, initially, more individuals were turning to private health care insurance. It was estimated that by 1977, 58.5% of the population had taken out private health insurance and a further 9.9% had taken out hospital only insurance (Sax, 1984). However, as those of lower risk became disillusioned with what was essentially their subsidising of those of higher risk, population coverage of private insurance began to fall – and has continued to do so.

By 1981 the universal health insurance scheme had all but been abandoned in favour of a publicly subsidised, but failing, system of voluntary health insurance (Gardner, 1997). Dissatisfaction with the scheme arose because of its inability to address the inequities in the health care system arising from individuals being uninsured or underinsured. The latter was seen as a consequence of the rise in private insurance premiums over what had prevailed at the start of the scheme.

With the return of a more socialist Labor government in 1983, the plans for an universal public health care system were reinstated. In 1984, the Medicare system was introduced, re-establishing many of the principles of the earlier Medibank system. This system was based on universal entitlement to access public hospital inpatient and outpatient services, as well as medical, dental and optometry services. Public funding would cover 85% of the agreed schedule fees, with a maximum of $10 being paid by patients for any one service. As with Medibank, the move to 'bulk billing' by service providers effectively eliminated the need for patient co-payments.

Medicare was to be financed from a combination of general taxation revenue and by a levy, initially set at 0.75% of taxable income, with high income ceilings and low income cut-offs

(Sax, 1984). Provision was also made for individuals to supplement public cover with private health insurance. The latter covered inpatient care in private hospitals and private care in public hospitals, and insurance for ancillary benefits. Funds were not able to provide insurance for medical services, or 'gap' insurance to cover items already covered by Medicare (Sax, 1984). These arrangements have remained largely in place, as is discussed below.

4. FUNDING

As previously stated, health care may be funded by the public sector, the private sector or a combination of the two. Public funding is managed by the Commonwealth and state governments, drawing on funds collected via the Medicare levy and general taxation, and accounts for approximately 70% of total health care expenditure.

Private funding is sourced from private health insurance companies, accounting for approximately 10% of total health care expenditure, and from out-of-pocket or self insurance by individuals, covering the remaining 20% of expenditure (AIHW, 1998a). However, the two are not mutually exclusive - individuals with private insurance are still required to pay the Medicare levy and therefore have access to both the public and private systems (Hopkins & Kidd, 1994).

The balance between public and private funding has shifted since the introduction of Medicare. In 1982/83 the public sector accounted for 65.3% of total health care expenditure, while private health insurance funds accounted for 20.1% of total expenditure (AIHW, 1997). Since that time, the share of total health care expenditure accounted for by private health insurance has decreased to 10.5% of the total in 1995/96. In contrast, public expenditure accounted for 68.5% of total expenditure, with the largest increase being in funding by individuals, from 14.7% in 1982/83 to 20.9% in 1995/96 (AIHW, 1997; 1998a).

4.1 Public Sector Funding

The public sector funding of health care in Australia is shaped by the underlying Federal system of government, and the resulting relationships between all three levels of government - Commonwealth, state and local. As a consequence, the divisions of responsibility in respect of the funding and organisation of public health care services are determined by that relationship. Prior to discussing public sector funding of health care services, it is therefore prudent to outline the nature of inter-governmental fiscal relations in Australia.

Government Financial Relations

Government financial relations are characterised by a high degree of vertical fiscal imbalance. While the Commonwealth government has the bulk of the revenue raising capacity, state and local governments are responsible for the bulk of outlays. This imbalance arose out of the historical and constitutional arrangements that govern the ability to collect and distribute government revenue, principally the devolution by the states to the Commonwealth government in 1942 of the right to tax personal income.

It has remained in the interests of the Commonwealth government to maintain this imbalance because it allows them to act towards achieving horizontal fiscal equalisation (HFE) between the states (Commonwealth Government,1998). This recognises that the states differ in their ability to collect revenue and in their expenditure requirements.

The process of equalisation occurs by the Commonwealth government making grants to the states. The commitment of the Commonwealth to fund some state based expenditure, and to provide financial assistance to states, is enacted via the Commonwealth Grants Commission (CGC), at the annual Premiers' Conference and by the Council of Australian Governments (COAG).

The CGC is an independent statutory body responsible for calculating the relativities used by the Commonwealth government to allocate funds between states (Commonwealth Government, 1998). These relativities are calculated so that each state has the capacity to raise the revenue required to provide the average level of government services per capita at a standard comparable to other states (Commonwealth Government,1998).

As Table 2 shows, the result is that some states, namely NSW, Victoria, Western Australia (WA) and the Australian Capital Territory (ACT) effectively subsidise the income flows to the other states. These states are called donor states in terms of effecting HFE. Donor states would receive a higher proportion of Commonwealth funding if those funds were distributed

according to states' populations, or on the basis of each states' contribution to personal income, rather than CGC relativities (Commonwealth Government, 1998).

TABLE 2 : HORIZONTAL FISCAL EQUALISATION 1998-99

	Funding under CGC Relativities $M	**Subsidy Based on per capita Distribution $M**	**Subsidy Based on Contributions to Income Tax $M**
NSW	6546	-920	-1538
Victoria	4814	-660	-704
Qld	4174	85	678
WA	2117	-40	-82
SA	2131	385	577
Tas	855	303	384
ACT	345	-18	-200
NT	1091	865	885
Total	*22074*		

Notes: NSW denotes New South Wales, Qld is Queensland, WA is Western Australia, SA is South Australia, Tas is Tasmania, ACT is Australian Capital Territory and NT is the Northern Territory.

Source: Commonwealth Government, 1998

Financial assistance to the states from the Commonwealth government takes two forms - specific purpose payments (SPPs), or general purpose payments. General purpose payments are not tied to any particular form of expenditure and include Financial Assistance Grants (FAGs), Special Revenue Assistance and Identified Road Grants.

SPPs allow the Commonwealth government to direct funds to areas where it feels expenditure is needed, either directly to state governments or through state governments. SPPs directed toward health expenditure form the largest component of direct to state payments, being approximately 40% of SPPs in 1998/99 (Commonwealth Government, 1998).

Health Care Grants (HCGs), previously Hospital Funding Grants (HFGs), are the largest component of SPPs. These are provided for within the Australian Health Care Agreements

(AHCA), which are the agreements governing Medicare and other health care expenditure by the Commonwealth government vis a vis the states. The payment of HCGs by the Commonwealth government to states requires that they provide relevant inpatient treatment and outpatient services free at public hospitals (Butler, 1994).

In calculating states' funding relativities, as described above, the CGC treats Commonwealth government grants received by the states as revenue. As SPPs are one of the main forms of Commonwealth government grants, they are included in the calculation of these relativities.

Health Care Financing

There is no clear demarcation of Commonwealth and state responsibilities in many areas of health care funding. At a broad level, Medicare governs public health care financing. Medical Medicare, for which the Commonwealth government is the key funder, provides for expenditure for medical services. Hospital expenditure is provided through hospital Medicare. Unlike medical Medicare, this is only partly funded by the Commonwealth as principal funding and provider responsibilities lie with state governments. Together, medical Medicare and hospital Medicare are driven by the principle of universal access to appropriate medical care for all.

The Commonwealth government is also responsible for the funding and maintenance of the Pharmaceutical Benefits Scheme. This aims to ensure that individuals have access to necessary, cost effective pharmaceutical products at the lowest cost to themselves and the government.

Medicare

All Australian residents are required to contribute to Medicare funding via a levy on yearly taxable income, currently set at 1.4%. These funds were only ever intended to account for a proportion of total public health care expenditure, with additional funding being drawn from the general pool of taxation revenue.

Via medical Medicare, the Commonwealth ensures that individuals are able to access community medical services at minimum or no cost by reimbursing individuals via the MBS. This allows individuals to purchase the appropriate medical services without being faced with excessive price barriers. It provides for 85% of the scheduled fee for out of hospital services provided on Medicare approved items and 75% of the scheduled fee for private patients treated in a public hospital. The aim of universal access is served further by the practice of 'bulk billing', discussed previously.

Besides medical services, the MBS also covers pathology services, obstetrics, ophthalmic services, optometry services, diagnostic and other imaging services. Coverage of dental services was removed from the MBS in February 1997.

As Table 3 shows, the majority of Medicare benefits in 1996/97 were paid in respect of unreferred general practitioner (GP) visits, with specialist attendances and diagnostic imaging accounting for over a quarter of benefits paid.

TABLE 3: MEDICARE BENFITS BY SERVICE 1996-97

Service	**Proportion of Benefits Paid %**
Unreffered GP attendances	38.0
Specialist attendances	14.6
Diagnostic imaging	14.3
Pathology	13.9
Operations	9.8
Optometry	2.4
Obstetrics	0.9
Other	4.0

Source: AIHW, 1998b

Hospital Medicare is established by the Commonwealth Medicare Legislation, and is enacted by the AHCA between the Commonwealth and state governments. The latest version of the AHCA was brought down in July 1998, but was not ratified by the states until September of that year.

This agreement provides for all individuals to receive free public hospital services as public patients based on clinical need and regardless of their geographical location (AHCA, 1998). However, individuals with private health insurance may choose to be treated as private patients in a public hospital. This gives them the right to request the care of a particular doctor, whereas a public patient is allocated a doctor upon admission. A private patient may also have a greater possibility of accessing a private room, although these are first allocated on the basis of medical need (Davis et al, 1991).

Although equality of access would preclude private patients being given preferential treatment in public hospitals, the current Agreements do not state this explicitly – a departure from the previous Medicare Agreement (AHCA, 1998; Medicare Agreement, 1993). Under the AHCA, states are to meet agreed target levels in respect of the treatment of public patients. These targets address such issues as the total number of patient separations, waiting times for emergency departments and waiting times for elective surgery.
The Commonwealth and state governments also agree to collaborate on a variety of roles, including; establishing a standard casemix based management and information system that may form the basis of an alternative hospital funding system; developing national health goals and targets and monitoring the progress towards those objectives (AHCA, 1998).[2]

Local government responsibilities in health care are more public health oriented. More specifically, local governments are in charge of environmental hygiene and sanitation practices, the collection of waste material, home care services, advisory services at infant

[2] For a more detailed description of the individual and joint roles of state and Commonwealth governments see the AHCA, 1998.

health centres, antenatal clinics and community health centres, which may include implementing immunisation programs (AIHW, 1996b).

Pharmaceutical Benefits

The Commonwealth government targets access to pharmaceutical products by subsidising the cost to individuals of purchasing pharmaceutical products listed under the PBS.[3] Community pharmacists, where up to 90% of prescribed pharmaceutical products are dispensed outside of hospitals, are subsequently reimbursed by the Commonwealth government for the difference between the PBS listed price charged to individuals, and the cost to the pharmacist of purchasing that product.

Individuals purchasing a PBS listed item pay a contribution per item, up to a maximum value, currently set at $20. However, some individuals, such as holders of Pensioner Health Benefits Cards and certain other cards issued by the Department of Social Security, pay a lower contribution, currently set at $3.20 per item. For the remainder of the population, a safety net is in place which ensures that once an individual or family has spent a set amount on PBS items in a given year, all other PBS items will be available to them free of charge for the remainder of that year.

The Commonwealth government also helps in the provision and purchase of drugs through the Repatriation Pharmaceutical Benefits Scheme (RPBS), which provides assistance to specific groups of war veterans and dependants and provides benefits similar to those available to concession holders under the PBS.

In 1996/97 the Commonwealth government spent $2,333 million on PBS prescription items, of which $1,867 million was spent on benefits to concession holders (AIHW, 1998b). Total PBS costs, as a per cent of GPD, increased from 0.4% in 1994/95 to 0.5% in 1995/96 (AIHW, 1998a).

3 Note that the PBS, the Pharmaceutical Benefits Schedule, prescribes the schedule of payments for pharmaceutical products covered by the Pharmaceutical Benefits Scheme.

Insofar as expenditure on the PBS is a relatively large budget item for the Commonwealth government, Australia has perhaps one of the most stringent regimens for the listing of pharmaceutical products. Australia has a two tier system of regulating prescription pharmaceutical products.

In the first tier the Therapeutic Goods Administration and Australian Drug Evaluation Committee must approve the product. These bodies may grant approval for the manufacturers to market the product if it is found to be safe, efficacious and of acceptable quality.

Once this approval has been given the product may be submitted to the second tier of regulation – the consideration of approved products for inclusion on the PBS. Submissions for inclusion of pharmaceutical products on the PBS are made to the Federal Minister for Health, but referred to the Pharmaceutical Benefits Advisory Committee (PBAC). The PBAC is an independent statutory body that assesses whether there is net social gain to listing a product, submitted for inclusion, on the PBS.

As part of this process, in 1993, the PBAC introduced a new requirement that all submissions for the listing of pharmaceutical products on the PBS be accompanied by an economic evaluation of that product. The onus is therefore on the manufacturers to ensure that their product, and the evaluation of that product, meet the guidelines as specified by the PBAC (CDHSH, 1995). The final decision on whether to include that product on the PBS is made by the Federal Minister for Health on the advice of the PBAC (Harris, 1994).

Other Commonwealth / State Funding

Some areas of health care are seen as being outside the reach of the general public health care system, and therefore deserving of funding outside of that provided by Medicare and the AHCA. These areas generally attract Commonwealth SPPs to the states, which are typically supplemented by state own source funding.

In the past this has included funding for a National Youth Suicide Strategy, a National Mental Health Strategy, women's health, AIDS, family planning, drug strategies, health services for homeless youths, child immunisation and health education and practice.

In the 1998/99 Federal Budget the funding for a number of these priority areas was broad banded into one block grant, known as the Public Health Outcome Funding Agreement (PHOFA). The PHOFA replaced the payment of individual SPPs for the National Breast Screening Program, National Cervical Cancer Screening Program, Female Genital Mutilation Education Program, National Women's Health Program, National HIV/AIDS Program, National Alternative Birthing Services, National Drug Strategy and Immunisation. It is then at the discretion of each state to allocate that block grant to programs covered by the PHOFA.

Although the Commonwealth government does not specify that funds must be allocated to particular programs, it does require that states comply with a set of agreed performance indicators related to the health issues covered by the PHOFA. Compliance with these indicators effectively ensures that states direct monies to those areas that the Commonwealth government considers to be a priority for health care expenditure.

Who'll Look After Angela?

Angela is a working woman who fractures her finger while roller blading. She goes to the emergency department of the nearest public hospital, where she is attended by the resident doctor. The cost of the services Angela receives while at the hospital, including the doctor, the nursing staff, the X-ray of her finger, the splint, bandage and pain killers, are all met by her state government out of its health care budget.

If Angela had chosen to go to her local general practitioner, then the overall cost would be shared between her and the Commonwealth government. Because her doctor bulk bills, this cost is born by the Commonwealth through Medicare. Angela's doctor refers her to the local imaging and diagnostic centre for an X-ray of her finger. If they also bulk bill, then this cost is also met by the Commonwealth, but if they do not bulk bill then Angela will have to meet the difference between what she is charged for her X-ray and what the MBS fee is for that service. Angela will then have to go back to her doctor for diagnosis of the X-ray, which is another service charged to the Commonwealth.

Finally, although it is likely that Angela's doctor will supply and fit the bandaging and splint to her finger, if she is prescribed a pain killer, she must meet the cost of those drugs as prescribed in the PBS. The Commonwealth is subsequently liable to the pharmacist where she purchased those pain killers for the difference between the purchase price to the pharmacist and the PBS listed price.

4.2 Private Sector Funding

As previously stated, private sector funding for health care expenditure in Australia is from one of two sources – private health insurance funds or out of pocket payments by individuals. Since the introduction of Medicare, the balance has shifted away from funding by private health insurance funds, towards a greater reliance on self insurance by individuals.

Private Health Insurance

The current status of private health insurance in Australia is largely a result of the long history of association between private medical providers and private health insurers. Its structure has undergone many changes in the last few decades, including an increase in the number and type of products offered by funds and the reduction of the number of funds in operation nationally.

Historically, private health insurance funds have been, and remain, heavily regulated in the types of products they may offer, the pricing of those products, risk sharing arrangements and the way in which individuals are to be charged for insurance coverage. These regulations can be summarised by:

- community risk rating of premiums - insurers are required to comply with community rating, they cannot discriminate between potential fund members according to risk profiles;

- risk pooling – all funds are required to contribute to state based risk pools. This allows the funds to effectively risk share, allowing smaller funds and those with members who are of greater risk to remain in operation;

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TABLE 4: POPULATION COVERAGE OF PRIVATE HOSPITAL INSURANCE

	Numbers Covered '000s	Proportion Covered %
1983/84	7,784	50.0
1984/85	7,514	47.7
1985/86	7,812	48.8
1986/87	7,859	48.3
1987/88	7,770	47.0
1988/89	7,643	45.5
1989/90	7,588	44.5
1990/91	7,548	43.7
1991/92	7,164	41.0
1992/93	6,967	39.5
1993/94	6,632	37.2
1994/95	6,304	34.9
1995/96	6,149	33.6
1996/97	5,916	31.9
1997/98	5,728	30.5

Source: PHIAC, 1998.

The decline in population coverage of private health insurance is attributable to a number of factors, including:

- the introduction of Medicare;
- increasing insurance premiums;
- uncertainty regarding insurance products;
- the complexity of insurance products;
- higher patient charges and copayments; and
- general confusion about insurance entitlements.

(AIHW, 1996b; Productivity Commission, 1997).

Perhaps the main factor cited for the reduction in coverage is the increase in premiums relative to the benefits paid by funds (Productivity Commission, 1997). Rising premiums have resulted from a combination of higher administrative costs and increasing claims by fund members.

The latter effect has largely been in response to the impact of adverse selection - that is, as premiums have risen, healthier individuals and poorer individuals have left insurance funds in favour of self insurance or the public system. This has resulted in an increase in payments as funds are left with an increasing pool of high risk individuals, comprising largely of the sick and the elderly who are able to afford the premiums. Consequently, premiums have risen to cover expenditure (Productivity Commission, 1997).

The decline in memberships has raised concerns that the current system of private health insurance is not sustainable, particularly given the strength of the public system. Precisely at what level of membership the industry will cease to be financially viable is not clear, but historically a figure of 30% has often been touted (Productivity Commission, 1997).

In an attempt to combat the decline in memberships, and to bolster the viability of private health insurance in Australia, both the Commonwealth government and the insurance funds have implemented a number of initiatives. Commonwealth government initiatives have focused on two issues – relaxing product regulations on funds to allow them to offer more tailored products (see below) and offering financial incentives to the population designed to halt the decline in membership and increase the number of new members.

The Commonwealth government announced financial incentives for private health insurance in 1997, coming into effect in July of that year. These incentives paid a tax rebate for private health insurance to individuals earning less than $35,000 and families earning less than $70,000 per annum. To further encourage take up of insurance by the more wealthy, individuals earning more than $50,000 per annum and families earning more than $100,000 per annum, who do not have private health insurance, were charged an impost of 1% on their taxable income (Productivity Commission, 1997). The impost on higher income earners was increased to 1.25% in 1998.

However, in the first year in which these incentives operated they failed to have the desired effect, in fact private health insurance coverage continued to fall in 1997/98. To further halt

this slide, in January 1999, the Commonwealth replaced these incentives with a 30% rebate on annual private health insurance premiums. This rebate is available to anyone with private cover regardless of their level of income, and may be accessed as a tax deduction, a lump sum reimbursement through the Medicare system, or a 30% reduction in premium payments. In all three cases, the Commonwealth is responsible for the payment of 30% of the private health insurance premiums.

On the supply side, in the last two years the insurance industry has altered the nature of the products they offer in an attempt to keep existing members and entice new ones. These new products have included the use of exclusionary tables that allow certain treatments to be excluded from private insurance benefit schedules, front end deductibles that require the payment of some previously organised portion of treatment costs, and new membership categories - couples and single parent families (Productivity Commission,1997). Overall the success of these initiatives has been limited in that they failed to reverse the decline in private insurance membership.

Nearly 46% of recurrent expenditure by private health funds in 1993/94 was for private hospital treatments (AIHW, 1996b). Only 6% of recurrent expenditure by funds in that year was for the treatment of private patients in public hospitals.

Private patients who have insurance for ancillary services such as dental, optical, chiropractic and physiotherapy are eligible for a rebate on payments for those services. Ancillary benefits paid by the funds are approximately one third the size of the hospital benefits paid per person insured.

Amongst these ancillary benefits dental benefits made up 52% of total payments in 1994/95. NSW recorded the highest payment of ancillary benefits in that year (AIHW, 1996b). While Medicare does cover services provided by optometrists and surgery performed by dental surgeons, it does not cover normal dental work, physiotherapy, chiropractic or the cost of glasses. Thus public patients have to pay out-of-pocket payments for these services.

4.3 Hospital Funding

In the past, public hospitals in Australia were funded using a capped budget based on historical funding needs, funds subsequently distributed to hospitals by the respective health authorities of each state.

In recent years there has been a general movement away from historical based funding towards adopting improved funding methods, involving greater matching of inputs, outputs and population needs. There has been a commitment, in principle at least, to adopting the use of casemix payments as the means of hospital funding.

Casemix funding uses DRGs to classify hospital outputs and set hospital payments. To standardise this approach, the Commonwealth government has been involved in setting up a standard for DRG classifications - the Australian National DRGs (AN-DRG), currently in its third version (Owens, 1995).

The move toward casemix funding is driven by the desire to promote greater efficiency within the hospital sector and to ensure that hospitals receive the returns to which they are entitled (Owens, 1995). However, some concern remains that moving to casemix funding will result in a fall in the quality of hospital based services (Owens, 1995).

Unlike public hospitals that relied on state funded historical budgets, private hospitals relied on payments from private health insurance funds and individuals to meet their costs. The split between private for profit and not for profit hospitals also led to differences in how funds were raised for longer term capital expenditure and to meet financing shortfalls. Smaller not for profit hospitals preferred to raise funds by issuing equity options, while larger not for profit hospitals and for profit hospitals relied more heavily on debt financing (NHS, 1991b).

Although undergoing some change in relation to payment systems, private hospitals have experienced comparatively fewer changes than the public hospitals. Many private hospitals have been slow to develop casemix based funding, remaining with per-diem funding, or negotiating payment contracts with health care funders (see 4.3.1 for a discussion of these contracts). Out-of-pocket payments by individuals are also an important source of funding for private hospitals.

Consequences of the Hospital Funding System

One of the major consequences of the current system of funding hospitals is that it encourages the treatment of individuals with private hospital insurance at public rather than private hospitals.

That is, since public hospitals are not able to charge private patients for items over and above that for which they are insured, individuals with private insurance have an incentive to be treated as private patients in public hospitals. In that way, they avoid the out of pocket expenses associated with private hospital care. Furthermore, public hospitals have an incentive to admit privately insured patients as they receive payment from the health insurance funds for patient accommodation costs, which exceed payments received for public patients.

Consequently, private patients may be admitted to public hospitals at the expense of admitting public patients (Macklin, 1991). Public patients may therefore be forced to wait longer for hospital services, or may be discharged earlier than would normally be the case, in order to make room for private patients. However, the extent to which private patients displace public patients or the size of the public subsidy to private patients in public hospitals has never been clear.

In the 1993 Medicare Agreement some provision was made to rebalance this situation. Bonus funding was made available to public hospitals that increased their public admissions as a proportion of the total hospital admissions. Table 5 shows that, despite some fluctuation

in the intervening years, the proportion of public hospital admissions accounted for by public patients increased in all states between 1991/92 and 1994/95.

TABLE 5: PUBLIC ADMISSIONS AS A PROPORTION OF TOTAL HOSPITAL ADMISSIONS

	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
1991/92	50.2	47.2	57.5	60.0	54.7	53.4	72.9	57.9	52.5
1992/93	49.4	46.7	57.2	60.4	54.2	54.8	78.3	55.9	52.0
1993/94	52.8	52.5	59.2	60.6	56.9	55.1	78.7	61.0	55.4
1994/95	56.6	53.9	57.6	62.3	57.7	55.8	80.3	58.8	57.0

Source: Commonwealth Department of Health and Family Services, 1996a.

To what extent this bonus funding influenced the proportion of public patient admissions is, however, open to some debate. At least two other factors may have also had some kind of an impact, one improving the rate while the other would cause it to decrease. In the first case, the increase in the proportion of public patients treated in public hospitals coincides with the fall in private hospital insurance coverage (as discussed in Section 3.2). The apparent improvement may therefore be a result of a decline in the demand to be treated as a private patient in public hospitals rather than an improvement in public hospital admission practices.

In the second case, the new AHCA has made it possible for hospitals to give priority to private patients over public patients without contravening the agreements themselves. That is by failing to preclude the discrimination against public patients in favour of private patients by public hospitals it implies that this practice is in some way acceptable. This not only undermines the universality of the Australian health care system but institutionalises an inequality already in existence.

Private hospital payment systems have also been reformed in an attempt to further encourage private patients to use private hospitals. These reforms allow private health insurers to form contracts with private hospitals, basing payments either on a casemix basis or on an agreed fee for service basis. Such contracts are known as purchaser provider contracts and may be applied more generally to other areas of the health care system.

Forming purchaser provider contracts allows funds to negotiate with hospital providers, or even private practitioners, so that patients are subject to low or zero out of pocket payments for services provided. This may encourage more private patients to be treated in private hospitals (Productivity Commission, 1997). By reducing out of pocket costs, private insurance funds are better able to direct their members to private hospitals for treatment. This not only reduces the incentive for private patients to be treated in public hospitals, it may also help to bolster private health insurance membership.

Andrew had a big fall...

Andrew breaks his leg in a skiing accident and is taken by ambulance to the emergency department of a public hospital. When Andrew presents to the emergency department, he is asked whether he wishes to be treated as a private or public patient.

Considering that Andrew has private health insurance with top hospital cover, he elects to be treated as a private patient. He is therefore able to choose his doctor and he is given a private room. The doctor requests that Andrew be given an X-ray, and upon diagnosis that a pin be surgically implanted in Andrew's leg.

As a private patient in a public hospital, he is charged a fee for his medical treatment, the X-ray, surgery costs - including theatre costs, anaesthetist costs and surgeon costs - and for accommodation. Medicare covers 75% of the scheduled fee for his medical treatment and the gap will be paid for by the private health insurance company. However, as the doctor charges above the scheduled fee, Andrew has to pay the additional amount.

Andrew's insurance fund pays 100% of the set daily accommodation fee and 100% of the ambulance costs. Furthermore, because Andrew's insurance fund has a purchaser provider agreement with the hospital he attended, his theatre fees are

fully covered. Andrew's surgeon also has a similar agreement with the fund so her fees are also fully covered. The anaesthetist, on the other hand has no such agreement and charges above the fund's agreed fee for that service. Andrew is therefore liable for that difference.

If Andrew had elected to be treated as a public patient, he would have been allocated the doctor who was available at the time and he would have had no favourable treatment with respect to his room. There would have been no fees charged for his treatment.

State Based Hospital Funding

Although the overall principles of hospital funding are determined within the AHCA, the states do differ in their individual approaches to hospital funding and care management responsibilities. Whilst none of the approaches are identical, most have split resources by type of care and have attempted to separate purchaser and provider functions to some extent. All have moved away from the allocation of funds to hospitals on a predominantly historical basis and adopted some form of output based funding (Hindle & Braithwaite, 1998)

ACT

The ACT has 2 public hospitals. From July 1996, the Department of Health and Community Care implemented output based funding for these hospitals for all patient related services. In that same year a purchaser provider structure was implemented, with the Department having the role of the purchaser. Purchasing contracts are signed with health service providers, including non-government agencies (Chin, 1997).

NSW

The NSW health system is organised into 17 geographically based Area Health Services. Each Area is provided with a global budget for hospital, community health, mental health,

population health and rehabilitation services (Pearse, 1997). Resources are allocated to the Areas by the NSW Department of Health on the basis of population size and need.

The basis of hospital funding allocations varies between Areas but is largely via output based measures. Casemix based funding is used to guide how the Areas will allocate funds to the public hospitals within their jurisdiction but other information, such as strategies to address the health needs of the local population may also be used to guide allocation (Pearse, 1997; ACB, 1996a).

Queensland

For the purposes of organising the health system Queensland is divided into 38 District Health Services, each allocated a global budget according to a resource allocation formula. This formula is based on the health needs of the population that each district serves (CDHFS, 1997). Within districts, hospitals are funded on a casemix basis.

There are now 2 corporate divisions within the Queensland Department of Health: the Planning and Systems Division and the Health Services Division. The Planning and Systems Division is responsible for funding and purchasing while the Health Services Division (which includes the District Health Services) is responsible for the provision of services (Robson, 1997).

South Australia

South Australia has 7 country health services and a number of health services within the metropolitan region. The health service arrangement varies from many of the other states in that health units (equivalent to health districts or areas) can legally be incorporated. Funding of health services is via health service agreements with the South Australian Health Commission (SAHC). Where the health service agreement is made will depend on the structure of the health service (SAHC, 1998 - personal communication).

Casemix based funding for acute public hospitals was introduced in 1994, replacing the existing flat per-diem payment system (CHDFS, 1997). This is a 2 tiered system output based funding system in which hospitals receive a combination of annual payments, reflecting the fixed costs of operation, and activity payments to cover the variable costs of providing care to patients. These payments are made directly to the hospital by the state health authority. During 1997/98 services within the SAHC were realigned allowing them to be managed under a purchaser provider structure (Phelan, 1997).

Tasmania

Up until 30 June 1997, Tasmania was divided into 3 health regions which were allocated budgets according to a population based funding model (Crawford, 1998). Since that time the regional structure has been replaced with five statewide divisions: Health Advancement, Community and Rural Health, Child, Family and Family Support, Hospitals and Ambulance Service, and Housing Services (DHHS, 1999).

The Hospitals and Ambulance Service Division has responsibility for all public, hospital based admitted and non-admitted services. As only major hospitals are incorporated into this division, acute admitted services provided in district hospitals are purchased from the relevant division (Crawford, 1997). Hospital funding for the 3 major hospitals has been based on casemix since July 1997. District hospitals are still receiving block funding (Crawford, 1997).

Given the relatively small population, there has been no split between the purchaser and provider roles, with the Director of the Hospitals and Ambulance Service Division responsible for both (Crawford, 1997).

Northern Territory

Health care services in the Northern Territory are funded through two Regions: Operations North and Operations Central. The Territory Health Services altered the method by which it funded its 5 public hospitals on 1 July 1996, adopting a casemix funding model for acute and

non-acute inpatient and non-inpatient care (ACB, 1996b). This was managed and developed by the Casemix Clinical and Resource Management Project.

During 1997, however, the focus changed from hospitals funded according to casemix to casemix information being used to inform the allocation of resources to hospitals (Beaver, 1998).

Victoria

Hospital funding in Victoria has been conducted via a casemix based system since July 1993. Hospitals are paid directly by the state health authority under a system of fixed annual grants and variable case payments. The latter comprise approximately 40% of payments and are based on hospital services performed according to DRG classifications (CDHFS, 1997). Fixed annual grants are designed to cover non-admitted patients, fixed overheads, teaching and research, while variable case payments are for inpatient treatment.

With the introduction of the metropolitan Health Care Networks in 1995/96 funding arrangements have been amended to allow greater flexibility and accountability for these networks (CDHFS, 1997).

Casemix funding has now extended beyond inpatients following the introduction of activity based funding for ambulatory care in major hospitals in July 1997. The new ambulatory system affects approximately 75% of the total outpatient budget, with hospitals being funded on the basis of encounters in clinical specialty categories (Marshall, 1998).

Western Australia

Casemix information has been used in WA since 1988 as a means of patient and service classification. In 1994/95, the WA Department of Health introduced a system of hospital payments based on a purchaser provider model. The state was divided into Regional Health Authorities which then negotiated directly with health service providers, either within or outside their own region, to purchase health services.

These arrangements were dropped in the last financial year and the Health Authorities were disbanded. Contract managers or coordinators were subsequently appointed to take on the role of negotiating individual contracts with health care providers. Contract managers may be located within one of four 'purchasing arms' of the WA Department of Health.

Contracts with providers are currently negotiated on an historical basis. The monitoring of provider efficiency and other information systems utilises casemix based information.

5. PROVISION

Discussion of the provision of health care services in Australia can be structured in a similar manner to that of health care financing. That is, health care provision can be classified according to the three types of services provided – hospital services, medical services and other services, including pharmaceutical, dental services and public health services.

The split in providing these services between the public and private systems is that the majority of hospital services are provided by the public system, medical services are largely provided by private practitioners, while both sectors combine to provide a mix of public health and specialty services.

5.1 Hospital Services

There are approximately 700 public hospitals in Australia, that are the responsibility of state governments, in terms of finance, management and organisation.[4] Private hospitals, of which there are about 350, are owned and operated by private for profit commercial organisations, such as Mayne Nickless' Health Care of Australia, and not for profit, charitable and religious and other organisations.

The number of hospitals is not a good indicator of how the provision of health care services is divided because the institutions differ in their size and services they provide. A better indication of the capacity to provide health care services is the number of hospital beds per 1,000 population. In 1995/96 there were 3.0 available beds per 1,000 population in public acute hospitals and 1.3 in private hospitals (AIHW, 1998b). This indicates that the public hospital sector, which treats about 75% of all patients, has a much greater capacity to provide hospital services than the private hospital sector (Goss, 1991).

[4] Although public hospitals are directly accountable to state health authorities, standards of operation, service delivery and location for both public and private facilities are regulated by state based legislation.

Historically, private hospitals have also been differentiated from public hospitals by the less complex nature of the procedures they perform (AIHW, 1996b). For example, in NSW in 1988/89, 12% of patients having surgery in private hospitals had surgery on the ear, nose, throat or eye. In comparison these procedures only accounted for 5% of surgeries in public hospitals (AIHW, 1996b). This type of surgery generally requires that patients have a shorter hospital stay and is considered less complex than operations involving circulatory or respiratory systems. The latter comprised 16% of the surgical cases in public hospitals and 6% in private hospitals in NSW in 1988/89 (AIHW, 1996b).

However, more recently, the distinction between public and private hospitals is becoming less clear. There are a number of private hospitals providing complex services and offering standards of acute care which are comparable with those offered in the major public teaching hospitals (NHS, 1991b). Nonetheless, there are other smaller private hospitals that are still characterised by a limited range of services and a lower quality of care.
The private hospital sector also includes free-standing day hospital facilities (there were 125 in 1994/95) (ABS, 1995). These include general surgery centres, ophthalmic centres, specialist endoscopy centres, fertility management clinics, plastic surgery clinics and sleep disorder clinics (ABS, 1995). Surgical and medical procedures in these areas are provided to patients who do not require overnight accommodation and care. In 1994/95, 189,863 patients were treated and separated from these facilities, over half of which had private hospital insurance (ABS, 1995).

Hospital Utilisation

In terms of hospital utilisation, as previously discussed either public or private patients may be treated in public hospitals. However, private hospital services are only accessed by those with private hospital insurance, who accounted for 81% of private hospital patients in 1994/95, or those who self insure (ABS, 1995). This stems from the fact that although Medicare reimburses 75% of the medical fees in private hospitals for all patients, there is no Medicare reimbursement for the accommodation costs.

Over the last decade, both public and private hospitals have experienced an increase in occupancy rates, public hospitals reaching an average occupancy rate of 80% in 1993/94 and 67% in private hospitals (AIHW, 1996b). This could be due to an increase in the number of hospital admissions, a reduction in the number of hospital beds, or a combination of the two (AIHW, 1996b).

Public hospital admissions increased from 2.5 million in 1985/86 to 3.4 million in 1993/94, and private hospital admissions increased from 0.9 million to 1.3 million over the same period (AIHW, 1996b). By 1995/96 there were 3.6 million separations from public hospitals (69% of total hospital separations) and 1.6 million (31%) from private hospitals (AIHW, 1998b).

Although a higher number of admissions places greater pressure on the delivery of hospital services it has been off set to some extent by a reduction in the average length of stay (NHS, 1991b). Average length of stay in public hospitals fell from 5.2 days in 1991/92 to 4.6 days in 1995/96, while private hospital stays fell from an average of 5.1 days to 4.5 days (AIHW, 1998b).

The fall in average length of stay in both sectors can be attributed to a number of factors. These include better anaesthetics and antibiotics, a reduction in the use of acute care beds by patients who only require nursing home care and the use of less invasive surgical techniques (AIHW, 1996b). Moreover, average length of stay has fallen due to a higher proportion of patients having day only surgery. This is particularly the case for private hospital admissions. In 1995/96, 49% of all separations from private hospitals were same day separations, increasing from 34% in 1991/92. The number of same day separations from public hospitals increased from 29% to 40% over the same period (AIHW, 1998b).

Elective Surgery

One of the most contentious issues in the Australian health care system at present is the length of waiting time for elective surgery. Patients who can safely wait at least 24 hours

before admission are referred to as 'elective' patients (AIHW, 1996b). Historically, the length of time spent waiting for elective surgery has been seen to mark a major difference between public and private patients.

One of the major selling points for private health insurance is that waiting times for elective surgery are lower for private patients, due to shorter waiting times for private hospitals. On the other hand, public hospitals have been characterised as having long waiting times for elective surgery. This is often due to the fact that intending patients are often not given an admission date for their elective surgery because hospitals cannot accurately predict the resources required to treat emergencies, and therefore the availabilities to perform elective procedures (AIHW, 1996b).

The AIHW reports that waiting times for elective surgery in public hospitals in Australia depend on the clinical urgency of the procedure. Patients may be categorised into three groups: category 1 patients for whom admission is desirable within 30 days; category 2 patients for whom admission is desirable within 90 days; and category 3 patients, those undergoing elective surgery, for whom no desirable admission time is set (AIHW, 1998b).

Estimates indicate that the median waiting time for category 1 patients is 8 days and 36 days for category 2 and 3 patients combined (AIHW, 1998b). On average, 12% of category 1 patients waited longer than 30 days for their surgery, 16.5% of category 2 patients waited longer than 90 days and 5.5% of category 3 patients waited longer than 12 months (AIHW, 1998b). There was also considerable variation in waiting times for category 2 patients depending on the specialty of surgery. For example patients waited on average 18 days for neurosurgery and 60 days for opthalmology surgery (AIHW, 1998b).

Other factors that impact on waiting times for elective surgery include social factors, the geographical distribution of hospitals, referral patterns to particular specialists, hospital resources allocated to the specialty involved, the clinician workforce supply in that specialty

and the impact of the emergency admissions on elective admissions in the hospital (AIHW, 1996b; Gillett & Mays, 1994).

Joe and Mabel need new hips...

Joe and Mabel are independently told by their general practitioners that they need to have hip replacements to increase their mobility. Joe does not have private health insurance of any kind, and he cannot afford to pay for the operation himself. He therefore has to have the procedure in a public hospital. As the operation is considered to be elective surgery, Joe is placed on waiting list for his surgery. He knows that when a hospital bed and surgeon become available for his procedure then he will receive the operation at no cost to himself.

Mabel, on the other hand, has private hospital insurance so she chooses not to wait for her surgery and elects to have it in a private hospital within the fortnight. However, her private health fund does not have a purchaser provider agreement with the hospital where she elects to have her surgery. Mabel therefore has to pay the difference between what her insurance will cover for that surgery and the fee her surgeon charges, including theatre and anaesthetist's fees. Mabel is also required to pay a proportion of the accommodation costs.

Although both have the same procedure, Mabel is able to choose to have her surgery sooner rather than later because she has private hospital insurance, while Joe must wait until the resources become available in the public system for him to have his surgery.

5.2 Medical Services

Medical services in Australia are ostensibly provided by the private sector. Non-hospital medical services can be categorised into six groups; GP consultations, specialist consultations, pathology, radiology, operations and other (including ultrasounds, endoscopies, ECGs, obstetrics, anaesthetics and assistance at operations) (AIHW, 1996a).

In 1996 there were a total of 44,156 medical practitioners in Australia, of which nearly half practiced as GPs (AIHW, 1998b). The composition of the medical practice workforce is such that practitioners are concentrated in urban areas, leading to a relative shortage in service provision in rural and remote areas. Attempts to address this imbalance in access to services in rural areas have focused on providing financial incentives for new practitioners to practice in rural areas, the implementation of remote technology to allow distance practice and permitting non medical personnel, namely nursing staff, to perform less complicated medical procedures.

The composition of the medical workforce has also altered in that there has been an increase in the number of female practitioners, increasing to 30% of the workforce in 1996 (AIHW, 1998b). Among younger, training GPs, the proportion of female practitioners is much higher, approximately 57.6% (AIHW, 1998b).

In 1996/97 on average, each person in Australia received 10.7 items under Medicare, including 5.5 unreferred attendances, 1.0 specialist attendance and 2.7 pathology items (AIHW, 1998b). Rates of utilisation were higher among females than males, females consulting a general practitioner or a specialist an average of 7.4 times in that year compared to 5.5 consultations for males (AIHW, 1998b).

5.3 Pharmaceuticals

Most of the manufacture, dispensing and prescription of medicinal drugs is conducted within the private sector, but as previously discussed the industry is highly regulated by the Commonwealth government (Palmer & Short, 1994). In 1996 there were 12,310 pharmacists practicing in Australia (AIHW, 1998b)

Pharmaceutical drugs include those that are only available from pharmacists on the prescription of a medical practitioner, some non-prescription drugs that can only be provided by the pharmacist and a range of over-the-counter drugs such as analgesics, antacids and cough mixtures, that are available from pharmacies and other outlets (AIHW, 1992).

5.4 Dental Services

In Australia, the majority of dental services are provided privately and approximately 90% of total dental costs are met privately through either direct out-of-pocket payments or private health insurance arrangements (NHS, 1992). In effect this means that the use of private dental services is far less frequent for low income earners than high income earners (NHS, 1992). Evidence suggests that low income earners and rural dwellers are more likely to have untreated decay, fewer fillings, more missing or no natural teeth (Brennan et al, 1996).

Public dental services, which are mainly funded by the state/territory governments, provide free dental care to children up to the age of 14 years and to those people who hold one of several government health entitlement cards, which cover people such as the unemployed and the aged (NHS, 1992). These services are largely limited to basic dental care, with some specialist dental treatment available, mostly through dental hospitals and community health clinics and school dental services (NHS, 1992).

Public dental services generally have long waiting lists as demand has grown to exceed available resources (Brennan et al, 1996). The ability to provide such services has decreased following the cessation of the Commonwealth Dental Program in January of 1997.

6. OTHER HEALTH CARE INITIATIVES

6.1 Indigenous Health Care

The health status and health care needs of indigenous Australians, Aboriginal and Torres Strait Islanders (ATSI), is one of the most difficult issues to be faced by all levels of government. It is well recognised that ATSI people are, on average, of poorer health than the rest of the Australian population, and that their access to mainstream health services is well below that of the non ATSI population (Mooney et al, 1999).

A recent survey of ATSI health status indicated that the median life expectancy for an ATSI individual is 15 to 20 years below that of a non ATSI individual (ABS, 1997). The ATSI population also exhibits a higher incidence of coronary heart disease, diabetes, glaucoma, HIV/AIDS, pneumonia, rheumatic fever, sexually transmitted diseases, violent death, cervical cancer and breast cancer than the non ATSI population (AIHW, 1995; KAMSC, 1996).

ATSI Health Policies and Services

In the past ATSI health was not viewed as a priority of the Australian health care system, indeed up until the late 1960's ATSI individuals were often refused treatment or segregated from non ATSI individuals in mainstream health care facilities (Saggers & Gray, 1991).

Generally, the responsibility for funding ATSI health services lies with the Commonwealth government, while service provision is the responsibility of state governments (Saggers & Gray, 1991). However, a lack of certainty as to who should be funding those services can be seen as a barrier to improving the health status of the ATSI population (Mooney et al, 1999).

The first coordinated Commonwealth policy on ATSI health was adopted in December 1987 (NAHSWP, 1989). This established a Council of Aboriginal Health to be jointly funded by the States and Commonwealth. The existing Aboriginal and Torres State Islander Commission (ATSIC) bill was also amended to provide for an Office of Aboriginal Health.

The thrust of this new policy was to develop a National Aboriginal Health Strategy (NAHS), predicated on health being defined in the ATSI population as more than just physical well being, encompassing social, emotional and cultural well being of the entire community (NAHSWP, 1989).

The NAHS Working Party (NAHSWP,1989) recommended that control of, and participation in, health care provision should be handed over to the Aboriginal community in order to begin to address the inequalities in ATSI health status. The shift to a greater role for the ATSI population in determining the health care it receives is part of the principle of self determination and management (Saggers & Gray,1991). Prior to this strategy, the Aboriginal community in the inner Sydney suburb of Redfern had already commenced its own Aboriginal Medical Service (AMS) (Mooney et al, 1999).

AMSs became part of the NAHS. They are designed to allow for more cultural input from the ATSI community into the health services with which they are provided. Services are funded largely through Medicare reimbursement for service provision (Mooney et al, 1999). Greater autonomy through AMSs has been enhanced by a concerted effort to increase the number of ATSI medical workers and the liaison between mainstream medical services and ATSI communities.

Recent steps towards increased self determination included the development of Aboriginal Health partnerships. Announced in the 1996/97 Federal budget, this states that the Commonwealth and state governments, ATSIC and the AMSs are to coordinate jointly the provision and priorities of Aboriginal health services (Commonwealth Government, 1996b).

In addition to on going ATSI health funding, the Commonwealth government expects that funds directed at other national health projects, such as primary care, diabetes and HIV/AIDS will add to the improvement in ATSI health (Commonwealth Government, 1996a). However, poor access to such programs by ATSI individuals, and the cultural

inappropriateness of many mainstream health care services to the ATSI population, reduces the capacity of ATSI individuals to benefit from mainstream health services (AIHW, 1995).

Issues of access among the ATSI population extend beyond those of access to primary care to include access to pharmaceutical products. Poor access to medication often means that ATSI individuals suffer needlessly from quite curable diseases (KAMSC, 1995). Two of the major obstacles in this case, besides geographic location, are poverty and pharmaceutical dispensing policies. In the case of the latter the inability to obtain some pharmaceuticals from registered health workers or community nurses in remote areas, such as in WA, means that ATSI individuals either go without required prescriptions or are forced to travel large distances to pharmacists secure the medications they require (KAMSC, 1995).

Beyond the need for primary health care, the needs of many rural ATSI communities for adequate water supplies, sewerage systems, electricity, shelter and infrastructure to improve access to health care remain unmet. This is despite formal recognition that improving environmental health factors is vital to improving the health status of the ATSI population (AIHW, 1995). Failure to address these issues, as well as the cultural inappropriateness of mainstream health care, is cited as one of the main factors contributing to the declining ATSI health, both in absolute and relative terms.[5]

[5] See Mooney et al, 1999, for a discussion of future issues relating to ATSI health services

6.2 Aged Care Services

Aged care services in Australia are comprised of both residential and community components, with residential care being funded by the Commonwealth and community care funded by the Commonwealth and state governments.

Until relatively recently, residential care took the form of nursing home and hostel places, with nursing homes catering for clients with higher dependency needs and hostels for those with relatively lower dependency needs.
Formal community care includes the use of the Commonwealth/state funded Home and Community Care (HACC) services and Commonwealth government funded community aged care packages and pilot care packages. Informal care, that is care provided by family and friends, is also an important component of community care. The 1993 ABS Survey of Disability, Ageing and Carers estimated that over 50% of individuals relying on aged care received some assistance from the informal sector (AIHW, 1995)

Funding Aged Care Services

Prior to 1997, nursing home funding supplied by the Commonwealth government adhered to arrangements set out in the Standard Aggregated Module (SAM) and the Care Aggregated Module (CAM). These modules related to different aspects of nursing home costs, SAM specifying payment for infrastructure costs while ongoing and personal care costs were funded through CAM. Funding through CAM depended on the number and dependency levels of the nursing home residents.

Other costs of running nursing homes, including payroll tax, long service leave and superannuation for nursing and personal care staff, and workers compensation were met through Other Cost Reimbursed Expenditure (DHHLGCS, 1993).

Smaller nursing homes, in remote areas, or those that cater to special needs groups were also eligible for viability funding to ensure their existence. This funding was available as either top up funding to CAM or, in the case of isolated homes, as a top up to SAM (DHFS, 1997c).

Hostels provide two levels of service, hostel care (comprising accommodation and associated support services) and hostel care plus personal care services (Orme, 1994; Mathur, 1996). They were funded by the Commonwealth government with the amount of funding for each hostel place dependent on the care needs of each resident.

With the introduction of the Aged Care Structural Reform Package in the 1996/97 budget, nursing homes and hostels were unified into a single classification of aged care facilities, with the funding for residents being dependent on the level of care needs (DHFS, 1997c). These reforms were implemented on 1 October 1997 and provided for accredited aged care facilities to charge new residents an asset tested accommodation bond; the maximum payable being $2,600 (indexed) per annum for a period of 5 years.

Following a very brief implementation period, further changes were made so that 2 types of accommodation payments now apply to residential care facilities. Accommodation bonds can now be charged for people entering hostel level care or an 'extra service' place if they meet the eligibility criteria. Eligible people entering nursing home care may be asked to pay an accommodation charge of up to a maximum of $12 per day for a maximum of 5 years (CDHAC, 1998a). From 1 March 1998, new residents of aged care facilities may also be charged an income tested daily care fee, in addition to the basic daily care fee, up to a maximum combined charge of $64.56 per day (CDHAC, 1998b).

Provision of Aged Care Services

Nursing homes are owned by both the public and private sector, but predominantly by the latter. In 1994, 47% of nursing homes in Australia were owned by the private for profit sector, 36% by the private not for profit sector and 16% by state governments. However, the extent of public ownership varies greatly between the states, with Victoria having the highest

at 31%, and NSW and South Australia the lowest with 9% and 5% respectively (Mathur, 1996).

The majority of hostels are owned by the private not for-profit sector, accounting for 93% of ownership in 1994 (Mathur, 1996).

6.3 Home and Community Care Program

The HACC program was introduced in 1985 to redress the imbalance between residential and community care in Australia. It aims to offer a range of basic support services to the frail aged, other individuals with a disability and carers in order to prevent inappropriate admission to residential care facilities (HACC, 1993; Mathur, 1996).

The program is jointly funded by the Commonwealth and the states, providing funds to non-profit organisations, predominantly based in local communities (Fine, 1995). Local governments also play a significant role in the provision and funding of HACC services (ALGA, 1996).

A range of services are eligible for funding under the HACC program and include home help, personal care, community respite care, allied health services, food services and community nursing (HACC, 1992).

6.4 Disability Services

Disability services are provided to individuals with long term disabilities and span a broad age range (AIHW, 1997). From the mid 1980s the focus of services for the disabled moved from institutional care to community based care.

In 1991 the first Commonwealth State Disability Agreement (CSDA) was signed, establishing a joint funding arrangement between the states and the Commonwealth

government. Annual expenditure on disability services through the CSDA exceeds $1.2 billion, of which approximately 60% is funded by the states (Yeatman, 1996). Excluding employment services, government funded services accounted for 60% of total CSDA expenditure with non government organisations funded services responsible for the remainder (AHA, 1996).

By May 1998 all states, with the exception of the ACT, had signed the second CSDA. Under the CSDA the Commonwealth is responsible for the provision of employment and related services and the states are responsible for accommodation, respite and other support services (Baume, 1995; Yeatman, 1996).

HACC also provides services to individuals with disabilities, with an estimated 20% of HACC clients being under 65 years of age (DHSH, 1995). Responsibilities between the CSDA and HACC are, however, poorly defined (Yeatman, 1996).

6.5 Respite Care Services

Individuals who care for a frail aged individual or an individual with a disability at home are entitled to receive respite care. This encompasses a broad spectrum of services, including the provision of in home help, full day respite at a day centre, extended breaks at an aged care facility, host families voluntarily providing care for people with disabilities for a brief period, and peer support houses for people with disabilities (DHHCS, 1995).

Respite services are currently funded by either the Commonwealth, the states, or as a joint Commonwealth/state responsibility. Commonwealth funded programs include residential care (aged care facilities), Carer Respite Centres, Community Aged Care Packages and the funding of respite care through the Department of Veterans Affairs (DVA). Respite care is also provided through HACC and through state disability programs as part of the CSDA (Hearn, 1996; DHFS, 1996c).

In 1995/96 expenditure on nursing home and hostel respite care was $39.2 million and expenditure on respite care under the HACC program was $81.5 million. Under the CSDA the states funded $58 million of respite care in 1994/95 and the DVA was responsible for the funding of $4.5 million of respite services in the same period (DHFS, 1996c).

6.6 Mental Health Services

Mental health services are a joint Commonwealth/state responsibility. The Commonwealth government directly funds health care services for mental health under the MBS (private psychiatrist and general practitioner services), the PBS (psychiatric drugs) and the DVA (services for veterans).

The states are primarily responsible for the planning and delivery of mental health services (DHFS, 1996b). These responsibilities have increased following the implementation of the National Mental Health Strategy in 1992. This proposed a number of reforms including strengthening the rights of consumers (underpinned by appropriate legislative change) and the closures of separate psychiatric hospitals for the provision of care. Under the strategy it was proposed that psychiatric services be integrated with mainstream services and that a greater emphasis be placed on community based care (DHFS, 1996a; DHFS, 1996b; DHFS, 1997a).

At the time of implementing the Strategy over 70% of specialist psychiatric beds were in separate psychiatric hospitals and only 29% of funds were allocated to community based care (DHFS, 1996a). In the following years, the provision of psychiatric hospital services has become the responsibility of state run public hospitals.

Community based mental health services include the provision of outpatient clinics, mobile assessment and treatment teams and day programs; specialised residential psychogeriatric nursing homes; and services such as accommodation and rehabilitation provided by not-for-profit organisations (DHFS, 1996a).

The Commonwealth has acted to coordinate and monitor the implementation of the strategy and the transition in service provision. By 1995 it had provided a total of $269 million to facilitate this process. Approximately 70% of these funds have been in the form of 'reform and incentive' grants to assist the states in the restructuring of services (DHFS , 1996b).

Total expenditure on mental health services in 1994/95 was $1.72 billion. About 61% of this was recurrent expenditure on state funded services, 32% on Commonwealth funded services and the National Mental Health Strategy and 7% on health insurance funded private hospital services (DHFS, 1996b).

6.7 Public Health Services

In its earliest form, public health policy in Australia was directed at preventing migrants from introducing new diseases into the country. Since then, public health services in Australia have progressed to tackle a wide range of health issues, ranging from immunisation to tobacco control.

Under the Australian Constitution the Commonwealth is not provided with any specific public health powers apart from quarantine. State public health legislation encompasses a number of areas including notification of disease, immunisation, regulation of tobacco use, sales and promotion, poison schedules and radiation (Bidmeade & Reynolds, 1997). Local government also plays an important role in public health with key responsibilities being in relation to health protection services such as waste management and ensuring water and food quality. In many states local government also plays a major role in the provision of immunisation services and services related to maternal and child health (ALGA 1996, Bazley & Kemp 1994).

However, throughout the last few decades the Commonwealth has been responsible for establishing a number of National Health Priority Areas and National Public Health Programs. These health priority areas have included initiatives to look at health in the areas of cardiovascular health, cancer control, injury prevention and control, mental health and diabetes mellitus (AIHW,1998b). Programs to target these areas have been approached at a collaborative level, involving the Commonwealth governments, state and local governments and various community groups.

The Commonwealth, in conjunction with the states, has also been responsible for establishing a number of National Public Health Programs. As stated in section 3.1.2.4, funding for public health programs altered in 1998/99 when the Commonwealth and states signed the National Public Health Partnership, to be funded by the PHOFA.

This partnership called for a coordinated national approach to public health in a number of areas, including the National Breast Screening Program, National Cervical Cancer Screening Program, Female Genital Mutilation, National Women's Health Program, National HIV/AIDS Program, National Alternative Birthing Services Program, National Drug Strategy and Immunisation. Service delivery is however at the discretion, and is the responsibility of, the states, provided that program outcomes meet with a number of agreed performance indicators.

Having said that, the implementation of many of these programs is based on a collaborative approach with the community groups affected. For example, the delivery of breast and cervical screening programs depends on the collaboration of women's groups, and GPs, to ensure that the screening message is reaching the appropriate target groups in the most effective manner. Similarly, Australia's relative success in reducing the spread of HIV/AIDS is in part due to the collaborative approach taken by the homosexual community, often guiding and directing the implementation of education and prevention strategies (Altman, 1992).

7. DISCUSSION

The Australian health care system is thus a complex machine, involving all levels of government and the private sector in funding and providing health care services. Despite its complexities, it could be argued that health care costs in Australia have been contained without sacrificing the quality of service provision. On the other hand, perhaps greater efficiencies could be achieved by altering certain incentives and structures within the current system.

For example, bulk billing arrangements under the current Medicare system may provide an incentive for over utilisation of medical services by individuals, or for medical practitioners to over-prescribe the use of services. Similarly, the provision of pharmaceutical products at a subsidised cost may provide an incentive to turn to such products more often than required, or for conditions for which they may be less than effective. As the number and expense of medical services and pharmaceutical products on offer increases, there is the potential for health care expenditure to increase at a faster rate than can be sustained by current funding practices.

Pressure on health care budgets may also be felt as a result of Commonwealth government attempts to bolster private health insurance, presumably at the expense of funding to public hospital services. The failure to date of initiatives to increase private health insurance coverage does not bode well for future initiatives. Moreover it may be the case that these initiatives will increase resource pressures on the public system rather than alleviate them by attracting labour resources to the private sector, away from public hospitals, by offering higher remuneration (Gittins, 1998).

As history has shown, the capacity to achieve successful and meaningful reform of the Australian health care system is straight jacketed by the strength of the lobby groups involved, namely medical practitioners and private health insurance organisations, and the nature of inter government relations.

It is unlikely that the Commonwealth would be willing to surrender its role as chief financier in that it allows the Commonwealth government to direct policy and expenditure to areas it deems appropriate. This enhances the Commonwealth's influence over the Australian economy and population, including over areas in which it does not have constitutional jurisdiction. On the other hand it is not clear that, given limited capacity to raise revenue, that state or local governments would be willing to accept a greater role in the funding of health care services.

What is clear is that under current arrangements, the overlap between the roles and responsibilities of different levels of government may introduce disincentives for efficient operations. To illustrate, the Commonwealth has alleged that state governments are shifting some hospital costs over to the Commonwealth government by releasing patients earlier than usual, requiring more protracted out of hospital care. As this care is largely provided by the Commonwealth this results in a cost shifting from the states to the Commonwealth.

In 1996/97 the Commonwealth government sought to gain some recompense for this cost shifting by imposing cost shifting penalties totalling $75 million on the states. However, the basis on which these were levied is not consistent. The states would argue that such a penalty was unjustified, given that there is also some evidence of the Commonwealth shifting costs on to the states (Pearse et al,1997). For example, many of the national health programs are funded on a matched basis, Commonwealth and state governments contributing equal amounts. However, it is often the case that states must contribute a greater amount than the Commonwealth if they are to meet Commonwealth reporting requirements and effectively implement those programs.

Perhaps it is appropriate that the level of government to fund a service should depend on the geographical area affected by those services and whether there are spill-over effects. Given that health services apply mainly to within state populations, and the difficulty in demonstrating the flow of health services and status across state borders, it is feasible that the responsibility for health care funding and provision should be handed over to the states.

Although theoretically appealing, the nature of vertical fiscal imbalance in Australia means that such a change is not practicable. The result is that under the current arrangements, some policy decisions may not be as appropriate as they could be if left entirely up to the states. That said the impact of large interest groups and the view of health services as a part of national welfare all legitimise the interaction of the Commonwealth government (Palmer & Short,1994).

The need for reform, and the capacity to achieve that reform, however is unclear. Perhaps greater advances could be made with the system by implementing all over reform, and not attempting isolated repairs to areas that appear to be struggling.

GLOSSARY OF ABREVIATIONS

ABS	Australian Bureau of Statistics
ACB	Australian Casemix Bulletin
ACT	Australian Capital Territory
AHA	Australian Hospitals Association
AHCA	Australian Health Care Agreements
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnostic Related Group
ATSI	Aboriginal and Torres Strait Islander
ATSIC	Aboriginal and Torres Strait Islander Commission
CAM	Care Aggregated Model
CDHFS	Commonwealth Department of Health and Family Services
CGC	Commonwealth Grants Commission
COAG	Council of Australian Governments
CSDA	Commonwealth/State Disability Agreement
DCHS	Department of Community Health Services
DHFS	Department of Health and Family Services
DHHLGCS	Department of Health, Housing, Local Government and Community Services
DHSH	Department of Human Services and Health
DRG	Diagnostic Related Group
DVA	Department of Veterans' Affairs
FAG	Financial Assistance Grant
HACC	Home and Community Care
HCG	Health Care Grant

HIC	Health Insurance Commission
HFE	Horizontal Fiscal Equalisation
HFG	Hospital Funding Grant
KAMSC	Kimberley Aboriginal Medical Services Council
MBS	Medical Benefits Schedule
NAHS	National Aboriginal Health Strategy
NAHSWP	National Aboriginal Health Strategy Working Party
NHS	National Health Strategy
NSW	New South Wales
OECD	Organisation for Economic Cooperation and Development
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Schedule
PHIAC	Public Health Insurance Administration Council
PHOFA	Public Health Outcome Funding Agreement
RPBS	Repatriation Pharmaceutical Benefits Scheme
SAM	Standard Aggregated Model
SAHC	South Australian Health Commission
SPP	Specific Purpose Payment
WA	Western Australia

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