This paper surveys current Australian health services, paying particular attention to recent and continuing reforms. The Australian health care system is described, including a discussion of funding systems such as Medicare and private health insurance. Five main elements of the health care reform agenda are covered in some detail: evidence-based decision-making; continuity and coordination of health care; improving Australia’s research capacity; strengthening partnerships; and the medical workforce and primary health care access. Among the public health strategies covered are the National Mental Health Strategy, the National Drug Strategy, the National Women’s Health Policy and Programme, the National HIV/AIDS Strategy, cancer control, immunization and the National Diabetes Strategy. Finally, the paper discusses the evaluation of Australia’s response to the Global Strategy for Health for All.
1. INTRODUCTION

1.1 Australia

Australia has a land mass roughly the same size as Western Europe or the United States of America (excluding Alaska). Initial settlement of Australia, by people now known as Aborigines and Torres Strait Islander peoples, occurred some tens of thousands of years ago. Settlement by people from Great Britain and subsequently other countries began in 1788. Australia today has a population of about 18 million with a diversity of cultural and ethnic backgrounds.

With more than four million people in Australia born overseas (representing 23% of the total population) Australia has one of the largest immigrant populations in the world.

The number of settler arrivals to Australia has varied with the economic and political situations in other countries as well as the situation in Australia. The post-war period (1946-1960) in Australia saw high annual population growth rates averaging 2.7% per year. Migration was an important component of this growth, with the Government actively encouraging migration to boost Australia’s population. During this period net overseas migration added 1.2 million people to the population, many of them Europeans displaced by World War II. Of this increase, 43% occurred during the four years from 1949–1952.1

Population growth remained relatively high during the 1960s, averaging 2.1% per year. However, growth rates fell sharply in the first half of the 1970s, from a peak of 2.1% in 1970 to 1.0% in 1975. The average annual growth rate for the 1970s was 1.5%. Levels of net migration declined as the economy slowed and employment opportunities contracted. Australia’s population increased from 15.1 million at the end of 1981 to 18.1 million in June 1995. The rate of growth due to net migration fluctuated considerably during the period 1981–1994, recording some of the lowest and highest rates since World War II.1

People from the United Kingdom and Ireland still form the largest group of overseas-born Australians. However, their number as a proportion of the total population has declined, falling from 41% in 1976 to 29% in 1996. While the number of people from these countries was still higher in 1996 than in 1976, it has fallen since 1991. There has also been a decline in the size of populations
from other European countries. For example, Italian and Greek populations, the second and third largest in 1976, have declined numerically and proportionally.¹

The Asian-born population has grown rapidly in Australia, particularly in the last decade. In 1996 people born in Asian countries represented 22% of all people born overseas, and five of the top 12 birthplace groups were from Asian countries. The Vietnamese population, Australia's largest Asian birthplace group, increased from 2500 in 1976 to 149 900.¹

Eighty per cent of the total population lives in cities, mainly on the coast. There are large regions in the centre of the continent which are not arable and have only small, scattered settlements. Australia is a developed country with a generally high standard of living.

1.2 Australia's system of government

Since 1901 Australia has had a federal system of government with origins in the British system of government and law. The constitution established a Commonwealth (Federal) Government with specific powers. Each of the States and Territories has a parliament with powers in all areas not specified in the constitution as Commonwealth powers. The Commonwealth, State and Territory Governments operate on the Westminster system, in which the political party or coalition with the majority of elected members in the lower house of parliament forms the Government. Ministers with executive powers are drawn from these elected members of Government (not all State or Territory parliaments have an upper house). Within States there are local governments such as municipal and shire councils.

1.3 Government and health

From 1901 the only Commonwealth health power was in quarantine matters. However, in 1946 the Constitution was amended to enable the Commonwealth to provide health benefits and services. The Commonwealth currently has a broad policy leadership and financing role in health matters, while the States and Territories are largely responsible for the delivery of public sector health services and the regulation of health workers in the public and private sectors. The Commonwealth is responsible for collecting income tax and other charges, including a health levy (the Medicare levy) which provides universal health coverage.
The levy is paid by individuals at 1.5% of taxable income above certain income thresholds (as of 1 July 1997 individuals with incomes above A$ 50 000 per year will pay an additional 1% Medicare surcharge – see Section 2.3 for further discussion on this). Medicare levy revenue for 1996-1997 is estimated at A$ 4.06 billion, which is 21% of total Commonwealth health expenditure and approximately 8.5% of total national health expenditure.

The States and Territories control the registration of medical practitioners, nurses, dentists and most other health professionals. Environmental health, which includes sanitation and hygiene, to ensure compliance with State and Territory public health law, is largely the province of local governments.

There is also a strong private sector in health services operating with substantial direct and indirect government subsidies (see Section 2.4). Private sector funding currently accounts for about one-third of health expenditure. Nongovernmental non-profit organizations play a significant role in health services, public health and health insurance. There are few for-profit registered health benefit organizations in Australia.

1.4 The health of Australians

Australia is a relatively rich country and one of the healthiest countries in the world. Generally, the health of Australians continues to improve. In 1993, Australia’s gross domestic product per capita was A$ 18 530 (PPP$). One indicator of health status is infant mortality rate, which in Australia was 5.9 per 1000 live births in 1994, and which has been steadily falling from a rate of 24.5 per 1000 live births in 1950. This has been due to a combination of socioeconomic, technological and individual factors. The health status of some groups in Australia, however, is not as good as others. For example, Aboriginal and Torres Strait Islander peoples can expect to live 15-20 years less than other Australians, and infant mortality rates remain three to five times higher than those of other Australians.

Low family income is generally linked to worse health. There are, however, few people living in absolute poverty in Australia and the issue needs to be seen as a relative rather than absolute. There are difficulties in estimating the level of poverty in Australia because of the need to include both cash (wages or benefits) and non-cash payments (housing subsidies, home care, universal health coverage, etc.).
Groups that have been identified at risk of poverty in Australia include: the homeless, Aboriginal and Torres Strait Islander peoples, single-parent families, young and older single people (especially those who do not own their own homes), people who are unemployed or not in the workforce, very large families, recent migrants from other than English-speaking backgrounds, and many rural families who may be asset rich but cash poor. For example, in low-income Australian families more serious chronic illnesses were reported for children (0–14 years of age) than in high-income families. Adults in the age group 25–64 years in low-income families reported much worse self-perceived health status than adults in higher-income families. Low-income Australians are also more likely to have lifestyle risk factors such as smoking, risk drinking, being overweight or obese and taking little exercise. They also are less likely to make use of preventive and screening services.

Life expectancy

Life expectancy in Australia has improved significantly over the 20th century. An Australian boy born in 1994 can expect to live 75.0 years and a girl can expect to live 80.9 years. In 1920–1922 life expectancy at birth was 59.2 years for boys and 63.3 years for girls. Figure 1.1 compares expectation of life in Australia in 1992 with that in a number of other countries. Australia has a similar life expectancy at birth to Sweden and Canada but lower than Japan, which has the highest life expectancy at birth for both sexes.
Figure 1.1 Life expectancy at birth by sex, selected countries, 1992

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>84</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>84</td>
</tr>
<tr>
<td>Iceland</td>
<td>82</td>
</tr>
<tr>
<td>Sweden</td>
<td>84</td>
</tr>
<tr>
<td>Canada</td>
<td>84</td>
</tr>
<tr>
<td>Australia</td>
<td>84</td>
</tr>
<tr>
<td>Greece</td>
<td>84</td>
</tr>
<tr>
<td>Israel</td>
<td>84</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82</td>
</tr>
<tr>
<td>Italy</td>
<td>82</td>
</tr>
<tr>
<td>Netherlands</td>
<td>82</td>
</tr>
<tr>
<td>Norway</td>
<td>82</td>
</tr>
<tr>
<td>France</td>
<td>82</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>82</td>
</tr>
<tr>
<td>Spain(a)</td>
<td>82</td>
</tr>
<tr>
<td>Singapore</td>
<td>82</td>
</tr>
<tr>
<td>New Zealand</td>
<td>82</td>
</tr>
<tr>
<td>Ireland</td>
<td>82</td>
</tr>
<tr>
<td>USA</td>
<td>82</td>
</tr>
<tr>
<td>Germany</td>
<td>82</td>
</tr>
<tr>
<td>Malaysia(a)</td>
<td>82</td>
</tr>
<tr>
<td>Poland</td>
<td>82</td>
</tr>
<tr>
<td>Lebanon(a)</td>
<td>82</td>
</tr>
<tr>
<td>Philippines(a)</td>
<td>82</td>
</tr>
<tr>
<td>Russia</td>
<td>84</td>
</tr>
</tbody>
</table>

(a) Philippines, Spain 1991; Lebanon, Malaysia 1990-95

Sources: WHO 1995; UN 1995

Burden of disease

Noncommunicable diseases account for the major causes of fatal illnesses in Australia. The leading cause of death in Australia is cancer, followed by coronary heart disease (ischaemic heart disease) and stroke (cerebrovascular disease). These three causes accounted for over 60% of all deaths, as can be seen in Table 1.1.²
### Table 1.1 Leading causes of death, number and percentage of total deaths, 1994

<table>
<thead>
<tr>
<th>Cause of death/ICD-9 code</th>
<th>Number</th>
<th>Percentage of total deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm (cancer) (140-208)</td>
<td>33,658</td>
<td>26.6</td>
</tr>
<tr>
<td>Ischaemic heart disease (410-414)</td>
<td>30,573</td>
<td>24.1</td>
</tr>
<tr>
<td>Cerebrovascular disease (stroke) (430-438)</td>
<td>12,838</td>
<td>10.1</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and allied conditions (including asthma, emphysema and bronchitis) (490-496)</td>
<td>6,713</td>
<td>5.3</td>
</tr>
<tr>
<td>Accidents (E800-E819)</td>
<td>4,491</td>
<td>3.5</td>
</tr>
<tr>
<td>Motor vehicle traffic accidents (E810-E819)</td>
<td>1,959</td>
<td>1.5</td>
</tr>
<tr>
<td>Disease of arteries, arterioles and capillaries (including atherosclerosis and aortic aneurysm) (440-448)</td>
<td>3,070</td>
<td>2.4</td>
</tr>
<tr>
<td>Diabetes mellitus (250)</td>
<td>2,742</td>
<td>2.2</td>
</tr>
<tr>
<td>Suicide and self-inflicted injury (E950-E959)</td>
<td>2,258</td>
<td>1.8</td>
</tr>
<tr>
<td>Hereditary and degenerative diseases of the central nervous system (330-337)</td>
<td>2,254</td>
<td>1.8</td>
</tr>
<tr>
<td>Senile and presenile organic psychotic conditions (290)</td>
<td>2,227</td>
<td>1.8</td>
</tr>
<tr>
<td>All other causes</td>
<td>25,859</td>
<td>20.4</td>
</tr>
<tr>
<td><strong>All causes</strong></td>
<td><strong>126,683</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


However, measuring the burden of illness does not take into account the difference between the death of a younger and of an older person. An alternative measure, which does take age at death into account, is the potential years of life lost (PYLL) attributable to a cause of death. Table 1.2 lists the leading cause of death in 1994, ordered by PYLL. Cancer is again at the top of this list, followed by accidents, particularly motor vehicle accidents. This reflects the fact that motor vehicle accidents are a leading cause of death among young Australian men. Similarly, suicide is the fourth leading contributor to PYLL, and it is the eighth leading cause of death – again reflecting the frequency of suicide among young people.  

---

2
Table 1.2 Leading causes of death, potential years of life lost (PYLL) before age 75, 1994

<table>
<thead>
<tr>
<th>Cause of death/ICD-9 code</th>
<th>Potential years of life lost</th>
<th>Percentage of total PYLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasms (cancer) (140-208)</td>
<td>253 809</td>
<td>26.3</td>
</tr>
<tr>
<td>Accidents (E800-E949)</td>
<td>118 359</td>
<td>12.3</td>
</tr>
<tr>
<td>Motor vehicle traffic accidents (E810-E819)</td>
<td>65 731</td>
<td>6.8</td>
</tr>
<tr>
<td>Ischaemic heart disease (410-414)</td>
<td>99 114</td>
<td>10.3</td>
</tr>
<tr>
<td>Suicide and self-inflicted injury (E950-E959)</td>
<td>67 610</td>
<td>7.0</td>
</tr>
<tr>
<td>Certain conditions originating in the perinatal period (760-779)</td>
<td>48 503</td>
<td>5.0</td>
</tr>
<tr>
<td>Congenital anomalies (740-759)</td>
<td>42 368</td>
<td>4.4</td>
</tr>
<tr>
<td>Cerebrovascular disease (stroke) (430-438)</td>
<td>26 858</td>
<td>2.8</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and allied conditions (including asthma, emphysema and bronchitis) (490-496)</td>
<td>24 636</td>
<td>2.6</td>
</tr>
<tr>
<td>Acquired immunodeficiency syndrome (AIDS)(a)</td>
<td>23 509</td>
<td>2.4</td>
</tr>
<tr>
<td>Diseases of pulmonary circulation and other forms of heart disease (415-429)</td>
<td>23 423</td>
<td>2.4</td>
</tr>
<tr>
<td>All causes of death</td>
<td>963 833</td>
<td>100.0</td>
</tr>
</tbody>
</table>

(a) This category includes deaths directly attributed to AIDS and deaths where AIDS was mentioned on the death certificate.


Communicable diseases

The impact of communicable diseases preventable by immunization has been much reduced in Australia. However, they have not been eradicated. Between 1981 and 1985, measles killed 18 children at a rate of 0.1 per 100 000 per year, even though immunization had been available for many years. For this same period there were also 22 deaths from subacute sclerosing panencephalitis (SSPE), a delayed complication of measles. With the availability of immunization there should no longer be any deaths from measles. Unfortunately, the disease still occurs. There were 1380 cases of measles notified in 1991, the first year the disease was notifiable throughout Australia. Then an outbreak started at the end of 1992 (1425 cases) continuing through 1993 (4536 cases) into 1994 (4895 cases).2
Poliomyelitis appears to have been eradicated in Australia, with the last natural infection reported in 1986, although there has been a vaccine-associated case since then. It is anticipated that Australia will soon be formally declared free of poliomyelitis.\(^2\)

Other infectious diseases of childhood also still occur and still cause deaths. In 1994 there were 5633 notifications of pertussis (whooping cough, no deaths), 3315 notifications of rubella (no deaths), 327 notifications of hepatitis B (41 deaths), 85 of mumps (1 death), and 169 of Haemophilus influenzae type b infection (4 deaths from meningitis). There were 15 cases of tetanus notified, more than for any year since 1979, with three deaths. The only disease preventable by immunization for which no cases were notified was diphtheria.\(^2\)

Australia belongs to that group of OECD countries – including Canada, Germany, the Netherlands, New Zealand, Sweden and Switzerland – in which AIDS incidence appears to be levelling off. In France, Italy, Spain, the United Kingdom and the United States of America, AIDS incidence is still increasing.

Despite a trend towards HIV infection at a younger age as the epidemic has progressed, HIV incidence in Australia was estimated to have declined in all age groups from a peak in the mid-1980s.

In the period to June 1995, 19 087 HIV infections were recorded in Australia, but it is now agreed that there was a substantial amount of double counting in the early years of the epidemic, and the true figure is believed to be about 15 000. In the same period, there were 6035 diagnoses of AIDS and 4309 deaths from AIDS.

In cases where route of infection was reported, the vast majority of diagnosed cases of HIV infection in Australia were in men who became infected as a result of sexual contact between men. The numbers of diagnosed cases of HIV infection associated with sexual contact between men and women, the injection of drugs, or medical procedures have been relatively small in comparison.

By the end of 1994, 90% of cumulative AIDS cases among adults whose exposure category was reported had occurred in men with a history of homosexual contact. This proportion has remained almost constant, at close to 85%, during the HIV epidemic in Australia. Although the proportion of new diagnoses of AIDS and HIV occurring in homosexually active men has remained high, there has been a considerable fall in the absolute number of new diagnoses of HIV in this group, from a peak of 2284 in 1987 to 567 in 1995. Using back projection, the estimated annual
incidence of HIV infection among homosexually active men decreased from a peak of 2840 in 1984 to around 400 in 1990.

The annual rate of notification of gonococcal infection in Australia was 16.7 cases per 100,000 population in 1994. This is comparable with the rates observed in the previous three years but lower than the rates recorded 10 years ago. The rate of notifications of syphilis has remained stable in the last few years: in 1994 it was 13 per cases per 100,000 population. National surveillance data suggest very high rates of STDs in the Aboriginal and Torres Strait Islander population.

The tuberculosis notification rate fell steadily from over 50 per 100,000 population in the early 1950s to less than 10 per 100,000 since the early 1980s. In contrast with many countries, the notification rate has remained static in recent years, fluctuating between 5.5 and 6.0 per 100,000 per year.

National health priority areas

Australia’s response to WHO’s Health for All by the Year 2000 included the adoption of national health goals and targets. This approach attempted to include a wide range of priorities and many indicators to monitor progress. However, Australia has taken a new direction which attempts to focus effort on areas where significant beneficial change to health can be identified.

Five health priority areas were selected against criteria including:

- the importance of the disease to the community;
- the impact of the disease (including morbidity, mortality, prevalence, potential years of life lost, costs to the individual and the community, and inequities such as those resulting from socioeconomic disadvantage);
- the achievability of improved outcomes; and
- whether the impact of activities undertaken in relation to the disease could be measured.

Based on these criteria Commonwealth and States have agreed to focus attention on five national health priority areas: cancer control, cardiovascular health, injury prevention and control, mental health and diabetes mellitus.
Cancer and cardiovascular diseases are two major causes of death in Australia. Cigarette smoking and fat consumption contribute to the risk of developing cardiovascular disease and to the initiation or promotion of cancer. Almost one in three men and one in four women smokes regularly; the proportion of adults (20-69 years of age) with blood cholesterol levels equal to or greater than 6.5 mmol/l exceeds 15% in the general population. Aboriginal and Torres Strait Islander peoples die from cardiovascular disease at approximately twice the rate of the total Australian population.

The contributions of injuries and mental health problems to mortality, morbidity and disability, and their overall impact on the quality of life are similarly substantial. In 1994 the 7187 injury deaths made up 5.7% of deaths in Australia and the injury death rate was only just higher than that of 1993, the lowest on record. A national target for the year 2000 is that the injury death rate should be 20% below that in 1992. The 1994 rate was 6% below that in 1992, well on the way to the target. The highest injury death rates are in old age, where the most important cause of death is falls.

Road transport injury was, until recently, the most common form of injury death, but death rates have been declining since 1970, and there was particularly rapid decline from 1988 to 1992. The number of people killed on Australian roads has fallen by 49% from a peak of 3798 in 1970 to 1940 in 1994. The 1994 road toll was the lowest since 1954. Progressive introduction and enforcement of seat belt wearing in 1970, random breath testing in 1978, and speed limits have played a major part in the steep decline in the road toll. Other significant features in reducing the road toll over this period have been continuing improvements in vehicle design and improved roads.

Drowning is another frequent cause of injury deaths. Drowning rates remain particularly high at 1-4 years. In 1992, 42 of 76 drownings in this age group occurred in a swimming pool. The number of deaths from accidental poisoning by drugs (i.e. overdoses) is rising. Half of these are due to heroin overdoses. These deaths are only some of the deaths related to heroin; if addiction is mentioned on the death certificate, the death is classified as due to addiction, rather than to overdose.

Suicide is now the most frequent form of injury death. It is more frequent among males, but the upward trend in young male suicide rates from 1960 to 1990 seems to have levelled off. For males, suicide rates are highest in 'remote and rural' areas, with those in all other areas being similar. Females in urban areas have higher rates than females in the country. All-ages suicide rates are similar for males across all areas except 'remote other', but males aged 15-29 years and 40-59 years
show elevated risk in rural and remote areas. For the younger males, the high suicide rates coincide with rural production areas rather than rural towns. The middle-aged male group experiencing higher rates coincides with the age distribution of the agricultural and forestry industry male worker populations. These rates may therefore reflect the impact of the rural recession, although further work would be required to demonstrate that.\(^2\) Table 1.1 shows suicide as accounting for 1.8% of total deaths and reflects the frequency of suicide among young people.

Almost 2% of Australians have been diagnosed with diabetes. A similar proportion is believed to have the condition but is as yet undiagnosed. Diabetes also disproportionately affects certain population groups including Aboriginal and Torres Strait Islander peoples.

Identifying and focusing effort on these five national health priority areas provides a unique opportunity to direct interventions based on the underpinning determinants of health, a primary health care approach and identifying the most appropriate points of intervention, treatment and management of priority conditions.

**Hospital utilization**

In Australia in 1993–1994 there were approximately 700 hospitals, including veterans' hospitals. The total number of beds available was, on average, 56,140 on any day. Similarly, there were 30 public psychiatric hospitals with 5,106 beds; 329 private acute and psychiatric hospitals with 21,241 available beds; 1,457 nursing homes with 74,236 beds and 1,365 hostels with 55,082 beds.\(^2\) Excluding beds in free-standing day hospital facilities and in public psychiatric hospitals, there were 4.3 hospital beds available for acute care per 1000 population in 1992–1993.\(^2\)

In 1992–1993, Australia had a rate of 246 hospital admissions per 1000 population. This rate was higher than other OECD countries for which data were available, for which the admission rates ranged from 135 per 1000 in Ireland to 237 per 1000 in Finland. Australia’s comparatively high admission rate results from the inclusion of same-day admissions, which most OECD countries exclude from their calculations.\(^2\)

Again because of the inclusion of same-day admissions, Australia has a comparatively short average length of stay, 4.9 days for 1992–1993. This is the lowest among the OECD countries reporting, except for Mexico (3.5 days). The United States of America reported an average length of stay in 1993 of 6.0 days, with Switzerland reporting 11.8 days and New Zealand 7.7 days. Excluding
same-day admissions increases the Australian average length of stay to 6.7 days, still at the lower end of the range.\textsuperscript{2}

Accurate comparison with other countries is difficult. However, the most recent data (for 1993) suggest that Australian acute hospital bed ratios for 1992–1993 were high compared with those of some OECD countries. The United Kingdom had 2.1 beds per population, the Netherlands 4.1, Denmark 4.1, Sweden 3.4 and Ireland 3.2. However, some European OECD countries had higher ratios: e.g. Austria 5.4, France 5.0 and Germany 7.2.\textsuperscript{2}

The broad trends in Australian public hospital utilization are that:

- admissions are increasing (37\% over five years to 1993-1994), reflecting a growing and ageing population, the introduction of new technologies and a historical decline in private health insurance coverage since 1984;

- the average length of stay (4.9 days for 1992–1993) for admitted patients has declined (30\% over five years to 1993-1994), attributable to:
  - reductions in hospital-based nursing home care;
  - improved anaesthetics and antibiotics;
  - use of less invasive surgical techniques; and
  - increasing use of same-day procedures;

- bed days have declined (4\% over five years to 1993-1994), reflecting a decline in average length of stay.\textsuperscript{2}

The health workforce

The number of people employed in the health industry has risen from 536,000 in 1989 to 584,100 in 1995. This increase of 9\% is greater than the 6.4\% increase which occurred in the total number of employed persons over the same period. Employment in the health industry represented 6.9\% of total employment in Australia in 1989 and rose to 7.4\% in 1991 but declined to 7.15 in 1995 as general employment improved.

The health industry is a major employer of women, providing 13\% of national female employment but only 3\% of male employment. Females constitute 76\% of those employed in the health industry and this proportion has remained stable from 1989 to 1995. The occupation with the
highest proportion of females is nursing; 91% of registered nurses were female in 1989 and this increased to 93% by 1995. In the professional diagnosis and treatment occupations the proportion of females has fluctuated between 40% and 46%.²

The number of doctors increased by 89.5% from 20 480 to 38 800 between 1976 and 1991. In 1976, medical practitioners were 11.2% of health personnel; this had increased to 14.2% by 1991. The number of medical practitioners per 100 000 population increased from 156 in 1976 to 230 in 1991 (for further discussion on managing the health workforce see Section 3.5). Table 1.3 shows Australian medical practitioners and nurses, by type and age group for 1992–1993.²

Table 1.3 Medical practitioners and nurses, by type and age groups, 1992-1993

<table>
<thead>
<tr>
<th>Age group</th>
<th>Less than 25</th>
<th>25-35</th>
<th>35-44</th>
<th>45-59</th>
<th>60-64</th>
<th>65 &amp; over</th>
<th>Total</th>
<th>% female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical practitioner clinicians (a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General/primary care</td>
<td>10</td>
<td>3 360</td>
<td>6 736</td>
<td>5 337</td>
<td>1 154</td>
<td>1 891</td>
<td>18 488</td>
<td>29.6</td>
</tr>
<tr>
<td>Non-specialist salaried hospital</td>
<td>327</td>
<td>3 434</td>
<td>7 58</td>
<td>223</td>
<td>35</td>
<td>44</td>
<td>4 821</td>
<td>13.6</td>
</tr>
<tr>
<td>Specialist</td>
<td>5</td>
<td>854</td>
<td>4 548</td>
<td>6 069</td>
<td>1 142</td>
<td>1 382</td>
<td>14 000</td>
<td>24.7</td>
</tr>
<tr>
<td>Specialist-in-training</td>
<td>6</td>
<td>2 032</td>
<td>539</td>
<td>56</td>
<td>-</td>
<td>-</td>
<td>2 633</td>
<td>29.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>348</td>
<td>9 680</td>
<td>12 581</td>
<td>11 685</td>
<td>2 331</td>
<td>3 317</td>
<td>39 942</td>
<td>24.7</td>
</tr>
<tr>
<td>% female</td>
<td>42.7</td>
<td>37.6</td>
<td>28.1</td>
<td>16.2</td>
<td>13.9</td>
<td>9.5</td>
<td>24.7</td>
<td></td>
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<td><strong>Nurses</strong></td>
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<tr>
<td>Registered nurses (b)</td>
<td>11 065</td>
<td>47 952</td>
<td>56 387</td>
<td>41 969</td>
<td>4 055</td>
<td>(c)</td>
<td>163 408</td>
<td>92.6</td>
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<tr>
<td>Enrolled nurses (d)</td>
<td>2 400</td>
<td>12 049</td>
<td>12 579</td>
<td>6 700</td>
<td>462</td>
<td>(c)</td>
<td>45 519</td>
<td>93.6</td>
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<tr>
<td><strong>Total</strong></td>
<td>13 465</td>
<td>60 001</td>
<td>68 966</td>
<td>48 669</td>
<td>4 517</td>
<td>(c)</td>
<td>208 927</td>
<td>92.8</td>
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<tr>
<td>% female</td>
<td>93.2</td>
<td>92.2</td>
<td>91.6</td>
<td>94.9</td>
<td>93.6</td>
<td>(c)</td>
<td>92.8</td>
<td></td>
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</tbody>
</table>

(a) A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, of patients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).

(b) Age data not available for Northern Territory (NT). NT is included in the total.

(c) Included in the 60-64 age group.

(d) Age data not available for New South Wales (NSW) and NT. NSW and NT are included in the total.

2. THE AUSTRALIAN HEALTH SYSTEM

2.1 National structures

There are a number of national structures that play an important role in the development of health policy, including the Council of Australian Governments (COAG), the Australian Health Ministers’ Conference (AHMC), the Australian Health Ministers’ Advisory Council (AHMAC), the National Health and Medical Research Council (NHMRC), the Health Insurance Commission (HIC) and the Australian Institute of Health and Welfare (AIHW).

At the highest level, the activities of Commonwealth, State and Territory Governments are coordinated through the Council of Australian Governments (COAG) which deals with broad policy on the operations of governments and their regulation of the private sector.

The main objective of AHMC is to promote a consistent and coordinated national approach to health policy development and implementation. AHMAC consists of senior Commonwealth and State and Territory health officials and it considers health matters referred by AHMC or any Health Minister and reports on these matters to the annual meeting of AHMC.

The Australian Government’s main funding body for health and medical research is the National Health and Medical Research Council (NHMRC). In addition to providing advice to the Government on health, health ethics and medical research and administering the research funds, the NHMRC also publishes an extensive range of guidelines and information relating to health ethics and health care.

The Health Insurance Commission (HIC) is a Commonwealth statutory authority. HIC processes and pays claims and benefits and records relevant data on Medicare, Pharmaceutical Benefits Scheme, Childcare Cash Rebate Scheme, National Childhood immunization Programme, Department of Veterans’ Affairs Treatment Accounts and Australian Hearing Services. HIC also operates a global consultancy service providing advice on health, health insurance, large scale claims processing systems and related matters.

The Australian Institute of Health and Welfare (AIHW) is an independent statistics and research agency within the Commonwealth Health and Family Services portfolio. The Institute
provides information and analysis on the health and welfare of Australians and their health and welfare services.

2.2 The funding of health care

The Australian health system is a strong performer by international standards.

National health spending in Australia accounts for 8-9% of Gross Domestic Product (GDP). In 1993–1994 national spending on health in Australia was around A$34.1 billion and includes services provided by doctors, hospitals, pharmaceuticals, dental, physiotherapy and other allied health services, community and public health and nursing homes.

This compares favourably with other OECD countries most of whose expenditure falls within the range of 7-9% of GDP.

Health care in Australia is financed by a mix of public and private funding arrangements: public funding represents about 67% and the private health sector about 33% (15% from private health insurance funds and 18% self-funded, including health expenditure by workers' compensation and compulsory motor vehicle third party insurance funds).

Outlays on health (for 1993–1994) by the Commonwealth, States and private health expenditure by major programmes can be seen in Figures 2.1, 2.2 and 2.3.
Figure 2.1 Commonwealth outlays on health by major programmes


Figure 2.2 State outlays on health by programme AS$ 6.7 billion recurrent (1993-1994)

The Commonwealth Government is able to provide leadership and influence national health policy in a number of ways. It exerts influence through its financial arrangements with State and Territory Governments, through the provision of benefits and grants to organizations and individuals, through the regulation of health insurance, and the development of national health policies and programmes. Health and health delivery research projects also receive funding under various programmes.

The Australian health system provides universal access to many areas of the system at no or minimal cost (at the point of delivery) to the majority of the population:

- public hospitals: free access;
- doctors: free access for 80% of the population;
- pathology and radiology: free for 78% and 62% of the population respectively;
- prescription drugs: small contributions for concessional eligible consumers plus a safety net for all the community to ensure that the burden of costs for medicines is not excessive.

The Commonwealth Government plays the major role in health financing by allocating public funds to health care in the form of:
- subsidies for medical services under Medicare;
- pharmaceutical benefits;
- direct grants to nongovernmental organizations for the provision of health care;
- specific purpose payments to State and Territory Governments to support publicly owned hospitals and other infrastructure;
- Financial Assistance Grants (FAGs) which provide general assistance to states; and
- a substantial contribution through Hospital Funding Grants (HFGs) to the states.

Under current arrangements, it is the State and Territory Governments which determine:
- the total amount of funds available to the public hospital system;
- budgets for individual hospitals and the arrangements under which they are paid, e.g. case mix;
- the number and location of hospitals and community health services; and
- the range of services available at each hospital.

2.3 National health care system – Medicare

The centrepiece of the Australian health care system is Medicare, which, in its current form, was introduced in 1984 – it provides universal access to the doctor of choice for out of hospital care, free public hospital care and subsidized pharmaceuticals.

Public hospital funding is one component of Medicare, the other two being the Medical Benefits Scheme (covering fees for practitioner services) and the Pharmaceutical Benefits Scheme.

Medicare is based on a set of policy objectives – universal access, affordability, quality care and outcomes, and equity, both in the distribution of costs and in the allocation of resources and efficiency. Within the Medicare arrangements measures such as safety nets and direct billing seek to protect individuals and families from unnecessarily high costs.

Medicare funds health care through grants to State and Territory Governments for the operation of hospitals; medical benefits, providing patients with rebates on fees paid to privately practising doctors; pharmaceutical benefits, providing subsidies to patients for a broad range of
medicines; and grants to governmental and nongovernmental service providers for a range of other health care services (for example, screening programmes, and services to meet special needs and high technology health care).

Medicare funding is supplemented by State and Territory Governments (mainly through publicly-owned hospitals) and by private sources, mainly out of pocket payments by consumers. A Medicare levy is paid by individuals at 1.5% of taxable income above certain income thresholds.

From 1 July 1997, a Medicare levy surcharge of 1% was introduced for single individuals with taxable incomes in excess of A$ 50 000 and couples and families with combined taxable incomes in excess of A$ 100 000 who do not have private hospital cover through private health insurance. This measure was introduced to encourage private health insurance membership, for those who can afford it, with the intention of relieving pressure on the public hospital system.

Medicare benefits schedule

The Commonwealth Government’s Medicare Benefits Schedule (MBS) lists a wide range of consultations, procedures and tests, and the Schedule fee applicable for each of these items, according to whether the patient was admitted to hospital at the time of the service.

The Schedule covers services by medical practitioners (general practitioners and specialists), refraction testing by optometrists, and some specialized dental surgery services.

Although Schedule fees are used to calculate Medicare medical benefits entitlements, medical practitioners can charge whatever fee they wish, provided the service is not bulk-billed (see billing arrangements below).

The rate of benefit for out of hospital medical services, such as visits to a doctor in his/her rooms, is 85% of the Medicare Schedule fee, with a maximum gap between Schedule fee and benefit. Where one person’s or a family’s gap payments exceed a certain amount in a year, all further benefits in that year are paid at up to 100% of the Schedule fee.

Private patients in all hospitals, including public hospitals, are charged for medical treatment and accommodation. They may also be charged for other services such as operating theatres and physiotherapy.
The rate of Medicare benefit for medical treatment provided while the private patient is in hospital is 75% of the Medicare Schedule fee. Registered private health insurers offer insurance for the difference between 75% and 100% of the Schedule fee, together with additional benefits for hospital accommodation and other hospital charges.

Some medical services attract higher Medicare rebates when performed by recognized specialists or consultants when patients have been referred by another medical practitioner.

A patient may consult any specialist or consultant directly, but such services attract a Medicare rebate at an unreferred (lower) rate, rather than the higher specialist rate.

For most pathology and diagnostic imaging services, Medicare medical benefits are paid only when the patient has been referred by another medical practitioner to the practitioner providing the pathology or imaging service. These requirements are in place in order to promote quality of care through appropriate clinical practice and to constrain costs by removing financial incentives to provide unnecessary specialist services. As a consequence, most access to specialist medical services is on referral from general (primary) medical practitioners.

About 60% of all claims for Medicare medical benefits are for services provided by non-specialist doctors and optometrists.

_Medicare benefits schedule billing arrangements for private medical services_

Patients may claim Medicare medical benefits in the following ways:

- pay the doctor’s account and then claim the benefit from Medicare; or

- obtain from Medicare a cheque for the benefit payable to the doctor, and then give the cheque, and any balance, to the doctor.

Claims may be made either by post or over the counter at Medicare offices throughout the country.

Alternatively, doctors can send accounts directly to Medicare, accepting the Medicare rebate of 85% as full payment for service to private patients. This practice is known as direct billing or bulk billing. It is illegal for the doctor to make any additional charge for a bulk-billed service, and so the service is free to the patient at the point of provision.
Unless a service is bulk-billed, Commonwealth law does not restrict the level of the fee charged. Nevertheless, around 65% of services for which Medicare medical benefit are paid are bulk-billed. Moreover, around 80% of services for which Medicare medical benefit are paid are charged at or below the Medicare Schedule fees, showing the major influence which the Medicare Benefits Schedule has in the private market.

The Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) aims to provide all Australians with access to effective and necessary prescription medications at a reasonable cost to the patients and to the nation.

Since it began more than 40 years ago, the PBS has grown from supplying 139 “life saving” drugs to over 500 kinds of drugs in more than 1800 formulations. The PBS also provides other forms of assistance to improve affordable access to medicines. For example, the Pharmacy Restructuring Programme was set up to rationalize the number and location of pharmacies in Australia. The subsidies are paid, in the main, as cash transfers direct to pharmacists who dispense the medicines. It is estimated that around 65% of all prescriptions issued in Australia are subsidized under the PBS. The other major source of subsidized medicines is public hospitals, where medicines are provided free to hospital Medicare in patients.

The PBS benefits everyone, whatever his/her health or income, making necessary medicines available at affordable prices.

Specific grants

Under Medicare, the Commonwealth Government also provides a range of grants to governmental and nongovernmental bodies in order to achieve specific health care objectives. These include:

- the provision of services to special needs groups such as rural Australians, Aboriginal and Torres Strait Islanders, and people with mental illness;

- ensuring the appropriate use of high-cost and high-skill technologies such as magnetic resonance imaging scanners, radiation oncology or organ transplants;

- targeting preventive services to the appropriate groups, for example breast cancer screening for women aged over 50 years;
- improving general medical practitioner and associated services.

Medicare agreements

A significant forthcoming event in the health sector is the expiry of the current five-year Medicare Agreements on 30 June 1998.

The present agreements are predominantly acute hospital funding agreements. But, in keeping with the broader agenda for health reform currently being considered by Health Ministers, the replacement agreements will need to have a broader focus giving more consideration to the linkages between hospitals and other parts of the acute care system. To reflect this, Health Ministers have decided that the new agreements will be known as the Australian Health Care Agreements.

While negotiations are still underway, Health Ministers have endorsed some principles to underpin the negotiations:

- Funding will be based more clearly on identified outputs and outcomes, including quality, rather than inputs.

- Patient-based information will be collected across the health system for improved policy analysis and management and for improved individual care planning.

- There will be improved capacity to manage the health system as a whole, particularly across the boundaries between primary and acute care.

- Structural change will reduce cost pressure on acute care and allow better non-acute care and day surgery.

- Improved risk management will promote cost control for the benefit of both the Commonwealth and the States.

2.4 Private health insurance

While Medicare provides universal access to public health services to all Australians, private health insurance provides added benefits such as choice of doctor, hospital and flexibility in time of treatment. In addition, services such as dental care, physiotherapy, and ancillary services are mostly privately provided and funded.
Private health insurance both complements and competes with Medicare. Public supply and private supply of both medical and hospital services therefore coexist, with many medical services provided on a fee-for-service basis. The Government supports a strong link between the public and private health sectors, further deregulation of the industry and promotion of the principles of competition across the health sector as a whole.

A continuing feature of the regulation of private health insurance is the requirement for community rating. This means that private health insurers may not set premiums on the basis of the likely claims expenditure for a class of customers, such as the aged or the chronically ill. For example, a sick older person will pay the same rate for private health insurance as a healthy younger person. In effect, for a given insurance product, there are only two rates of premiums – one for single people and one for families. Community rating ensures that private health insurance is available to a wide range of people in the community.

Different private health insurance funds have different proportions of aged and chronically ill customers. In order to minimize competitive disadvantages for insurance firms with high proportions of such customers, there is a reinsurance arrangement resulting in transfers of funds from other insurance firms to firms with high proportions of aged and chronically ill customers.

Prior to 1995, Commonwealth law required that private health insurance:

- pay a specified minimum daily amount for hospital services;
- pay specified amounts for in-hospital medical services to inpatients, supplementing Medicare benefits; and
- not pay any other benefits for medical services, i.e. not insure out of hospital medical services, or insure in hospital medical fees above the schedule fee.

Insurers could and still can offer supplementary insurance for hospital services, and ancillary insurance for paramedical services, appliances etc. However, even with supplementary hospital insurance, customers often found that they faced large out of pocket costs for private hospital services and for medical fees charged at above the schedule fee rate. Private patients in public hospitals did not face out of pocket costs for hospital services, but could face such costs for medical fees and post-discharge paramedical services.
Changes introduced in 1995 enable insurers to negotiate arrangements with hospitals and doctors so that the insurers will be able to offer customers coverage for periods in hospital without out of pocket costs. Other products may eliminate out of pocket costs for private hospital services while leaving some out of pocket costs for medical services.

In Australia, public hospitals provide the majority of hospital services. However, in the last few years substantial increases have been made in the range and sophistication of private hospital services available, including:

- complex surgical procedures;
- accident and emergency procedures;
- psychiatric; and,
- care for nursing home type patients.

At present there are 45 registered health benefit organizations in Australia. Of these:

- 28 are ‘open’ for anyone to join and 17 are ‘closed’ to a restricted group of people, such as the armed forces.
- 42 operate on a ‘not-for-profit’ basis and the remaining three operate as ‘for-profit’ businesses.

Since the introduction of Medicare in 1984 the overall participation rate in private health insurance has declined significantly. On 30 June 1996, 33.6% of Australians (or 6.15 million) were covered by private health insurance, compared to about 50% in mid-1984 (see Figure 2.4). Younger and healthier members are dropping insurance and choosing to rely solely on Medicare. This results in a greater proportion of higher risk members who are more likely to claim benefits.
From 1 July 1997, income tested incentives were provided to families and individuals with private health insurance. Incentives will be available to single people with a taxable income of less than A$ 35,000 and to couples and families with a dependent child, with a combined taxable income of less than A$ 70,000. The family income threshold increases by A$ 3000 for each additional dependent child. Incentive payments will be A$ 100 per annum for single people, A$ 200 for a couple or A$ 250 for a family. Incentive payments are available as reduced premiums or income tax rebates.

This measure is also being introduced to encourage private health insurance membership – with the intention of relieving pressure on the public hospital system by stopping the decline in membership.

In addition, a recent Government inquiry into the private health insurance industry has made recommendations relating to ways to reduce the cost pressures which have led to premium increases. One recommendation, accepted in principle by the Government, is to introduce a system of 'unfunded lifetime community rating' whereby those joining a health fund earlier in life will have to pay a lower premium compared with those joining later. This will encourage long-term membership and reduce the problem of 'hit and run' membership while still maintaining the Government commitment to community rating.
3. THE HEALTH CARE REFORM AGENDA – A FOCUS ON OUTCOMES

The Government's health care reform agenda and its commitment to a sustainable health care system encompasses three key themes:

- a focus on better outcomes for consumers, better quality care and greater fairness in access to services;
- steady reform for long-term change, including micro-economic reforms requiring specification of programme outputs and outcomes, and opening up opportunities for more competition and consumer choice; and
- the need to deliver these improvements in ways which ensure that these programmes, including Medicare, are sustainable in the medium to longer term.

The following initiatives are examples of the reforms being implemented: health funding through evidence-based decision-making, a seamless approach to health care delivery through coordinated and continuity of care, improving Australia's research capacity, strengthening partnerships across the health spectrum, and managing Australia's medical workforce.

3.1 Evidence-based decision-making

In past years, Commonwealth Government involvement in the acute health sector has been characterized by funding input with a relatively narrow focus on access to free hospital treatment. In addition, judgements about clinical relevance have been based largely on expert professional opinion alone, such as medical colleges, societies or associations.

Only in more recent times has the debate started to shift towards the performance of the health care system with a focus on outputs and outcomes. There has also been an increasing international recognition that there should be a more systematic approach to the assessment of new and emerging medical technologies and procedures – based on evidence, where possible, derived from well-conducted clinical trials, rather than on expert advice alone. Consequently, there is increasing importance being placed on collating and analysing information on what is actually happening in Australian health services, and in using that information as a management tool to improve the quality, efficiency and efficacy of those services.
At the same time, community standards are becoming more demanding. Health care consumers expect that the products and treatments they are offered have been proven to be safe and effective. Many consumers regard the availability of a Medicare Benefit as government acceptance, if not endorsement, of a medical procedure, as is the case with the Therapeutic Goods Administration's licensing of a therapeutic product.

Australia is, therefore, working to foster a strong evidence base for decisions in health service delivery, so that knowledge can be used to improve quality and to ensure better outcomes for consumers which are as cost-effective as possible.

One of the most important developments in the practice of medicine in recent times is the increasing reliance on evidence-based clinical care and medicine. While clinical practice guidelines have existed for some time, it is only relatively recently that there has been a strong emphasis on analysis of the evidence on which the guidelines are based.

Evidence-based decision-making is an approach based on using all the available evidence on the benefits and harms of the health care intervention compared to alternative ways of managing the relevant conditions. It involves systematically identifying, assessing and then combining this evidence to arrive at an overview position. Evidence-based clinical care and medicine emphasize adherence to the highest standards of scientific rigour in developing systematic overviews. Randomized trials constitute the cornerstone of the evidence assessed. It is being advanced primarily due to the efforts of individuals working within the Cochrane Collaboration, an international effort geared towards conducting and maintaining these systematic overviews at accepted standards of practice.

Evidence-based decision-making is seen as an important driver in improving health care and health outcomes for the community and represents a significant shift in emphasis away from providers to consumers of health care services. It is about distinguishing those health care interventions for which the benefits outweigh the harms from those which do nothing or for which the harms actually outweigh the benefits.

An evidence-based approach is expected to deliver better quality health care at a better price, and slow the rate of growth in expenditure on medical services where the evidence base is weak or inconclusive.
Australia will be looking towards working more closely with its international partners in the area of evidence-based decision-making and care.

**Evidence-based decision-making and the Pharmaceutical Benefits Scheme**

A good example of an evidence-based approach which has been in place since the early 1990s is the listing arrangements of pharmaceuticals on the Pharmaceutical Benefits Scheme (PBS). In 1993, Australia also formally introduced a systematic approach to including information from economic evaluations when deciding whether to add new drugs to the PBS. The manufacturer sponsors, collects and presents the therapeutic and economic evidence to the Government for consideration within an approved scientific format. The evidence is reviewed using expert independent advice and forms the basis of a recommendation on its listing.

The process has not reduced expenditure on pharmaceuticals, but it has put in place processes which safeguard the interests of the community.

Several hundred economic evaluations and the use of evidence-based decision-making have now been used to help inform decisions as to which drugs should be subsidized. Several lessons have been learnt:

- The preparation, assessment and use of evidence-based decision-making and economic evaluation is inherently a multidisciplinary activity. It involves a constructive collaboration of at least clinical sciences, biostatistics and health economics.

- Evidence-based decision-making and economic evaluation are most defensible when done systematically with careful attention to scientific rigour.

- The introduction of evidence-based decision-making and economic evaluation involves the need to develop clear requirements and then back these up with adequate skills and resources. It is a complex and skill-intensive activity.

- By definition, introducing evidence-based decision-making and economic evaluation does not necessarily result in successful cost-containment. For many interventions, it provides a rigorous basis for cost-justification. The PBS budget is still growing at a 15% compound increase each year.
- The systematic use of evidence-based decision-making and economic evaluation has highlighted the fact that there are many factors that go into making resource allocation decisions that lie outside a simple consideration of efficiency, such as equity issues.

- Evidence-based decision-making and economic evaluation have highlighted many areas for further development, some important ones being: the frequent need to interpolate from average incremental benefit to identify patients likely to benefit most; and the frequent need to extrapolate to patient-relevant outcomes, to longer time horizons and to regular clinical practice.

The net effect of the introduction of evidence-based decision-making and economic evaluation is to turn the PBS listing process into an outcomes-based reward system. Australia explicitly rewards evidence of greater benefits to the health of Australians with higher prices.

Although this can come into apparent conflict with an industry policy of rewarding greater research and development costs with higher prices, it brings incentives to bear on the precise reason medicines are developed in the first place: to promote better health.

Evidence-based medicine and the Medicare Benefits Schedule

The current Medicare Benefits Schedule (the MBS) has a long history. The vast bulk of the items represent long-term accepted medical practice. Inclusion of services on the schedule has been guided by the principle of clinical relevance. The Health Insurance Act, 1973 states a service must be 'necessary for the appropriate treatment of the patient to whom it is rendered'. Over the past decade expenditure on medical services funded by Medicare has been growing at a real rate of around 5% per year. This growth is attributable to a range of factors such as population growth, changing demography and with it changing patterns of health and use of health services, fee drift, changing community expectations, and the availability of new and expensive medical technologies.

In Australia the degree of rigour used to assess claims prior to their listing on the Medicare Benefits Schedule (MBS) has been variable, mainly because individual practitioners have had to meet most of the cost of assembling and submitting available evidence. In addition, resources set aside from the Medicare programme to support this activity have not kept pace with the rapid growth of new medical technologies.
Much of the evidence currently available on the effectiveness of medical interventions is based on weaker evidence such as single case studies and professional opinion, and rarely addresses economic issues. While many new medical technologies do deliver on the promised benefits, some make little difference, and others are questionable in terms of benefits, cost-effectiveness and safety. Examples of medical technologies which are high growth services in Australia and are promising, but for which the evidence on their efficacy and cost-effectiveness is inconclusive, are sleep medicine and hyperbaric oxygen therapy.

Encouraged by the success in applying evidence-based medicine and economic evaluation to pharmaceutical subsidy decisions, Australia is now embarking on using these tools more systematically in decisions about subsidizing other health interventions, such as MBS. This involves applying more systematically and explicitly the criteria of efficacy, safety and cost-effectiveness to the process to decide whether to reimburse such interventions as medical services, procedures, pathology services and imaging technologies. Evaluative work is already being done in this area and Australia is moving to consolidate these activities. The expectation is that many interventions which are harmful or ineffective will be able to be excluded from subsidy.

There are, however, some important differences between this new area and Australia's current experience with pharmaceuticals:

- There is normally no clear sponsor of non-pharmaceutical interventions. This means that the onus of proof will reside mainly with Government.
- The culture of scientific evaluation is less advanced than in the area of pharmaceuticals. Well-conducted randomized trials are rarer (and may not always be possible), there is often no detailed appraisal of efficacy and safety is not already conducted by a regulatory body.

3.2 Continuity and coordination of health care

Coordinated care

One of the most immediate and practical demonstrations of the potential for improving the delivery of health and community services is being undertaken in the form of a series of Coordinated Care Trials.
As explained in Section 2 the health and related community care needs of Australians are funded from three main sources. The Commonwealth, which is responsible for meeting the bulk of medical and pharmaceutical costs (provided outside of public hospitals); the States and Territories, which have responsibility for public hospital service provision, and individuals, who, either through private health insurance or out of pocket expenses, meet both the gap between the medical and pharmaceutical benefit paid by the Commonwealth and the full cost of private hospital accommodation. The costs of related community care are met through a range of Commonwealth and State/Territory programmes and individual contributions.

These funding arrangements clearly provide opportunities to shift the costs involved in meeting a patient’s needs from one funder to another.

The needs of the patient and the overall cost-effectiveness of service provision sometimes do not appear to be the major considerations in the provision of services.

In recognition that the needs of patients should be of paramount concern, trials are taking place of an important reform of Australia’s systems of health and community service delivery. The trials are being conducted through the Coordinated Care Programme, an initiative developed jointly by Commonwealth, State and Territory Governments. Twelve Coordinated Care Trials based in five States and one Territory are now undertaking a concentrated period of design and tracking prior to considering whether they should enter the second, live phase. A further four trials in Aboriginal communities are being developed. Those trials selected for funding for the live phase will explore new, more effective, mechanisms for providing health and community services to individuals with complex, chronic health problems. Target populations will include the frail aged and those with chronic conditions such as hepatitis C, asthma and cancer.

At the centre of Coordinated Care Trials is a care coordinator who will be responsible for designing a tailor-made care plan, in partnership with the client and the client’s general practitioner, and for ensuring that the services specified in that care plan are delivered.

An important component of the trials will be the new arrangements between the Commonwealth, State and Territory Governments to pool funds in such a way that care plans can be built around the needs of clients rather than around traditional allocations between services.

The amount of funds to be pooled will be an estimate of the cost of services that trial clients would have been expected to use over the trial period. Using this pool of funds, the Care Coordinator
can then decide which services to purchase to ensure the most effective, most appropriate and efficient combination of services is provided to the client.

The types of services selected for trial clients will be those services which most closely match the needs of clients, provided by the most suitable service provider. In the current system, there are perverse incentives which discourage this approach. For example, clients often use the services most available (e.g. emergency admission to hospital, or a general practitioner) rather than the services they most need. Pooling removes the incentive to cost shift from one programme to another.

Care coordinators will be able to make decisions about the type of service the client needs and which health or community service worker will bring the most appropriate skill mix to provide that service. Depending on the client’s particular needs, the care coordinator may be chosen from a wide variety of fields. For example, the care coordinator may be a medical practitioner, a diabetic specialist nurse, a podiatrist, or a psychologist. The care coordinator will also be able to arrange for the client’s service to be provided by a practitioner working in the private sector and to pay for that service from the trial fund pool.

In all cases the medical side of a client’s care will be overseen by the client’s general practitioner. Where the general practitioner is not the care coordinator, the general practitioner will still be involved in the development of the care plan and will have responsibility for the medical aspects of it.

The aim of Coordinated Care Trials is to create flexible services available to all clients at no additional expense to the clients or to governments, and a health and community services sector which is able to be more responsive to the individual needs of clients, rather than responding to the sometimes irrational incentives created by the current system of funding.

The trials represent a determined effort by Australian governments to undertake several different innovative approaches to health and community care, planning and delivery. The trials will be running from July 1997 to mid–1999. Results of the evaluation of these trials will assist policy makers in making major decisions on the potential structure of Australia’s health care system in future years.

Coordinated Care Trials, whether or not they are successful, have the potential to change significantly the way health and community services are funded and provided. The future of
coordinated care appears to be one where there is far greater cooperation among providers, the bureaucracy and clients, and where the clients' needs are placed at the centre of the planning, funding and delivery of services.

Ambulatory care

Publicly provided and funded ambulatory care services have historically been recognized as areas where reform is overdue. In a concerted effort to stimulate reform to the ambulatory care sector, the Commonwealth funded the Ambulatory Care Reform Programme from 1993 to July 1997. The Programme was established to examine the organization, delivery and funding of hospital-related ambulatory services and links to community-based services.

The programme focused on developing models to assist and support clinicians and patients at the service delivery level through State-based projects. It also examined the systems required to support service delivery, including classification and costing systems, information systems and performance measures related to ambulatory care.

The Commonwealth has funded a number of projects nationally to look at more integrated and innovative ways to deliver care between the hospital and the community. Arising from these projects, seven guides have been produced covering priority areas of service delivery including chronic care, preadmission and post-acute care, discharge planning, service delivery in rural and remote areas and the non-clinical management of outpatient services. It is planned that the guides will be linked to hospital accreditation processes.

A collaboration between the Commonwealth, the States and industry will also consider the introduction of the guides nationally. This forum will also link funding arrangements that support optimal access to integrated, cost-effective and quality care.

National Demonstration Hospitals Programme

The National Demonstration Hospitals Programme (NDHP) was set up in 1995 to reduce clinically inappropriate waiting times for elective surgery through the transfer of best practice models for managing elective surgery from major teaching hospitals to collaborating hospitals throughout Australia.
NDHP projects achieved a 20 to 30% reduction in the average length of stay (up to 58% for people over 65 years), through pre-admission clinics which address patients medical, social and environmental problems before admission, and begin making arrangements for the care that will be required during the post-discharge period.

Other projects have also been established. They include:

- programmes which screen elderly patients in emergency departments to prevent inappropriate admission;
- on site accommodation for patients not able to return home following an acute phase of hospitalizations but who no longer need to occupy an acute hospital bed;
- Hospital-in-the-Home programmes; and
- programmes which use hotel accommodation near hospital campuses (with on-call care facilities) for patients not able to return home following an acute phase of hospitalization but who no longer need to occupy an acute hospital bed.

Palliative care

Recent debate on euthanasia in Australia has focused public attention on the area of palliative care, that is care provided to people who are terminally ill. The Commonwealth Government has been providing significant amounts of funding for palliative care for a number of years. In particular, in 1993, the Commonwealth established the Palliative Care Programme (PCP). Its aims are to:

- ensure that adequate and appropriate services are available;
- prevent inappropriate admissions to hospitals of terminally ill patients in need of palliative care and to reduce lengths of stay for these patients;
- maximize and promote the quality of life of terminally ill patients and support for their families and carers; and
- ensure that appropriate use is made of the resources and experiences of nongovernmental providers, for example, volunteers, charitable institutions and private providers.

The emphasis of the PCP has been on shifting palliative care from hospitals to home-based care.
A two stage review of the PCP commenced in 1996. The first stage of the review identified that a multidisciplinary team approach which includes nurses, GPs, specialist palliative care consultants, allied health workers and volunteers is a critical factor to the success of the PCP. This is based on a model of care adopted in Australia which "embraces care in the home, hospice, acute hospital and, to a very limited extent, in nursing homes". The review also noted that Commonwealth funding had resulted in a significant increase in the amount of palliative care provided in Australia and that people were now able to receive care in their homes.

The Commonwealth Government is now working with the States and Territories to agree on processes whereby current approaches to palliative care and funding can continue under broader health agreements. Inherent in this will be the continuance of a model of palliative care which allows for an easy transition between hospital, hospice and home so that terminally ill people can receive care in the setting of their choice.

3.3 Improving Australia's research capacity

Australia has a strong medical research record, having received four Nobel physiology and medicine prizes – Florey for the discovery of penicillin, Burnet for work in immunology, Eccles for the study of neurotransmission and last year Doherty for a study in immunology.

Two major cost-saving advances of our time have also been Australian discoveries: Lithium for manic depressive disease by Cade; and Warren and Marshal’s work on the bacteriological origin of ulcers and stomach cancer.

Funding for health and medical research is an investment in the future health of all Australians because advances in Australian and overseas research will lead to further improvements in clinical practice and health service provision. To help achieve this, the Australian health and medical research community are maintaining a high level and broad base of skills.

As outlined in Section 2 the National Health and Medical Research Council has the primary responsibility for the support of health and medical research. The Commonwealth Government is also funding the Australasian Cochrane Centre through the office of the NHMRC for a four-year period from 1994. The Cochrane Centre is part of the International Cochrane Collaboration which is a network of researchers dedicated to preparing, maintaining, and disseminating up-to-date
systematic reviews of randomized controlled trials of health care interventions to help influence service provision and clinical practice.

The Australasian Cochrane Centre has been involved in supporting major national reviews of health technology including reports on Prostate Cancer Screening and Colorectal Cancer Screening, and the Tobacco Harm Minimization's Review of Nicotine Replacement Therapy. The Cochrane review groups established in Australasia include Acute Respiratory Infections, Breast Cancer, Consumers and Communication, Depression, Anxiety and Neurosis, and Menstrual Disorders.

Additionally, the Government has a new initiative aimed at encouraging young Australians working in overseas research institutions to return to research careers in Australia. Although Australia is a leader in health and medical research, some of Australia's best young researchers move to overseas research institutions immediately after completing their doctorates rather than seek postdoctoral training in Australia. Once they have completed their overseas training it is often difficult for them to secure research support in Australia. The new initiative has three elements:

- a programme of research fellowships which will encourage young researchers to return from overseas after gaining valuable international experience;
- scholarships and fellowships in areas of health and medical research identified as health priorities but which are areas of research weakness; and
- a review of Australia's health and medical research workforce to develop a strategy for strengthening Australia's research capacity.

3.4 Strengthening partnerships

Two of the more significant national health policy initiatives in Australia at present are the National Public Health Partnership and the Aboriginal and Torres Strait Islander Health Framework Agreements.

National Public Health Partnership

In October 1996, Health Ministers agreed to the implementation of the National Public Health Partnership as a new working arrangement to plan and coordinate national public health activities, provide a more systematic and strategic approach for addressing public health priorities and provide a vehicle to assess and implement new directions and major national initiatives.
The main aim of this national effort in public health is to improve the health status of Australians, particularly population groups most at risk. The Partnership is a mechanism and a process to ensure that Government responsibilities in public health are consistent (where needed), coordinated (where complementary activities are required) and collaborative (where pooling of expertise and resources is beneficial).

The broad objectives of the Partnership are:

- improved collaboration in the national public health effort;
- better coordination and sustainability of public health strategies; and
- strengthening of public health infrastructure and capacity.

As such, the Partnership provides a better way of managing existing issues (such as immunization and food safety) as well as more efficient and strategic responses to emerging issues (such as hepatitis C, where available surveillance data suggests high rates of hepatitis C infection among injecting drug users). Additionally, this national collaboration should improve consistency in the public health information and regulatory framework and more strategic investment in research and workforce development.

The Partnership arrangement enhances the capacity of States and Territories to respond to public health issues of particular relevance. It also adds value to the work of each jurisdiction, rather than inhibiting decision-making or the setting and pursuit of local priorities. It is not concerned with a uniform approach, except where appropriate, nor with dictating the way each jurisdiction arranges and carries out its public health responsibilities. It recognizes that, in such a geographically and culturally diverse country as Australia, different approaches will be adopted in different localities even for the same priority issue. At the same time, it enhances the capacity to account for outcomes and benchmark activities across the nation.

The National Public Health Partnership functions as a subcommittee of the Australian Health Ministers' Advisory Council, and its work is overseen by the Partnership Group, comprising Chief Medical Officers or Directors of Public Health from each jurisdiction.

Several priority areas have been identified for inclusion in the Partnership Group’s work programme. These include:
reviewing the public health legislative and regulatory framework with a view to harmonization and modernization;

developing a national public health information framework and improving current systems of data collection;

developing a national public health research and development strategy and plan;

assessing a system for coordination and monitoring across national public health strategies/programmes;

investigating means of improving public health planning and decision-making (including resource allocation);

considering standards of best practice for public health and benchmark performance; and

undertaking a review of current and emerging issues for public health workforce.

The Partnership Group has also conducted a preliminary consideration of progress on such issues as: mental health promotion; food hygiene; communicable diseases surveillance strategy; environmental health strategy; immunization initiatives; and implementation of food and nutrition policy.

Aboriginal and Torres Strait Islander Health Framework Agreements

Although there have been major improvements in infant mortality rates in Aboriginal and Torres Strait Islander communities over the last 30 years—resulting from a combination of improved access to medical care (initially through evacuation systems) and improving the living environment—the health of indigenous Australians generally remains poor (see Section 1.4). Indigenous Australians’ health status is much worse than that of other Australians. Life expectancy is lower, infant and maternal mortality is higher and hospital admission rates are also higher.

It was recognized that, in order to address some of the key problems affecting the health status of indigenous Australians, the various governmental agencies and the indigenous community-controlled health sector needed to work together more constructively than in the past. In response to this need, partnership agreements were developed between the Commonwealth, the States and Territories, the Aboriginal and Torres Strait Islander Commission and the Aboriginal and Torres Strait Islander community-controlled health organizations. They establish a number of mechanisms
to ensure community input at the broad strategic policy level and in planning for services, including primary health care services. They provide a framework for all parties to work together to improve the planning and provision of health care services for Aboriginal and Torres Strait Islander peoples.

The agreements also form a framework for accountability for the delivery of basic health services to indigenous Australians. Currently, governments are considering how best to report publicly their efforts to improve indigenous health against specific targets for the reduction of the key causes of disease and death.

These partnership agreements, coupled with strategies to strengthen further indigenous community-controlled health services and to tackle some of the key conditions and diseases that contribute to the prevalence of disease and ill health among indigenous communities, signify progress towards developing the institutional framework needed in order to maximize opportunities for sustainable improvements in indigenous health.

3.5 The medical workforce and rural primary health care access

General practice accounts for the largest volume of primary health services in Australia. In 1995-96 approximately 102 million consultations were conducted by general medical practitioners (GPs). This represents an average of 5.6 consultations per head of population. These consultations cost the Commonwealth around A$ 2.3 billion under Medicare.

GPs are private practitioners and around 30% are in sole practice. They are financed by the Commonwealth through rebates to patients against a fee for service schedule.

In Australia there is an oversupply of general practitioners (there are about 20 000 GPs, or 1 for every 900 Australians), and yet there are many rural and remote areas with little or no access to general practice services. The ratio of GPs to allied health professionals greatly favours GPs.

There is no doubt that general practice is a key component of Australia's health system, and GPs are the first point of contact with the system for the majority of consumers. Until recently, however, GPs in Australia were extremely isolated and in competition with each other and other providers.

A study conducted in 1992 found that GPs had few professional interactions and contacts other than with their patients. Contact between GPs was extremely rare and much less common even
than their contact with other allied health professionals and hospitals. GPs commonly complained that they heard in a variety of ways about the death of their patients following hospital admission and that there was no systematic way for them to access professional support or research skills and updates.

Reliance on fee-for-service forms of payment has greatly influenced the way in which general practice operates. It encourages fast throughput of patients to the possible detriment of quality and comprehensive care. This model of practice has also made it difficult to engage GPs in health promotion and preventive activities.

A range of reforms over the last four years have led to phenomenal change and have been based on engaging GPs to be actively involved in advocacy and in improving the health of their communities.

The General Practice Strategy, which began in 1992, but continues to evolve has four broad objectives:

- to improve access to general practice services;
- to improve the integration of general practice with the rest of the health care system;
- to enhance quality in general practice; and
- to develop and introduce new financing arrangements.

Improving the integration of general practice with the rest of the health system has been greatly enhanced through the introduction of the divisions of general practice (see below).

_Rural primary health care access_

A comprehensive range of financial and professional support initiatives have been developed to improve access to general practice services. These are based on in-depth analyses of the range of factors which act as disincentives to rural medical practice in Australia. These include:

- professional issues such as lack of exposure to rural practice; isolation from other health care providers; shortage of locum relief so that practitioners can take recreational and educational/training leave; and, for some practitioners, the need to develop new procedural skills so that they can appropriately service their communities;
economic issues such as the high costs associated with relocating to and starting up in a new community and, for very small communities, the financial viability of sustaining a practice;

- educational factors such as inadequate training for rural medicine and limited opportunities to undertake continuous education activities; and

- social and cultural issues including a lack of awareness by GPs of lifestyles in rural or remote communities and the difficulties for their families such as lack of employment opportunities for spouses and limited schooling options for children.

There has been a particular emphasis on developing training for rural general practice at the undergraduate level. It is widely acknowledged that students who come from rural backgrounds, or who have had positive rural experience early in their medical training, are more likely to embrace rural practice as a career.

A number of programmes are being supported through medical schools to:

- improve student selection;

- expand the rural curriculum content;

- provide structured rural placements (of at least eight weeks for all students);

- develop educational support for teachers;

- develop full-time academics for on-site support of rural teaching;

- improve student assessment and support systems;

- develop and enhance departments of general practice; and

- facilitate active cooperation with state-based agencies over student placements.

Other initiatives have aimed to increase recruitment and retention of rural and remote health care providers. For example, the Rural Incentives Programme aims to attract and retain general practitioners to rural and remote communities in Australia and to retain them there. It includes relocation grants, training grants, support at the undergraduate level, help with skill updates, locum relief and grants for GPs in remote areas. The Rural Health Support, Education and Training Grants Programme is part of the Government's commitment to a National Rural Health Strategy. It aims to
provide support for initiatives intended to improve education, training, and support opportunities for health workers in rural and remote areas and to implement strategies to overcome major barriers to the recruitment and retention of rural and remote health workers. The Rural Health Training Units endeavour to develop and deliver a range of education and training opportunities to rural health care providers and to increase the recruitment and retention of health care providers in rural and remote areas.

Australia is a vast continent, and a large number of rural and remote communities experience isolation in terms of distance from major population centres and, therefore, access to services, particularly health services. Because of this isolation, the concept of "telehealth", or "telemedicine", is being explored as a way of improving access to health services and is currently the subject of a major Federal Parliamentary Inquiry.

Telehealth is a health delivery system which provides health-related activities at a distance between two or more locations using modem communications. For example, a doctor in a city location could communicate with and diagnose a patient in a remote part of Australia via a video link up or a rural hospital might seek a medical opinion on an X-ray by transferring the radiology image by electronic media to a city health service. The concept also has implications for efficiencies within major population centres. A number of Australian State and Territory Governments are allocating significant resources to trial telehealth systems. There is still considerable debate about the benefits and disadvantages of, and funding arrangements for, telehealth systems, and Australian Health Ministers have agreed to establish a national committee to examine a range of issues impacting upon the national implementation of telehealth.

Improving integration of general practice with the rest of the health system

In Australia, the introduction of divisions of general practice has enabled the establishment of networks needed to enable microeconomic reform to occur. Divisions of general practice help bridge the Commonwealth and State/Territory financial boundaries and the divide between acute and community care.

Essentially, the Government has supported the development of local organizations which are independent incorporations of GPs. They are funded through a geographical base which ties health issues to populations and places the emphasis on improving health outcomes.
Divisions have provided GPs with the professional support and network that they previously lacked. They have provided GPs with the opportunity to develop skills in research and health project management and have established an avenue for them to undertake skills development within their local environment. Most importantly, divisions have brought local GPs, consumers and other health professionals together by creating a focus for dialogue at a local level.

The success of divisions of general practice can be seen in the growth of the system – from ten divisions of general practice trialled in 1992–1993, to 118 divisions in 1994–1995. Over 1400 local projects on issues such as health promotion; service delivery; shared care arrangements; and management of specific health issues are being undertaken by individual divisions in 1996–1997.

The latest development being undertaken by divisions is the move to an outcomes-based funding arrangement. Single block contracts will be negotiated on the basis of performance against agreed outcomes including health, service delivery by GPs and others, professional activities and management functions.

Enhancing quality in general practice

The Government has sponsored the development of national standards for the accreditation of practices and the establishment of an independent body to accredit practices against these standards. The initial work on development of guidelines for general practice and reviewing areas of cost-effective care has also been supported.

Australia has recently introduced a system to prevent access to public funding for practitioners without appropriate postgraduate training. A process has also been initiated to ensure listings on the Medicare Benefits Schedule (MBS) are based on evidence of cost effectiveness. Additionally, Australia is now moving to look at better articulation of undergraduate, postgraduate and continuing education and greater connection with community-based need, through a review of general practice training.

The development of baseline data so that change can be monitored through a synthesis of information which describes the general practice industry is also well advanced. The launch in late 1996 of the report 'General Practice in Australia' was a world first in profiling the general practice industry.
Since 1992–1993, significant funds have been committed to the General Practice Strategy. The strategy aims to improve access to general practice services, encourage the improved integration of general practice with the rest of the health care system, enhance the quality and cost-effectiveness of general practice, and support training for GPs.

A General Practice Strategy Review Group has been appointed by the Minister for Health and Family Services and comprises general practitioners, consumers and Commonwealth Government representatives. The Review Group will address questions such as the extent to which the strategy has fulfilled its purpose and has been successfully implemented; the elements of the strategy which have actually benefited general practitioners and the community; and the extent to which general practitioners are aware of the strategy. The Review Group will also review progress on the general practice strategy to date; identify achievements and areas for improvements; and provide advice on future directions in general practice. Recommendations are expected in December 1997.

**Financing arrangements for general practice**

In keeping with evidence from WHO, reforms have been based on changes to the supply side which are most able to achieve the objectives of efficiency, equity, effectiveness and health gain.

Australia is looking at what needs to be done for the greatest health gain rather than focusing on how to arrange payments and services.

General practices within the divisions have the capacity to develop holding funds for downstream services (for example, pathology and radiology services). The move to contracts based on performance indicators could create a parallel effect to fundholding. These approaches may be the most sustainable in the longer term.

Descriptions of market-derived financing systems focus on either negotiated contracts (patient follows the money) or the patient choice model (money follows the patient). Australia's Coordinated Care trials are exploring the patient follows the money option.

The Better Practice Programme explores the money follows the patient option through a unique financing arrangement for general practice which is aimed at encouraging and rewarding quality rather than fast throughput of patients. This creates an incentive for the GP, not to provide multiple services, but to achieve the greatest proportion of services. The Programme's payment
formula also takes into account the size, age and gender of a practice's total patient population. However, no patient registration is involved.

Development work to extend this concept to include outcomes payments for performance and control of downstream costs is now underway and bonus payments for achieving 90% immunization rates will be made later this year.

Although fees for service will remain the dominant form of payment for some time, the Schedule is being reviewed and case mix payment systems are also being explored. There is growing interest in moving to more innovative funding systems based on practice, division/region, state and nationally efficient service delivery models.

*Rural obstetrics*

One of the measures the Government has introduced in rural and remote health is a pilot study of alternative funding arrangements aimed at improving local access to quality obstetric services in rural areas.

In rural and remote Australia obstetric services are less accessible and may be of poorer quality than in metropolitan centres. The Review of Professional Indemnity arrangements for Health Care Professionals produced a background paper on ‘Birthing Issues - A Rural Perspective’ at the end of 1993. In this paper, a clearer picture of the difficult practice conditions facing rural GPs who practice obstetrics emerged. One issue is that of professional indemnity cover. However, this is not the only factor.

In addition there are issues such as lack of training and continuing education for general practitioners, difficulties in obtaining locum relief, and a lack of peer support in the rural setting, which the alternative funding arrangements will seek to alleviate.

Pilot studies will also address problems faced by specialist obstetricians in rural areas. Some of these problems parallel those faced by GPs, including difficulties in obtaining locum relief and lack of peer support due to low numbers of specialists in rural areas.

The broad thrust of the new arrangements will be to establish a single level of government providing funding for obstetric services, instead of the existing mix of Medicare Benefits and State Government funding. Integral to these pilot studies will be the development of performance
indicators as part of the evaluation strategy. The evidence collected through these pilots, in conjunction with other Commonwealth activities such as the Rural General Practice Incentives scheme, and the various initiatives being undertaken by the States and Territories, has the potential to deliver marked improvements to services for pregnant women who live in rural areas.

4. PUBLIC HEALTH STRATEGIES

4.1 National strategies

There are several national health strategies which showcase Australia's achievements in developing effective approaches to specific health issues and highlight the partnership approach to implementing health programmes.

The National Mental Health Strategy

The National Mental Health Strategy is a national programme for mental health reform agreed by all Health Ministers in 1992. A key objective of the National Mental Health Strategy is to integrate care between hospital and community settings, and to link specialized mental health services with services provided in other sectors, thus providing continuity of care for consumers. In practice integrated mental health services usually have a number of features including:

- a single management structure covering all specialized mental health services in hospital and community-based settings in a particular area, usually with an identified budget;
- arrangements such as case management which coordinate the care needs of people with mental illness who need to access care in different settings; and
- links with other services accessed by people with mental illness, including general practitioners, disability support, and employment services.

Fundamental to the effectiveness of service integration is the availability of a mix of services appropriate to the needs of people with mental illness. To improve the appropriateness of the mix of mental health services, the central aims of the National Mental Health Strategy are to expand community-based services and to reduce the size of stand-alone psychiatric institutions. Since 1992-
1993, spending on community-based services has increased by 28%, and expenditure on stand-alone psychiatric institutions has decreased by 10%.

Trends away from the tradition of hospital inpatient services to more cost-effective and quality-assured alternatives dictate the need for a package of investigations and trials to focus on health care innovations from the national perspective. These initiatives will result in the integration of hospital and community sectors, improvements to patient outcomes across the care continuum and the reduction of health service costs.

*The National Drug Strategy*

The National Drug Strategy (NDS) and its forerunner, the National Campaign Against Drug Abuse (NCADA) were created with strong bipartisan political support to minimize the harmful effects of drug use in Australian society. Drugs affect virtually every Australian family. The NDS recognized the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options based on the concept of harm minimization. It adopts a comprehensive approach to drugs, which encompasses the misuse of licit drugs such as alcohol, tobacco and pharmaceuticals, as well as illicit drugs. The NDS’s approach to drugs stresses the promotion of partnerships – between health, law enforcement, education, nongovernmental organizations and private industry and attempts to address drug issues in a balanced fashion.

The NDS was recently independently evaluated. The evaluators concluded that “under the NDS and its predecessor, the NCADA, Australia has one of the most progressive and respected drug strategies in the world” and that “from its inception, the NDS has been characterized by a unique combination of features which have bought it international attention and acclaim”.

The Commonwealth Government has recently launched a national advertising campaign aimed at encouraging the 25% of adults in Australia who still smoke to quit. The campaign includes television commercials, print advertisements and practical support for smokers wanting to quit, and delivers a very graphic message that ‘every cigarette you have damages your health’. Even more importantly, the campaign is the first truly national collaborative anti-tobacco campaign between the Commonwealth, State and Territory Governments, professional health bodies (including the Australian Medical Association and the College of General Practitioners), and nongovernmental organizations such as QUIT, the Australian Cancer Society, and the National Heart Foundation.
National Women's Health Policy and Programme

Australia is one of the few countries in the world to have a national women's health policy. This was launched in April 1989 and received approval in principle from Commonwealth and State/Territory Health Ministers. The policy was developed in consultation with organizations and individuals representing the views of over one million women Australia-wide. The objective of the policy is to improve the health and well-being of women in Australia and to encourage the health system to be more responsive to the needs of women.

As its major response to the National Women's Health Policy, the Australian Government established the National Women's Health Programme in 1989.

The programme addresses the seven priority health issues identified in the policy:
- reproductive health and sexuality;
- health of ageing women;
- women's emotional and mental health;
- violence against women;
- occupational health and safety;
- the health needs of women as carers; and
- the health effects of sex role stereotyping in women.

The programme has been successful in establishing a range of innovative primary health care services for women at the local and State/Territory level, and in ensuring that significant numbers of rural and indigenous women, as well as women from diverse cultural and linguistic backgrounds have been reached by those services. Some of the major strengths of the programme include: its capacity to respond flexibly to differing priorities across the States and Territories; the diversity of services across and within different jurisdictions; and the degree of consumer satisfaction with services received.

National HIV/AIDS strategy

Australia's response to the challenge of HIV/AIDS is recognized and respected around the world for the successes it has achieved. This success has been built upon three elements.
The first element is that Australia's response to the epidemic has been guided by the best available medical and scientific information and enlightened pragmatism. Public policy and public health measures have had as central components innovative approaches such as harm minimization and community-based responses to effective education, treatment and care.

The second element has been to ensure that policies are based on developing, fostering, valuing and strengthening partnerships throughout Australia. The principal partnership has been between governments, community-based organizations, affected communities, health professionals and researchers, all working together and learning from each other in developing appropriate policies. But other partnerships – between governments at all levels, between governments and various community organizations, between medical and non-medical groups, between a multiplicity of voluntary and community-based organizations, between educational authorities and the media, and so on – have also been crucial to Australia's success. The role of people directly affected by the virus, especially HIV-positive people, their carers and organizations, has also been recognized and valued.

The third element is that non-partisan political support has been given to Australia's efforts, and consensus has underpinned the development of appropriate public policies. This has allowed those policies to display national leadership and to be innovative in their scope.

While Australia has much to be proud of in its broader response to HIV/AIDS, there remains a challenge in addressing these issues within Aboriginal and Torres Strait Islander communities. A National Indigenous Sexual Health Strategy has recently been adopted. It is based on public health evidence and emphasizes that improving the sexual health of Aboriginal and Torres Strait Islander people is not primarily a task of changing sexual behaviour, but rather depends on the provision of appropriate and comprehensive primary health care, particularly in remote areas.

_Cancer control initiatives_

Two cancer control initiatives for Australian women are the breast screening programme (BreastScreen Australia) and the National Cervical Screening Programme. By 1999, the breast screening programme aims to achieve a 70% participation rate by asymptomatic women aged 50-69 years. To assist in achieving this, the Commonwealth has recently undertaken television, radio and print advertising as part of its campaign.
By 1999, the National Cervical Screening Programme aims to achieve an 80% participation rate among women 20-69 years with an intact cervix. To enhance participation, a communication strategy has been developed aimed at medical practitioners and at women in the target group. This particularly addresses the benefits and limitations of the Pap smear test; regular two-yearly participation in screening by women aged 20-69 years; promoting cervical screening to unscreened and underscreened women, especially indigenous women, women of non-English speaking backgrounds, women with disabilities, older women and women from rural areas.

A new initiative is the National Cancer Control Initiative, which is a partnership between the Commonwealth Department of Health and Family Services and the Australian Cancer Society (a non-profit organization). It aims to develop a national response to cancer control including the development and uptake of national guidelines. This will involve wide consultation with Commonwealth, State and Territory health jurisdictions, cancer organizations, consumers, health professionals and researchers.

Immunize Australia – the seven point plan

In response to declining rates of immunization in Australia (it is estimated that a little more than half Australia’s target population has fully completed childhood immunization coverage) the Commonwealth Government has developed the Immunize Australia programme, which has seven initiatives to improve completed childhood immunization rates. There will be provisions for those parents who do not have their children immunized due to medical contraindications or conscientious objection.

The first initiative directed towards parents is the restructuring of the Maternity Allowance to provide a bonus to parents who ensure that their child’s immunization coverage is complete. This initiative is designed to act as a strong incentive and reminder to parents to immunize their children. The timing of these payments allows a generous window of opportunity for parents to ensure their children complete the three key childhood immunization milestones at the end of 6 months of age, 12 months of age and 18 months of age. New requirements will also be introduced for recipients of the Childcare Assistance Rebate and/or the Childcare Cash Rebate.

The second initiative will be to encourage GPs through the Better Practice Programme to obtain high immunization coverage levels with the aim of making sure that 90% of doctors ensure that 90% of the children attending their practice are fully immunized. Divisions of General Practice
will be asked to increase their involvement to ensure that GPs follow current immunization protocols, that proper arrangements are in place locally for vaccine storage and that data are sent to the Australian Childhood Immunization Register (ACIR).

The third initiative is to ensure data on ageing rates from the ACIR will be published annually to encourage competition and inspire those with low rates to improve their coverage. A system of incentives and annual awards will be instituted for local councils, GPs and health clinics providing immunization services that record the best or most improved immunization rates in defined areas in each State and Territory. The worst performing areas will also be publicly highlighted.

The fourth initiative involves the Commonwealth Government, together with the States and Territories, piloting the notion of immunization days to increase immunization coverage. It is anticipated that these days will be held in areas of low immunization coverage, and be supported with a range of educational materials.

The fifth initiative is a measles eradication programme which will be developed by the Commonwealth Government in consultation with the States and Territories. The programme will draw on the expertise of countries such as the United Kingdom which conducted an extremely successful campaign during 1995.

The sixth initiative will be a communication strategy to:

- increase immunization service providers' commitment to actively promoting childhood immunization and educate providers about the National Health and Medical Research Council (NHMRC) policies and guidelines relating to immunization delivery, including recent changes to the Standard Immunization Schedule and clarification of the contraindications to vaccination. It is anticipated that this initiative will better equip general practice to address the concerns of parents about the benefits and risks of vaccination;

- a community campaign consisting of a multifaceted mass media campaign and an extensive public relations strategy designed to support the mass media campaign. The community campaign will also support parents who require more information about side effects and risks of vaccination.
The main objectives of the campaign are to increase the level of full age appropriate childhood immunization coverage by increasing understanding of the need for immunization and creating a climate of acceptance and active support from both parents and service providers.

In addition to the above, the Commonwealth Government will establish a centre which will undertake epidemiology and social research, surveillance and clearing house activities. The Centre will also provide advice and assistance to client groups and stakeholders, including those health professionals involved in the policy, planning and delivery of immunization services.

A final initiative will be governments working together to introduce tougher school entry requirements. This will ensure that parents submit details of their child's immunization history on the child's enrolment. School entry requirements are also important because they will capture the last booster shots required under the NHMRC immunization schedule for children. If a child is not fully immunized at the point of entry, this can serve as a safety net to ensure the child is fully immunized.

**National Diabetes Strategy**

Another new initiative being developed is the National Diabetes Strategy and Implementation Plan which will include Non-Insulin Dependent Diabetes Mellitus, Insulin Dependent Diabetes Mellitus and Gestational Diabetes Mellitus.

Diabetes Australia (a non-profit organization), through a contract with the Government, will be responsible for supporting the Ministerial Advisory Committee on Diabetes, administering funds in accordance with the recommendations of the Committee and undertaking negotiations with key stakeholders, including the States and Territories. Several diabetes projects have been recommended, for example: preliminary work on a national diabetes prevalence study; a pilot programme networking urban and rural services for people with diabetic problems; a community awareness project and the establishment of a National Diabetes Register which would initially focus on Insulin Treated Diabetes Mellitus.
5. HEALTH FOR ALL BY THE YEAR 2000

5.1 The evaluation of Australia’s response to the global health-for-all strategy

The Thirtieth World Health Assembly in 1977 decided that the main social goal of governments and WHO in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as Health for All by the Year 2000.

As a signatory to the WHO Global Strategy for Health for All by the Year 2000 Australia has demonstrated its commitment to the health of all Australians and a reduction of the inequities in health status between population groups.

The 1997 evaluation of Australia’s implementation of the Health for All by the Year 2000 has recently been completed. This was the third to be conducted by the Australian Commonwealth Government for the World Health Organization.

Several key findings emerged from this evaluation. The first is that there is continued commitment by the Australian Government to achieving the goals of Health for All.

Specifically there is:

- a commitment to a universal health care system based on need rather than ability to pay;
- support for a strong primary health care system that is integrated into the broader health care system;
- increased identification of health differentials between population groups and commitment to develop mechanisms to address them; and
- recognition that many of the determinants of health lie outside the health care system.

There has been an increased reorienting of the health system towards the investment of resources in health gain. There have been significant achievements in increasing life expectancy, reduction in mortality in some key areas, strategies to improve management of many common diseases (for example, asthma) and those that carry a high burden of disease (for example, diabetes). There has also been a reduction in several recognized risk factors such as smoking.
The Government is committed to access to health services on the basis of need rather than capacity to pay. There is a greater appreciation that access to services may not by itself ensure equity of outcomes, and this is leading to a more sophisticated debate on strategies to reduce health inequities.

This is supported by a greater understanding that many of the factors which influence and/or determine health are outside the direct control of the health sector. There is increased commitment to finding ways of working with other sectors and the community in addressing these issues.

A number of government initiatives have been put in place which assist in ensuring that the health sector develops the capacity to improve the health of the population. These include:

*The establishment of health priority areas*

In 1993 the revised goals and targets for Australia's Health were adopted by all States and Territories as part of the Medicare Agreements. The States and Territories have made a commitment to developing strategies to address priority health areas which currently include: cardiovascular disease, mental health, cancer, injury and diabetes.

*Policy development*

There have been a number of significant policy developments such as the National Nutrition Policy and the National HIV/AIDS Strategy that have provided leadership in addressing important health issues in collaboration with other parts of the health sector, other departments, community organization and consumers.

*Development of a better information system*

The Australian Institute of Health and Welfare (AIHW) has been strengthened to provide a wide range of information on health issues. The expansion of the Institute to include welfare issues, such as child abuse, has meant that there is increased access to data on a broad range of social and economic issues that may impact on health. The relationship between the AIHW and Australian Bureau of Statistics has been strengthened to improve the quality and relevance of data that is collected.
Public health and health promotion infrastructure

There has been development and strengthening of the public health and health promotion infrastructure through a diverse set of strategies including: strengthening of professional associations, increased range of training options, programme development and reviews such as the review of public health and health promotion infrastructure.

General practice strategy

The General Practice Strategy has sought to increase the quality of general practice in Australia and to increase the links between GPs and the wider health system again through a variety of strategies including vocational registration, establishment of Divisions of General Practice and increased research into general practice and primary health care.

Healthy public policy

Increased recognition of the value of healthy public policy in promoting health gain. The impact of healthy public policy in reductions in smoking, improvements in food supply and establishment of needle exchange programmes have highlighted the potential role for joint policy and legislative development across sectors.

Establishment of the national public health partnership

The recent establishment of the National Public Health Partnership has provided a vehicle for taking many of the initiatives mentioned above to State and Territory level and provides a collaborative approach within the various parts of the health sector.

There were also challenges for the future identified in Australia's response to Health for All by the Year 2000. Some of these challenges come from outside the health sector, some come from within it and some relate directly to implementing the vision of Health for All.

Australia is emerging from an economic downturn that was reflected in related high rates of unemployment, a slowing of rates of increase in GDP and the need to reduce current account and budget deficits. There has been increased emphasis by all governments in increased efficiency, a focus on core business, a smaller role for Government and an increased emphasis on competition and market forces as tools for bringing about efficiency.
These values and strategies have been increasingly mirrored in the health care system and have led to an emphasis on efficiency, use of performance indicators and benchmarking. While these trends have assisted in streamlining the health sector and encouraged better use of limited resources, they have also put pressure on managers to judge their performance in terms of health service delivery rather than improved population health.

At the same time technical advances are changing the nature of hospital stays. Doctors are increasingly under pressure to practise defensive medicine that may lead to overinvestigation, and there are greater demands on health services by an ageing population and the growing number of people who are living with chronic disease. There is a perception by many people that the health sector is in crisis, as is reflected in long waiting lists for non-urgent procedures. The focus of public debate on health issues is often the success of the health sector in treating disease rather than whether it is actually improving health.

These forces also appear to be influencing primary health care services in many parts of Australia. Generalist primary health care nurses in particular are finding their time increasingly taken up by supporting people who have been discharged early from hospital with complex medical problems. This is putting pressure on their ability to address wider issues that may be relevant to the health of their local community. The increased specialization and integration of many community health services back into hospitals needs to be closely monitored. The lessons learned from the GP Strategy can potentially benefit the entire primary health care system and lead to better integration of general practitioners and other community health services.

6. HEALTH AND INDUSTRY RELATIONSHIPS

6.1 Reducing the regulatory burden

Regulatory reform has been a prominent issue in Australia’s concern to reduce the cost burden on business, and to improve productivity and enhance competitiveness.

Small businesses are critical to the Australian economy, as they are the country’s largest employer and the main source of employment growth in recent years. For some time, small
businesses have been burdened with overregulation, with unquantifiable losses to the Australian economy in opportunity costs in terms of forgone investment and employment opportunities.

Small business is also becoming a major contributor to Australia’s export performance; 11% of small businesses export a proportion of their output, and a further 5% are planning to export in the near future.

Australia has responded to a range of small business concerns about streamlining and improving regulatory decision-making. Three areas of change have particular relevance to health.

The first area of change is the streamlining of government processes and regulation. Immediate reviews are necessary in food regulation, and agricultural and veterinary chemicals.

A programme of legislative reviews addresses legislation which may be costly to business and/or restrict competition. Each review will include an assessment of the impact of the legislation being reviewed on small business, and report on ways to reduce the compliance and paperwork burden associated with the legislation.

The second area is improving regulatory quality. Regulation Impact Statements have been made mandatory for all new and amending primary legislation which impacts on business or restricts competition, and which requires high-level government approval. Agencies are to be required to develop performance indicators to measure the impact of their regulatory activities on small business.

The last area relates to changing the regulatory culture. Service charters have been identified as an important means of boosting the accountability of Government to small business clients. Government departments and agencies will be required to report annually on performance against these charters.

Currently, the Commonwealth Government is developing a ‘Policy and Guidelines’ document for an ongoing programme of regulation review and a comprehensive study to identify health service regulation that impacts on business. It is also obtaining industry views on the level of burden resulting from existing regulation and asking for suggestions for improvement and publicizing the review process and outcomes to relevant areas of government and business and industry interests.
6.2 National public health regulation and legislation

There is fragmentation of responsibility between the Commonwealth and States/Territories in many regulatory domains. Regulatory standards need to be harmonized to support a consistent approach to public health and to contribute to microeconomic reform within a health framework. In doing so, new models of regulation may be developed as well. The first task is to chart a current and anticipated review of public health–related legislation so that common issues can be jointly examined and consistent approaches developed where needed.

The Legislation Review Working Group of the National Public Health Partnership is clarifying the role and function of public health legislation, and overseeing review and reform activities. The Working Group has started identifying priorities for harmonization and modernization, within the context of the significant review and reform activity already under way in most Australian States and Territories.

Responsibilities for legislation with important public health implications may reside outside the health portfolio. Consideration of such legislation (e.g. Coronial Acts and legislation pertaining to environmental protection and road safety) will require a comprehensive approach.

The Partnership Group will also consider Trans-Tasman Mutual Recognition and involve New Zealand in discussion of regulatory harmonization.

7. CONCLUSION AND FUTURE PRIORITIES

The Australian health system is a strong performer by international standards. Australians have access to high-quality health services, underpinned by a universal health care system, a strong primary care network, and an environment which supports healthy public policy to protect and promote health.

Australia’s health, however, cannot be seen in isolation from the international context, both in terms of sharing health knowledge and in stopping the spread of disease. The global market and the links Australia has globally, in particular those with our closest neighbours in South-East Asia and the Pacific, has the potential for more sharing of health expertise and experience across countries. For example, HIV is now a global pandemic. Efforts to control its spread in Australia
cannot be made in isolation from the international context or from international efforts to contain the disease. Australia has an internationally respected approach to HIV/AIDS and potentially has much to offer other countries. Similarly, Australia can learn from other countries' successes, for example, Australia can learn much from the United Kingdom's successful measles eradication campaign.

The continued commitment of the Government to maintaining Australia's high health standards and to ensuring equity of access to health services on the basis of need rather than the ability to pay will require further exploration of funding approaches. Service demand is growing and the Government is looking for ways to fund increases to supplement current arrangements. The Government is exploring ways in which the private health insurance industry can be made more attractive to high- and middle-income earners with a view to reducing pressures on the public health care system.

Fundamental to any future development is a continued commitment to investing resources in health as reflected in the current strategies to address priority health problems.

There will also need to be a continued commitment to equity in the distribution of resources between communities and across conditions. The following areas are priorities for future action.

*Strengthening of primary health care services*

The General Practitioner Strategy has shown that a well thought through and adequately resourced set of strategies can enhance the quality, relevance and coordination of primary health care services. The integration of GPs with other primary care services needs to be more formally addressed. This involves assessing the implications of the vertical integration of specialized health services into the community on the long-term viability of general community health services. A review of Primary Health Care is being considered.

*Reducing inequity of outcomes*

Life expectancy of indigenous Australians (see Section 1.4 for further discussion on the health of indigenous Australians) is 15 to 20 years less than that of other Australians and a succession of Australian governments have recognized this as a national disgrace. Currently, Commonwealth and State and Territory Governments are working together to improve tactical measures to improve
health services and quality of health outcomes for indigenous Australians. This is seen as a generational exercise and strategies are being developed accordingly.

Further development of partnerships

Through the National Public Health Partnership and the Aboriginal and Torres Strait Islander Health Framework Agreements many of the central issues in promoting the health of the community and reducing inequity are being pursued. However, these partnerships will also need to be supported by other partnerships across government departments, other sectors, community organizations and the community. This will require the development of a more strategic approach within the health sector and a commitment to intra and intersectoral action.

Increased community awareness and involvement

There is good evidence in Australia that consumers can play an important part in the development of health policies and services that are relevant to their needs. The value of consumer input is increasingly recognized and needs to be strengthened across a broader range of programme areas.

Australia will need to further promote involvement of local communities in articulating the nature and scope of health problems and in the development of innovative, local solutions to meet these identified priorities.

By working closely with local communities it will be possible to respond to community perceptions that the health care system is in crisis, and to allow for a more strategic response to current and emerging health issues.

Focused research

In many areas of health it is still not clear what are the most effective interventions, or at what point in the prevention-treatment continuum the most health gain can be made for the available resources. The recent refocusing of medical research funding in Australia to focus on areas of high burden of disease will assist in ensuring that research activities relate to the priority issues of the Government. Over time it is anticipated that there will be more emphasis on research which
addresses some of the broader determinants of health and in looking at the effectiveness of interventions that are multilevel and complex.

*Commitment to monitoring and development of indicators*

Australia is now much better placed to describe patterns of health and health inequity than it was even five years ago. This capacity needs to be further developed. In particular, there should be a move away from more traditional health indicators such as mortality, morbidity and risk factors to other dimensions of health such as community capacity and locational disadvantage. There also needs to be more emphasis on developing processes or intermediate indicators for strategies such as intersectoral action and healthy public policy goals such as improved food supply.

*References*

