INDUSTRY
COMMISSION

EXPORTS OF HEALTH SERVICES

REPORT NO. 16

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5 December 1991

Honourable J C Kerin MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with Section 7 of the Industry Commission Act 1989,ÿ we have the pleasure in submitting to you the report on Exports of health services.

Yours sincerely

Roger G Mauldon
Presiding Commissioner

Neil J Paterson
Associate Commissioner

Acknowledgment

The Commission wishes to thank those staff members who contributed to this report.

CONTENTS

LIST OF ABBREVIATIONS

Abbreviations used for inquiry participants who made a written submission are given in appendix A. Other abbreviations used in the report are listed below.

ABS	Australian Bureau of Statistics
AHB	area health board
ALOS	average length of stay
AMC	Australian Medical Council
ANAC	Australian Nursing Assessment Council
CAFAT	Caisse de Compensation des Pr,stations Familiales des Accidents du Travail et de Pr,voyance des Travailleurs de Nouvelle Caledonie
CGC	Commonwealth Grants Commission
DEET	Commonwealth Department of Employment, Education and Training
DILGEA	Commonwealth Department of Immigration, Local Government and Ethnic Affairs
DITAC	Commonwealth Department of Industry, Technology and Commerce
DRG	diagnostic related group
EEC	European Economic Community
EPAC	Economic Planning Advisory Council
FP	for profit private hospitals
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
GP	general practitioner
HIC	Health Insurance Commission
HMO	health maintenance organisation
IAC	Industries Assistance Commission
IC	Industry Commission
IPA	Institute of Public Affairs

MBAC	Medical Benefits Advisory Committee
MBBS	Bachelor of Medicine, Bachelor of Surgery
MBCC	Medical Benefits Consultative Committee
MBS	Medicare Benefits Schedule
NBA	negotiated benefit agreements
NSQAC	National Specialist Qualification Advisory Committee
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OSHC	Overseas Student Health Cover
POB	per occupied bed
UK	United Kingdom
USA	United States of America

TERMS OF REFERENCE: EXPORTS OF HEALTH SERVICES

The following are the terms of reference received by the Commission on 6 December 1990.

Industry Commission Act 1989

I, PAUL JOHN KEATING, in pursuance of Section 7 of the Industry Commission Act 1989 hereby:

1. refer the question of exports of health services for inquiry and report by 31 December 1991;

2. specify that the Commission report on any institutional, regulatory or other arrangements subject to influence by governments in Australia which impede the efficient export of health services, and advise on their effects and on any appropriate changes to these arrangements;

3. specify that, in the context of the development of the export of health services, the Commission have regard to established social objectives of governments and the potential impact of export development on access to, and the cost of, health services for the Australian community;

4. specify that the Commission is to avoid duplication of any recent substantive studies undertaken elsewhere; and

5. specify that in the context of its inquiries, the Commission have regard to: controls over the various components of the migration program and measures which need to be applied to ensure that appropriate controls are maintained.

P. J. KEATING
6 December 1990

OVERVIEW AND RECOMMENDATIONS

The Commonwealth Government's agenda for microeconomic reform is being progressively extended to the services sector. It is now generally accepted that the efficient provision of services is important not only for those services which are used as inputs to other business activities such as transport and electricity, but also for community services such as health and education which account for a large part of government expenditure.

In this inquiry, the Commission has been asked to identify institutional, regulatory and other arrangements which impede the efficient export of health services and to advise on any changes which should be made to deal with those impediments. The inquiry follows a previous Commission report on international trade in services. The terms of reference for the inquiry are reproduced on the facing page.

This report focuses on exports made through the provision of health care to foreign patients in Australia. While some inquiry participants identified the potential for exports through the international movement of health care information and Australian health professionals, none identified any institutional or regulatory impediments to exports made in these ways. Because the focus is on foreign patients coming to Australia, the operation of our health care system and our immigration laws are central to this inquiry.

The provision of health care in Australia is strongly influenced by government. Government involvement is directed mainly at providing universal access to affordable health care. Australia's health-related immigration laws are intended to ensure that foreign patients treated in Australian hospitals do not threaten the health of Australians, deny Australians access to medical or hospital treatment, or become a burden on the taxpayer.

There is potential for conflict between the objective of providing equitable access for Australians to medical and hospital services and promoting wealth creating international trade in these services. Thus in formulating its advice, the Commission has examined the wider health care system and the place of exports within that system.

The Commission has identified a number of features of the wider health care system which impede exports of health services or detract from the efficiency with which Australian resources are used in providing those exports. But as is to be expected, these features of the wider system have a much greater impact on the delivery of services to Australians than on their delivery to foreigners.

Australia's health care system and the role of exports

In 1988-89, Australians spent $26 billion or 8 per cent of gross domestic product on health services. Around half a million people were employed in providing these services.
The health care system is dominated by Commonwealth and State Governments. Under Medicare, which is at the heart of government involvement, all Australians have access to free or heavily subsidised medical and hospital services. In total, governments fund around two-thirds of expenditure on health care services.

Services provided to foreign patients account for considerably less than one per cent of total health care services provided in Australia.

In 1989-90, at least 4800 visitors to Australia obtained medical services in Australian hospitals. Around 2000 of these entered Australia specifically to obtain medical treatment. The remainder comprised tourists or business people who were hospitalised while in Australia. The Commission estimates that the provision of health care services to these two groups generated gross revenues for treatment of around $31 million with up to a further $22 million for their accommodation and associated expenses. More than 70 per cent of these patients were treated in public hospitals.

The other major source of foreign demand for Australia's health care services comes from the 56 000 foreign students in Australia. The Commission estimates that the value of services supplied to this group would be at least $10 million per annum and may be considerably higher.

Some exports are subsidised

Treatment provided to foreign patients in public hospitals appears to be subsidised by Australian taxpayers. The Commission recommends that State Governments, which are responsible for fee setting in this area, introduce fees which at least cover the costs of treatment provided to foreign patients.

Tourists and business people who require hospital treatment while in Australia account for a disproportionately high share of public hospitals' bad debts. This is another cost of exporting which must be met by the Australian taxpayer. To assist public hospitals to reduce the extent of bad debts, the Commission recommends that public hospitals obtain assurance of payment from foreign patients before major treatment is provided. If this is not forthcoming, only that care necessary to stabilise the patient would be provided.

Charges levied on fee-paying foreign students for compulsory health insurance provided under the Overseas Student Health Cover (OSHC) scheme appear to be lower than required to meet the cost of benefits provided. The Commission recommends that the charges set for this cover be sufficient to meet costs and that Medibank Private's monopoly over the supply of insurance under the OSHC be revoked.

Direct impediments to the export of health services

Inquiry participants identified a number of institutional, regulatory and other factors which they claimed directly impede the export of Australia's health services. The most important of these are:

- the criteria for granting medical visas to foreign patients seeking treatment in Australian public hospitals;

- the difficulty of guaranteeing access for foreign patients to public hospital treatment in Australia because of waiting lists for many services;

- constraints on the training and accreditation in Australia of foreigners as doctors or specialists, which in turn retard the development of professional links between overseas practitioners and the Australian health care system. Such links are important in obtaining referrals of foreign patients;

- regulations which restrict doctors advertising their services to potential foreign patients; and
- a general ambivalence in the community to the export of health services.

Medical visas allow fee-paying foreign patients to enter Australia while permitting immigration officials the flexibility to deny entry to those who are likely to become a charge on the Australian health care system.

The Commission recommends some minor changes to the criteria for granting medical visas for treatment in Australian public hospitals which would give those hospitals greater control over the decision of whether or not to accept a foreign patient.

Constraints on medical training for overseas students, the accreditation of foreign doctors and the advertising of Australian medical services overseas, are parts of a wider set of regulations governing entry to the medical profession and the provision of medical services. The difficulty of guaranteeing foreign patients access to Australian public hospitals is due to policies which encourage domestic patients to seek treatment in public hospitals but which limit the resources available to meet that demand.

Changes to features of the health care system which impede exports would therefore have wide ramifications. In the Commission's view, such changes are best considered as part of more wide ranging reform focussing on the domestic health care system.

Achieving greater efficiency in service delivery

Features of the delivery of health care in Australia which raise the cost of services or encourage their overuse by domestic patients indirectly impede the efficient export of health services. These features reduce the attractiveness of Australia as a destination for foreign patients.

Such impediments result from the inappropriate incentives facing patients and service providers under Australia's health care system. Patients have an incentive to overuse hospital and medical services most of which are paid for by either government or private insurers. Moreover, where health care providers are paid on a fee-for-service basis, they have strong incentives to provide the additional services sought by a patient, and may recommend treatment that is not warranted in

terms of its contribution to the patient's health. Funding arrangements for public hospitals provide strong incentives for cost containment but only weak incentives for improved efficiency and productivity. And, regulation of health insurance precludes insurance and health care delivery alternatives, such as health maintenance organisations, that could go some way to redressing these incentive problems.

Many of these features of the Australian health care system predate the Medicare and Medibank schemes. However, the availability of free or heavily subsidised medical and hospital services under these schemes may have exacerbated problems of overuse and further weakened the incentives for efficient service delivery. Further, the need to constrain government expenditure under Medicare has limited the availability of some services, leading to a significant waiting list problem.

Given the minor role of exports in Australia's health care system, and the wider social objectives underlying that system, it would be foolish to predicate change solely on removing impediments to efficient exports. Rather, the potential benefits that greater efficiency could bring in lowering the cost to the community of providing services to domestic and foreign patients alike should be the driving force for change.

The Commission considers that there is scope for improving incentives within the current institutional framework without undermining the objective of ensuring universal access for all Australians to affordable basic medical and hospital services. Among the options and issues which need to be explored are:

- the benefits from, and scope for, introducing full cost charging for private patients treated in public hospitals;

- the case for requiring some patient contribution for Medicare hospital services;

- whether the replacement of funding for public hospitals on the basis of past costs with funding directly related to the number and types of patients treated would encourage greater efficiency in the provision of hospital services;

- whether there would be benefits from ending the mandatory community rating of private health insurance premiums and terminating the regulations which preclude health maintenance organisations;

- whether easing or abolishing restrictions on advertising by doctors could promote greater competition in the provision of medical services and allow for better information to consumers on the price and range of health services without placing them at any health risk; and

- the sources of the seeming major inefficiencies in at least some Australian states in the use of labour and capital in hospitals and the ways in which those inefficiencies could be addressed.

In this inquiry, with its focus on exports, the Commission has not explored these important options and issues in any detail. However, it has concluded that they have a major bearing on the efficient export of health services and believes that they should be considered in the context of the concurrent review of the national health strategy.

Recommendations

The Commission recommends that:

- **regulations setting out the criteria on which all medical visas are to be granted be rewritten to reflect the current practice for granting medical visas to foreign patients who intend to receive treatment in private hospitals. Specifically, medical visas would be granted to applicants who:**

  - **do not have a condition which could be a threat to public health in Australia;**

  - **have made substantiated arrangements with a hospital or doctor for treatment and payment;**

  - **have made substantiated arrangements, if the treatment involves an organ transplant, to obtain the organ in a manner which does not compromise the access of an Australian to such an organ transplant; and**

  - **satisfies other relevant immigration criteria such as those related to national security and the prohibition on entry of criminals (section 4.2).**

- **State Governments set fees for foreign patients treated in public hospitals that at least match the cost of the services provided (section 5.1).**

- **public hospitals obtain assurance of payment from all foreign patients before major treatment is provided. Where no assurance of payment is forthcoming, patients be informed that they will receive only that medical care necessary to stabilise their condition (section 5.2).**

- **foreign students continue to be required to take out health insurance cover before a visa is granted (section 5.3).**

- **foreign students be permitted to purchase that insurance cover from approved domestic or foreign insurers, subject to the following conditions:**

  - **at a minimum, the insurance provide cover against major medical expenses and hospital care in public hospitals at fees which represent the full cost of the services provided;**

  - **where cover is obtained from a foreign insurer, the insurer provide the student with a letter stating that the cover at least meets the minimum outlined above;**

  - **the list of approved insurers include all those which establish that they have suitable facilities for paying benefits to students and/or the providers of medical and hospital services; and**

  - **the administering department have the power to remove from the list of approved insurers those organisations which are a source of bad debts (section 5.3).**

- **If the Commonwealth Government continues to meet the health insurance costs of subsidised foreign students, the department(s) responsible for funding the students make a payment to the Health Insurance Commission equivalent to the expected cost of providing Medicare benefits to those students, and this payment be published (section 5.3).**

The Commission draws attention to its discussion of:

- the various ways in which inefficiencies in the Australian health care system impede the efficient export of health services (chapter 4); and

- possible approaches for improving the efficiency of Australia's health care system without compromising the established social objectives of government (chapter 6).

1 THE INQUIRY

1.1 Origin of the reference

In 1989, the then Industries Assistance Commission (IAC) reported on impediments to international trade in services (IAC 1989). The IAC identified health and education as two areas in which Australia may have a comparative advantage. However, the IAC concluded that there is potential for conflict between the current arrangements adopted to provide equitable access to health care and education and the sale of these services to foreigners. The IAC found that:

> Incentives to export vary between public and private institutions and are complicated by funding arrangements and regulations at both the Commonwealth and State levels. Some fundamental changes to these regulations and funding arrangements may be needed before the community could be confident that a proper balance has been achieved between subsidised domestic use and the promotion of exports for profit. This would require a more thorough investigation than has been possible in this inquiry (IAC 1989, p. 11).

The Industry Commission was subsequently sent two references, one on exports of health services, the other on exports of education.

The reference on exports of health services, which is the subject of this report, asks the Commission to report on institutional, regulatory and other arrangements which impede the efficient export of health services and to advise on the effects of these arrangements and on any appropriate changes to them.

The reference directs the Commission to have regard to the established social objectives of governments when forming any proposals for change, and to have regard to the potential impact of export development on access to, and the cost of, health services for the Australian community.

The reference also asks the Commission to have regard to controls over the various components of the migration program and to report on measures which need to be applied to ensure that appropriate controls are maintained.

1.2 Inquiry information

The Commission met with a wide range of interested parties in all mainland states, including representatives of the Commonwealth Department of Health, Housing and Community Services (hereafter referred to as the Department of Health); State Government departments; the trade union

movement; Ms Jenny Macklin, head of the review of the national health strategy; various hospitals and doctors; and some industry associations (see appendix A).

In January 1991, the Commission released an issues paper that canvassed many of the issues it saw as being relevant to the inquiry (IC 1991a). Some 38 submissions were received from interested parties responding to the issues paper (see appendix A). In April, following receipt of submissions, the Commission held public hearings in Perth, Adelaide, Melbourne, Sydney and Canberra.

In mid September 1991 the Commission released its draft report on Exports of health services (IC 1991c). Eleven submissions were received from interested parties responding to the draft report (see appendix A). The Commission met with participants in Canberra during the last week of October to discuss the draft report.

1.3 The Industry Commission's approach

When reporting on matters referred to it, the Commission is required to have regard to both the reference and to the policy guidelines set out in the Industry Commission Act. These guidelines refer to the Commonwealth Government's desire to encourage the development of efficient industries, facilitate structural adjustment, reduce unnecessary regulation and recognise the interests of other industries and consumers.

The Commission's guidelines require it to assess matters under review in terms of effects on the community as a whole. This requirement reflects the economic linkages which exist between the various commercial and social activities within the community. For this inquiry, the most important linkages are those between the sale of health care to foreign patients and the provision of health care to Australians.

In addressing the issues that arise out of these linkages, it is important to establish the place of exports in the total health care system and the extent to which services to domestic and foreign patients compete for available resources. To this end, background information is provided in chapter 2 on features of the health care market and on the institutional, regulatory and other arrangements governing the delivery of health care and health insurance in Australia. Information is provided in chapter 3 on current and past exports of health services, the impact on the Australian community of providing those exports and the potential market for those services.

Inquiry participants identified a number of factors which they claimed directly impede exports of health services by either reducing the information foreign patients have about opportunities for obtaining health care in Australia or making it more difficult for foreign patients to come to Australia. Direct impediments to the export of health services are discussed in chapter 4.

Some exports of Australia's health care services are inefficient because the revenues generated are less than the costs of providing the services. The sources of these inefficiencies are identified in chapter 5.

Participants also identified a number of institutional, regulatory and other arrangements which impede the efficiency with which the Australian health care system delivers services to foreign and domestic patients alike. Changes to Australia's health care system which reduced waste and inefficiency, would free up resources that could be used to cater for foreign patients without compromising the current level of services provided to domestic patients. More generally, greater efficiency in the provision of those services would provide major savings to the Australian community. As the Minister for Health, Housing and Community Services (hereafter referred to as the Minister for Health) recently commented:

> The Government is committed to microeconomic reform across all sectors of the economy. The health sector -- which constitutes almost 8 per cent of GDP -- is no exception (Howe 1991, p. 1).

Sources of waste and inefficiency in the delivery of health care, and possible options for change while giving full consideration to the established social objectives of governments, are discussed in chapter 6.

1.4 The national health strategy

Three months before the Government sent the reference on exports of health services to the Commission, the Minister for Health asked Ms Jenny Macklin to conduct a review of the national health strategy. That review has already published a number of background and issues papers of relevance to the efficiency and equity of Australia's health care services. Its activities are scheduled to be completed about nine months after the Commission completes its final report on exports of health services. Thus the Commission has had access to some of the preparatory material for the Macklin review and the review will have access to the Commission's report well before it completes its reporting to the Government.

The Commission's reference requires that it avoid duplication of any recent substantive studies undertaken elsewhere. However, because of the linkages between the domestic and export markets, referred to above, there is inevitably some overlap between the Commission's inquiry and the national health strategy review. Such issues are dealt with mainly in chapter 6 of the report. At the Commission's initial round of public hearings in April, and again at the draft report hearing in October, some participants said that they preferred to address issues related to the efficiency of Australia's health care system in the context of the review of the national health strategy rather than in the context of exports of health. However, most participants agreed that these issues are central to the promotion of efficient exports.

2 HEALTH CARE AND HEALTH INSURANCE

2.1 Features of health care and health insurance

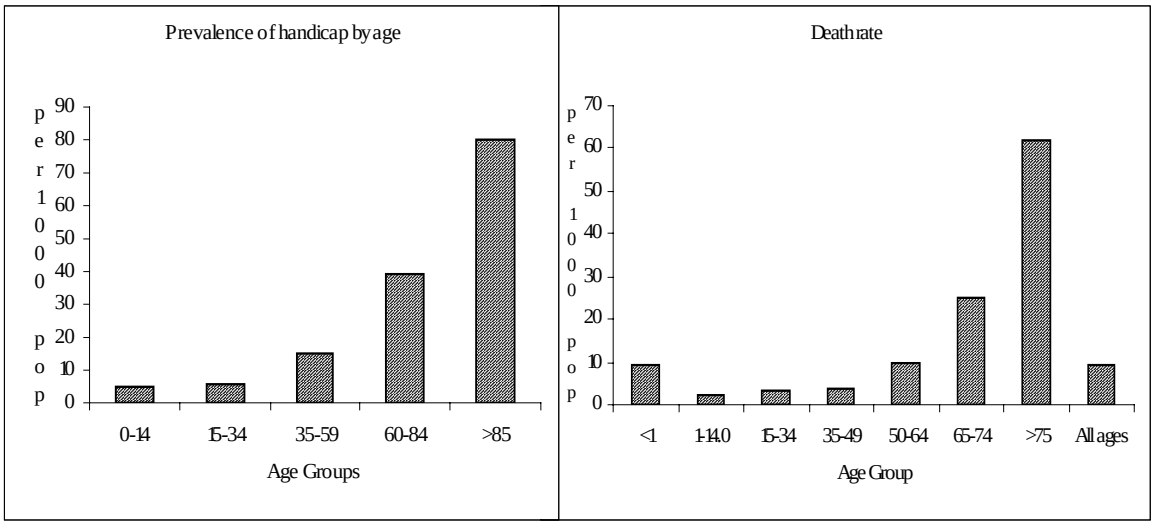
Exports of Australian health care services are incidental to the provision of health care to Australians. Any discussion of impediments to the efficient export of health services must therefore take into account the range of factors, including the institutional and regulatory framework, which characterise the provision and usage of health services and health insurance in Australia. The purpose of this chapter is to provide an appreciation of these factors as a backdrop to the discussion of exports which follows in subsequent chapters.

In some respects, the forces which shape the provision and usage of health care services are similar to those for other goods and services. Part of the chapter looks at the characteristics of health care markets using a standard economic framework.

However, governments frequently intervene in a variety of ways because they believe that some special characteristics of health care markets would otherwise give rise to social outcomes which do not match up with social objectives. Thus the chapter also deals with government health care objectives and how governments are involved in the provision and financing of health care.

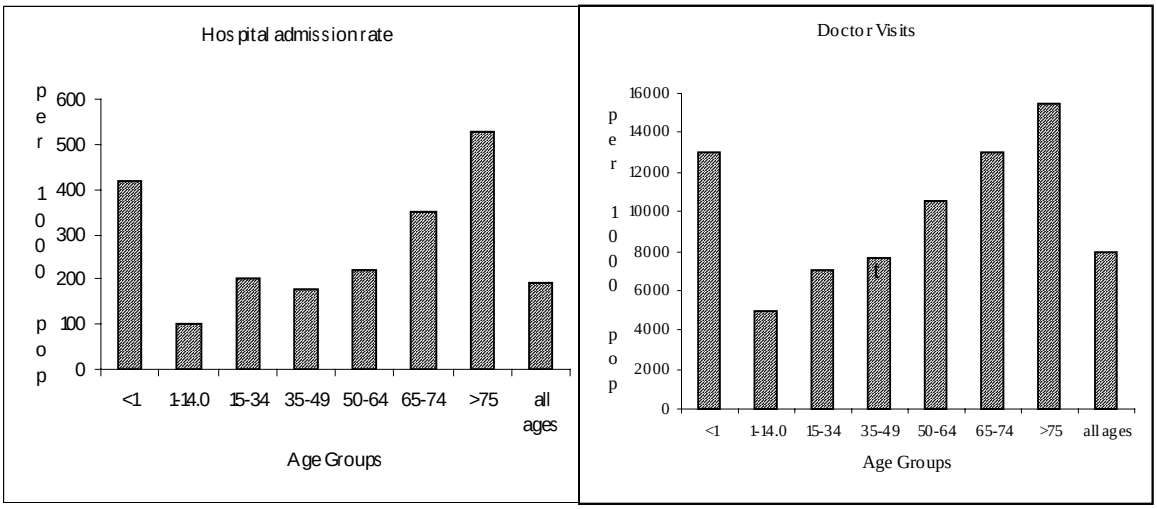
The amounts and types of health services which individuals and households seek depend on factors such as age, gender, susceptibility to illness or injury, household income and lifestyle choices and the costs to them of those services. Age is particularly important since the probability that a person will experience debilitating handicaps and death increases as he/she gets older. The very young also have a relatively high need for health services (see figures 2.1 and 2.2).

Figure 2.1: **Disability and death rates by age group, 1988**



Source: ABS 1988, cat. no. 4118.0, p. 2; AIH 1990, *Australia's Health* 1990, AGPS, Canberra, p. 16.

Figure 2.2: **Utilisation of hospitals and doctor visits by age group, 1988**



Source: AIH 1990, *Australia's Health* 1990, AGPS, Canberra, p. 16.

Health services can be broadly divided into three groups -- medical services, short-term or 'acute' hospital care and long term care.

The first two groups comprise services which are provided to either stabilise patients or assist in their recovery. It is these services which are provided to foreigners as exports and which are the focus of this report.

Long term care comprises services provided to those people who, as a result of illness, injury or age require continuing assistance. Such services may include accommodation in nursing homes or hostels, meals and assistance with household chores, personal care and transportation. In Australia, long term health care services are not generally supplied as exports to foreigners. Accordingly, they are not considered in any detail in the remainder of the this report.

Demand for health care services

The demand for health care services -- that is, the amounts of medical and hospital services which individuals and households purchase at different levels of prices and incomes -- has three features of importance for this report.

The first is the limited responsiveness of demand for services to price. Most estimates of the relationship between demand and price have been derived in the USA. Typically, they indicate that a ten per cent rise in the price of services will lead to a two per cent reduction in services used.[1]

[1] For a review of the evidence, and a discussion of the conceptual difficulties of deriving a relationship between price and the demand for health services, see Richardson 1991, pp. 11-29.

One reason that demand for hospital and medical services is not particularly responsive to the price charged by the provider, is that the cost to the patient also includes the cost of travelling to the provider, the time taken to obtain the service, and the cost of any pharmaceuticals that may be prescribed. For some services, these other costs may be more significant than the direct charge by the service provider. This underlying feature of demand for hospital and medical services is reinforced where third parties, such as health insurance companies and government, meet a large proportion of the patient's direct costs. Richardson (1991) and others also argue that the ability of doctors to 'create' demand for their services is another reason why the use of health care displays only limited responsiveness to price (see chapter 6).

The second feature of demand for hospital and medical services is that it is very responsive to changes in income. Again, based on USA experience, a ten per cent increase in income is typically associated with a greater than ten per cent increase in usage. This has relevance to Australia not only in terms of overall demand for health services, but also in terms of potential export demand as income levels increase in neighbouring countries.

The third feature of demand for hospital and medical services is that individuals are typically uncertain as to whether they will become ill or injured. The large potential cost to them if they do become ill or injured creates a pre-condition for the development of markets for health insurance.

Referral procedures

General practitioners (GPs) operating in private practice and clinics, together with outpatient and emergency facilities, provide the first point of contact for people seeking health services. In most cases, services are provided at the point of contact. However, sometimes GPs refer their patients to specialists or to hospitals.

Referral networks among health care providers and prospective patients are an important component of the overall health care system. As discussed in chapters 3 and 4, the development of an international referral network is an important prerequisite to the export of health services.

At one end of the network is the relationship that GPs establish with patients. It is to the advantage of GPs and patients to develop long term relationships. A long term relationship means, for example, that less time is spent collecting and assessing the patient's history when the patient consults the GP. Moreover, the information gathered about the patient's medical history during a long term relationship is likely to increase the probability of correct and early diagnosis. However, these benefits may tie a patient to a particular doctor, with the consequence that there will be less scope for price to influence the patient's choice of health care provider.

Specialists develop referral networks by providing information to GPs and other specialists through attendance at, and participation in, conferences and by contributing papers on their speciality for publication in medical journals.

Hospitals determine who can admit and treat patients using their facilities. They have scope to compete for referrals through adjusting their admission and treatment policies and through the quality of the facilities provided and the manner in which theatre time is allocated.

Health insurance

Governments in virtually all developed countries are heavily involved in the funding and/or delivery of medical and hospital services. Nonetheless, in most of these countries, patients face some out-of-pocket expenses. Because these expenses can be large and people are often uncertain as to whether they will become ill or injured, they typically seek some form of private insurance against health care costs.

The provision of private health insurance is characterised by the sorts of problems that occur in most insurance markets. People purchasing private health insurance often have more information about their future need for health care than does the insurer. This poses obvious problems for insurers in relating premiums charged to expected payouts. Further, for those holding insurance, the incentive to avoid overuse of services is diminished. In turn, this may encourage overservicing by service providers.

In order to overcome these problems, private health insurance arrangements in most countries are quite complex. They may involve screening to improve the information that the insurer has about the insured. Some insurance contracts may also involve a minimum time before an insured person becomes eligible for benefits. Such a requirement is intended to deter people from opportunistically taking out insurance once they know that they will need health care.

Private health insurance arrangements in most countries require the patient to meet some part of the payment to the health care provider. One objective of such patient 'co-payments' is to make patients aware of the cost of treatment and thereby retain some element of cost consciousness in their behaviour. Another objective is to provide patients with an incentive to monitor health care providers to guard against overservicing.

Private health insurance arrangements may also include agreements which give preference to particular health care providers, though this is not prevalent in Australia. The aim is to allow the insurer to act as an informed buyer on behalf of the insured. As an informed buyer with some market power, the insurer may be able to obtain discounts for its clients at particular hospitals and to monitor providers so as to reduce overservicing. And, in some countries, health insurers have

vertically integrated to become what are termed health maintenance organisations. These provide guaranteed access to all necessary services through the organisation for a fixed up-front fee.

Private health insurance arrangements are regulated in most countries. Moreover, governments' role in providing and/or funding a large proportion of health care limits the range of services for which private insurance is available and influences the terms on which it is supplied.

Objectives of government involvement in health care

Government has been central in shaping arrangements for delivering health care and for providing health insurance in most developed countries. Social objectives of governments are rarely defined comprehensively. Moreover, as in other areas, objectives have changed over time as health care technology, income, society's attitudes and understanding of the factors influencing health have evolved.

Two changes are particularly notable.

First, in most countries as wealth has increased, there has been an increased emphasis on ensuring that all individuals in the community have access to health care services without facing an undue financial burden. As discussed in appendix F, universal coverage for inpatient and ambulatory care is provided in 14 of the 23 OECD countries, with coverage in the majority of the other countries being close to universal. In only three OECD countries -- the USA, the Netherlands and Ireland -- does public cover for inpatient and/or ambulatory care apply to less than 90 per cent of the population. And, 12 of the 23 OECD countries provide universal coverage for pharmaceuticals, prostheses and the like.

Second, most countries have increased their emphasis on preventative measures. In Australia, for example, the National Better Health Program has promoted healthy behaviour, healthy environments and the prevention of disease and injury (AIH 1990a).

The influence of health services on good health and longevity

The increasing emphasis on preventative measures is in recognition of their importance in promoting good health and longevity.

According to the Australian Institute of Health (AIH), improvements in nutrition, housing, sanitation, quality of water supply, quality of waste disposal, safety of leisure practices, work and travel facilities, and lifestyle choices have been particularly important factors underpinning lower death rates and thereby increased life expectancy. Increased expenditure on medical and hospital services appears to have had a much lesser impact. The Institute summarised the current state of knowledge as follows:

> The relationship between declining death rates and use of health services is tenuous. Various studies have shown that the main determinants of a country's death rates are the living conditions of its people. In Australia, as in other developed countries, death rates from most major infectious diseases had declined dramatically before any effective treatment or vaccine was available. McKeown (1976) concluded that in England and Wales the decline in death rates for these diseases was mainly attributable to improvements in nutrition and the physical environment. Similarly, recent declines in the death rates from circulatory diseases in Australia and in other developed countries have been due largely to changes in diet, smoking, and possibly exercise, although the management of high blood pressure has also played a part (AIH 1990a, p. 1).

Overall it appears that expenditure on health services is directed more at restoring health after episodes of illness or injury, than at effecting major increases in longevity.

2.2 Health care in Australia

Statistical overview of the health services and health insurance sector

Expenditure

Health care is one of Australia's major service industries. In 1988-89, Australians spent $26 billion or some 8 per cent of gross domestic product on health services.

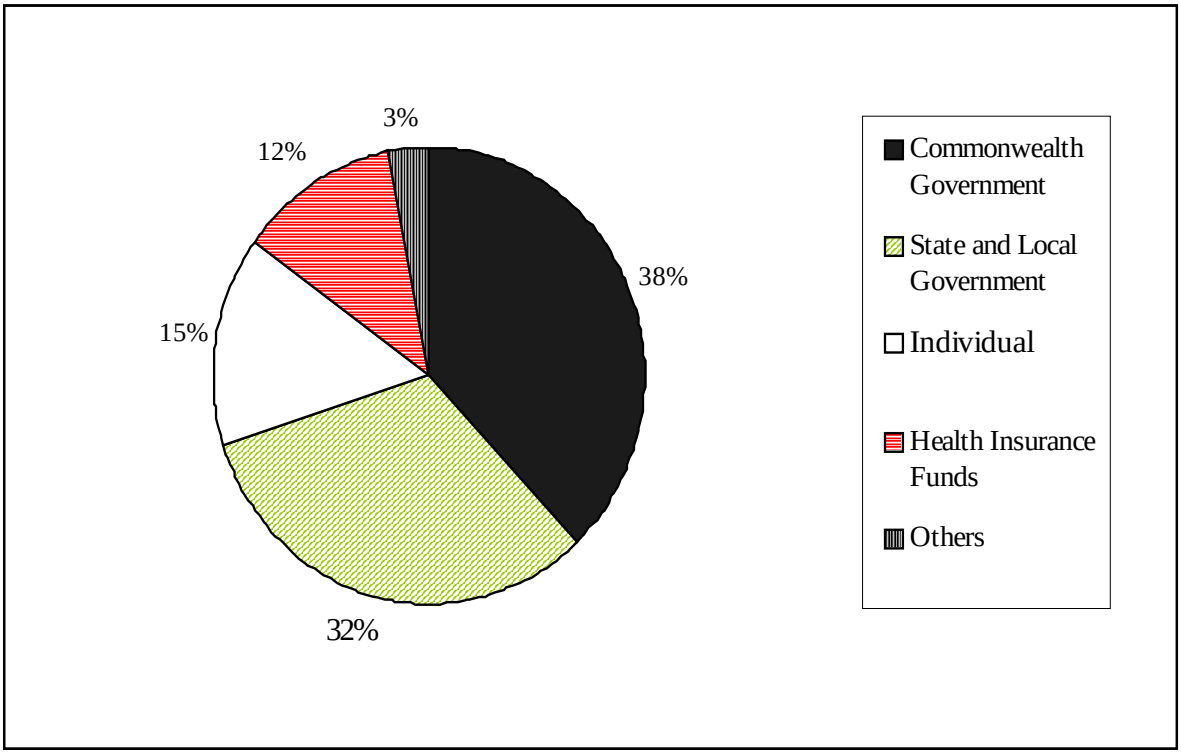
Governments at all levels are major players in the health service industry, funding over two-thirds of total expenditure. Together, health insurers and private individuals account for about one-quarter of expenditure (see figure 2.3).

Expenditure on hospital care accounts for around 44 per cent of all expenditure on health services. Services provided in public hospitals account for more than 80 per cent of the total value of these hospital services. Medical services are the next most important item of health expenditure accounting for 18 per cent of outlays. Nursing homes (9 per cent) and pharmaceuticals (8 per cent) are the remaining large expenditure items (see figure 2.4).

Employment

Health services employ a little under half a million people. Hospitals account for 51 per cent of employment in the industry. Nursing homes and medical services account for a further 29 per cent.

Figure 2.3: **Source of funds for health care expenditure, 1987-88**



Source: AIH 1991, *Australian health expenditure to 1988-89*, Information Bulletin no. 6, May, p. 11.

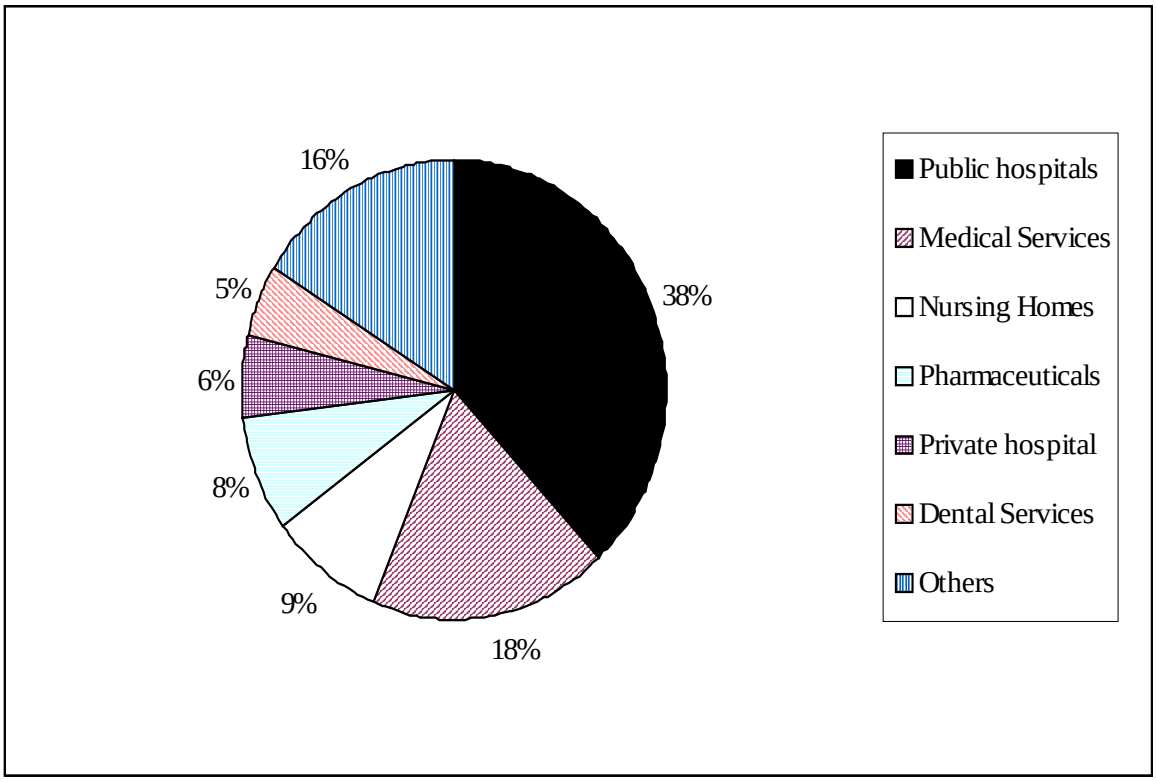
The majority (56 per cent) of people employed in the industry have professional health training. At the aggregate level, employment of health professionals is equally divided between the public and private sectors. The majority of doctors are, however, employed in the private sector.

The patients and institutions

Australia has about 85 800 acute care hospital beds, three-quarters of which are provided in public hospitals. In 1988-89, the average occupancy rates for public and private hospitals were 68 per cent and 56 per cent respectively.

Nearly 5000 foreigners, other than students, were treated in Australian hospitals in 1989-90. Additional details on exports are provided in chapter 3.

Figure 2.4: **Expenditure on health by service, 1987-88**



Source: AIH 1991, Australian health expenditure to 1988-89, Information Bulletin no. 6, May, p. 11.

There are 73 000 beds in nursing homes where the average occupancy rate is over 90 per cent. Care is also provided in psychiatric hospitals and institutions, and hostels for the disabled. Further details of the Australian hospital system are provided in appendix B.

Medical services

There were about 37 600 practising doctors in Australia in 1989-90 (Deebleÿ1991, p. 55). About three-quarters of all practising doctors are general practitioners.

Overall, there is one practising doctor for every 470 Australians (Deebleÿ1991, p. 55), but there are marked variations in the geographic distribution of people per doctor. There are up to 2000 persons per doctor in the country and remote locations, but relatively few in certain urban areas. According to 1986 census data, the population per doctor ranged from 427 in New South Wales to 539 in Queensland and Tasmania (CIMEMW 1988, p. 4). The number of people per doctor in Australia is close to the average for all OECD countries (OECD 1990).

Health insurance arrangements

Some 75 health funds provide insurance cover for health expenditures not covered by Medicare (see below). In 1989-90, these funds had income from premiums of $3 billion. Details of private insurance in Australia are contained in appendix C.

2.3 Government objectives and involvement in health

Current objectives of governments

Social objectives of governments in Australia for health care are enunciated through the operational objectives of the authorities responsible for the administration of health policy and the policy objectives underlying Medicare.

At the broadest level the objective of the Commonwealth Department of Health is:

> To develop and promote the well being of all Australians through health, housing and community care strategies (Department of Health 1989b, p. 8).

With respect to Medicare which lies at the heart of the Commonwealth Government's involvement, the Department stated in its submission to the IAC's inquiry into international trade in services that:

> In designing the Medicare program the Government aimed at producing a publicly funded health insurance system which provided basic cover for medical and hospital treatment and which embodied the principles of universality, equity, simplicity and affordability. These principles remain the objectives of the Medicare program and it is the Department's responsibility to ensure that all Australian residents have access to adequate health services at a cost they can afford. It is implicit in current health policies that no private patient should have preferential access to health services because of the ability to pay (Department of Health 1989a, p. 1).

More specifically, in relation to financial support for the purchase of private medical and hospital services, the Department's objective is:

> To enable eligible patients to obtain appropriate private medical and hospital services which are necessary for their health care, without excessive price barriers, through payment of Medicare benefits and oversight of private health insurance arrangements (Department of Health 1991a, p. 167).

Policy objectives of State Government Health Departments are broadly similar to those of the Commonwealth Department of Health. For example, the goal of the Health Department of Victoria is:

> to ensure that all Victorians develop and maintain a level of health which enables them to participate as citizens in the life of the community and when affected by illness their health and physical and mental capabilities are restored or maintained (Health Department of Victoria 1989, p. ii).

In some States, cost effectiveness or efficient service delivery of publicly provided services are explicit components of operating goals. For example, one of the primary goals of the NSW

Department of Health is 'to ensure services are delivered efficiently and effectively' (NSW Department of Health 1990, p. 7), while the Queensland Department of Health has amongst its goals 'to manage the public health care system of Queensland in a cost effective and efficient manner' (Queensland Department of Health 1990, p. 4).

Commonwealth involvement in funding of health care

In pursuit of these objectives, the respective roles played by Commonwealth and State Governments are determined, in part, by the Constitution. Section 51 of the Constitution gives the Commonwealth power to provide, among other things, pharmaceuticals, sickness, hospital, medical and dental benefits.

The Commonwealth Government's involvement in health is administered by the Department of Health. In 1989-90, the Department spent $13.1 billion which was 16 per cent of total Commonwealth Government expenditure. Two-thirds of the Department's expenditure went in providing health care access, primarily through Medicare and the Pharmaceutical Benefits Scheme. Medicare provides free or heavily subsidised medical services and treatment in public hospitals. Under the Pharmaceutical Benefits Scheme, government subsidises the cost of some 523 approved pharmaceuticals.

Medicare is funded, in part, through a levy which is currently set at 1.25 per cent of taxable income above a threshold that depends on individual or family circumstances. In 1989-90, revenue from the levy comprised a little more than one-third of the Commonwealth Government's payments of medical and hospital benefits. The remaining two-thirds of the Government's obligations under Medicare were met from general revenue.

Under the 1988 Medicare agreements, the Commonwealth allocates hospital funding grants to assist State and Territory Governments to provide public hospital services at no charge to Medicare patients. The hospital funding grants also compensate State Governments for the difference between the cost of providing beds for privately insured patients and the amount that hospitals receive under the basic table from registered health insurance funds (see below). Medicare is described in more detail in appendix C.

Commonwealth regulation of health insurance

As noted earlier in the chapter, governments in many countries regulate the provision of private health insurance. In Australia, the rules governing the provision of health insurance are set out in the *National Health Act 1953* which prohibits the conduct of health insurance business by organisations other than those registered with the Minister for Health.

The *National Health Act* allows two categories of private health insurance. The first covers hospital care and treatment as a private patient, and the second, health services not provided by a medical practitioner and which are not covered by Medicare. These additional services are often referred to as ancillary services.

All private health insurance in Australia must be community rated. That is, insurers must charge a uniform premium for all clients and therefore cannot discriminate on the basis of age, sex, level of health etc.

There are two levels of hospital insurance cover -- basic and supplementary. *The National Health Act* allows the minister to determine the nature and level of benefits in the basic table.

The basic table provides cover for a range of items including treatment in a public hospital by doctor of choice, fees for private patients in public hospital shared ward accommodation, fees for private hospital shared ward accommodation and the 25 per cent gap between the Medicare payment and the Medicare Benefits Scheduled Fee for medical services provided in hospital to private patients.

Private hospital fees exceed the benefits provided in the basic table. Consequently, people intending to use private hospitals need to take out supplementary cover if they are to avoid out-of-pocket expenses. Supplementary cover is not regulated other than through the requirement for community rating of premiums.

State Government involvement in the funding and operation of hospitals

Each State Government is responsible for administration and funding of individual public hospitals within its State. In all States, the administration of public hospitals is devolved (or soon will be) to regional offices and responsibility for the running of each hospital is further devolved to a board of management.

Funding

In the past, public hospitals generally received funds for each year based on the amount allocated in the previous year adjusted for inflation. Recently, however, there have been moves to link funding more closely to the level and range of services provided by a hospital. For example, NSW has introduced what it terms a 'resource allocation formula'. This takes into account variations in population growth, utilisation of private hospitals, interstate flows of patients and the level of services provided by tertiary hospitals. Victoria has moved to a system of 'health service agreements' with individual public hospitals. These agreements set out the hospital's budget, agreed goals and performance indicators.

State Governments set the fees for private patients treated in public hospitals. For most private patients, State Governments set fees in line with the basic table (see appendix B for schedules).

However, these fees are not sufficient to cover hospital costs. As noted above, part of the grants made to the states under the Medicare agreements are designed to cover the shortfall.

State Government regulation of the health industry

Regulation of private hospitals

All States license private hospitals. Licences typically specify either the number of beds in a hospital or the number of patients that may be treated in that hospital.

The procedures adopted for determining whether a new hospital will be granted bed licences vary across the States. The Queensland Government provided an indication of the factors that are taken into account:

> In granting a licence the Department must be convinced by the applicant that a proposed development meets standards of accommodation and care, meets a real need and will not destroy the viability of previously licensed and properly operating institutions (submission no. 20, p. 15).

Regulation of health professionals

All States license medical practitioners and nurses. Control is generally effected through registration boards which set standards for registration and, in some cases, for the conduct and control of the profession. The boards operate as independent statutory authorities responsible to the State Health Ministers. Organisations representing the medical profession are actively involved in advising on and administering registration requirements. Details of the registration requirements for health professionals are provided in appendix D.

3 AUSTRALIAN EXPORTS OF HEALTH SERVICES

3.1 Introduction

Health services can be exported in three ways. Foreigners can seek treatment in Australia, Australian health care professionals can temporarily move overseas to provide their services, or health care professionals based in Australia can provide information and/or advice to clients located overseas.

Information supplied by DITAC indicated that there were at least 285 paid Australian health professionals working overseas in 1990.[1] It said that this number was lower than in previous years because of the gulf war. The Commission received no evidence on institutional, regulatory or other impediments to the movement of Australian health professionals overseas.

Several participants pointed to the scope for exporting health services through the international movement of information. The South Australian Government, for example, based its submission around 'telemedicine' and 'smart card' facilities that could be associated with the proposed multi function polis in Adelaide.[2] But it would seem that this type of activity is in its infancy. Participants provided little quantitative evidence on current or potential exports of health services through this channel. Nor did they provide evidence of any institutional, regulatory or other impediments to exports made in this way.

The bulk of those participants who provided evidence concentrated on the movement of foreign patients to Australia. The discussion in the remainder of this chapter focuses on exports made in this way.

3.2 Why do foreign patients come to Australia?

Many foreign patients who receive medical treatment or hospitalisation do not choose to come to Australia specifically to obtain those services. Rather, they come as students, tourists and business people who find that they need medical treatment or hospitalisation after their arrival in Australia.

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1 Based on applications for taxation relief under the provisions applying to Australians working overseas.

2 Telemedicine is the real time satellite transmission of patient data to a specialist centre. 'Smart cards' are cards which store a patient's history and health-related personal records which can be accessed and up-dated by a practitioner providing treatment.

However, some people come to Australia specifically to obtain specialist treatment. In some cases they cannot obtain the treatment in their own country. In other cases Australian treatment is chosen because it is less expensive and/or considered to be of a higher quality than the treatment available in their home country.

Four factors were identified by participants as being particularly important in influencing where foreign patients seek treatment: health insurance arrangements providing for treatment in particular countries, referral networks, an international reputation for excellence in the provision of health care and price.

Health insurance arrangements

Several health insurance arrangements providing cover for treatment in particular countries operate in the Asia Pacific region. For Australia, the most important is that operating in New Caledonia which accounts for about one-third of all foreign patients who enter Australia on a medical visa.

Residents of New Caledonia pay a little over 8 per cent of their salaries into a universal health insurance scheme. This scheme covers the cost of hospital and medical care in New Caledonia. When specialist treatment is required but unavailable in New Caledonia, air fares to Australia and the cost of Australian hospital and medical care are covered.

CAFAT, a private firm, administers the health insurance scheme and maintains a representative in Australia to assist patients as they arrive.

The arrangements in New Caledonia generally require patients going overseas for treatment to obtain that treatment in Australia. Only 6 or 7 New Caledonian patients going overseas each year have not obtained treatment in Australia. These patients have expressed a special preference for treatment in New Zealand.

The bulk of patients from New Caledonia are treated in two Sydney public hospitals-- Princess Alexandra Hospital for Children and Royal Prince Alfred Hospital. Where necessary, some New Caledonian patients are sent to Brisbane and Melbourne.

Australian insurers also provide health insurance to foreigners. However, this cover is not designed to attract foreign patients to Australia. Rather, it is purchased by visitors who did not take out travel insurance and by diplomats and their dependents. MBF said that very few foreigners subscribe to long term Australian health cover.

Currently, MBF offers cover for visitors in four States, while HCF provides cover in NSW and Mutual Community in South Australia. Under these arrangements, visitors are provided cover for medical services similar to that provided to Australians under Medicare, together with cover for services provided in either public or private hospitals. MBF said that it charges a premium of $2600 per year for visitors seeking family cover.

McKay and Associates (1991) identified medical evacuation insurance as another factor that could influence foreign patients to come to Australia. However, they were unable to estimate either the number of people in the Asia Pacific region with this type of insurance or the extent to which they constitute potential demand for Australian medical and hospital services.

Referral networks

People who come to Australia for specialist treatment are typically referred by doctors in their home country. Thus the confidence of foreign doctors in Australian specialists, and in Australia's health care system as a whole, is an important factor in determining the number and pattern of referrals. The Australian Hospital and Medical Services Association stated that:

> the primary decisions taken by patients from overseas in selection of hospital for admission are those made by the referring doctor. ... professional contacts gained during post-graduate training and from attendance at conferences, establish networks of referral between specialists. It is through these networks that most selections are ultimately made (submission no. 24, p. 3).

Mr Tan, a paediatric surgeon based in Melbourne, expanded on this proposition:

> Our most successful doctors succeed because they have patients who are referred directly to them, and not to their institution. ... Mr Roger Mee in Melbourne has built up a large clientele of overseas patients who are not referred to the institution, but to himself in person (submission no. 34, p. 6).

Confidence in Australian doctors and in the Australian health care system is generated in a number of ways. One source of confidence is the fact that a number of Australian doctors have earned international reputations in their particular specialities. The South Australian Government said that:

> Whilst promotional activities have been singularly unsuccessful, there are individuals such as Mr David David (Cranio-facial Unit) and [the late] Mr Victor Chang (Cardio-thoracic surgery) who have been successful in overseas markets ... Needless to say, both are recognised internationally as leaders in their fields (submission no. 32, p. 8).

Some of the firms involved in facilitating the movement of foreign patients to Australia have brought foreign doctors to Australia to inspect the health care system and observe the specialists in action. For example, Medi-Link International bought fifteen top surgeons to Perth from Djakarta and Surabaya in October 1990. The company said that:

> Not one of them had been to Perth. ... None of them knew anybody here in terms of doctors, and they were amazed. And out of those fifteen, since that trip 30 per cent of them -- five of them had started referring clients down here to Perth through our organisation (transcript, p. 47).

Foreign doctors who received their training in Australia are likely to be familiar with the Australian health care system and be confident that patients they refer to Australia will receive a high standard

of care. International Healthcare said that health professionals who have studied in Australia:

> will be natural promoters of Australia as a medical services destination. Therefore strong promotion of these educational opportunities should be continued and perhaps upgraded (submission no. 16, p. 6).

Mr Tan expanded on this proposition and suggested that the late Mr Chang in Sydney and Mr Mee in Melbourne:

> have been largely successful because they have successfully networked themselves, each of them travelling extensively, teaching and training specialists from the surrounding region to return to their homeland (submission no. 34, p. 6).

Excellence

In addition to the referral networks mentioned above, a reputation for excellence is important in encouraging foreign patients to seek treatment in Australia. When describing the factors that motivate those seeking specialist treatment, Med Assistance Pacific (MAP) said that:

> Australia's system of Health Care has been consistently recognised as equal to and, for some procedures, superior to Health Care Systems of the United States and Western Europe. Advances in biotechnology, microsurgery, cardio-thorasics surgery, craniofacial reconstruction, genes splicing and plastic and cosmetic surgery are among the areas in which Australian medicine is considered the pioneer. The first gold metal vapour laser was developed in Australia as well as the first IVF pregnancy was introduced into Australia (submission no. 6, p. 3).

Price

MAP also identified the generally lower prices at which health services are available as another factor that would attract foreigners to Australia. Table 3.1, derived from MAP's submission, shows that more than three-quarters of services mentioned by MAP are less expensive in Australia than they are in the USA. In many instances the price differences are substantial. Some procedures, coronary artery by-pass surgery for example, can be obtained in Australia at one-third of the price charged in the USA.

The cost to foreign patients of receiving treatment in Australia is, however, increased by travel and accommodation. Thus, the medical and hospital costs must be substantially lower in Australia before it would be worthwhile for foreign patients to come to Australia for care. One way of reducing the costs of hospital and medical care is to promote increased efficiency. The scope for increasing efficiency in the delivery of hospital and medical care is reviewed in chapter 6.

3.3 Visitors who obtain treatment in Australia

Evidence provided by State and Territory Governments shows that in excess of 4800 visitors were treated in Australian hospitals during 1989-90. Although information is not comparable for all States, it appears that more than 70 per cent of these visitors were treated in public hospitals (see table 3.2).

Table 3.1: **Ratio of Australian to USA hospital charges by procedurea, 1991**

Cardiovascular		**Orthopaedics**	
Angioplasty - PTCA	0.6	Arthroscopic Surgery	1.1
Coronary Artery Bypass Surgery	0.4	Joint Replacement Hip or Knee	0.7
Pacemaker Insertion	0.4	Laminectomy	0.6
Ear, Nose & Throat		**Plastic & Reconstructive**	
		Breast Augmentation	0.6
Acoustic Neuroma	2.5	Cleft Lift	1.3
Sinusitio Maxilaris	0.5	Face Lift	1.0
		Rhinoplasty	0.8
General		**Urology**	
Cholecystectomy	0.6		
Hepatoma	0.4	Artificial Sphincter	1.3
		Bladder Neck-Suspension	0.6
		Bladder Reconstruction	0.5
Paediatrics		Endoscopic Bladder/Prostate	0.5
		Endoscopic Renal Surgery	0.5
Hypospadias	1.5	Open Renal Surgery	1.1
Orchidopexy	0.9	Open Eruthral/Testis	1.0
Ureteric & Renal Surgery	0.6	Penile Prosthesis	0.7
		Enterocystoplasty	0.8
		Radical Prostatectomy	0.7
Obstetrics		Total Cystectomy	0.4
Hysterectomy	0.6		
		Vascular	
Ophthalmology		Carotid Endarterectomy	0.6
		Abdominal Aortic Aneurysm	0.4
Cataract & Intraocular	0.7	Aortofemoral By-pass Grafting	0.4
Squint Repair Surgery	0.9	Femoropoplitael By-pass Grafting	0.5

a) Exchange rate used $1 US = $1.24 AUS. USA data are for the years 1988-89.
Source: Derived from information supplied by MAP.

Estimates of the number of foreigners obtaining hospital treatment in Australia are based on the home addresses of patients when discharged and therefore exclude foreign patients who gave the home address of relatives in Australia. Consequently, table 3.2 may underestimate the number of visitors treated in Australian hospitals. Against this, table 3.2 may include some foreign students who gave an overseas address rather than their local address when treated in Australian hospitals.

Table 3.2: **Visitors who obtained hospital treatment in Australia during 1989-90 (number)**

State or Territory	*Public hospital*	*Private hospital*	*Total*	*Average length of stay (days)*
New South Wales	937	416	1 353	7.4
Victoria	926	na	926	5.3
Queensland	983	470	1 453	5.9
Western Australia	339	12	460	5.6
South Australia[a]	349	58	407	5.1
Tasmania	123	na	123	na
Northern Territory	97	-	97	7.3
Australian Capital Territory[b]	41	-	41	na
Totals	3795	1065[c]	4860[c]	6.1

a) Figures are for 1988-89.
b) Figures are for 1987-88.
c) Minimum number of foreign patients.
na not available.
Source: Various State Health Departments.

People who visit Australia specifically to seek hospital or medical treatment are required to obtain a medical visa. The number of people who enter Australia on these visas has fluctuated between 1200 and 1670 persons in recent years (see table 3.3).

The bulk of medical visas are granted to residents of islands in the Pacific and Indian Oceans. New Caledonia accounts for one-half of all successful visa applications from these islands. Indonesia accounts for one-half of all people coming from Asia (see table 3.3).

The Commission received no information on medical treatment provided to visitors outside hospitals.

What treatments do they receive?

A number of State and Territory Governments provided evidence on the types of treatment received by foreign patients in Australian hospitals, classified according to major diagnostic groups (see table 3.4).

Table 3.3: **Successful medical visa applications by region of applicant, 1986-87 to 1990-91 (number)**

	Year				
Region	*1986-87*	*1987-88*	*1988-89*	*1989-90*	*1990-91*
Islands in the Pacific and Indian oceans					
Fiji	76	182	127	124	170
Nauru	97	108	161	155	112
New Caledonia	541	659	624	492	585
New Zealand	1	5	16	25	42
Papua New Guinea	167	176	149	179	192
Samoa	1	2	126	3	1
Solomon Islands	9	24	11	19	39
Vanuatu	15	30	26	25	30
Other	6	12	6	13	10
Sub-total	**913**	**1 198**	**1 246**	**1 035**	**1 181**
Asia					
Burma	7	7	10	6	1
Hong Kong	13	5	12	10	10
Indonesia	96	102	111	139	187
Malaysia	61	68	43	43	57
Philippines	5	5	9	10	11
Singapore	29	36	23	18	22
Thailand	3	5	7	9	16
Other	2	6	1	4	2
Sub-total	**216**	**234**	**216**	**239**	**306**
Central and Northern Asia					
China	2	3	1	2	-
India	8	9	8	12	14
Japan	-	8	50	42	38
Pakistan	5	4	6	1	2
Sri Lanka	2	10	7	7	14
Vietnam	-	2	11	14	5
Other	3	8	1	4	7
Sub-total	**20**	**44**	**84**	**82**	**80**
Middle East	**9**	**22**	**33**	**67**	**46**
Europe	**15**	**12**	**19**	**11**	**36**
Americas	**25**	**8**	**17**	**14**	**12**
Africa	**8**	**10**	**8**	**9**	**7**
All Sources	**1 206**	**1 528**	**1 623**	**1 457**	**1 668**

Source: Department of Immigration, Local Government and Ethnic Affairs.

In commenting on the figures for its State, the Queensland Government said that:

> Closer examination of the diagnoses that account for an average of one or more discharges per week shows that most conditions are those likely to occur as emergencies. Of other diagnoses the largest groups are those concerning liver care and related gastrointestinal conditions which include a number of diagnoses grouped under congenital abnormalities (submission no. 20, p. 8).

For South Australia, in 1989-90, three-quarters of all foreign patients received basic medical and minor surgical services, 19 per cent received more complex services provided by regional hospitals and 6 per cent received super speciality services. The South Australian Government said that it had:

> not been able to establish how many of these patients had visas issued for medical treatment, how many ended up in hospitals due to an unplanned circumstance although 206 have been categorised as "emergency" and how many (are likely to) have planned the consumption of medical services in Australia. It could be expected that a substantial number of the 195 admissions categorised as "elective" would have planned to receive medical treatment in South Australia (submission no. 32, p. 7).

How much revenue is generated?

Reliable estimates of gross revenues earned from treating foreign patients are not available.

In the issues paper released for this inquiry (IC 1991a), the gross revenue to the health system from foreign patients who entered Australia on medical visas was estimated to be in the range of $5 million to $15 million per year[3] with a further $4 million accruing from air fares and accommodation.[4] The Department of Health questioned these estimates saying:

> the Commission's estimates of gross revenue from medical treatment for foreign fee paying patients would seem to be too high in this Department's opinion if those estimates are based on averages ranging from $5000 to $15ÿ000 per patient. South Australian statistics on accounts raised for non-medicare patients (persons who usually live outside Australia and are not residents of any of the countries with which Australia has reciprocal agreements) in public hospitals indicate that the average charge per patient in the 1989Ä90 financial year was $2061. In the five year period from 1985 to 1990, the average charge per patient for non-medicare patients was $1820 (submission no. 21, p. 2).

3 The Lower estimate was based on information which suggests that patients from one island in the Pacific Ocean, on average, spend about $5000 for medical and hospital treatment. The upper estimate was provided by Austrade (1988) which assumed that hospital and medical coasts would average $15 000 per patient. Both estimates were based on the assumption that 1000 patients would come to Australia each year under medical visas.

4 The estimate for accommodation and airfares was based on the assumptions that were employed by Austrade; namely expenditure of $3000 per patient on accommodation and Qantas obtaining 50 per cent of passengers at $2000 per person.

Table 3.4: **Foreign patients treated in hospitals by principal diagnosis (per cent)[a]**

	New South Wales		*Queensland*[b]		*Western Australia*		*South Australia*		*Australian Capital Territory*	
	1988-89		*1988-89*		*1989-90*		*1988-89*		*1987-88*	
Principal Diagnosis	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
Infectious & Parasitic Diseases	5	-	3	3	4	2	2	3	5	–
Neoplasms	6	5	5	8	5	3	5	5	7	-
Endocrine & Metabolic Diseases	1	2	1	-	2	3	1	-	-	-
Diseases of the Blood	1	-	1	-	1	-	3	-	-	-
Mental disorders	3	1	3	-	3	2	1	3	-	-
Diseases of the Nervous System	3	3	4	8	3	6	4	12	-	-
Diseases of the Circulatory System	14	38	8	11	9	5	10	31	15	-
Diseases of the Respiratory System	6	2	5	9	4	6	5	7	10	-
Diseases of the Digestive System	8	5	15	10	8	16	17	10	7	-
Diseases of the Genitourinary System	4	11	3	23	5	5	5	5	5	-
Complications of Pregnancy & Birth	2	2	2	4	2	2	7	-	15	-
Diseases of the Skin	3	2	1	1	3	5	4	-	7	-
Diseases of the Musculoskeletal System	2	6	1	7	1	5	5	3	2	-
Congenital Abnormalities	3	-	18	1	1	-	2	-	-	-
Perinatal Conditions	-	-	-	1	-	-	1	-	-	-
Ill-Defined Conditions	7	5	10	5	6	11	6	7	2	-
Injury & Poisoning	21	7	10	4	36	17	18	2	20	-
Supplementary / Other	11	11	10	5	7	12	4	12	5	-
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**-**

a) Data supplied by Victoria and Tasmania was not comparable to other States and is not included in the table.
b) The figures for Queensland are from a survey of major public and private Brisbane hospitals.
Source: Evidence.

However, it is not clear whether the average charge for foreign patients in South Australian hospitals was low because the patients required limited services or because they were not charged full cost. One possible explanation is that there were fewer foreign patients going to South Australia for expensive medical treatment.

In contrast to the Department of Health, Dr Catchlove, formerly Chief Executive of the Royal Children's Hospital (RCH) in Melbourne, said that:

> The 100 patients [foreigners treated at the RCH] on average contribute approximately $15 000 per patient in direct payments to the hospital and ... probably another $15 000 to $20 000 of indirect benefits to the country through travel, accommodation, spending etc. (Catchlove 1991, p. 2).

Similarly, International Health Care said that the Commission's estimate of $15 000 for hospital and medical costs is close to the mark. However, the company observed that:

> the other figure of $4000 ... for accompanying family members, with air fares and accommodation and living costs ... is probably a bit under(stated), because often the patients will come with at least two or three family members and often up to six or seven. And also, if the patient is down here for an extended period, then family members will come and go between the home country and Australia (transcript, p. 23).

Against this, patients with medical visas are often sponsored by relatives in Australia and thereby avoid many of the accommodation and other incidental expenses (and perhaps some treatment costs) which would otherwise be associated with treatment in Australia. No reliable estimates are available of the extent to which accommodation is provided to foreign patients by Australian relatives.

The Commission's assessment is that about 2000 of the 4800 foreign patients treated in Australian hospitals during 1989-90 came to Australia specifically to obtain that treatment.[5] Of these about 600 patients came from New Caledonia. For these patients, gross revenue for hospital and medical care was about $4 million, with air fares and accommodation adding perhaps another $1 million. For the remaining 1400 people who are estimated to have come to Australia specifically for treatment, a figure of $15 000 per patient is probably appropriate for the cost of hospital and medical care, yielding estimated gross revenue of $21 million. Applying the range $4000 to $15 000 per patient for expenditure on travel, accommodation and the like, yields estimated gross revenue of between $6 million and $21 million. Finally, for the estimated 2800 patients who received emergency hospitalisation while in Australia, applying the figure of $2000 per patient suggested by the Department of Health, yields estimated gross revenue of about $6 million.

Thus the Commission estimates that, in 1989-90, sales of health services to foreign patients (other than students) yielded a gross revenue of around $31 million for hospital and medical services and

[5] Based on the assumption that 85 per cent of people coming to Australia for treatment enter under medical visas (see section 4.2).

between $7 million and $22 million for travel, accommodation and associated expenses.

Against this revenue there is the cost of providing services. On the basis of the available evidence, the Commission considers that at least some foreign patients treated in public hospitals are subsidised by the Australian community. Moreover, the Commission received evidence which suggests that foreign tourists are a major source of bad debts in public hospitals. These matters are discussed in chapter 5.

3.4 Provision of health care to foreign students

The other important source of foreign demand for Australian health services comes from foreign students attending Australian institutions.

According to DEET, there were 56 000 foreign students in Australia on 30 June 1991 of whom about 48 000 were full fee-paying. When they become ill or injured, these students and any dependents seek health care in Australia.

Before they can obtain a visa, foreigners who intend to study in Australia must establish that they have suitable health insurance arrangements. Currently, students who are sponsored by the Australian International Development Assistance Bureau are covered by Medicare and do not need to take out private health insurance in order to obtain a student visa.[6] Full fee-paying students and any dependents who will also be resident in Australia are required to purchase Overseas Student Health Cover (OSHC) from Medibank Private at a cost of $150 per year.

The OSHC scheme provides cover for all medical and hospital expenses that an Australian patient would be covered for under Medicare. In addition, OSHC provides benefits toward treatment as a private patient in either public or private hospitals.

The arrangement for Medibank Private to provide OSHC was made in March 1989 with the Commonwealth Government agreeing to underwrite any excess of claims over the premiums collected. The OSHC scheme is discussed further in chapter 5 and in the Commission's recent report on *Exports of education services* (IC 1991b).

Information on the value of medical and hospital services provided to foreign students is not available. Based on the charge for OSHC, the value would be of the order of $10 million annually. However, as discussed in chapter 5, it appears that the charge of $150 per student does not fully

6 Privately sponsored students who commenced study before the Overseas Students Health cover arrangements were introduced in March 1989 are also covered by Medicare.

cover the cost of services reimbursed under the scheme. Accordingly, the value of services provided to foreign students would be greater than $10 million.

3.5 What is the potential foreign demand for Australia's health services?

As an input to this inquiry and the review of the national health strategy, Austrade commissioned a study of foreign demand for Australia's health services; including factors influencing that demand, both now, and in the future. The Health and Medical Exports Task Group[7] provided the Commission with a draft of that study (Health Economics and Technology Assessment Corporation 1991).[8]

The study suggests that the market for providing health care to foreign patients in the Asia and Pacific region is small (see table 3.5). Australia serves about 10 per cent of this market with limited scope to expand its share.

Indonesians comprise the bulk of the market, accounting for 15 000 out of the estimated 20 000 patients in the Asia and Pacific region who received treatment outside their home country during 1988-89.

The main competitors to Australian hospitals are located in Singapore, USA, UK, Japan and France. Thailand and Malaysia also appear to be emerging as competitors in the provision of hospital services to non-nationals.

The study suggests that :

- people in the Asia Pacific region perceive Australia as a nation whose health services are sophisticated but less "high tech" than those in the USA;
- potential patients in some countries -- Indonesia for example -- do not recognise the quality of care provided in Australian hospitals;
- Papua New Guinea, New Zealand and New Caledonia have well developed medical referral networks with Australia but in other countries -- Indonesia and Malaysia for example -- medical referral networks are not well developed;
- Australia is perceived by people in the Asia Pacific region to not be as sensitive to the cultural needs of patients as are other major competitors, such as Singapore;
- while there is a widespread perception that Australia's health care is good, little information is available on the different treatment centres in Australia;

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7 The Task Group comprises representatives from DITAC, the Department of Health, the Department of Foreign Affairs and Trade and Austrade.

8 The Take Group has not yet released the report to the public. However it expects to release the report in the near future. In the interim, arrangements to peruse the report can be made by contacting members of the group.

- where information on Australian hospitals is available it usually relates to public teaching hospitals. The Austrade consultants said that in their interviews overseas the Australian private hospital industry was not mentioned as a major source of care; and

- on the basis of the total cost to the patient[9], Australia is not a low cost option for patients other than those in New Zealand, Fiji and New Caledonia.

The study identified a number of impediments to future growth, which generally accord with those identified by the Commission in the following chapter.

3.6 Capacity of the Australian hospital system to serve foreign patients

As an input to this inquiry and the review of the national health strategy, the Department of Health commissioned a study of the Australian health services industry's ability to supply services to foreign patients (McKay and Associates 1991).

The main conclusions from this study are that:

- overall 'spare' capacity would, in principle, allow for a substantial increase over the existing 4000 foreign patients who are treated in Australia each year;

- bed capacity is sufficient for an additional 22 700 foreign patients in major private hospitals and 58 000 foreign patients in public teaching hospitals each year;

- theatre capacity would enable an extra 38 000 to 51 000 patients to have surgical procedures in major private hospitals and 69 000 to 92 000 to have surgical procedures in public teaching hospitals;

- intensive care units and coronary care units have capacity to treat an additional 5500 patients in private hospitals and 9600 in public teaching hospitals. Because a relatively small proportion of procedures require intensive or coronary care, these facilities are more than sufficient given the number of beds and theatres available to treat foreign patients.

The consultants asked the hospitals that it contacted to identify other constraints on expanding capacity to treat foreign patients. They found that:

- there is no shortage of nurses, although theatre, intensive care and coronary care nurses are harder to find than general nurses;

- in most cases there is no shortage of suitable clinicians;

- the level of support equipment is sufficient to treat most foreign patients in their specialty areas. The hospitals have access to the latest diagnostic facilities and the equipment levels of the

9 Total cost includes all hospital and medical charges, plus transport and administration costs.

major private hospitals have improved significantly over recent years; and

- blood products are not a constraint; but
- availability of organs for transplants is an issue. However, most transplant units have introduced a policy of requiring overseas patients to bring their own donor, stipulating that the donor must be a relative to avoid ethical problems.

Table 3.5: **Estimated hospital usage by patients from Asian and Pacific nations, various years 1986 to 1990**

Nation	*Population size (millions)*	*Number of acute beds (thousands)*	*Beds per 1000 persons*	*Estimated number of domestic hospital admissions (thousands)*	*Estimated average length of stay (days)*	*Estimated medical evacuations or overseas treatments (persons)*	*Major destinations*
PACIFIC							
New Zealand	3.4	11.4	3.4	541.0	13.1	40	Australia
Fiji	0.8	1 8	2.4	na	na	200	Australia
Fr. Polynesia	0.2	1.1	5.8	16.9	10.5	354	France
New Caledonia	0.2	0.9	5.8	15.0	11.6	674	Australia
Samoa	0.2	0.6	4.0	73.0	4.5	na	New Zealand
Solomon Is.	0.3	1.5	4.9	7.7	11.4	na	New Zealand
Tonga	0.1	0.3	3.1	6.2	8.3	23	New Zealand
Vanuatu	0.2	0.4	2.9	na	na	50	Australia, New Zealand
ASIA							
Malaysia	16.5	37.9	2.3	601.1	5.9	100-300	Singapore, UK
Thailand	53.6	16.5	0.3	na	na	2000	Singapore
Hong Kong	5.8	14.7	2.6	817.8	5.0	250-500	Singapore, UK
Taiwan	19.6	na	na	165.2	18.9	na	USA
Korea	42.6	73.4	1.8	1 292.0	9.0	na	Japan, USA
Philippines	61.5	90.3	1.5	252.2	na	na	Singapore
Indonesia	180.0	95.5	0.5	2 530.4	6.6	15 000	Singapore, USA
China	1 108.7	2 296.8	2.1	44 670.0	15.9	na	Hong Kong
Japan	122.5	1 118.0	9.1	8 683.0	40.0	na	USA
Singapore	2.6	6.0	2.3	272.8	5.5	na	USA

na not available.
Source: Health Economics and Technology Assessment Corporation 1991.

However, the consultants concluded that although there is considerable spare capacity in the public hospital system, it does not represent 'real' or usable capacity because:

- most of the beds are closed because of a shortage of financial resources;
- in most States the revenue collected from overseas patients would be deducted from the hospitals grant received from Government. Thus the hospital would not receive the extra resources needed to open the additional beds;
- many public teaching hospitals are operating in excess of 90 per cent capacity, which is regarded by many clinicians as undesirable for patient care and staff morale; and
- it would be difficult to convince the public that closed public hospital beds should be opened for treating foreign patients while there is a perception of long waiting times for domestic patients.

4 DIRECT IMPENDIMENTS TO EXPORTS OF HEALTH SERVICES

4.1 Introduction

Impediments to the efficient export of Australia's health services can be classified as direct or indirect. Direct impediments either reduce the information that potential foreign patients can obtain about opportunities to receive health care in Australia or make it more difficult for them to come here. Indirect impediments are arrangements that reduce the efficiency with which the Australian health care system delivers its services, whether to foreign or domestic patients.

Direct impediments are discussed in this chapter; indirect impediments are discussed in subsequent chapters.

Factors which participants claimed directly impede the efficient export of health services include the visa requirements that apply to foreigners who seek medical or hospital treatment in Australia; restrictions on the training in Australia of foreign medical students which impede the establishment of international referral networks; restrictions on advertising; waiting lists in public hospitals; and the ambivalence of Commonwealth and State Departments of Health and the community in general towards exports of health services.

4.2 Immigration procedures

Health-related immigration procedures are intended to protect Australia's public health, to ensure that ineligible foreigners do not become a burden on the public purse through their use of government-subsidised public hospitals, and to ensure that Australian residents are not disadvantaged by the provision of health services to foreigners. DILGEA said that it has the responsibility:

> to ensure that Australia does not admit persons who constitute a risk to public health or persons who may make demands on health services, particularly the public health system, without the ability or intention of meeting the costs (submission no. 8, p. 2).

People who enter Australia as permanent settlers, together with those who have long term residence in Australia, are covered by Medicare. Temporary residents from countries with which Australia has reciprocal health care agreements are also eligible to receive limited benefits under Medicare.

Foreign students must provide evidence that they have adequate health insurance cover before they are granted a visa. Health insurance arrangements for foreign students are discussed in chapters 3 and 5.

The balance of foreigners who are temporarily admitted to Australia are advised by DILGEA that they are not eligible to access subsidised health services in Australia and that they should take out private insurance to cover any health care costs which they might incur. DILGEA said that:

> This group is by far the largest group as it includes the Visitor classes of visa applicants. It needs to be acknowledged that many visitors are from countries which have reciprocal health services agreements with Australia and many others carry adequate private health insurance as a matter of course (submission no. 8, p. 2).

Visitors who enter Australia on tourist or business visas can obtain hospital and medical treatment in Australia. However, the *Migration Act* says that a visitor suffering from a prescribed disease, physical or mental condition[1], is an illegal entrant and liable for deportation if he or she does not hold a visa which recognises that disease or condition.

Medical Visas

Visitors who enter Australia specifically to obtain medical treatment are required to obtain a medical visa. DILGEA said that:

> when deciding applications for Medical Treatment Visas the major health consideration is the potential threat to public health in Australia. If the prescribed disease, or prescribed physical or mental condition, does not constitute a threat to public health in Australia the application may be approved subject to appropriate endorsements on the entry visas (submission no. 8, p. 5).

Medical visas are intended to be more restrictive than tourist visas. The additional criteria require applicants to establish that they are willing to meet treatment costs; have made firm arrangements with the doctors and hospitals involved; treatment will not disadvantage any Australian resident;

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1 *Migration Regulation* 176 clarifies the reference to prescribed diseases and prescribed physical or mental conditions. These conditions include:

a) tuberculosis or any other communicable disease of a fatal or serious nature which is a threat to public health in Australia;

b) any other disease or condition which would be likely to endanger the Australian community during the person's intended period of stay in Australia;

c) any disease or condition which during the person's intended period of stay in Australia would:

   i) require significant care or treatment; or

   ii) require care or treatment involving the use of community resources in short supply; or

   iii) prevent a person who has entered Australia pursuing an intended occupation in Australia; or

   iv) result in such a person becoming a significant charge on public funds.

will not constitute a public health risk; and if the treatment is an organ transplant, either the donor of the organ is accompanying the applicant to Australia or all requisite arrangements to effect the donation of the organ have been concluded in Australia.

In practice, visitors seeking medical visas are not required to establish that all these criteria are met.[2] Patients seeking treatment in private hospitals are not required to establish that their treatment would not disadvantage any Australian resident. DILGEA stated that:

> Current medical entry policy is based on the premise that there is minor excess capacity in the private health care area and that it makes good economic sense to export services which would otherwise be under-utilised. It is acknowledged that certain services, such as organ transplants, are available only in the public health system in major teaching hospitals and entry for those medical services is only permitted after the relevant government authorities have agreed that the provision of the service to a medical visitor would not be prejudicial to a local resident (submission no. 8, p. 4).

The Princess Alexandra Hospital in Brisbane, for example, advises intending foreign liver transplant patients that Australian patients will receive precedence when a liver becomes available for use. The procedure adopted is to check with other transplant facilities to see if the liver could be used for an Australian before it is used for an overseas patient. Of course, domestic and foreign patients can obtain more timely access to transplants if they nominate a suitable live donor. For example, a family member may donate one kidney for transplant into another family member or a parent may donate part of his/her liver for transplant into a child. Accompanying organ donors also require a medical visa.

Availability of medical visas

Although DILGEA was unable to document the number of applications for medical visas which has been rejected, it said that:

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2 The Commission was informed by DILGEA that current practice requires applicants for medical visas to produce evidence that:

a) they do not suffer from a condition which could be a threat to public health in Australia;

b) all documentation/arrangements are in place to carry out the treatment or consultations;

c) arrangements have been concluded to cover payment of all medical and any other costs associated with the treatment or consultations and the visit both for the applicant and any person(s) accompanying; and

d) the payment of these costs will not be a charge on public funds except where the relevant accompanying; and

e) the payment of these costs will not be charge on public funds except where the relevant government authority has otherwise approved.

DILGEA further advised that, in addition to these stated requirements, the officer issuing the visa needs to be satisfied as to the applicant's bona fides. How this is done and what documentary evidence may be called for, varies from post to post. According to DILGEA the most stringent checks o bona fides are made in countries which a history of abuse of immigration entry criteria.

> in contrast to most other categories of visa entry, very few medical entry applications are actually rejected. The reason is that most applicants have already been advised of the specific entry criteria in advance of application and do not follow up their inquiry with an application unless they know those criteria are satisfied. The fact is that medical entry criteria are more objective in nature than the general tourist entry criteria. A simple example is that of a single, unemployed person from a high risk country who might stand little chance of getting a tourist visa, would almost certainly get a visa if medical treatment was being sought and evidence of satisfactory treatment and payments arrangements are presented (letter to Commission).

Although visitors seeking treatment are supposed to obtain a medical visa, some people enter Australia for this purpose under tourist or other visa categories. DITAC said that:

> Health visas issued to foreign patients are relatively few in number and currently average about 1500 a year. However, this figure is considered to significantly understate the true position, due to the number of foreign patients who choose to enter under more readily obtainable tourist visas (submission no. 10, Task Force Report on Health and Medical Services Exports, appendix, p. 11).

On the basis of the number of foreign patients (other than students) estimated to have been treated in Australia in recent years (discussed in chapter 3), less than one-third would have entered Australia under medical visas. Some foreign patients who enter under other visa categories would be tourists or business people who unexpectedly fall ill while in Australia. Nonetheless, some are likely to come to Australia specifically for treatment while on tourist or business visas. Mr Popper of the Australian Hospital and Medical Services Association said that anecdotal evidence both from the Epworth Hospital and from discussion with colleagues suggests that about 15 per cent of people who come to Australia specifically for health care enter on tourist or other non-medical visas.

A. L. Bloom and Associates stated that:

> It is perceived to be extremely difficult to obtain a medical visa to enter Australia legally for medical treatment. On the other hand most elective medical procedures can easily be provided during the duration of a tourist visa. Consequently, full fee-paying patients can enter Australia on a tourist visa, purchase health care and depart without being identified by immigration authorities (submission no. 5, p. 3).

DITAC said that some of these difficulties encountered by persons trying to obtain medical visas may arise because:

> Under the current immigration procedures, responsibility for the issue of visas is delegated to overseas posts. This policy has led to some complaints about the responsiveness of immigration officials to the needs of overseas patients and poses difficulties for applicants living some distance from Australian posts. It is also claimed that immigration requirements regarding escorts of patients are too restrictive (submission no. 10, Task Force Report on Health and Medical Services Exports, appendix, p. 21).

Mr Popper expanded on this saying:

> you hear the comments that [DILGEA] have got a problem, it is not really the Australian end of the immigration that necessarily has the problem, it is the management of the nationals at the point of visa issue. That comes through

> quite a lot from Djakarta and that is why a number of our patients do not even [take] the medical visa approach. It is not because we have a particular policy of making life difficult, that has been eased considerably since some work Austrade did on behalf of the industry, but it does not change how the local nationals perceive their own populous leaving; they really do give them a hard time (transcript, p. 172).

However, Mr Popper felt that medical visas are not a major impediment to exports. International Healthcare (IHC) went even further and said that the visas serve a useful purpose:

> From our point of view we believe that the medical visa is a good move because there are some strong guidelines as to what the patient has to provide before they can get medical cover (transcript, p. 17).

IHC also felt that the visa guidelines help to screen patients and serve to underwrite its risk. Moreover, the company said that many of the problems that were initially encountered with medical visas had now been ironed out:

> initially when we started, visas could take up to 2 weeks, which was absolutely a pain, but now visas can be issued quite promptly. I guess that is a part of the experience of the overseas missions becoming familiar with how they operate and with each of the broker groups liaising with the government to make sure they are providing the correct information in their applications for visas. So we believe that the visas are a good idea because they do set solid guidelines (transcript, p. 18).

However, Medi-Link International doubted the effectiveness of medical visas. It said that:

> a lot of Indonesians enter Australia for medical treatment, but only come in on tourist visas and ... when they get here there is nothing to stop them from going to hospital (transcript, p. 51).

Overstay rates for medical visas

DILGEA stated that the overstay rate[3] as at March 1989 for visitors entering under medical visas was 8.1 per cent compared with 4.0 per cent for those visiting relatives, 3.4 per cent for visiting academics, 1.3 per cent for tourists and 1.1 per cent for business visitors. The rate for all categories of students was 12.2 per cent, while the overstay rate for those who came for english language intensive courses was 23.3 per cent.[4]

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3 Overstay rates, as calculated by DILGEA, are based on the number of arrivals in a particular time period who have not departed (disregarding those granted resident status or entry permit extensions) nine months after the end of that time period. As most arrivals have entry permits valid for no more that six months, most of those not accounted for at the end of the nine months would have overstayed for at least three months.

4 Since 1989, the overstayed rated for students have fallen significantly. At April 1991, the overstay rated for all categories of students, and for students enroled in english language intensive courses, were 6.8 per cent and 10.6 per cent respectively.

Establishing bona fides of applicants for medical visas

DILGEA considered that the creation of an export oriented health care industry would pose a number of problems. It was concerned about the adequacy of bona fides testing should the number of medical visitor applicants rise dramatically.

DILGEA said that it often obtains advice as to the bona fides of the applicant for a visa from the receiving institution -- for example, a university receiving overseas students or a hospital receiving foreign patients. DILGEA said that institutions which do not rely for their commercial survival on serving foreigners are more likely to provide reliable unbiased advice. It went on to say that, as exports grow, and more firms depend on foreigners for their profits, their advice tends to become less reliable, making bona fides testing more difficult.

Visa requirements for medical treatment in other countries

Most other countries competing for overseas patients such as Singapore, Switzerland, the UK and the USA do not have a special medical visa requirement. Nevertheless, some of these countries have regulations for medical patients under other types of visa requirements. The USA, for example, requires a letter of referral from the institution offering the medical treatment indicating that the treatment is needed, before it will consider issuing a visitor visa.

Response to the Commissions draft recommendations on visa requirements

In its draft report the Commission recommended that a medical visa be granted, if among other things, the applicant "does not have a disease that will put the health of Australians at risk".

Royal Brisbane Hospital commented on this aspect of the Commission's draft recommendations saying that:

> The Commission's proposal would probably exclude hepatitis B carriers and HIV infected persons although such persons can enter the country as tourists. It is conceivable that Australia could develop services for the treatment of the hepatitis B carrier status the market for which could be substantial. The Commission's formulation would probably exclude them from medical visas. Similarly a patient with tuberculosis has a "disease that will put the health of Australians at risk" but does not necessarily have "a condition which could be a threat to public health in Australia" (submission no. 40, p. 2).

In response to this information the Commission has changed its recommendation to accord with the current DILGEA wording.

The Consumers Health Forum said that it did not agree with the removal of the requirement that DILGEA must determine whether treatment of a foreign patient would disadvantage Australian patients before issuing medical visas. The Consumers Health Forum went on to say that:

it would be more sensible to make the visa requirements relating to admission of foreign patients in either public or private hospitals consistent by adding the requirement to check that Australian residents are not disadvantaged in their access to private hospitals rather than removing it from public hospitals (submission no. 49, p. 8).

The Commission's assessment

The terms of reference require the Commission to have regard to controls over the various components of the immigration program and measures which need to be applied to ensure that appropriate controls are maintained. The Commission is unable to assess the various components of the overall migration program in the context of this inquiry and therefore makes no recommendation regarding whether the visa system, including medical or any other category of visa, should or should not continue.

However, while medical visas may impose some costs and divert some potential foreign patients to competing countries such as Singapore, which do not require visas for entry, the Commission considers that they are not a major impediment to foreigners coming to Australia and they provide some benefits. It is easier to deter potential foreign patients who do not have the capacity to pay for health care, prior to leaving their home country or at the point of entry into Australia. Once these patients present themselves at an Australian public hospital it is ethically difficult to refuse them treatment even though they cannot pay.

Medical visas therefore provide a mechanism to allow fee-paying foreign patients to enter Australia while continuing to allow immigration officials the flexibility to deny entry to foreigners who are likely to become a charge on the Australian health care system. In addition, medical visas provide a mechanism through which the Australian public can be reassured that access by Australians to organ transplants will not be compromised and, where the donor of an organ accompanies a foreign patient, the arrangement between the donor and recipient does not compromise Australian ethical standards.

On the assumption that medical visas are to be retained, the question arises as to the degree to which those visas should restrict entry.

The Commission recommends that the regulations setting out the criteria on which all medical visas are to be granted be rewritten to reflect the current practice for granting medical visas to foreign patients who intend to receive treatment in private hospitals.

Specifically, medical visas would be granted to applicants who:

- **do not have a condition which could be a threat to public health in Australia;**
- **have made substantiated arrangements with a hospital or doctor for treatment and payment;**

- **have made substantiated arrangements, if the treatment involves an organ transplant, to obtain the organ in a manner which does not compromise the access of an Australian to such an organ transplant; and**

- **satisfies other relevant immigration criteria such as those related to national security and the prohibition on entry of criminals.**

This recommendation involves no change in visa requirements for foreigners who seek treatment in private hospitals. Rather, it is intended to streamline the process for granting a medical visa to foreigners who seek treatment in public hospitals, without compromising the interests of the wider community.

Under the recommendation, the question of whether treatment of a foreign patient in an Australian public hospital would disadvantage Australian patients would no longer be an issue in the granting of a medical visa. Instead, it would be left to each State and Territory Government to determine the guidelines under which public hospitals would accept foreign patients on referral from overseas. Within the guidelines set down by their State Government, individual public hospitals would then determine whether they had the capacity to accept the referral of foreign patients on a case by case basis.

Under the proposed visa arrangements, DILGEA would continue to play a role in protecting the nation's public health, ensuring that foreign patients are not a burden on the public purse and, where organ transplants are involved, do not disadvantage potential Australian recipients of those transplants. They would encompass the situation of a foreign organ donor accompanying a foreign organ recipient, both of whom would be eligible for consideration to enter under a medical visa.

In regard to DILGEA's concern that bona fides testing will become more difficult if exports of health services grow, the Commission observes that, for services provided in the private sector, the institutions and practitioners concerned have strong financial incentives to ensure that the conditions attaching to medical visas are met. And, while public institutions continue to be funded from consolidated revenue, their incentives to supply truthful information on the bona fides of foreign patients should be unaffected by the number of those patients treated. Accordingly, the Commission does not consider that specific action is warranted to address DILGEA's concerns, at least in the foreseeable future.

In the longer run, there may be scope for further relaxation of the criteria for granting medical visas. In particular, it may be feasible to further delegate to individual hospitals the responsibility for determining whether the transplant of a particular organ would disadvantage Australian patients. To some extent this delegation already occurs. For example, as noted earlier, before transplanting a liver in a foreign patient, the Princess Alexandra hospital checks with other transplant facilities to see whether that liver could be used in an Australian.

It is currently illegal to sell or charge for organs and human tissue in Australia. The Commission's assessment is that organ availability is limited and, for the time being, the Commonwealth should retain some control over the entry of foreigners seeking organ transplants. The objectives of these controls should be to reassure the Australian community that they will not be disadvantaged by the provision of organ transplants to foreigners. This should minimise the likelihood of backlash against exports of health services that could arise if some hospitals were to grant foreigners access to organ transplants in a way that disadvantages Australians.

4.3 The sale of health insurance to foreigners

As noted in chapter 3, around one-third of patients entering under medical visas come from New Caledonia. The importance of New Caledonia as a source of patients is attributable to the CAFAT insurance arrangements operating in that country. Under those arrangements, if specialist care is not available in New Caledonia, the cost of treatment in Australia is covered.

Given the impact of the CAFAT arrangements on Australia's exports of health services, the question arises as to whether packages providing both health insurance and treatment in Australia could have wider application and, if so, whether there are impediments which prevent this happening.

As discussed in chapter 3, some of the health funds operating in Australia provide insurance cover for visitors to Australia who failed to take out travel insurance in their home countries and to diplomats and other foreign nationals who do not pay the Medicare levy. According to MBF some residents in the Pacific Islands also purchase 'visitor' cover.

Information from health insurers suggests that Australian regulations governing the provision of health insurance are not an impediment to the provision of insurance to foreigners for treatment in Australia. MBF said that:

> If Australian health insurers were to enter overseas markets in any scale, it would have to be subject to local regulation. Coverage offered would have to be general and not specifically for treatment in Australia ... (letter to Commission).

However, the difficulty of guaranteeing foreign patients access to Australian public hospitals (see below) is seen as a constraint on the provision of insurance to foreigners. HCF stated that:

> As the foreigners would have limited knowledge of local medical/hospital conditions, any successful service would need to be able to guarantee the access required to Australian facilities (letter to Commission).

4.4 Guaranteeing access to public hospitals

In order to attract foreign patients, a hospital must have the patronage of specialists with international reputations who can obtain referrals of foreign patients. The patronage of such specialists is not won easily and in most cases requires that the hospital establish a history of providing superior services and facilities. According to McKay and Associates (1991) less than one-third of Australian hospitals have the attributes necessary to attract foreign patients. While some of the hospitals that meet these criteria are in the private sector, most are in the public sector. Indeed the bulk of foreign patients are treated in public hospitals.

The APHA, the Royal Australian College of Ophthalmologists and Worldcare differed with the Commission's assessment in its draft report of the relative capabilities of public and private hospitals. For example, the APHA said that:

> To enable microeconomic gains in efficiency in the provision of export of health services the potential of the entire health sector must be recognised. In particular, the expertise available in the private sector, combined with current excess capacity in private hospitals (submission no. 42, p. 2).

It further said:

> the best of the private hospital facilities have grown to match the best of the public facilities. Indeed, the major private hospitals are currently investing more capital in medical technology than their public hospital counterparts. Surveys of the capabilities of the private hospital industry indicate that the ability of private hospitals to treat a greater range of patient types and perform more complex procedures is increasing rapidly (submission no. 42, p. 2).

However, as long as government funding arrangements for hospital care are orientated almost entirely towards public providers, it is unlikely that the private sector can develop to the stage that it will obtain the patronage of the majority of those specialists capable of attracting foreign patients. Consequently, the Commission expects the public sector to continue to be the principal source of exports of hospital services. Thus, the ease with which foreign patients can obtain treatment in public hospitals will continue to be one of the principal determinants of export activity in the short to medium term.

Patients seeking treatment in public hospitals are admitted on the basis of assessed need. Because there is excess demand for many 'elective' services provided by public hospitals, some patients are placed on waiting lists. The Department of Health said that:

> there is evidence that substantial waiting times do exist in most States for certain types of treatment, particularly where shortages of practitioners in specialist areas exacerbate the problem. Victorian data, for instance suggests that there are excessive average waiting times in orthopaedics (3.3 months), urology (2.9 months), cardiac surgery (2.7 months) and ear, nose and throat surgery (3.3 months) (submission no. 21, p.ÿ17).

The Department went on to relate waiting lists to the perceived need for restrictions on the export of health services:

> Any exacerbation of this discomfort and/or social cost by allowing foreigners to receive services for which significant waiting times exist or of which there is a shortage for domestic patients is clearly not acceptable and could have serious consequences in terms of the well-being of Australian patients. It is worth noting that such services could also be regarded as less marketable to foreign patients insofar as they could not be guaranteed early priority treatment in the public hospital system (submission no. 21, p. 17).
>
> Waiting times present an important constraint to the ability of public hospitals to sell health services to foreigners. Additional demand for the services for which there are waiting lists will obviously increase the time Australian patients will have to wait for treatment (submission no. 21, p. 9).

Waiting lists for treatment in public hospitals arise for a variety of reasons. The mix of incentives created by Medicare, regulation of private hospitals and regulation of private health insurance all play a role (see chapter 6). But whatever their cause, waiting lists are likely to constitute a significant impediment to the export of Australia's health services.

McKay and Associates (1991) provided information on the procedures with the longest waiting lists and the average waiting time for each procedure (see tables 4.1 and 4.2).

Table 4.1: **Specialty areas with the longest waiting lists, public hospitals, 1990-91**

Specialty	*Per cent of total waiting list*		
	Victoria	*South Australia*	*New South Wales*
General Surgery	22	19	21
Orthopaedic	19	20	16
Urology	9	10	10
Plastic surgery	10	9	3
Gynaecology	9	11	11
Ophthalmology	8	5	5
Cardiac/Thoracic	2	2	2
Vascular surgery	2	3	2
Neurosurgery	1	1	1
Paediatric	1	na	6
Other	2	2	11
Ear, nose and throat	15	20	11

Table 4.2: **Waiting times for elective treatment by specialty, public hospitals, 1990-91**

Specialty	*Victoria expected admission time (months)*	*South Australia % waiting more than 6 months*	*New South Wales Average waiting time (months)*
General Surgery	2.0	-	0.7
Orthopaedic	3.6	37	1.7
Urology	2.8	27	1.2
Plastic surgery	4.6	40	1.2
Gynaecology	1.0	11	0.6
Ophthalmology	1.9	23	1.1
Cardiac	2.5	nil	1.2
Vascular surgery	2.5	43	1.0
Neurosurgery	2.2	29	0.6
Paediatric	1.6	-	1.2
Thoracic	0.3	23	0.7

Source: McKay and Associates 1991, tables 7 and 8.

In NSW, an informal arrangement between its Department of Health and the New Caledonian Government provides foreigners entering under the CAFAT arrangement with some certainty of treatment in certain public hospitals. The arrangement with the Department of Health is supplemented by informal agreements between CAFAT and the two main hospitals -- Princess Alexandra Hospital for Children and Royal Prince Alfred. However, the Departments of Health in other States are unwilling to countenance such guarantees.

Eliminating, or significantly reducing, waiting lists in Australia's public hospitals would require substantial changes to the wider health care system. Accordingly, this particular impediment to exports is more appropriately addressed in the context of the efficiency of that system (see chapter 6).

4.5 Limits on the training of foreign doctors

As discussed in chapter 3, professional links between overseas doctors and Australian specialists and/or hospitals are important for obtaining referrals of foreign patients. Several participants stated that foreigners who graduate from Australian medical schools, and return to their country of origin, form part of the network for future referrals of patients to Australia. The importance of training to the establishment of referral networks has also been documented in other countries (see, for example, Berliner and O'Toole 1988).

Dr Coster from the Department of Ophthalmology at the Flinders Medical Centre and others contended that the relationship between the medical systems of Australia and its immediate Asian

neighbours (one of the largest potential sources of overseas patients) is very weak. This was attributed, in part, to the limited number of places made available in Australian medical schools and hospitals for foreign undergraduate and postgraduate medical students.

The NSW Medical Board questioned whether the development of referral networks provided a sufficient rationale to expand the intake of foreign students into Australian medical schools. The Board said that:

> The [draft] report indicates that only about 1500 patients per year come to Australia specifically for medical treatment (via medical visas). It is impossible to conclude what contribution foreigners who graduate in Australia and return to their country of origin make to this. Strong evidence would be needed that this was a significant factor if this were to be the only justification for increasing the entry of overseas students to Australian medical schools (submission no. 45, p. 2).

However, almost all participants who were directly involved in the treatment of foreign patients said that the existence of a referral network was one of the most important factors in bringing those patients to Australia. The Health Economics and Technology Assessment Corporation who undertook the demand study for Austrade (see section 3.5) said that:

> The availability of a referral network of doctors linked to supplying hospitals is, in our view, the most significant determinant of demand for hospital services by foreign patients. The evidence [from the eleven countries surveyed] is unequivocal: nations with which Australia has developed strong linkages continue to send patients to Australia (e.g. PNG, Fiji, New Caledonia and some other Pacific islands) but from those nations in which the experts contacted in this consultancy indicated that Australia had not developed or sustained such linkages, few patients are sent (e.g. Malaysia, Indonesia) (Health Economics and Technology Assessment Corporation 1991, p. 42).

Undergraduate medical training

Quotas have been imposed on admissions to Australia's medical schools since the early 1950s. Currently, quotas only apply to Australian and subsidised overseas students. However, the medical schools must ensure that the enrolment of fee-paying foreigners does not conflict with the requirements of Australian students.

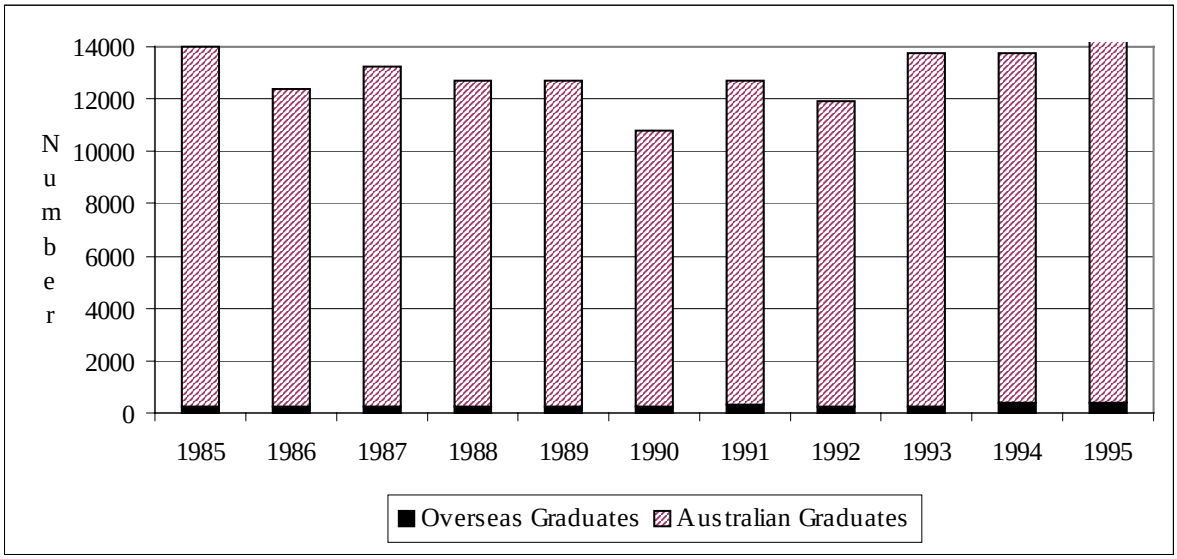
Only a small number of overseas students received undergraduate medical training in Australia during the 1980s. For example, between 1985 and 1990, an average of only about 35 foreign students graduated from the 10 Australian medical schools each year (see figure 4.1).

However, the number of foreign medical students is likely to increase significantly in the future. This follows a 1986 decision by the Commonwealth giving universities almost complete control over the use of funds generated from fees charged to overseas students.

The policy requires universities to charge foreign students fees at least equal to the average cost of providing a place in the course. For undergraduate courses in medicine, the minimum annual fees for overseas students were set by the Commonwealth at $13 700 for 1991.

Although the minimum fees set by the Commonwealth are supposed to reflect full average costs, it appears that they are set in part to reflect the prices charged in other countries. The minimum annual fee for overseas students studying medicine was reduced from $16 000 in 1989 to $13 500 in 1990 to reflect these competitive pressures. The NSW Medical Board stated that the minimum fee of $13 700 set for 1991 falls far short of the full cost of the education provided.

Figure 4.1: **Students graduating from Australian medical schools, actual 1985 to 1990, projected a 1991 to 1995**



a) Projections provided by medical schools on the basis of no change in current policies.
Source: Information provided by university medical schools.

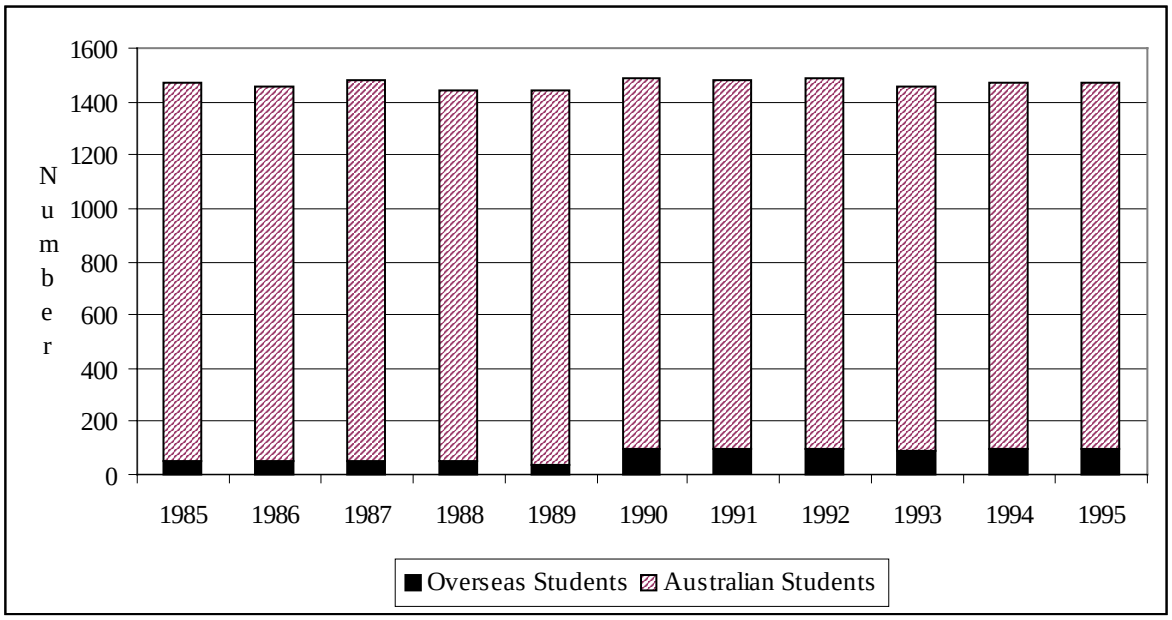
Universities are permitted to set higher fees where there is excess demand. In fact, medical schools have set fees for overseas students of almost twice the minimum set by the Commonwealth. For example, the University of Sydney Medical School is charging foreign undergraduates $21 000 per year in 1991. Even with fees set at this level, applications by overseas students for admission exceeded the available supply.

Reflecting the increased incentive for universities to enrol foreign medical students, medical schools are now increasing the number of foreigners they accept and this trend is expected to continue (see figure 4.2). Full fee-paying medical students are now an important source of revenue

in a number of institutions. The Acting Dean of the Faculty of Medicine, University of Sydney stated that:

> Until the late 1980s the University of Sydney offered places to relatively few overseas students - in Medicine only six places were available. With the change in Commonwealth Government policy and the consequent elimination of the subsidy received on account of the enrolment of overseas students, tertiary institutions have had to accept full-fee paying overseas students simply to maintain their income. Institutions have frequently increased their overseas intake to compensate themselves for other reductions in Commonwealth funding (letter to Commission).

Figure 4.2: **Students commencing MBBS courses in Australian medical schools, actual 1985 to 1990, projected a 1991 to 1995**



a) Projections provided by medical schools on the basis of no change in current policies.
Source: Information provided by university medical schools.

While the incentive to train foreigners in Australian medical schools has increased, further expansion in the number of places offered to foreign students would be profitable for the universities. This is indicated by the gap between the fees that medical schools charge foreign students and the marginal cost of providing training. The NSW Medical Board stated that although the fees of about $21ÿ000 charged by most medical schools barely cover the full cost, they exceed the marginal cost of taking on additional students.

In the longer run, further expansion would also increase the size of Australia's international referral network, potentially leading to an increase in the number of foreign patients referred to Australia for treatment. However, there are several constraints to further expansion. The universities of

Sydney, NSW and Melbourne stated that these include the limited availability of space, resources, facilities and opportunities for clinical placements in teaching hospitals.

There are also pressures from several quarters to constrain the number of places available for both domestic and foreign students in Australian medical schools. The medical profession, for example, seeks to limit the number of future entrants to the medical profession to protect the incomes of existing practitioners. And, the Government has recently announced initiatives to limit the number of doctors in an effort to reduce overservicing of patients. A related concern voiced by the NSW Medical Board is that foreign medical students will stay in Australia after their education is completed and thereby contribute to the perceived oversupply of doctors. Arguments for restricting the supply of doctors are discussed in chapter 6.

The NSW Medical Board disputed that there have been pressures to constrain the number of places available to fee-paying overseas students. It stated the medical schools were nevertheless concerned that some overseas students were able to obtain residency status before completing their education. Once such students became Australian residents the medical schools would not be able to charge them full fees. The medical schools argued that as DEET funding was determined by pre-agreed 'student profiles', they could only compensate for this by reducing the intake of other Australian students. They further stated:

> Foreign students who obtain residency during their course defeat the purpose of increasing 'export education income' and reduce the positive effects on 'health service exports' (submission no. 45, p. 2).

Some universities have elected not to admit full fee-paying foreign medical students because of the excess demand from local students. At the Commission's recent inquiry into exports of education, the Western Australian Department of State Development stated:

> Full fee paying overseas students are not permitted access to the medical faculty due to the fact that the [University of Western Australia] has not been permitted to increase its quota of medical student intake since 1981 (Western Australian Department of State Development 1991, p. 12).

Postgraduate medical training

In addition to undergraduate medical training, postgraduate medical training was also identified by participants as important for the development of international referral networks. Indeed, it could be argued that postgraduate training is the more important of the two because those who return home with postgraduate training are more likely to fill the specialist positions from which future referrals to Australia will come.

Overseas doctors wishing to undertake postgraduate training in NSW generally have to apply to a hospital or the proposed supervising specialist for training arrangements. The hospital forwards the

application to the NSW Medical Board with information on a number of particulars, including:

- the proposed position;
- the nature of the training program;
- the identity and availability of supervisors;
- the supervisory responsibilities that may be given to the postgraduate trainee;
- the relevance of the position to the trainee's career; and
- the trainee's curriculum vitae.

The NSW Medical Board stated:

> If the Medical Board is satisfied that the position is one of bona fide postgraduate training and the applicant is a suitable person to take the position, then approval for limited registration under section 16(c)(ii) of the Medical Practitioner's Act is given (letter to Commission).

In the year ending 31 March 1991 the NSW Medical Board approved 183 `suitably qualified overseas doctors' for training in NSW.

Dr Catchlove, formerly Chief Executive of Melbourne's Royal Children's Hospital, estimates that Australia provides postgraduate training for about 450 foreign doctors annually. Of these, about 80 obtain their training at Melbourne's Royal Children's Hospital. Dr Catchlove said:

> The ideal arrangement for the development of an export market in health is firstly to train foreign graduates. Secondly, to provide services within those countries and to support those graduates who have been trained and then if you have a product to market you can anticipate a steady growth in foreign patients (Catchlove 1991, p. 3).

However, it is generally acknowledged that there is a shortage of clinical facilities in some medical specialities in Australia, which limits the back-up resources necessary for the postgraduate training of overseas doctors. For example, the Task Group Report on Health and Medical Services Exports said that:

> Specialist training generally takes five years and the positions needed in some specialities are not available because there are insufficient clinical teaching resources (submission no. 10, Task Group Report on Health and Medical Services Exports, p. 19).

The Overseas Trained Doctors Association (OTDA) stated that specialist training facilities are limited and under-represented compared with those of other developed countries. It went on to argue that, in several specialities, qualified training cannot be provided and, when it is available, its standard is not up to that available in certain overseas countries. The Association said that this was because there is a lag period between new developments overseas and their application in hospitals in Australia (submission no. 36, p.ÿ1). The NSW Medical Board rejected these views.

The University of Melbourne stated that a constraint to its postgraduate overseas student intake is the substantial fee that needs to be charged (ranging from $16 000 to $24 000 per year per postgraduate overseas student) to cover costs.

As discussed in appendix D, some general practitioners have argued that the limits on training opportunities for specialists also reflect a deliberate attempt by existing specialists to restrict entry to their professions.

The Commission's assessment

The small number of places that are made available to foreign students in Australian medical schools limits the extent to which an international referral network can be developed and thereby limits Australia in terms of its ability to attract referrals of foreign patients. This constraint reflects limits on the ability of universities and the health care system to provide training to both foreign and domestic students. As such it is part of a wider set of regulations governing entry to the medical profession and the provision of medical services. These regulations, and their effects on efficiency, are discussed in chapter 6.

4.6 Restrictions on the accreditation of foreign trained doctors

Regulations in all States govern the accreditation of foreign trained doctors. Foreign trained doctors who are not granted automatic accreditation may sit exams which test their english language ability and their medical knowledge. Doctors who pass these exams may then be required to undertake a period of supervised practice before full recognition is granted.

These regulations, which are discussed in detail in appendix D, have become much more stringent over the last twenty years. There are about 1500 overseas trained doctors, who are either citizens or permanent residents, who are not able to practise medicine in Australia.

The OTDA claimed that the Australian medical profession is using accreditation procedures to restrict competition to the detriment of the overall efficiency of the health care system. This claim gains support in a recent report by the Human Rights and Equal Opportunity Commission. The report concluded:

> Many overseas trained doctors have been the unwilling and undeserving victims of Australia's rigid medical registration system. No doubt the system operates to ensure the maintenance of high medical standards in Australia but it also deprives permanent Australian residents of proper recognition of their hard-earned qualifications and experience and it deprives the rest of the Australian community of their skills and expertise. There can be no doubt that it is in effect a restrictive trade practice that preserves medical practice as a virtual "closed shop" for local

graduates. There is compelling evidence that it is also discriminatory within the terms of s. 9 of the *Federal Racial Discrimination Act 1975* and therefore unlawful (Human Rights and Equal Opportunity Commission 1991, p. 20).

The AMC stated that the draft report was not up-to-date in terms of the assessment and registration of overseas trained specialists. It stated:

> Following the release of the AMC Interim Report, the AMC, Medical Boards and Specialist Medical Colleges commenced work on the development of new assessment procedures for overseas trained specialists which would address many of the perceived difficulties with the current provisions. On the question of registration, the recent developments in mutual recognition, when implemented, will provide a more effective registration mechanism to register specialists who do not hold recognised primary medical qualifications than is available under the current legislation (submission no. 41, p. 2).

In early November 1991 the Commission sought from the NSW Medical Board an up-date of the latest procedures for the assessment and registration of overseas trained specialists. The NSW Medical Board said that it now deals:

> with overseas trained specialists on a case-by-case basis, submitting their details to the relevant colleges individually. Each of the Colleges has handled the matter slightly differently, but the general procedure is that an overseas trained doctor, who is a permanent resident of Australia, approaches the Medical Board, which screens out those applicants who have no specialist background. The applicant's curriculum vitae and other information required by the different colleges is then forwarded to the relevant college which submits it to the appropriate assessing committee. In due course the Board receives a report from the college indicating whether the applicant's training and experience is the equivalent of an Australian trained specialist, whether further training and/or examination is required, or whether the applicant's level of experience is significantly below what would be required of an Australian specialist.
>
> The Medical Board will register applicants in the first category to practise as specialists only, while it may register applicants in the second category with conditions upon their registration which enable them to undertake the required training or examinations. Applicants in the third category are advised that the AMC examinations provide the appropriate avenue to registration (letter to Commission).

The NSW Medical Board stated that it has not been necessary to amend *the NSW Medical Practitioners Act* to implement this policy change.

In its draft report, the Commission said that the accreditation procedures for foreign doctors potentially impeded the export of health services in three ways.

First, to the extent that the procedures limit competition among providers of medical services in Australia (see chapter 6), they are likely to increase the cost of those services. This will reduce the attractiveness of Australia as a destination for overseas patients.

The NSW Medical Board questioned this assessment saying that:

> there is no reason for believing that limiting the number of providers of medical services is likely to increase the cost of these services -- indeed the evidence in the context of the current debate on overservicing is entirely to the contrary! (submission no. 45, p. 3).

However, in every market with which the Commission has had experience, restriction of supply results in an increase in price. Appropriate policies to address overservicing, which do not involve restricting the supply of providers of medical services are discussed in section 6.3.

Second, for some foreign patients, access to practitioners who speak their language and are familiar with their culture, may be an enticement for them to receive treatment in Australia. The report by the Health Economics and Technology Assessment Corporation to Austrade provides some evidence. They say that:

> The importance of race and culture on the decision to use a particular foreign provider is great. There is significant use made of Taiwanese [doctors] working in the US currently. The need for Australia to expand the exchange programmes [for specialist training] becomes pressing if government wants to cultivate these markets (Health Economics and Technology Assessment Corporation 1991, Annex 6, p. 2).

Thus, if the accreditation procedures make it difficult for doctors from non-english speaking backgrounds to achieve registration, they may inhibit exports.

Finally, more liberal accreditation procedures could facilitate the entry of specialists to areas where the Australian system is under-resourced and thereby encourage more exports.

As the accreditation procedures are part of the wider set of regulations governing the medical profession, the issue of whether those procedures are overly stringent is considered in chapter 6.

But whatever the accreditation procedures applying to permanent practice in Australia, temporary entry of foreign doctors to treat foreign patients in Australian institutions should be facilitated. In this regard, the temporary accreditation procedures applying in each State and Territory (see appendix D) should be examined to see if they constitute an impediment to such entry.

4.7 Restrictions on advertising

Registered medical practitioners are constrained from advertising their services by the codes of medical ethics and professional conduct. Constraints on advertising are written into the regulations and laws under which medical practitioners are registered and practise in all States and Territories.

Generally, advertising by doctors in Australia is not permitted except under strict guidelines. This is similar to the position in the UK but contrasts with that in the USA where the rules of the American Medical Association state that there are no restrictions on advertising by physicians except those that can be justified to protect the public from deceptive practices.

Independent commercial organisations, medical brokers, public and private hospitals and practitioners of alternative medicine are not restricted in advertising their services.

The Report of the Commonwealth Government's Task Group on Health and Medical Services Exports (1990) stated that:

> State medical registration laws prohibit individual doctors from advertising their services within Australia, and that this prohibition extends to overseas publicity. In certain foreign markets the prohibition of such advertising is a major restraint [on exports of health services] (submission no. 10, Task Group Report on Health and Medical Service Exports, p. 22).

There is, however, some uncertainty as to whether the powers which underpin laws restricting advertising domestically, extend to advertisements by Australian doctors in overseas media.

Most State regulations do not define the boundaries within which compliance with advertising regulations is required. The Commission asked several States to clarify whether their regulations have extra-territorial application. The Registrar of the South Australian Medical Board stated that the rules controlling advertising are restricted to conduct which takes place within the Commonwealth. The Registrar of the Medical Board of Western Australia stated that the Board is only responsible for advertising in the State of Western Australia. However, the NSW Medical Board stated that a medical practitioner registered in that State must comply with the NSW advertising regulations when advertising medical services overseas. The situation is further confused by the separate registration requirements which, among other things, require that doctors be in good standing with the medical profession.

The Commission's assessment

On the basis of information put before it, the Commission is unable to judge whether current advertising restrictions constitute a significant impediment to the export of health services.

In principle, the Commission considers that Australia's laws should not have extra-territorial application and that therefore the advertising of doctors' services overseas should be governed by the regulations applying in the countries concerned.

However, the Commission acknowledges that such separation may be difficult to achieve given the requirements in Australia for doctors to be in good standing with the medical profession.

More generally, like the accreditation procedures, restrictions on advertising form part of a wider set of regulations governing the medical profession. In the Commission's view, the case for easing or abolishing restrictions on the advertising of doctors' services overseas, is best considered as part of a more general review of these regulations (see chapter 6).

4.8 Ambivalence to exports of health services

The community appears to be more ambivalent about exports of health services than it is about international trade in most other services. For some, this ambivalence appears to arise because exporting health services has not been discussed in detail in the wider community. For others, this ambivalence may be attributable to people's concerns about the ethics involved in trade that involves, say, organ or tissue transplants.

Ambivalence towards exports also arises from the concern that the treatment of foreign patients could compromise the current arrangements for providing health care to Australians. For example, the Consumers' Health Forum said:

> Our current health system is complex. So are many of the medical procedures currently performed in our hospitals. Many inter-relationships and inter-dependencies exist between them. These must be fully understood to ensure no adverse effects result such as longer waiting lists for public patients; staff shortages; donor organ shortages; or increased pressure for Government subsidy to provide more public hospital places, higher wages, more technology, or to change health insurance arrangements for Australian citizens (submission no. 19, p. 4).

The Forum also said that:

> the crucial question that needs to be looked at by the inquiry is whether Australia can export its health and medical services without adversely affecting its own citizens in any way (submission no. 19, p. 3).

The Task Group on Exports of Health and Medical Services said that:

> A view held by the Task Group which has been confirmed through its discussions with key individuals and organisations is that in order for there to be an expansion of exports of health and medical services it will be necessary to overcome the negative perception about the treatment of foreign patients that is apparent within some sections of the Australian community, exacerbated on occasions by unbalanced media coverage (submission no. 46, p. A2).

The Task Group also said that a general statement of the Government's objectives in relation to health care and a statement of broad support for exports of health would be important steps towards not only developing a positive community perspective on exports but also in creating a stable policy framework upon which exports can be based.

Ambivalence to exports in health departments

In its report on international trade in services, the IAC drew attention to the difference between DEET and the Department of Health in their respective approaches to exports. The IAC said that:

> In education, policy adjustments have been made to encourage exports. The conflict which can arise between the objectives of subsidising domestic users of an exportable service while simultaneously promoting exports has been minimised, for the time being at least, by attempting, through regulation, to keep the domestic and export markets separate.

> In contrast to education, exports of health services (through bringing foreign patients to Australia for treatment) appear to be discouraged by governments. Thus, the inherent conflict between domestic and export markets has been resolved by giving absolute priority to Australians (IAC 1989, pp. 71-72).

The Commission stated in its draft report on this reference that this ambivalence towards exports continues to find expression in the submission made to the inquiry by the Department of Health. The Department viewed exports as a way of utilising short run excess capacity in the health services industry and was reluctant to countenance changes to government involvement in health that could permit a wider role for exports if there were ramifications for domestic patients.

However, the Department rejected the Commission's assessment that it is ambivalent towards health services exports, stating that:

> The Department recognises that there may be potential for export of health services. It would endorse as a matter of principle any strategy which will improve this country's balance of trade where it can be shown that spare capacity exists within the healthcare system which can be utilised without disadvantaging Australian patients (submission no. 47, p. 3).

It elaborated on its concerns that:

> there is potential for a significant increase in overall health spending not commensurate with improvements in health outcomes. Any changes to the structure of health financing to accommodate export objectives would need to be weighed against the potential effects on the overall cost effectiveness of the health system. The Department notes that Medicare, with its existing financial framework, has been very successful compared to overseas systems. The Department does not believe this should be jeopardised, and as such, export potential needs to be considered within the context of the Medicare framework (submission no. 47, p. 3).

One aspect of the Department's concern is:

> that capacity, particularly in the major teaching hospitals, for treating foreign patients is limited to certain areas. Expansion of this capacity may not be cost efficient and could be subsumed by domestic demand (submission no. 47, p. 3).

Similar views were expressed by a number of State Health Departments. However, the study commissioned by the Department of Health of the Australian health service industry's ability to supply services to foreign patients concluded that there is no general shortage of physical or professional resources to meet the needs of overseas patients, and that bottlenecks in the public hospital system are largely institutional or caused by financial constraints which the treatment of foreign patients might help to address (McKay and Associates 1991).

It is important that departmental attitudes be clarified in the light of supply capabilities. Any abiguities are certain to impede wealth creating exports since it takes a long time to establish international referral networks. Also, foreign doctors are unlikely to invest the time and knowledge necessary to make informed referrals if those referrals will only be accepted into Australia when there is excess capacity.

While the health care of Australians is central to the charter of health departments, there is scope for adopting more flexible forms of government involvement in health that would facilitate wealth creating trade in health services. The Commission identifies some possible changes in chapter 6.

Organ transplants and blood transfusion for foreigners

Although organ transplants form only a small part of health services they raise a disproportionate number of ethical considerations. The National Health and Medical Research Council has prepared an Australian code of practice for transplantation of cadaveric organs and tissues which addresses many of these questions and serves as a guide for health professionals.

However, where organs are transplanted into foreign patients a number of special considerations arise. Australian recipients could be displaced by foreign recipients, although current practice provides two safeguards against this. First, most hospitals follow procedures to ensure that Australians get precedence over an overseas patient with respect to the use of any available organs. Second, current immigration procedures (and those recommended by the Commission) require that substantiated arrangements have been made to ensure that Australians would not be disadvantaged by foreign recipients of organs transplanted in Australia.

The illegal trade in organs that is alleged to occur in some other countries was mentioned informally by some participants as having the potential to generate ambivalence and even hostility towards exports of health services. However, the Commission has received no evidence on the extent to which these activities occur either in Australia or internationally. In any event, the Commission considers that the immigration procedures it has recommended for foreign patients seeking organ transplants, together with the procedures adopted by hospitals with transplant facilities, will prove adequate to deal with any problems in this regard in the future.

Issues are also raised by the current prohibition on charging for organs and human tissue. Similarly, no charge is currently made for blood products. The question arises as to whether foreign patients should be charged for these items. The Red Cross has already advised the Commission that it sees problems in charging for blood products. However, McKay and Associates (1991) said that blood products do not represent a constraint on Australia's ability to export health services.

5 THE EFFICIENT PROVISION OF HEALTH SERVICES TO FOREIGNERS

Because of some special features of providing health care in Australia, the sale of health care services to foreigners can result in an inefficient use of Australia's resources. Two such features -- the arrangements for charging foreign patients and the insurance provisions for foreign students -- are the subject of this chapter. The subsequent chapter looks at general features of the Australian health care system which may impede the efficient delivery of services to foreigners and Australians alike.

5.1 Fees paid by foreign patients

When treated in private hospitals, foreign patients must meet the full cost of their treatment. By contrast, the costs incurred by foreign patients treated in public hospitals are often subsidised by the Australian taxpayer. This is inefficient because it means that the revenue received from treating foreign patients is less than the cost to Australia of providing that treatment.

Foreign patients treated in public hospitals as private patients are ineligible for the subsidies provided under Medicare and are charged the so called 'ineligible rate'. The ineligible rate varies from $293 per day for non-teaching hospitals in Western Australia to $534 per day in South Australian teaching hospitals. In NSW, Queensland, the Northern Territory and the Australian Capital Territory, the ineligible rate applies across all public hospitals irrespective of facilities offered and nature of service provided. In Victoria, South Australia and Western Australia the ineligible rate is substantially higher for patients treated in teaching hospitals than in other hospitals (see table 5.1).

Table 5.1: **Fees charged per day for ineligible patients in public hospitals**

State	*State-wide*	*Teaching or larger than 250 beds*	*Non-teaching or smaller than 250 beds*
		$ per day	
New South Wales	512	-	-
Victoria	-	440	323
Queensland	388	-	-
South Australia[a]	-	534	354
Western Australia	-	414	293
Tasmania	475	-	-
Northern Territory	425	-	-
Australian Capital Territory	512	-	-

a) The South Australian fee includes both a professional and an accommodation charge.
Source: Information supplied from State Health Departments.

In some States, fees charged to ineligible patients include any pharmaceuticals and diagnostic services required. In States other than Victoria, these fees also include any use of intensive care facilities and theatre fees. Victoria charges fees that range from $622 per day for the first four days of intensive care in country hospitals up to $1518 per day for intensive care in metropolitan hospitals. Victoria also has a schedule of theatre fees which range from $45 to $3025.

The schedule of fees in place in Victoria suggests that, when foreign patients require major surgery and/or intensive care, the all-inclusive charges in place in the other States will be insufficient to cover the costs of treatment. Given that foreign patients entering under medical visas generally come for major surgery, subsidies under the current pricing arrangements may be significant. The substantial differences between the States in the ineligible rate adds weight to the view that foreign patients treated in public hospitals are often not meeting the full costs of their treatment.

Worldcare, a Brisbane based medical assistance company, said that the bed day charge in Queensland represents a discount of 50 per cent on the actual total cost of treatment. Worldcare also said that under current arrangements, foreign patients effectively receive free treatment as outpatients in Queensland because there is no gazetted charge for such patients.

In the private hospital sector, treatment charges for foreign patients are negotiated in advance on a case by case basis. Such an approach would also have applicability in the public hospital sector to ensure that the treatment of foreign patients is not a drain on Australia's health care resources.

A better linking of charges to the cost of treatment might also contribute to a more efficient allocation of foreign patients between hospitals. For example, in NSW where a single state-wide fee is charged irrespective of the nature of service or facilities offered, such a change might encourage CAFAT to divert some patients from the Royal Prince Alfred and Royal Alexandra Hospital for Children, to less expensive institutions. This could help to reduce the demands placed on these two major hospitals.

The Commission recommends that State Governments set fees for foreign patients treated in public hospitals that at least match the cost of the services provided.

5.2 Bad debts incurred by foreign patients

The Commission received no evidence from private hospitals to suggest that foreign patients are a more significant source of bad debts than domestic patients. However, it received evidence from public hospitals to the effect that foreign patients account for a disproportionate number of bad debts. In a letter to the Commission, the Royal Prince Alfred Hospital said that foreign patients accounted for two-thirds of the bad debts at that hospital. However, the hospital emphasised that

the problems it experienced were with tourists and business people treated at the hospital and not with patients referred from New Caledonia under the CAFAT insurance arrangements.

In a letter written to the Minister for Immigration and forwarded to the Commission, the Royal Melbourne Hospital said that it:

> has constant problems with overseas visitors who do not have Medical Insurance during their travels. Due to the fact that the majority of our overseas patients are retired or are not working in their countries they claim that they can't pay the account therefore we have no other choice but to write off the debt. Of recent times my department had to write-off $36 047.00 for an Indonesian visitor who unfortunately fell ill whilst in Australia. Although I sincerely feel for our visitors to have the misfortune of illness while in a foreign country I don't believe that our tax payers should have to 'foot the bill' (letter to the Minister for Immigration, Local Government and Ethnic Affairs).

The prospect of a bad debt on a foreign patient poses a dilemma for public hospitals because it is ethically difficult for them to refuse treatment to people in need. Private hospitals, on the other hand, have greater scope for negotiating payment arrangements in advance of treatment and therefore may experience less severe problems with bad debts. Consequently, there is justification for introducing special arrangements to assist public hospitals to reduce the extent of the bad debts problem from tourists and business people who require hospital and medical treatment while in Australia.

Procedures to assist public hospitals in reducing bad debts could include asking all foreign patients to provide some guarantee of payment before major treatment is provided. Such a guarantee might include evidence of suitable travellers' insurance, a signed credit card docket, travellers cheques, overseas money orders and the like. Where the foreign patient has relatives in Australia, it may be appropriate for the hospital to obtain guarantees of payment from those relatives before major treatment is provided.

The Commission recommends that public hospitals obtain assurance of payment from all foreign patients before major treatment is provided. Where no assurance of payment is forthcoming, patients be informed that they will receive only that medical care necessary to stabilise their condition.

At the draft report hearing the Department of Health said that it shares the Commission's concerns that the Australian taxpayer should not be required to subsidise foreign patients in Australian public hospitals. The Department said that it has met with representatives of DILGEA and is considering a range of options which may include the development of guidelines for admission of foreign patients to public hospitals and the extension of insurance arrangements for temporary visitors. The Department said that the problem may be resolved to a large extent by the introduction at the service delivery level of effective management strategies to ensure payment and deter avoidance. In this regard DILGEA said that the Minister had recently issued a direction to migration officers that is intended to tighten procedures so that visitors are aware of their obligation to pay any hospital and medical expenses incurred in Australia.

5.3 Provision of health services and health insurance to foreign students

As discussed in chapter 3, foreign students are the other important source of 'export' demand for Australia's health and medical services.

Before they can obtain a visa allowing entry into Australia, foreigners who intend to study here must establish that they have suitable health insurance arrangements. Government-subsidised foreign students are automatically covered by Medicare, while full fee-paying foreign students are required to take out Overseas Student Health Cover (OSHC) with Medibank Private. Details of these arrangements are given in chapter 3.

The Health Insurance Commission (HIC) began to identify separately foreign students who were given Medicare cards after 25 March 1991. Students given Medicare cards before 25 March 1991 who are currently in Australia cannot be identified by the HIC and therefore are not included in the figures presented below. According to the HIC, 5414 foreign students were identified as enrolled in Medicare on 7 November 1991. For the eight months between 25 March and 7 November these students used an average 2.75 medical services and were paid an average benefit for medical services of $69 per student for the eight month period.

The arrangements for government-subsidised foreign students who are covered by Medicare, mean that the costs of treatment are met by Australian taxpayers. While this may be justified in terms of the Government's foreign aid objectives, the sale of these health services provides no direct benefits to the Australian community.

While there may be administrative advantages in granting Medibank Private a monopoly over the provision of insurance through the OSHC scheme, the arrangement reduces the insurance choices available to foreign students. According to the Overseas Students Office of Western Australia:

> Some students have expressed dissatisfaction with Medibank and requested permission to take out medical insurance with other organisations, even if resulting in higher costs to themselves. Yet this is not allowed (Overseas Students Office of Western Australia 1991, p. 6).

Moreover, the monopoly granted Medibank Private precludes other insurers who might be prepared to provide the same cover. In its final report on Exports of education services, the Commission recommended that consideration be given to an administratively feasible scheme which would allow students who do not wish to obtain OSHC through Medibank Private to be permitted to use health cover under an alternative insurer acceptable to government.

In practice, however, it is questionable whether other insurers could compete with Medibank Private as there is some indication that the arrangements operate at a loss. Indeed, there is an explicit guarantee that the Commonwealth Government will underwrite any losses incurred in

providing OSHC. The Commission sought information from Medibank Private on the revenue from premiums and the benefits paid out. In a letter to the Commission, Medibank Private said that the contribution rate set under the OSHC is reviewed each year to 'ensure the viability of the table.' It went on to say that information relating to the types of services that overseas students are using, is 'not considered to be of relevance and consequently is not available.'

One way of obtaining an indication of the extent to which the OSHC arrangements cover the costs of insuring foreign students is to look at the Medicare benefits per person paid to eligible foreign students. The OSHC premium pro-rated for eight months cover would be $100. But for medical services alone foreign students eligible for Medicare receive benefits of $69 per eight month period.

Expenditure figures are not available on this basis for hospital treatment. However, Australians in the 15-34 age group have 195 hospital admissions per 1000 persons (AIH 1990a, p. 16) and an average length of stay in hospital of approximately 5 days (Harvey and Mathers 1989, p. 95). Thus, on average, there are approximately 975 hospital days per 1000 persons in this age group.

When treated in public hospitals, foreign students are charged at the ineligible rate which ranges from $293 per day in non-teaching hospitals in Western Australia up to $534 per day in some South Australian hospitals (see table 5.1). On this basis, the expected per student cost of hospital treatment would be in the range of $191 to $347 for an eight month period.

Overall, if foreign students have the same risk of needing hospital and medical care as Australians in the same age group, and if they received all of their hospital treatment in public hospitals, then the preceding calculations suggest that premiums which covered expected costs would need to be in the range $396 to $631 per year, depending on the sex and age group of the student and the State in which he/she resides.

There are, of course, a number of reasons why foreign students may use fewer health services than their Australian counterparts. For example, the demand for obstetrics services and related hospital admissions might reasonably be expected to be lower among students than in the general population. But even if foreign students used the hospital system with one-sixth of the intensity of their Australian counterparts, there would still be a small element of subsidy (evaluated at the ineligible rate of charges made by public hospitals) in the current OSHC arrangements where overseas students pay a premium of $150 per person per year. Because the ineligible rate of charges itself is considered to be well below the average cost of providing hospital services, the subsidies provided could be greater than these figures suggest.

The requirement that students obtain health insurance cover before a hospital or medical visa is granted is, in the Commission's view, justified to prevent foreign students who require treatment becoming a charge to Australian taxpayers.

However, the current arrangements are inefficient in that there is no assurance that they do not involve some subsidy to foreign students. Moreover, the OSHC arrangements give Medibank Private a monopoly in the provision of this insurance. This raises the possibility that losses made under the OSHC could be recouped from charges levied by Medibank Private for other types of private health insurance, rather than requiring a direct grant from the Government. In other words, Medibank Private's monopoly serves to further cloud the profitability (or lack of it) of the OHSC scheme.

Future health insurance arrangements for foreign students should have the goals of simplicity and flexibility while ensuring that hospital and medical treatment provided to foreign students in Australia is not a charge on the health budget.

In order to achieve these goals the Commission recommends that:

- **foreign students continue to be required to take out health insurance cover before a visa is granted;**

- **foreign students be permitted to purchase that insurance cover from approved domestic or foreign insurers, subject to the following conditions:**

    - **at a minimum, the insurance provide cover against major medical expenses and hospital care in public hospitals at fees which represent the full cost of the services provided;**

    - **where cover is obtained from a foreign insurer, the insurer provide the student with a letter stating that the cover at least meets the minimum outlined above;**

    - **the list of approved insurers include all those which establish that they have suitable facilities for paying benefits to students and/or the providers of medical and hospital services; and**

    - **the administering department have the power to remove from the list of approved insurers those organisations which are a source of bad debts.**

The Department of Health commented on these matters in a submission to the exports of education inquiry. It said that sample overseas health insurance policies it had examined were unsuitable for Australia. The Department also raised concerns about the administrative complexities of changing the current system to permit a variety of providers (Department of Health 1991b).

While acknowledging these concerns, the Commission believes that its recommendations are administratively feasible and would introduce a desirable element of contestability and transparency to insurance provision in this area.

The Commission accepts that the Government may wish to continue to meet the health insurance costs of government-subsidised students for overseas aid or other reasons. However, in the Commission's view, the way in which this is done could be made more transparent.

The Commission recommends that, if the Commonwealth Government continues to meet the health insurance costs of subsidised foreign students, the Department(s) responsible for funding the students make a payment to the Health Insurance Commission equivalent to the expected cost of providing Medicare benefits to those students and this payment be published.

6 EFFICIENT DELIVERY OF HEALTH CARE AND HEALTH INSURANCE

6.1 Introduction

Features of the wider health care system can impede the efficient export of health services. For example, policies that encourage overuse of hospital services can contribute to increased waiting lists in public hospitals and thereby restrict the access of foreign patients to public hospitals. Incentives for overuse of medical services may reduce the extent to which Australian doctors look to exports as a source of revenue. Inefficient use of inputs in hospitals increases the costs of providing health services to domestic and foreign patients alike. Restrictions on entry into the health professions limit competition among health professionals for domestic and foreign patients. This chapter looks at aspects of the wider health care system which impede efficient exports of health services.

However, given the minor role of exports in Australia's health care system, and the wider social objectives underlying that system, it would be foolish to predicate change solely on a concern to remove impediments to efficient exports. Rather, the potential benefits that greater efficiency could bring in lowering the cost of treating domestic and foreign patients alike should be the driving force for change.

Some of the inefficiencies in Australia's health care system stem from the policies governments adopt to ensure that all individuals in the community have access to affordable health care. Significantly, however, changes which would encourage greater efficiency in the provision of care to Australians and remove impediments to efficient exports, need not compromise that objective. Indeed, the elimination of waste in the provision of services might reduce the cost of providing access to affordable care.

6.2 What does efficiency in the health care system involve?

Efficiency in a health care system involves more than simply ensuring that services are provided at least cost. There are also questions about the appropriate levels of services and how expenditure on hospital and medical services should be balanced against other means of promoting good health.[1]

[1] For a discussion of the application of the concept of economic efficiency to health care see Enthoven (1988) chapter1.

Further, hospital and medical care has dimensions other than the number of patients treated, days spent in hospital and the number of procedures performed. The locational convenience of facilities, waiting times, quality of facilities, attitude of the personnel providing the services and the extent to which the treatment achieves the intended result are also important. Improvements in each of these can be achieved at extra cost. Efficient health care systems are those in which a balance is achieved between the cost of provision and the value to patients in all of these dimensions. Thus, for example, reducing expenditure on health care by denying patients services that they value at more than the cost of provision, would reduce rather than enhance efficiency.

Indicators of efficiency

Several participants used international comparisons of health care expenditure as a proportion of GDP to draw conclusions about the efficiency of particular health care systems. However, as discussed in appendix F, such comparisons should be treated with caution. For example, demand for many health care services is highly responsive to income. Thus, when countries are compared in terms of the proportion of GDP spent on health care, a strong pattern emerges -- countries that are richer typically spend a higher proportion of GDP on health care, than do poorer countries.

Waiting lists and waiting times provide some indication that there may be inefficiencies in a health care system. However, some waiting for services may be characteristic of an efficient health care system. A delay of several days may be necessary to schedule and organise surgical procedures. Furthermore, it may be efficient to keep expensive hospital facilities fully utilised with the possibility of periodic queues for services, rather than to invest in extra facilities which are frequently underused.

Finally, governments often choose to make health care affordable by providing services free or at highly subsidised prices. If governments did not place limits on access to these services, they would be used until the benefit to patients was trivial. Thus governments often restrict access through non-price means, for example, through waiting lists. Again this suggests that care must be exercised when using the length of time spent on waiting lists as an indicator of efficiency. For example, where access to health care is subsidised, too short a time spent on waiting lists may mean that public patients are receiving services which they value at less than the cost of provision.
These difficulties in judging the efficiency of a health care system by outcomes such as length of waiting times for certain surgical procedures suggests that the issue of efficiency is better approached by looking at the incentives facing service providers and patients. The remainder of this chapter looks at a number of incentives in Australia's health care system which detract from efficient service provision.

6.3 Incentives for overuse of health services

The contention that Australians overuse health services and that doctors overservice their patients is central to the current debate about future health care policy (see, for example, Howe 1991). Apart from the cost to the domestic health care system, overuse and overservicing may reduce the resources available to treat foreign patients and therefore impede efficient exports.

Overuse

A health service may be said to be overused by a patient, if the benefit to the patient is less than the cost to the community of providing that service. Clearly, where quality of life is involved, benefits to patients are at best imprecise. However, where fee-for-service medicine is combined with payment of health care bills by a third party such as a private insurer, there will undoubtedly be cases where patients receive services which they value at less than the cost of provision. In this regard, the Australian system is rare in combining both fee-for-service medicine and extensive reliance on third party payment or provision. In 1987-88, for example, 98 per cent of hospital care and 89 per cent of medical care was either paid for by a third party or provided free of charge (AIH 1990b).

Overuse of medical services, pathology and radiology has been documented in the background papers published by the national health strategy review (see, for example, Deeble 1991). Further, Australians use health services more frequently than people in most OECD countries. In 1987, admission rates to Australian hospitals were higher than for all but 2 of 20 OECD countries for which data are available. And, only the Italians visited their doctor more frequently (OECD 1991, p. 151).

Overuse of medical services in Australia is encouraged by the practice of bulkbilling. Bulkbilling refers to the practice whereby doctors send a bill for 85 per cent of the medical benefits schedule fee less $2.50 directly to the Health Insurance Commission. Under bulkbilling the patient faces a maximum charge of $2.50. The doctor may elect to absorb the $2.50 and in this case the patient bears no monetary cost for medical services. This means that under bulkbilling patients will seek services for which the benefit to the patient is substantially less than the cost of provision.

Of course, bulkbilling has some advantages. One possible advantage is that administration costs are reduced.

Bulkbilling may also serve a useful purpose if competition by doctors who bulkbill encourages other doctors to restrain their fees. However, as Butler (1991) points out, bulkbilling creates a floor

price for medical services at 85 per cent of the medical benefits schedule fee. According to Deeble (1991) 58 per cent of medical services were bulkbilled in 1989-90. Thus the main effect of bulkbilling may now be to set a floor in the prices received by most doctors for medical services.

According to Butler (1991) the recent decision by the Government to reduce the medical benefits schedule fee may result in at least some doctors lowering their fees rather than charging a patient co-payment.

Overservicing

The Health Insurance Act 1973 does not define overservicing as such. Rather, it defines as excessive those services that are not reasonably necessary for the adequate medical care of the patient.

However, opinions may vary among practitioners as to which procedures are necessary for adequate medical care of the patient. Moreover, the patient may seek to have some role in deciding what constitutes reasonably necessary care. Like doctors, patients are unlikely to have identical views on these matters.

The concept of overservicing is therefore ill-defined and difficult to make operational. In turn, this suggests that rather than trying to police overservicing directly, the problem may be best addressed by changing the incentives that encourage overservicing.

In Australia, overservicing is likely to be encouraged by the combination of fee-for-service medicine and third party payment which reduce the incentives for the patient to monitor the appropriateness of the services provided by the doctor.

Would an increase in the supply of doctors contribute to overservicing?

Third party payment and fee-for-service medicine have long been part of Australia's health care system. However, recently the debate has focused on the issue of whether an increase in the number of doctors has caused increased overservicing. Deeble (1991) has summarised the debate as follows:

> One view is that they [medical care markets] are basically no different to any others. Increased supply will lower prices, restrictions on entry will increase them. Demand and supply are thus regarded as independent and while some doctors may achieve elements of monopoly for a time, competition, if allowed, will eventually erode them.
>
> The alternative view, commonly summarised as the Supplier Induced Demand hypothesis, is that demand, supply and price are not independent. Doctors may, through their superior knowledge, influence their patients' perceptions of need and so increase demand for their services; or alternatively, raise the price of their services without reducing the demand for them. Price is not a mechanism which equilibrates supply and demand, only a variable which, with service volumes, can be ordered so as to achieve the driving force behind the whole system, namely, the doctors' target incomes (Deeble 1991, p. 50).

The supplier induced demand hypothesis suggests that doctors respond to increased competition by inducing additional demand from patients, thereby maintaining their incomes. Evidence in support of this hypothesis comes from statistical relationships which suggest that an increase in the number of doctors is associated with both an increase in the number of services provided and an increase in the price at which those services are provided. The main empirical evidence supporting the supplier induced demand hypothesis in Australia is found in the papers by Richardson (1981 and 1986). However, in a review of empirical studies Ramsey and Wasow (1986) concluded that:

> The empirical findings of the early researchers on the issue of supplier induced demand are most likely the result of improperly specified and inadequately analysed regression models. No, or certainly very few useful empirical generalizations can be drawn from any of the models as currently formulated and estimated. In this sense, the anomalous empirical findings are statistical artifacts. All the empirical models were shown to be either seriously flawed econometrically or were essentially uninterpretable because of the extensive use of proxy variables with only tenuous connections to the theory (Ramsey and Wasow 1986, p. 67).

While Richardson's Australian work was not included in Ramsey and Wasow's study it is based on the Fuchs and Kramer (1972) approach which Ramsay and Wasow considered to be flawed.

Policies to address overservicing

The problem of overservicing may be addressed in a variety of ways. One option is to restrict the number of doctors and thereby restrict the supply of medical services. Another option is to introduce a patient co-payment for medical services. Both these approaches were included in the package of health care measures announced recently by the Government (see Howe 1991 and the Department of Health MB circular no. 325). A third option would be to restructure Medicare to reduce the incentives for overuse and overservicing.

While it is possible that reducing the number of doctors practising in Australia will reduce overservicing, there are significant potential inefficiencies in tackling the problem in this way. Most importantly, reducing the number of doctors would not alter the inappropriate incentives associated with fee-for-service medicine and third party payment of hospital and medical bills. Thus reductions in overservicing achieved in this way are also likely to be accompanied by a reduction in the volume of necessary services provided. The same effect has been observed by Richardson (1991) with respect to the use of patient co-payments to limit demand for medical and hospital services. The role of patient co-payments and improved incentives in tackling problems of overuse and overservicing are considered in section 6.9.

At the draft report hearing the Department of Health said:

> The draft report asserts that Australians overuse health services and that significant overservicing is encouraged by the current fee-for-service payment system. It is widely accepted that demand for hospital and medical services has

been increasing in recent years but the Department considers that the Commission does not succeed in drawing a link between Government policies and over-use. The Department points out that all countries are experiencing growth pressures. Medicare's performance in dealing with those growth pressures needs to be recognised (submission no. 47, p. 5).

The Department further stated that factors such as the ageing of the population, public expectations and technology increased utilisation and this should not be confused with overuse.

The Commission accepts that the issues associated with overservicing and overuse are complex. It also accepts that Medicare may have met with some success in dealing with growth pressures. However, it considers that some links can be established between government policies, overuse and overservicing. For example, the fact that bulkbilling allows medical services to be provided to patients at a maximum monetary cost of $2.50 while also creating a floor in the price received by doctors must be taken as prima facie evidence that government polices encourage overuse and overservicing. Given this assessment, an important policy question is whether the current Medicare program could be restructured so that there are fewer incentives and opportunities for overuse and overservicing. However, the Department of Health went on to say that:

> The suggestion that there be a restructuring of Medicare is not and has never been considered a viable option by this Department. The brief of the National Health Strategy is to consider refinements and improvements to the Australian Healthcare system (submission no. 47, p. 4).

6.4 Accreditation procedures and regulation of the medical profession

Each State and Territory regulates medical practitioners and nurses and controls advertising by doctors. Details of accreditation procedures and restrictions on entry to the medical and nursing professions are provided in appendix D. Restrictions on the training in Australia of foreign doctors and on accreditation procedures for overseas trained doctors were discussed in chapter 4.

In the context of the current debate on overservicing, such regulations may be seen as a mechanism for reducing the supply of doctors. However, their original rationale was to protect patients from incompetent practitioners and to reduce the costs of acquiring information on the quality of services fered. It is significant that regulation of the medical profession has become more stringent in recent years and now seemingly goes well beyond that necessary to protect patients from incompetent doctors. As discussed below, there is evidence that the regulations have been used as a device to restrict competition within the medical profession.

Restrictions on entry into the medical profession

Since the 1950s, Australia has imposed quotas on the number of students entering medical schools. The number of places available in medical schools has been reduced by 21 per cent since 1978. Over the same period the Australian population grew by about 18 per cent. The reduction in the number of places, together with the increase in the number of qualified applicants has led medical schools progressively to tighten entry criteria over the past decade. The restrictiveness of the criteria for entry into medical schools is illustrated by the Dean of the Faculty of Medicine of Monash University who stated that:

> There is a strict quota for entry of both local and overseas students. ... Applications exceed these quotas by the order of 10 times (letter to Commission).

The medical profession was specifically identified by the Faculty of Medicine of the University of New South Wales as influencing decisions regarding student intakes to medical schools.

In addition to increasing restrictions on entry into medical schools, Australian governments have made it more difficult for overseas trained doctors to practise in Australia. In 1970, doctors who trained in 20 countries could obtain automatic accreditation in at least one Australian State or Territory. However, by 1990, automatic accreditation had been withdrawn from 16 of these countries.

Some of the countries for which automatic accreditation was removed, such as Uganda and Lebanon, underwent violent change. It is conceivable that their quality of medical education deteriorated significantly.

However, it is more difficult to argue, say, that medical training in the USA, Canada or Sweden has declined and declined to such an extent that their doctors are no longer suitable for Australia. Doctors trained in Singapore were granted automatic accreditation in 1970 but are not automatically accredited in 1990. Yet the Singaporean health care industry has developed rapidly over this period to the stage where it is a major centre for the export of health services and a major competitor with Australia for the treatment of Asian patients.

The NSW Medical Board agreed with the view that there are a number of countries -- such as the UK, Ireland, USA, Canada, South Africa, Hong Kong and Singapore where the standards of undergraduate medical training is comparable to that of Australia. However, it claimed that the same is not true of the education in many other countries from which overseas trained doctors who wish to practice in Australia originate. It claimed that:

> The requirement that doctors from all countries (excluding New Zealand) pass the AMC examination (or have specialised qualifications acceptable to the appropriate college) before being registered in NSW is a political decision based on a perceived need to treat all OTDs equally, and to be seen as not discriminating on grounds of country of origin or race (submission no. 45, p. 4).

Overseas trained doctors who are not granted automatic accreditation may sit exams which test their english language ability and their medical knowledge. Doctors who pass these exams may be required by a medical registration board to undertake a period of supervised practice before full recognition is granted.

While there is obviously a need for testing procedures, some have suggested that the medical and clinical examinations which overseas trained practitioners without automatically registrable qualifications must sit, are unduly restrictive. Dr Con Costa of the Doctors' Reform Society highlighted the restrictiveness of the Australian Medical Council (AMC) procedures when he stated that 'almost half of the nation's doctors over the age of 45 would fail the AMC exam if they were forced to take it'.

In response to the draft report the AMC said that the standards required of overseas trained doctors entering the medical Work force in Australia are the same as those required of graduates of Australian medical schools. However, the AMC did not respond to the implication in Dr Costa's statement that the standards currently imposed on new medical graduates and overseas trained doctors are more stringent than in the past.

Recently the Premiers and Chief Ministers reached an agreement on mutual recognition of standards between States. When announcing the agreement they said that:

> if someone is good enough to practice a profession or occupation in one State or Territory, then he or she should be able to do so anywhere in Australia (Premiers and Chief Ministers Meeting Adelaide 21-22 November 1991, Communique).

While the move to mutual recognition is welcome the issue of whether such a move will generate net benefits to the community depends in large measure on the standards that are adopted and the details of the legislation used to implement those standards.

The current regulations give the medical profession considerable control over the licence to practise. Such arrangements create an environment in which there is scope for the medical profession to use the regulations to restrict competition. In most markets, the removal of restrictions on competition is likely to reduce the price paid for medical services.

In particular, the removal of barriers to the entry of new providers, in most markets, would result in both lower prices and an increased number of services provided. However, in the current market for medical services the practice of bulkbilling sets a floor in the price received by medical practitioners. Thus without a reduction in this floor price, the gains from relaxing restraints on entry of medical professionals may not by passed on to patients and governments in the form of fee reductions. However, even with a floor price for medical services some gains from increased entry would be passed on to consumers through reduced waiting times.

Restrictions on advertising

In all States, advertising by doctors to members of the public is only permitted under strict guidelines.

Advertising restrictions on doctors' services are often advocated on the grounds that they are essential to preserve the relationship of trust between doctor and patient and to protect the patient, who may be particularly vulnerable to promotional advertising when ill. It is argued that patients must rely on the disinterested advice from doctors and that any suspicion that doctors were attempting to advance their own interests could destroy this trust.

However, restrictions on advertising deprive the public of a source of information about the services offered by individual practitioners and therefore may make it more difficult for patients to find the most suitable professional to handle a particular problem. From this perspective, the restrictions compound information problems which may exist in the market for medical services. Restrictions on advertising also reduce competition between practitioners and thereby have the potential to increase the price of services.

The Australian advertising regulations and codes for medical practitioners largely parallel the advertising guidelines applying in the UK. The UK Monopoly and Mergers Commission which undertook a study of those guidelines stated:

> We have taken note of various studies on the effects of the removal of advertising restrictions in different professions in the United Kingdom and the United States. Of particular interest was the evidence that, where restrictions were removed or relaxed, advertising led to lower prices to the consumer while maintaining quality standards (The Monopoly and Mergers Commission 1989, p. 18).

The Monopoly and Mergers Commission recommended that the guidelines should be revised to permit advertising, subject to the broad principles that such advertising:

- should not be of a character that could reasonably be regarded as likely to bring the profession into disrepute; and
- should not be such as to abuse the trust of patients or exploit their lack of knowledge.

In the light of these findings an important issue requiring further exploration is whether easing or abolishing specific restrictions on advertising by doctors could promote competition in the provision of medical services and improve the flow of information to patients without placing them at any additional health risk.

In its response to the draft report, the Consumers' Health Forum supported the easing of restrictions on advertising by doctors. They said that:

> The Forum considers that many existing professional regulations seek to protect professionals' privileged position in the market place rather than protecting consumers. Current restrictions on advertising are a good example of this, as they restrict the information available to consumers to make basic choices. Therefore, any move to ease restrictions

on advertising by doctors to provide consumers with more information on matters like price, areas of specialisation (if doctors work extensively in a particular area e.g. women's health) and other marketing items like additional community languages they may speak, are welcomed (submission no. 49, p. 6).

6.5 Use of inputs

Efficient use of inputs is important in ensuring the cost effective provision of health care services. However, a comparison of labour use across the States and Territories indicates that there are substantial differences among the States in the levels and mix of labour used per occupied hospital bed. Australian hospitals also use significantly more health personnel than OECD countries (see appendix E). These comparisons are particularly significant as labour accounts for more than 70 per cent of the cost of providing health care services.

Of course, such comparisons must be viewed with caution. Health care standards and patient mix may differ between jurisdictions. However, it seems highly unlikely that all of the differences in labour use can be explained in these ways. Moreover, such factors would seemingly carry much less weight in explaining differences in labour use within Australia.

Controls on the number of hospital beds in each State and Territory are one factor that may be important in explaining higher labour use in Australian hospitals. By restricting the number of public and private hospital beds, governments may be encouraging hospitals to allocate more staff and other resources to each patient. By so doing, hospitals can reduce the average length of stay of patients and therefore achieve the same throughput of patients with fewer beds. However, this may be less efficient than serving the same number of patients using more beds, with a longer average length of stay and fewer staff per bed.

The Department of Health acknowledged that:

> the suggestion that moves towards reducing the average length of stay may be increasing labour intensity and cost per patient is valid (submission no. 47, p. 5).

However, the Department went on to say that:

> these additional costs are offset by increased throughput associated with reduced length of stay (thereby reducing waiting lists) and facilitating timely access to healthcare services. Therefore reduced lengths of stay improve health outcomes in the longer term (submission no. 47, p. 5).

However, the question remains as to whether the gains from controlling bed numbers exceed the costs incurred.

Overall, evidence presented in appendix E constitutes prima facie evidence of substantial potential efficiency gains to be had from better use of inputs within Australian hospitals. For example, the

Commission's preliminary estimate is that savings in the order of $2 billion a year could be made if all Australian hospitals and nursing homes were to adopt the labour use practices followed in Queensland.

6.6 Funding of public hospitals

Under Medicare public hospitals treat two-thirds of patients free of charge and private patients pay fees that do not cover the cost of services provided. Consequently, public hospitals must call on State Governments for funds. In most States, the revenue raised from fees charged private patients in public hospitals goes to consolidated revenue. In NSW, public hospitals keep the revenue but a compensating adjustment is made to a hospital's annual budget.

Public hospitals in most States receive funding allocations based on what they received in the previous year adjusted for factors such as inflation. While this basis of funding allows tight central control over total expenditure, it provides few incentives for the efficient allocation of resources within hospitals. Many of the problems with historical funding have been identified by the review of the national health strategy:

> Although this gives flexibility to the service agency, there is little scope for moving resources between service agencies in response to changing consumer needs, demographic and geographic shifts, and new health practices. Resources are 'locked into' traditional patterns of use.
> The historical budgeting approach has weak and uneven incentives for improved productivity and efficiency. Again, analysis of public hospital costs per admission and bed day has revealed marked differences in costs, suggesting that widespread inefficiencies may be structured into hospital funding.
>
> There is little incentive for inpatient care to be provided n the best 'value for money' location, consistent with high quality care, including incentives for day surgery, day treatment, community and home care, and referral to lower cost hospitals. This arises from:
>
> - the block funding approach, which in most cases, has a limited relationship to a hospital's output;
> - the funding of hospitals as separate units, without consideration of which is able to provide needed and high quality services at the least cost; and
> - funding of hospital services separately from non-hospital health and community services (National Health Strategy 1991, p. 30).

The *resource allocation formula* used in NSW is one alternative for improving funding arrangements (see appendix B). The formula takes into account projected population growth within and between areas and makes adjustment for age and sex, health status, private hospital activity, interstate patient flows and the casemix of individual hospitals.

Agreements between the Health Department of Victoria and individual hospitals represent another alternative to historical allocation of funds (see appendix B). These agreements require public

hospitals to specify the services they are going to provide and how the resources will be allocated within their given budget. The agreements also specify the indicators that will be used to monitor a hospital's performance.

While these approaches build greater flexibility into the funding arrangements, they provide little scope for using a hospital's performance relative to other hospitals as the basis for reimbursement. One of problems in introducing relative performance to the funding equation is that hospitals differ in casemix, quality of care provided and size. All of these factors influence hospital costs.

There has been considerable interest around the world in casemix funding as a mechanism for encouraging greater efficiency in the hospital sector. The best known form of casemix funding is the system of diagnostic related groups (DRGs). Under a system of DRGs, patients are classified according to their diagnosis and age. Hospitals are paid a fixed amount for each patient falling within a diagnostic group.

The case for DRGs is based on the view that similar types of patients in different hospitals should require similar resources for treatment. Because an individual hospital receives fixed funding for each patient irrespective of length of stay, it is provided with an incentive to minimise the cost of treatment. DRGs provide these incentives for efficiency while ensuring that the funding needs of hospitals with different casemixes are recognised. Moreover, DRGs provide hospitals with an incentive to specialise in those services which they can supply efficiently.

However, casemix funding is not without problems. In particular, its efficiency enhancing impact is dependent on the doctor's initial diagnosis. A problem arises because in those cases where there is uncertainty about the diagnosis, hospitals have a strong incentive to encourage doctors to select the diagnostic group with the highest payment.

Another potential problem with DRGs is that there are problems with taking into account the severity of illness within a particular diagnostic group. Thus hospitals that treat more patients who are severely ill could be disadvantaged.

DRGs have been in operation in the USA Medicare system since 1983. It is generally accepted that they have resulted in improved efficiency and lower hospital costs. Admission rates, number of beds and occupancy rates have fallen, partly offset by an increase in the intensity of care. Hospitals have improved their purchasing behaviour by establishing groups to negotiate prices with suppliers. As discussed in appendix B, some preliminary DRG projects have been initiated in Australia.

6.7 Pricing of services provided by public hospitals

As mentioned earlier, two-thirds of patients in public hospitals receive treatment at no charge while the remaining one-third pay fees that do not cover the cost of treatment. Where services are available free of charge or at subsidised prices there is some presumption that those services will be overused. Such overuse of services might arise from people being too readily admitted to hospitals, from patients staying too long in hospitals and from use of inpatient care where day surgery would suffice.

Moreover, public hospitals vary considerably in terms of their facilities and the services offered. However, under current pricing arrangements no extra charge is levied on either public or private patients who obtain treatment in hospitals that are better appointed. This creates a number of incentives for inefficient utilisation of public hospitals. For example, the Department of Health said that one factor behind waiting lists is the preference of doctors and patients to be treated in tertiary referral hospitals. This is not surprising since tertiary referral hospitals provide a wider range of higher quality services than suburban hospitals.

However, within the current institutional framework these problems are not simply addressed. For example, increasing fees that private patients are charged to full cost would not necessarily improve incentives without some other changes to the arrangements for public patients. In this regard, the Department of Health stated that the subsidisation of private patients in public hospitals is a function of two opposing objectives. According to the Department:

> the fees for private treatment have never represented costs or market prices. They have been set at levels that represent the revenue raising needs of governments. This revenue raising requirement has had to be balanced with the need to keep private health insurance affordable to consumers (submission no. 21, p. 15)

Thus, if fees for private patients were to be raised to full cost, then some changes would be required to reduce the incentive for people to opt out of private health insurance and rely on Medicare. One way of achieving this would be to extend the patient co-payment recently announced for medical services provided under Medicare to cover hospital services.

6.8 Regulation of private health insurance

Private health insurance plays a major role in the Australian health care system. Indeed, as Scotton (1990) points out, the ability of the Government to provide benefits through Medicare while maintaining expenditure restraint, depends in large measure on a large proportion of the population electing to be covered against hospitalisation costs by private health insurance. Private health insurance also covers the 25 per cent of the schedule fee for medical services, obtained by private patients in hospital, that is not covered by Medicare. Private health insurers are not permitted to

provide cover for that part of the schedule fee that is not covered by Medicare for medical services obtained outside of hospitals.

Private health insurance is extensively regulated (see appendix C). All private health insurance is required to be provided by organisations in the form of health funds. And, health funds are required to charge premiums which are community rated. That is, a health insurance fund is not allowed to discriminate on the basis of age, state of health, frequency with which the client has used health services or the amount of benefits the client has received.

Government-mandated community rating is one of a range of measures intended to ensure that no person faces an unreasonable burden attributable to health care costs. However, community rating has a number of unintended effects which reduce efficiency. It requires low risk clients to subsidise high risk clients. This means that for low risk clients, the cost of community rated health insurance may well exceed the benefits from that insurance. The Department of Health said that:

> Community rating in the private health insurance sector has been associated with a cycle of adverse selection as there is a lack of incentive for low risk contributors to continue paying premiums which are not commensurate with their expected benefits. It is likely that any reduction in low risk contributors must be reflected in higher premiums which may serve as a further disincentive for remaining low risk contributors (submission no. 21, p. 8).

The Department acknowledged that adverse selection may have contributed to the decline in the numbers of people holding private health insurance between 1983 and 1986 (see appendix C).

Government-mandated community rating helps to make health insurance affordable to high risk persons who would otherwise have to rely on Medicare. However, it is questionable whether community rating is the best policy to achieve this end. A more direct policy of paying risk-rated subsidies to individuals who purchase private health insurance could achieve the Government's objectives without creating the disincentives for low risk people to purchase private health insurance. This approach is an integral element of the scheme recently proposed by Scotton (1990).

Alternative private health insurance arrangements

Australia's health insurance arrangements, both public and private, are based on third party payment of medical and hospital bills to fee-for-service providers. These arrangements mean that patients and service providers have little incentive to match the benefits of treatment against the costs or to ensure that services are delivered in a cost-effective fashion. Moreover, as noted earlier, third party payment, when combined with fee-for-service medicine, gives health service providers a

financial incentive to overservice patients and health service users little incentive to restrain their use of services.

Negotiated benefit arrangements

Within the current regulatory framework, private health insurers have taken some steps to deal with these problems. In Victoria, health insurers have contracted with particular private hospitals to supply services to their clients. These sorts of contracts, which are referred to as 'negotiated benefit agreements', involve fixed price service agreements between the fund, the patient and the hospital. The advantage of such agreements for patients is that they face no unanticipated charges. The advantage for hospitals is that they incur lower administrative costs and the advantage for insurers is that hospitals have an incentive to be cost conscious when providing services.

However, negotiated benefit agreements provide only a partial solution to the problems stemming from third party payment and fee-for-service medicine. This is mainly because of the substantial costs involved in writing and enforcing sufficiently detailed contracts. Integration of insurer and health care provider represents an alternative mechanism which has fewer 'transactions' costs.

Integration of insurer and health care provider

Current regulations preclude the full integration of insurer and health care provider. But such integration could be an effective means of ensuring that health care providers have an incentive to be cost conscious in the provision of services. In the USA these integrated organisations go under the generic name of health maintenance organisations (HMOs).

Enrolment in the USA in HMOs increased from 10 million persons in 1981 to 26 million persons in 1986. In summarising the reasons for this growth, Paul Feldstein, an American health economist, says:

> It appears that the total cost of medical care (premium plus out of pocket expenses) for HMO enrollees is 10-40 per cent lower than for persons with comparable insurance coverage using the [fee-for-service] delivery system. Further, HMOs have lower hospital use rates than those of [fee-for-service] plans. Lower hospitalisation is achieved primarily through lower admission rates, although there is some indication of shorter lengths of stay. In general, there are approximately 30 per cent fewer hospital days among HMO enrollees as compared to those with fee-for-service coverage (Feldstein 1988, p. 331).

The USA experience raises the question of why these organisations are not permitted in Australia. In commenting on the draft report the Department of Health disputed the relevance and applicability of HMOs to Australia. It stated:

> In the US there is some evidence to suggest that the total cost of medical care and the number of hospital days for HMO enrollees is lower than for persons using a fee-for-service delivery system. However the apparent efficiency of HMOs in the US can be attributed to the fact that HMOs could be expected to accept enrollees who are generally low risk and to the otherwise high cost of health services in the US which does not have an efficient universal health care scheme (submission no. 47, pp. 5-6).

These claims are not supported by the evidence from empirical studies summarised by Feldstein, who said that:

> A number of studies have looked at the issue of whether HMOs receive a favourable or an adverse risk group. Using different methodologies and data, these studies have found that the HMOs examined have had favourable and unfavourable risk selection; and some have found no evidence of biased selection or their results are inconclusive. These studies have investigated biased selection in HMOs among both working-age populations and Medicare [aged] enrollees. ... The findings above suggest that as HMO market share increases, it should be followed by decreases in hospital use rates. According to the earlier discussion on quality of care in HMOs, these reductions in hospital use rates are not accompanied by reductions in quality of care. Increasing copayments in the FFS [fee-for-service] sector will also reduce hospital use rates, but the style of care will be different than in the HMO studied; there will also be fewer ambulatory care visits (Feldstein 1988, pp. 330-331).

The Department of Health also claimed that:

> the selective nature of American HMO membership is difficult to reconcile with the community rating principle applying to Australian private health insurance. High risk clients, or high cost areas could be precluded from HMO membership, placing additional strain on other registered health funds and the public system (submission no. 47, p. 6).

However, Scotton (1990) in his submission to the Senate Select Committee on health insurance has proposed changes to Australia's health care arrangements which would permit the retention of community rating and allow consumers the option of electing to join a HMO. His proposal which is based on a scheme developed by Enthoven (1988) for application in the USA, is designed to increase competition while at the same time maintaining existing patterns of cross-subsidisation and controls of health expenditure through public budgets. It would establish a nexus between the public and private sectors which currently does not exist in the provision of health insurance.

The central feature of the proposal would be to allow Medicare beneficiaries more choice in the way that they take their entitlements and to permit private agencies to administer the benefits available under some options. People could elect to have their Medicare benefits provided by registered health plans (including HMOs), to which the Government would pay premium subsidies related to the expected cost of Medicare benefits incurred by individual subscribers. The health plans would be required to provide packages for at least all the services covered by the Medicare arrangements.

Central to the Scotton proposal is the payment of risk related premium subsidies to the health plans. The Government would pay the health plans a subsidy for each subscriber equal to the average cost

(or a percentage of that cost) of Medicare benefits for a person of the same sex and age group. Scotton envisages that these premium subsidies could be adjusted over time in the light of experience. The health plans would, of course, also derive income from premia recouped from private subscribers.

The Department of Health also argued that:

> Medicare is, in many respects, the ultimate HMO, as it confers membership on all Australians regardless of health status, and all share equally in its benefits. The advantages of American HMOs noted in the report are already enjoyed by all Australians under Medicare (submission no. 47, p. 6).

In one sense Medicare is indeed the ultimate HMO in that it provides universal insurance and the Government may have limited the extent of fee increases through its control of the Medicare Benefits Schedule.

But several large HMOs which provide health insurance cover and supply their own medical service packages may be able to supply the same or better services at less cost to the community. HMOs set in a competitive environment have strong economic incentives to innovate and minimise the cost of supply of good health services. They also have the economic incentives to introduce programs of preventative medicine that will reduce their customers' demand for medical treatment. Introducing more competition in the purchase and supply of health services through HMOs may be one way of introducing efficiencies in the delivery of health services. Moreover, as is increasingly being recognised in other industries -_ such as aviation, banking and electricity -- there is scope for competing private enterprises to provide additional capital and management, not readily available to budget constrained governments, to supply services more efficiently.

While Medicare may share some features in common with HMOs, it differs from them in other ways.

Under Medicare people who are dissatisfied with the service do not have the option of changing to another HMO. Of course, those who are dissatisfied with hospital services under Medicare can join a health care fund and seek treatment as a private patient. But such persons are limited to a choice between Medicare and fee-for-service private treatment, they do not have the option to join a HMO.

Both HMOs and Medicare achieve cost savings by rationing access to hospital care. However, they use quite different rationing methods. Under Medicare access is rationed by imposing budgetary constraints on public hospitals which limit the number of beds available and the equipment that may be purchased. Patients then gain access on the basis of assessed need. Those judged to be least in need are allocated to waiting lists. HMOs on the other hand achieve low hospitalisation rates by encouraging doctors to adopt a style of practice which is 'less hospital intensive' (Feldstein 1988). One way of achieving such a style of practice is to place greater emphasis on prevention. The studies reported by Feldstein show that while doctor visit rates are

similar between HMOs and free fee-for-service plans, the HMOs have a greater number of preventative visits. Thus, while Medicare achieves reductions in hospital utilisation rates mainly through reducing access, HMOs achieve this by reducing the need for access through early detection and prevention. Such an approach is seemingly both more efficient and more equitable.

6.9 Incentives for efficiency within Medicare

Under Medicare, all Australians are eligible to receive free or heavily subsidised medical and public hospital services. Individuals may elect to extend the coverage provided under Medicare by purchasing private health insurance.

The achievements of Medicare are substantial. By providing universal coverage, it has reduced the financial burden that ill health and injury places on the less well-off members of the community. This has been achieved during a period in which the proportion of GDP allocated to health care has remained stable.

Nonetheless, there is scope for improving the incentives within Medicare for the efficient delivery and use of health services.

Many of these inappropriate incentives arise because Medicare, like private health insurance, is centred around third party payment of fee-for-service providers. Third party payment of health bills and fee-for-service medicine, have long been part of the Australian health care system. However, the availability of free or heavily subsidised medical and hospital treatment under Medicare may have exacerbated problems of overuse and further weakened the incentives for efficient service delivery.

Improving incentives within Medicare

Patient co-payments represent one way of encouraging patients to avoid overuse of services. In its 1991-92 budget, the Government announced a patient co-payment for medical services provided under Medicare (see appendix C).

Co-payments have an important role to play in an efficient health care system. They increase the incentive for patients to use services judiciously and to monitor potential overservicing by medical practitioners. However, they cannot be used too extensively without the risk of compromising the objective of reducing the financial burden created by ill health and injury.

Further, Richardson's (1991) survey of co-payments suggests that while they reduce use of medical services, they do not discriminate between ineffective and effective services. This is because it is the doctor rather than the patient who has the information about the likely effectiveness of treatments. By itself, the introduction of patient co-payments does little to encourage doctors to

provide better information about the efficacy of alternative courses of treatment.

Integration of the service provider and those responsible for meeting the bulk of medical and hospital costs is the mechanism which offers the best prospects of providing the incentives to curtail unnecessary services. The virtue of integration is that providers have strong incentives to deliver services in a judicious and cost effective manner, while users have the incentive to obtain the best treatment possible. This tension between the cost consciousness of the service provider and the demand for quality by users generates many of the market-based forces which are so important for producing efficient outcomes.

Integration could be achieved, within the Medicare framework, in a number of ways. For example, area health authorities could be established and allocated funds on the basis of the risk characteristics of their population. The area health funds could then purchase health care on behalf of their patients from public and private health care providers.

Alternatively, the Government could let contracts for the provision of hospital and medical care, and perhaps pharmaceuticals, to Medicare patients. Competition among potential providers would help to ensure that the cost to government was contained. Differences in medical risks among the population could be accommodated by specifying those risk characteristics prior to letting the contracts.

Under the scenarios outlined above, strong incentives would exist for health care providers to contain costs. This raises the question of whether there would be a problem with the provision of too few services. To deal with this concern, the contract between the insured, health care provider and the Government could specify that the insured had the right to obtain a second opinion from an independent source as to whether treatment was required. Moreover, competition between providers for clients is likely to dull any incentives for underservicing.

An initial step in the modification of incentives provided by Medicare is canvassed in the recent Budget. This involves the use of practice grants to complement fee-for-service reimbursement (Howe 1991).

6.10 Conclusions

The preceding discussion illustrates that, within the current institutional framework for ensuring that all Australians have access to affordable health care, there are a range of options which would improve the efficiency with which health care services are delivered in Australia. This is particularly significant in the context of this inquiry since inefficiencies in the domestic health care system are perhaps the major impediment to the efficient export of health services.

Given the inquiry's focus on exports, the Commission has not explored the range of options available to improve the efficiency of Australia's health care system in any detail. However, the recent initiatives and statements by the Minister for Health (Howe 1991) indicate the Government's intention to include the health sector in its agenda for microeconomic reform. Given the importance of such reform to both domestic and foreign patients, the Commission believes that the options and issues raised in this chapter should be considered in the context of the concurrent review of the national health strategy.

A LIST OF PARTICIPANTS

The following parties have made written submissions to the inquiry. Abbreviations used for participants in the report are italicised and in brackets. Submission numbers are shown in brackets.

A.L. Bloom and Associates (5)
Australian Council of Trade Unions (Health Industry Unions Group) (22)
Australian Council on Health Care Standards (ACHS) (4)
Australian Hospital and Medical Services Association (24,30)
Australian Hospital Association (AHA) (9)
Australian Institute of Health (AIH) (7,26)
Australian Medical Association (AMA) (37)
Australian Medical Council (41)
Australian Nursing Assessment Council (43)
Australian Private Hospitals' Association (APHA) (17,42))
Consumers' Health Forum of Australia Incorporated (19,49)
Dass Apanah, N. (27)
Department of Health, Housing and Community Services (Department of Health) (21,33,47)
Department of Immigration, Local Government and Ethnic Affairs (DILGEA) (8,48)
Department of Industry, Technology and Commerce (DITAC) (10,46)
Government of Queensland (20)
Government of South Australia (32)
Government of Victoria (29)
Health Solutions Pty Ltd (23)
Hospital Salaried Officers Association of Western Australia (11)
International Healthcare (16)
Macquarie Health Corporation (18)
Mayne Nickless Computer and Health Care Services (14)
Med Assistance Pacific (MAP) (6)
MedikaLink (15)
National Occupational Health and Safety Commission (Worksafe Australia) (2)
New South Wales Nurses' Association (12)
NSW Medical Board (45)
Overseas Trained Doctors Association (OTDA) (36)
Royal Australian College of Ophthalmologists (44)
Royal Australian and New Zealand College of Psychiatrists (Vic Branch) (38)
Royal Brisbane Hospital (40)
Royal Children's Hospital Melbourne (25)
Sagric International Pty Ltd (28)
Tan, H.L. (34)
The Australian Cranio-Facial Unit (31)
Victorian Employers' Federation (1,13)
William A. Cook Australia Pty Ltd (3)
Worldcare (39)

The Commission also held informal discussions with:

CAFAT
Department of Business, Industry and Regional Development (Qld)
Department of Health (NSW)
Department of Health (Qld)
Department of Health (Vic)
Department of Health (WA)
Department of Health, Housing and Community Services
Department of Industry, Trade and Technology (SA)
Department of Ophthalmology Flinders Medical Centre, Adelaide
Department of State Development (WA)
Department of the Premier, Economic and Trade Development (Qld)
Epworth Private Hospital
Health Economics and Technology Assessment Corporation
Health Solutions Pty Ltd
Hospitals of Australia
Institute of Medical and Veterinary Science and AUShealth
International Healthcare
McKay and Associates
Med Assistance Pacific
MedikaLink
Medilink International Medical Services
Moran Clinic, Queensland
Mount Markalinga Hospital Group
New South Wales Medical Board
Overseas Trained Doctors Association
Overseas Trained Doctors Association (Qld)
Princess Alexandra Hospital
Royal Alexandra Hospital for Children, Sydney
Royal Brisbane Hospital
Royal Children's Hospital, Melbourne
Royal Perth Hospital
Royal Prince Alfred Hospital, Sydney
Sagric International, Adelaide
South Australian Health Commission
St. Andrews Private Hospital, QLD
The Avenue Private Hospital, Melbourne
Treasury (NSW)
Treasury (SA)
Victorian Employers' Federation
Victorian Hospital Association
William. A. Cook Australia Pty Ltd

The Commission also received valuable information from:

Australian Medical Association
Australian Medical Council
Commission of the European Communities
Department of Health (NSW)
Department of Health (Qld)
Department of Health (SA)
Department of Health (Tas)

Department of Health (Vic)
Department of Health (WA)
Department of Health and Community Services (NT)
Faculty of Medicine, Flinders University
Faculty of Medicine, Monash University
Faculty of Medicine, University of Melbourne
Faculty of Medicine, University of New South Wales
Faculty of Medicine, University of Newcastle
Faculty of Medicine, University of Queensland
Faculty of Medicine, University of Sydney
Faculty of Medicine, University of Tasmania
Faculty of Medicine, University of Western Australia
Hospital Contribution Fund of Australia Ltd
Medical Benefits Fund of Australia Ltd
Medical Board of Queensland
Medical Board of South Australia
Medical Board of the Northern Territory
Medical Board of Victoria
Medical Board of Western Australia
Medical Council of Tasmania
Medical Society of Victoria Inc
National Health Strategy
New South Wales Medical Board
NSW Nurses Registration Board
Nurses' Board of South Australia
Nurses' Board of the Northern Territory
Nurses' Board of Western Australia
Nurses' Registration Board of Queensland
Nursing Board of Tasmania
Victorian Nursing Council
Victorian Tertiary Admissions Centre

B THE AUSTRALIAN HOSPITAL SYSTEM

B.1 Introduction

Hospitals may be classified according to the form of ownership, the source of funding, the type of services provided and the length of stay of patients.

Hospitals used by patients on a short term basis are referred to as acute care hospitals whilst facilities in which the patients remain for long periods are referred to as nursing homes or hostels.

This appendix deals only with acute care hospitals as they are the main vehicles for delivering health care to Australians. There are a little over 1000 acute care hospitals in Australia. Overall, such hospitals account for nearly one-half of all recurrent health care expenditure.

Governments, both federal and state, play a dominant role in the acute care hospital sector. Approximately 75 per cent of acute care hospital beds available are funded by government. The bulk of these publicly funded acute care hospitals are owned and managed by government itself or a delegated government body. The remainder are owned and operated by religious/charitable institutions -- for example, St. Vincent's Public Hospital in Sydney is owned and run by the Catholic Church. Publicly funded hospitals have an obligation to admit and treat patients on the basis of assessed need.

The remaining one-quarter of acute care hospitals are funded privately. Private hospitals may be separated into those that are operated for-profit and those that require donations, bequests or some other form of contribution from private sources to meet costs.

B.2 Statistical overview of public and private hospitals

The number of beds available in acute care hospitals in 1989-90 was around 85 800. This is some 8600 fewer beds than were available in 1982-83.

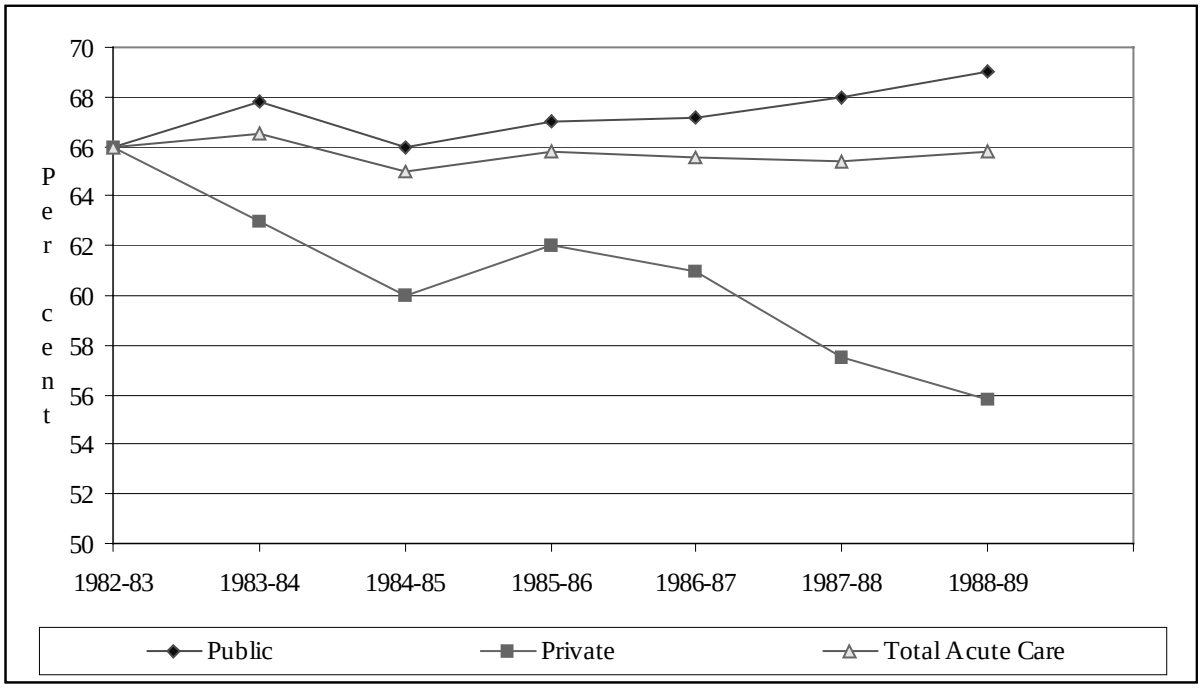
All of this reduction is attributable to changes in the public hospital sector where bed numbers fell by 10 600 over this period. Indeed, beds available in the private sector rose by 1900 between 1982-83 and 1989-90 (Department of Community Services and Health 1990b, AIH 1990b).

The occupancy rate[1] for acute care hospitals remained fairly constant from 1982-83 to 1988-89 at around 66 per cent. However, the trends in occupancy rates for public and private hospitals over

[1] Occupancy rates are the ratio of actual occupied bed days to available bed days provided during a year and are dependent on admission rates and on the average length of stay.

this period varied markedly. In the private sector, the occupancy rate fell from 66 to 56 per cent, whereas in public hospitals the occupancy rate increased from 65 to 68 per cent (see figure B.1).

Figure B.1: **Occupancy rates in acute hospitals, 1982-83 to 1988-89**



Source: AIH 1990, *Health Expenditur*e, Information Bulletin No. 5, Canberra, table 5, p. 4.

Within the private acute care hospital sector, occupancy rates also vary markedly. In 1985-86, smaller hospitals (25 or less beds) had a relatively high average occupancy rate of 67 per cent, reflecting a large proportion of longer stay patients. The largest hospitals (greater than 250 beds) also had high occupancy rates of 68 per cent. However, the occupancy rate for private hospitals of moderate size was only 53 per cent.

There are also significant differences in occupancy rates between the States and between metropolitan and country areas within a State. The Task Group into Health and Medical Services Exports said that:

> Over the past decade the level of private hospital occupancy has remained constant within the range of 56 to 62 percent. However, the level of occupancy is markedly different between States and the latest available data indicates significantly higher occupancy rates in metropolitan hospitals (submission no. 10, p. 9).

In the short run, hospitals have a fixed number of beds but can vary to a degree the length of time which patients stay in hospital. Therefore differences in occupancy rates may in part reflect variations in average length of stay (ALOS). Generally, the higher the ALOS, the higher a hospital's occupancy rate.

In 1988-89, ALOS in private hospitals was 5 days whilst public hospitals had an average of 6.24 days. These figures were 22 per cent and 12 per cent lower respectively than the ALOS in 1982-83. The declines are attributable to changes in medical technology and patterns of clinical practice along with increasing costs of patient bed-days. The variation in ALOS between private and public institutions mainly reflects differences in casemix between the two sectors.

B.3 The nature of hospital clientele

Hospitals deal with four groups: patients and their relatives; health professionals in private practice who use hospital premises and facilities to treat their patients; governments, which fund much of the treatment that is provided in hospitals; and health insurance organisations which pay benefits to cover the treatment of insured members who require hospitalisation. These groups place different demands on hospitals.

Patients do not form a homogeneous group. Some seek care and treatment that is inexpensive and effective, while others are less concerned with cost but seek timely treatment in comfortable surroundings. For some it is important to be treated by the doctor of their choice.

Governments specify that public hospitals should provide services to Medicare patients free of charge on the basis of assessed need. Further, governments urge that hospitals be efficient and cost effective in delivering services.

Health insurance organisations place two demands on hospitals. The first is that the services offered to private patients be sufficiently attractive relative to those offered to Medicare patients to generate demand for private health insurance. Second, health insurance organisations encourage hospitals to provide their services at minimum cost and not to supply unnecessary services to those privately insured. As discussed in chapter 6, hospitals and health insurance organisations may enter into agreements under which insurees are provided an incentive to seek treatment at particular hospitals, and hospitals agree to contain costs and avoid unnecessary services.

A patient can be admitted to a hospital either through a referral from a general practitioner or specialist, or after consultation with a general practitioner in a hospital casualty ward. However, not all hospitals have a casualty ward.

Whatever the form of admission, typically the patient will follow the advice provided by the doctor as to whether hospitalisation is required and in which hospital he/she should receive treatment.

However, doctors cannot admit and treat patients in all hospitals. Hospitals control which doctors can use their facilities, and admit patients for treatment, through either direct employment or appointment, or by granting clinical privileges. Patients who opt to be treated in public hospitals under the Medicare arrangements cannot be refused treatment but must accept a practitioner employed or appointed by that particular public hospital.

Access to clinical privileges is particularly important for specialists, as many of them rely on the use of hospital facilities to provide the bulk of their services. Access to clinical privileges is less important for general practitioners who provide a large proportion of their services at their own surgeries.

In most cases, health care professionals are not charged a fee for use of the hospital's facilities, nor are highly regarded doctors paid a fee by the hospital for their patronage. Rather, hospitals compete for the patronage of doctors through the facilities they offer.

B.4 Public hospitals

Public acute care hospitals provide inpatient care, outpatient care, teaching and research facilities. Inpatient services account for approximately 65 per cent of public hospital resources.

Government funding of capital facilities in the public hospitals, together with regulations which constrain the purchase of equipment by private hospitals, means that generally the facilities and range of services offered are superior in public hospitals. Accordingly, doctors often treat private patients in public hospitals. Indeed, some forms of surgery can only be performed in a public hospital. The Task Group into Health and Medical Services Exports stated that:

> private medical practitioners frequently refer patients with private insurance to public hospitals .... Evidence suggests that more than 20 per cent of patients treated in public hospitals carry private insurance, but are referred there by their doctors because of the availability of support services in public hospitals (submission no. 10, p. 14).

Reflecting these advantages, some public acute care hospitals have become the major teaching schools and furnish the leading research facilities for Australian medical practitioners.

Administration and planning

The administration and funding of public hospitals is the responsibility of State Governments. They choose the number, location, size, staffing mix and equipment levels of public hospitals.

In choosing the location and size of public hospitals, most States operate on a regional basis. Generally, within each region, there exists one base hospital and a number of smaller sized district hospitals.

Planning for future public hospital facilities and manpower has been based primarily on estimates of the need for hospital services. Generally governments have used World Health Organisation planning ratios which specify that so many beds per 1000 population are required to meet the needs of a community.

In determining whether to establish or close a hospital in any particular region, States generally take into account existing facilities, population projections, demand for services (current and future), resources available and inter-regional patient flows. For example, a recent report commissioned by the Health Department of Victoria was cited in The Age (Heath 1991) as recommending that the north-eastern region (one of three metropolitan regions in Victoria) should be redeveloped with the closure of Fairfield Hospital and three other hospitals in the region have their bed numbers reduced. The report argues that there is an oversupply of beds in this particular region and that 'such rationalisation would allow for the building of a new hospital at Wittlesea, one of Melbourne's fastest-growing areas'.

No direct formula is used by States to determine the allocation of medical staff to hospitals. However, factors such as the level of funding, the availability and expertise of staff, present and predicted workloads, and waiting times all play a role in determining staff numbers for hospitals.

The duty of administration of public hospitals in each of the five mainland States is separated between a central office and a group of regional offices. For example, NSW has developed area health boards (AHBs). Each is managed by a board of directors who are appointed by the State Health Minister for a period of seven years. Apart from other health related responsibilities, these boards are accountable for the direct administration and management of public hospitals within their region. Duties include the planning and delivery of hospital services, negotiations of recurrent and capital expenditures and the monitoring of the performance of public hospitals within their region. Decentralisation in NSW and the other States reflects a view that offices located within a region are better placed to determine the needs of the community within the area and to respond to those needs more quickly.

The regional boards' autonomy in all States is subject to the overriding authority of their respective governments. For example, in NSW, the Minister for Health can appoint and dismiss members of hospital boards and veto any decisions on how a public hospital intends to spend its money.

Tasmania is in the process of establishing regional hospital boards which will take over most of the management of public hospitals leaving a few state-wide services to be administered by the head office of the State Health Department.

In most States, hospital boards or AHBs submit to their State Department of Health any requests for additional staff. For example, in South Australia, role and function statements in area health plans stipulate staff requirements for the forthcoming year. In Queensland, applications for additional staff are submitted annually by hospital boards to the Health Department for assessment.

Boards of directors are also responsible for the purchase of capital. In all States, boards are able to purchase equipment up to a financial limit of around $50ÿ000 from recurrent or operating funds. Generally, when the value of the equipment exceeds this level, hospital boards must obtain approval for the expenditure from the appropriate State Health Department.

Not all public hospitals are managed by a government organisation. Charitable and/or religious groups also run a number of public hospitals. For example, St Vincent's, St Margaret's and the Royal Women's Hospitals in Sydney are operated by religious groups. This group of public hospitals have their own Acts of Parliament and are entitled to their own board of directors. These boards are responsible for the administration and day to day running of their hospitals in cooperation with the appropriate regional board. Funding for such hospitals is determined through a request made by the board of directors to the appropriate regional board. The board of directors is ultimately responsible for how the money is spent.

Funding of public hospitals

Public hospitals obtain revenue from Federal and State Governments, from fees paid by private patients and donations from the public.

Hospital funding grant

Public hospitals receive most of their funds from their respective State and Territory Governments. However, the bulk of this money is provided to the States by the Commonwealth in the form of general purpose or specific purpose grants. General purpose grants can be spent by the State Governments in any way they choose. Specific purpose grants are grants from one level of government to another made for the purpose of financing a specified service.

Currently, the States and Territories receive a specific purpose grant from the Commonwealth Government for public hospital services under the Medicare Agreement of 1988.

This hospital funding grant has four major components:

(1) Base grant

These grants are tied to movements in the consumer price index plus movements in the growth of demand for hospital services which result from an ageing population. This growth factor is measured by a weighted age/sex population index.

(2) Public provision adjustments

This provision requires that states provide at least 55 per cent of all occupied bed days in public hospitals to public patients. Failure to do so involves a penalty of $155 per bed day for excess private patients.

(3) AIDS payment

This grant provides for specific grants to assist the states in treating AIDS patients.

(4) Incentive package payments

These grants are specifically aimed at improving the effectiveness of resource use by public hospitals by promoting he substitution of some inpatient care for day surgery, post-acute early discharge and palliative care use. These grants also include a grant for any work undertaken to develop casemix systems which could be adopted by the states for management or funding purposes.

The Commonwealth also agreed, under the 1988 Medicare Agreement, to replace the previous Teaching Hospital Equipment Program with a broader Hospital Enhancement Program. Under this latter program, the Commonwealth provides funds to the States to help with the acquisition of new equipment and to upgrade clinical services. The Commonwealth shares the funding with the States -- for every $2 spent by the Commonwealth the States must contribute $1.

Table B.1 shows the Commonwealth's public hospital grants to the states for 1989-90.

State grants

The Hospital Funding Grant in 1989-90 covered approximately 27 per cent of all hospital funding. State and local governments, which made up the shortfall, contributed around $9 billion to public hospitals in 1989-90.

Since the late 1970s, annual allocations by State Governments have been based mainly on the amounts outlaid and earned in the previous year adjusted for inflation and productivity. Hospitals established in periods of relatively buoyant government expenditure enjoy the advantage of a more generous funding base than hospitals established in periods of government expenditure restraint.

Problems with current funding arrangements

Under current funding arrangements there is only limited flexibility for dealing with changes in patient workload or casemixes. That is, historically based funding provides little scope to relate funds allocated to the resource intensity requirements of the patients treated in different public hospitals. Due to the lack of meaningful data, high cost hospitals can claim that their patient mix is more complex and that therefore their costs are higher. From this perspective, the problem of how to fund hospitals is directly linked to problems of measuring hospital performance accurately. At the present time, it is not possible to determine whether differences in costs are due to differences in casemix, or the provision of different and/or additional services such as teaching or research costs, or reflect differences in efficiency, or the quality of care.

Table B.1: **Hospital funding grants, 1989-90**

Type of Payment	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*NT*	*ACT*	*Aust*
					$'000				
Base grant	1 166 239	868 871	557 163	299 329	298 480	91 265	20 483	43 583	3 345 413
Public provision adjustment									
- Public bed days	0	-15 419	0	0	0	0	0	–628	-16 047
- Medicare benefits	0	0	0	0	0	0	0	712	712
- Other	0	0	0	0	0	0	-100	-250	-350
Sub-total	0	-15 419	0	0	0	0	-100	-166	-15 685
- Adjusted base	1 166 239	853 452	557 163	299 329	298 480	91 265	20 383	43 417	3 329 728
AIDS payment	13 405	5 344	1 768	1 256	876	176	87	321	23 233
Incentive package									
- Post acute	9 697	7 225	4 632	2 489	2 482	759	171	362	27 817
- Day surgery	3 879	2 890	1 853	996	993	303	68	145	11 127
- DRGs[a]	1 410	1 130	706	384	631	158	120	67	4 606
Sub-total	14 986	11 245	7 191	3 869	4 106	1 220	359	574	43 550
Total	**1 194 630**	**870 041**	**566 122**	**304 454**	**303 462**	**92 661**	**20 829**	**44 312**	**3 396 511**

a) DRGs are Diagnostic Related Groups.
Source: Letter from Department of Finance.

Responses to current funding arrangements

In recognition of this problem, the Commonwealth Government has introduced a program to move towards a funding mechanism based on diagnostic related groups (DRGs). DRGs classify patients into groups according to the patient's diagnosis, where patients within a DRG are assumed to require similar treatment and care (resources).

The current Medicare Agreement makes explicit reference to the use of DRGs in the incentive package payments section. Under the program, which is still in its early stage, DRG grants are allocated by the Commonwealth on a submission basis. The Commonwealth has to set aside approximately $5 million per year (in real terms).

Most State health authorities are interested in improving the data base so as to assign patients to groups and/or to develop techniques which help with the collection of information about a patient's diagnosis. Projects include increasing the coverage and standard of medical records, and the development of costing and associated financial systems in individual hospitals with the prospect of aggregating this data to a State level.

Currently, preliminary casemix data are available in many public hospitals in Victoria and South Australia, whilst NSW has collated preliminary data for all types of hospitals and has published them in a statistical series.

Some State Governments have also introduced schemes to alleviate the rigidities of historically based funding.

For example, NSW introduced a *resource allocation formula* in 1989-90 to distribute funds to the AHBs. The principle behind the formula is to allocate a greater proportion of funds to growth areas, for example, the western suburbs of Sydney. The formula takes into account projected population growth within and between areas, makes adjustments for age and sex, health status, private hospital activity, interstate patient flows and the casemix of individual hospitals.

Changes in the distribution of funds following the introduction of the formula have led to shifts in hospital services. That is, the number of beds has increased in certain districts and declined in others. Also, the services provided by some hospitals have changed. For example, a 900 bed Sydney general referral hospital is directing its non-complex plastic surgery to a 200 bed district hospital (National Health Strategy 1991, p. 32).

In Victoria, the Health Department has established health service agreements with individual public hospitals. The agreements require public hospitals to specify the services they are going to provide and how their resources are going to be allocated within their given budget. Performance indicators have been established -- for example, inpatients treated, average length of stay and occupancy rates -- to measure the achievement of these objectives. The agreements also require hospitals to identify likely changes in the mix of service provision over the coming five years and to identify the longer term general direction of service delivery and mechanisms to provide those services with the given and projected availability of resources. Nearly 50 per cent of public hospital expenditure is covered by these agreements (HDV 1989, p. 35).

Fees paid by private patients in public hospitals [2]

Fees charged for private patients in public hospitals are set by State Governments. Most States have two classes of private patients. One group of private patients are classed as ineligible or compensable and include workers' compensation patients, motor car accident patients, overseas students and foreign patients entering under a medical visa. The second class comprise Australian patients receiving treatment which is covered by private health insurance. The fees charged to

2 Private patients refers to non-Medicare patients.

eligible private patients in each of the States are set out in table B.2.

Table B.2: **Standard hospital fees for eligible private patients in public hospitals, 1991**

	Shared ward	*Single room*	*Date of effect*
		$ per day	
New South Wales	182	302	1 July 1991
Victoria	145-217	283-365	1 Oct 1990
Queensland	181	283	1 July 1991
South Australia[a]	185		1 July 1991
Western Australia	173	243	1 July 1991
Tasmania	145-217	283-365	11 Mar 1991
Australian Capital Territory	182	302	1 July 1991
Northern Territorya	175		31 Oct 1990

(a) No single room charges exist for South Australia and the Northern Territory.
Source: Letter from the Department of Health.

Generally, the fees set for eligible private patients fall short of the actual costs of treatment. This shortfall is accommodated through grants given to public hospitals under the Medicare Agreement.

The Department of Health stated that the subsidisation of private patients in public hospitals is a function of two opposing objectives:

> the fees for private treatment have never represented costs or market prices. They have been set at levels that represent the revenue raising needs of governments. This revenue raising requirement has had to be balanced with the need to keep private health insurance affordable to consumers (submission no. 21, p. 15).

As well as failing to cover total costs, fees charged to private patients do not discriminate between the type of service provided. Rather, fee setting is based principally on the number of days of hospitalisation. At the IAC's inquiry into international trade in services, the Royal Children's Hospital stated that:

> Inpatient fees are only a fraction of the real costs and take no account of complexity of care. For example, intensive care at RCH is estimated to cost between $1,000 and $2,000 per day. Whereas daily charges for private patients must be contained to the schedule fee of $287 (Royal Children's Hospital 1988, p. 5).

In most States revenue raised from fees goes to consolidated revenue. For example, Queensland has an account known as the collection fund. Public hospitals in Queensland receiving money from

private patients, deposit this revenue into the Fund. The Queensland Health Department reallocates such funds to the public hospital system as a whole through general hospital funding arrangements. By contrast, in NSW, public hospitals keep the revenue raised from fees with a compensating adjustment being made to the public hospital's annual budget grant.

B.5 Private hospitals

Private hospitals receive no government funding. For those hospitals which are operated on a for-profit basis, patient charges must be sufficient to cover costs. There are also some not-for-profit private hospitals which supplement patient charges with private donations, bequests and the like.

Private hospitals are owned by either individuals, partnerships or companies, or by religious, charitable or community-based organisations.

Mayne Nickless is the dominant company in the private hospital sector owning 23 hospitals. The other four companies which have a major stake in private hospitals are; Health and Life Care, Ramsay Health Care, Markalinga Trust and Alpha Pacific. The two major religious and charitable owners of private hospitals are St John of God and the Mater Hospital group.

Typically, private hospitals are smaller than their public counterparts, catering principally for patients with less complex conditions and who require a lesser degree of intensive care. However, there are some large religious/charitable private hospitals, such as St Vincent's Private in Sydney, which provides a full range of specialty services similar to those of large public hospitals. Generally, the larger the private hospital the closer it will be to the more highly populated areas and the greater will be its ability to provide a wide range of services.

The APHA argued that the extent of any gap between public and private hospitals is being closed by increased capital expenditure. The APHA said that:

> The best of the private hospital facilities have grown to match the best of the public facilities. Indeed, the major private hospitals are currently investing more capital in medical technology than their public hospital counterparts. Surveys of the capabilities of the private hospital industry indicate that the ability of private hospitals to treat a greater range of patient types and perform more complex procedures is increasing rapidly (submission no. 42, p. 2).

Within the private sector, community hospitals are run at a local level and provide basic medical care in non-metropolitan areas. These hospitals are generally small with three-quarters of them having less than 25 beds. However, in South Australia, community hospitals tend to be larger and provide similar services to religious/charitable private hospitals.

The size of not-for-profit private hospitals typically falls between that of community and religious/charitable hospitals. They tend to concentrate on uncomplicated routine surgical procedures.

Australia-wide, private hospitals supply about one-quarter of acute care hospital beds. At the State level, this proportion varies from 20 per cent in NSW and Tasmania to 30 per cent in Victoria.

Regulation of private hospitals

Private hospitals in Australia are directly regulated by State Governments and additionally are influenced by Commonwealth regulations governing private health insurance and the Medicare arrangements.

State regulation

All States license private hospitals. To obtain a licence, a private hospital must meet a range of conditions which include such matters as construction, patient/staff ratios, maintenance of patient records, the provision of ancillary services and the fitness of proprietors to operate a hospital. The regulations range from being fairly general in Tasmania to quite specific in Western Australia where, for example, minimum nursing hours to be received by patients each day are defined.

- *Bed licences*

NSW, Victoria, South Australia and Tasmania state in their regulations that approval for private hospital bed licences can be withheld if increasing overall bed numbers would result in an `oversupply' of hospital services.

Despite the fact that there is excess capacity in the private hospital sector, bed licences are valuable. For example, citing newspaper reports, the Senate Select Committee on Private Hospitals and Nursing Homes (1987) claimed that two private hospitals in Victoria were sold in 1986 for $130 000 and $135 000 per bed. It further stated that the Hospital Benefits Association, one of the private health funds, purchased a hospital in July 1986 for an amount which translated to between $165 000 and $185 000 per bed.

More recently Mr Darryl Maytom, president of the Australian Private Hospitals' Association (APHA), was reported in The Age as saying that:

> a Victorian company paid about $180 000 a bed, including refurbishment costs ..... good quality beds in a general surgical hospital [can] return earnings of $20 000 to $30 000 a year before interest and tax, making them a reasonable buy at between $80 000 and $100 000 (Smithers 1991, p. 21).

And, Dr Barry Catchlove, the head of Mayne Nickless's hospital operations, was reported in the same article as saying that his company recently paid $116 000 per bed to gain control of Hospitals Corporation of Australia.

In its submission to the IAC's international trade in services inquiry in 1989, the APHA provided information on bed licence sale values in other States. In NSW the value was estimated at between $40 000 and $60 000 per bed, in South Australia between $30 000 and $40 000, and in Western Australia at approximately $100ÿ000 (APHA 1989, pp. 1-4).

Several factors may explain the apparent inconsistency between valuable bed licences and low occupancy rates within the private hospital sector. First, the price of bed licences primarily reflects expectations about future demand for services rather than current demand.

Second, occupancy rates vary between regions and according to type of bed-- such as, obstetric or psychiatric. This may mean that some private operators are unable to obtain beds in areas and for services that they want to provide. Further, quite low average occupancy rates may be inevitable given day to day fluctuations in demand for services. This does not deny the possibility that beds are profitable even if the average occupancy rate is only 60 per cent.

- *Capital expenditure*

In some States specific restrictions apply on the acquisition of equipment. In addition, procedures for gaining approval to pay Medicare benefits may allow the Commonwealth Government to indirectly control capital expenditure (see below).

In Victoria, permission must be sought from the Health Department for the purchase of radiation equipment costing more than $200 000 and legislation has been enacted prohibiting the acquisition of lithotriptors by private hospitals. The South Australian Health Commission has the power to deny the provision of any services or equipment in private hospitals which it cares to specify. It has also decided that no private hospital should operate a lithotripsy service. NSW, Queensland, Tasmania and Western Australia have no restrictions on the acquisition of new equipment by private hospitals. However, in Queensland, if the equipment requires special building facilities then these must be approved.

The Victorian Government also has the power to withhold plans and specifications for any private hospital, if it believes that the construction would not be consistent with proper supervision, maintenance and coordination of services in that State.

Commonwealth Government regulation

The Commonwealth Government does not directly regulate the private hospital sector, but its activities indirectly effect the sector in two ways. First, they influence the demand for private hospital services. Second, they restrict the private sector's ability to adapt and introduce new technology.

Medicare provides free treatment in public hospitals, therefore reducing the demand for non-subsidised services in the private hospital sector. However, the initial reduction will be offset to some extent if the increase in demand for free public hospital care leads to queuing for these

services. Limits on the supply of public hospital services seem to have restricted the growth of subsidised Medicare services.

Benefits paid by private health insurers are regulated by the Commonwealth Government. These regulations constrain private hospitals acquiring new high technology equipment. This is because private hospitals must gain approval for payment of benefits for procedures, using such equipment, if these have not been included in the Medical Benefits Schedule. To obtain approval, a hospital must apply to the Department Of Health which consults with the appropriate State health authorities before making its decision. According to the APHA in its submission to the IAC's *International Trade in Services* report:

> In practice such approval has not been forthcoming. It is an implicit or explicit policy of State and Federal Governments to limit the number of new equipment for use in the 'local market' and to limit them to public hospitals (APHA 1989, p. 5).

As a result of these restrictions on the acquisition of equipment, private hospitals' ability to cater for certain types of patients is diminished.

Self regulation of private and public hospitals

The Australian Council of Health Care Standards (ACHS) is a self regulating body established in 1974 by the Australian Medical Association and the Australian Hospital Association. The ACHS:
is a not-for-profit, independent industry association formed to promote professional review as the basis for the provision of optimal quality services in health care and also, continuing improvements in these services (submission no. 4, p. 4).

The ACHS accredits hospitals and nursing homes on a voluntary basis. As of February 1991, there were 309 accredited hospitals or some 28 per cent of total acute care hospitals in Australia. Some 55 per cent of private and 58 per cent of public acute care hospital beds were accredited under the ACHS program.

Private patients treated in ACHS accredited hospitals attract higher patient reimbursements from a number of private health insurers. The accreditation process is also seen as a peer review mechanism. The Senate Select Committee on Private Hospitals and Nursing Homes stated that:

> The accreditation process encourages the development of peer review because, in order to be accredited, hospitals must have documented evidence that peer review is being carried out. It can, therefore, be expected that, as more private hospitals gain accreditation, the process of peer review will be practised in increasingly more of these establishments (Senate Select Committee on Private Hospitals and Nursing Homes 1987, p. 360).

C HEALTH INSURANCE

Since the introduction of a public health care system in 1975, there have been significant changes in the health insurance choices facing Australians. Current health insurance arrangements are the subject of this appendix.

C.1 Medicare

The framework for the current health insurance arrangements was put in place in February 1984 when the Commonwealth Government introduced Medicare.

Medicare is a universal health insurance scheme which provides cover against the cost of medical and public hospital services, for Australian residents and for certain categories of visitors to Australia.[1] It also provides cover against part of the cost of medical services obtained in private hospitals, but does not provide cover for the cost of accommodation in those hospitals.

Specifically, Medicare provides:

- 85 per cent of the Medicare Benefits Schedule (MBS) fee for out-of-hospital medical services less $3.50. Patients who are bulkbilled may be required to make a co-payment of $2.50 each time they visit a general practitioner. A transaction fee of $1.00 will be paid to general practitioners who continue to bulkbill claims for services rendered. However, doctors can choose to absorb the reduced Medicare benefit. The 4.5 million people who hold cards allowing concessional access to health services will not be required to make a co-payment;

- additional benefits to ensure that:

  - the gap between the Medicare benefit and the schedule fee does not exceed $26; and

  - the accumulated gap between the Medicare benefit and the schedule fee does not exceed $246 in a calendar year;

- benefits for optometrical services and for a limited range of dental services;

- 75 per cent of the schedule fee for medical services provided to private hospital inpatients. Private health insurance funds may cover the remaining 25 per cent;

[1] Eligible foreign visitors include those who come to Australia for the specific purpose of taking up employment, government-subsidised and sponsored overseas students, and visitors from countries with which Australia has reciprocal health care agreements. Other individuals or groups can be declared eligible to receive Medicare benefits at the discretion of the minister (Department of Community Services and Health 1990a, p. 9).

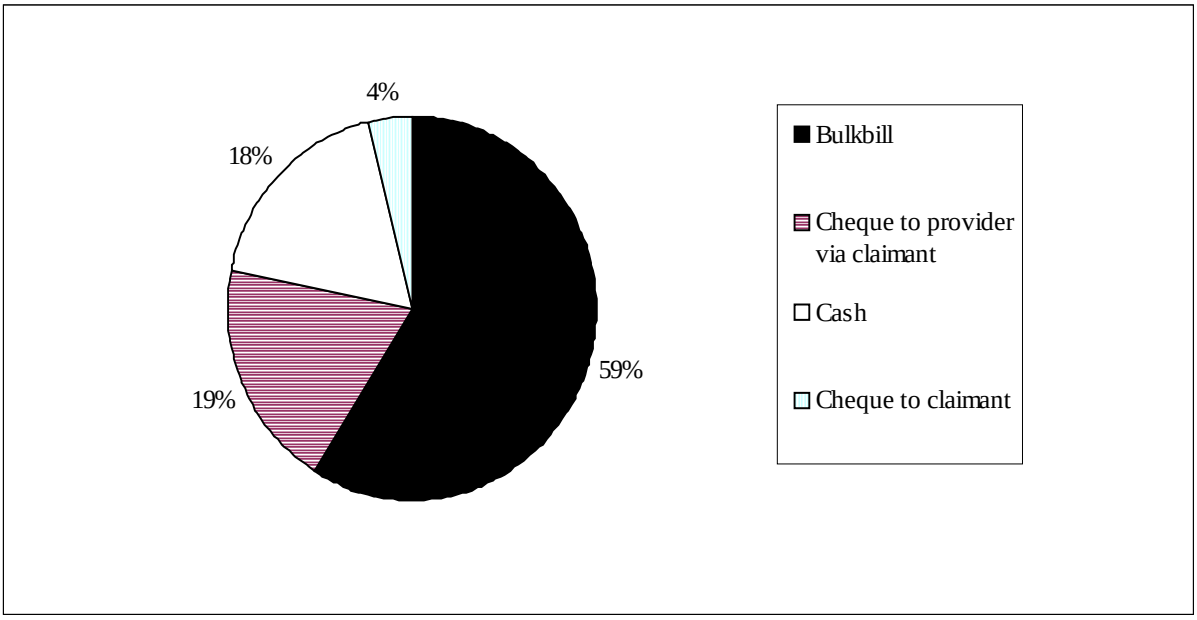
- free treatment for public hospital inpatients and free outpatient services in some public hospitals.

Medicare benefits for treatment by a general practitioner in private practice will be reduced by a further $1.50 from November 1992.

The medical services component of Medicare

The medical services component of Medicare is administered through the Health Insurance Commission (HIC) which arranges payments to claimants. There are three alternatives for claiming for medical services under Medicare. The patient may pay the doctor at the point of service and then seek reimbursement from Medicare. The patient may send the doctor's account to Medicare who then forwards its part of the payment to the doctor through the patient. Alternatively, the doctor may bulkbill the HIC directly. Where the doctor bulkbills, the scheduled fee must be charged and the patient is not currently required to meet the 15 per cent co-payment. However, as noted above, bulkbilled patients (other than health care card holders) may be required to make a co-payment of $2.50. Bulkbilling is the preferred method of charging and occurs in nearly 60 per cent of cases (see figure C.1).

Figure C.1: **Percentage of services processed by bill type in Australia, 1989-90**



Source: HIC 1990, Annual Report 1989-1990: Medicare Statistical Tables, Inprint Limited, Brisbane, table 3, p. 6.

In 1989-90, 145 million medical services were funded under Medicare at a cost to the taxpayer of about $3.8 billion. This represents $26 per service and $217 per Australian. Table C.1 shows the average Medicare benefit paid to persons, by sex, by age group and by State. The table indicates that as people age their demands on Medicare increase. Also, per capita expenditure on females is more than 50 per cent higher than for males.

The hospital services component of Medicare

Under the 1988 Medicare Agreements, the States have agreed to provide treatment for public hospital inpatients free of charge, and to provide accommodation for private patients in public hospitals at the rates set out in the basic health insurance table. This involves subsidising the accommodation costs of private patients. The Commonwealth compensates the State and Territory Governments for the revenue shortfall through hospital funding grants (see appendix B).

Financing of Medicare

Medicare is financed, in part, through a levy of 1.25 per cent of taxable income above a threshold that depends on individual or family circumstances. No levy is payable if an individual earns less than $10 330 (single) or $17 400 (couple or sole parent) a year. For each dependent child another $2100 a year can be earned before the levy has to be paid. In 1989-90, revenue from the levy comprised a little more than one-third of the Commonwealth Government's payments of medical and hospital benefits. The remaining two-thirds of the Government's obligations under Medicare were met from general revenue.

The Medicare Benefits Schedule

The MBS is an important component of Medicare. The fees set down in the MBS are derived from the initial list of 'most common fees'[2] charged for 1880 medical items drawn up by the Commonwealth and Australian Medical Association (AMA) in January 1970. This list was used as the basis for a revised schedule of medical benefits in the legislation.[3]

2 The 'most common fee' was arrived at by reviewing the charging patterns of doctors, item by item, to determine a modal fee.

3 'The 1970 Medical Benefits Schedule and the most common fee list on which it was based was used by the Australian Medical Association in developing the first AMA List of Medical Services and Fees issued in 1973. The AMA list was adopted as the starting point of the 1973 Medical Fees Tribunal, and the Medical Benefits Schedule flowing from the Tribunal's recommendations is, in effect, the basis for the present Medicare Benefits Schedule' (Auditor-General 1991, p. 9), with one significant exception. 'The pathology part of the MBS reflects the recommendations of the Pathology Services Working Party -- comprising commonwealth, state, AMA and private pathologists representation' (Layton 1985, p. 49). Further, as a result of a decision in the 1991-92 budget, the schedule of fees paid for pathology services, other than histopathology and cytology, will be reduced to 65 per cent of the current rate. The schedule of fees for radiological services will be restructured and a new schedule established after a review.

Table C.1: **Medicare: Average value of benefits processed per enrolled person by age and sex of patient, 1989-90, (dollars)**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*ACT*	*NT*	*Aust*
Male - Age (years)									
0-4	208	175	198	205	148	171	195	135	189
5-9	121	104	113	112	85	103	101	59	109
10-14	112	90	103	96	80	90	92	54	99
15-19	118	97	107	105	86	91	92	50	105
20-24	123	100	102	110	85	89	90	51	106
25-34	139	112	117	122	94	107	98	69	120
35-44	173	138	151	149	123	133	123	92	151
45-54	238	182	196	198	171	174	171	123	203
55-64	358	273	288	286	268	238	261	162	304
65-74	359	292	294	303	302	205	284	151	315
75 +	434	354	342	370	344	294	320	142	376
All Males	199	158	168	173	140	143	139	86	172
Female - Age (years)									
0-4	187	154	176	180	130	154	170	121	168
5-9	116	100	109	107	82	98	101	57	105
10-14	111	92	104	98	84	100	98	54	100
15-19	188	150	178	162	156	165	156	111	169
20-24	261	216	233	220	214	231	226	146	234
25-34	320	282	291	289	258	278	273	182	293
35-44	308	258	278	266	238	246	241	181	276
45-54	349	281	308	299	274	274	272	187	309
55-64	395	312	355	319	303	297	306	174	347
65-74	448	367	424	363	350	328	353	190	402
75 +	460	387	418	423	385	341	337	180	418
All females	295	245	264	258	224	234	226	142	263
All patients	247	202	216	215	182	189	183	113	217

Source: HIC 1990, *Annual Report 1989-90: Medicare Statistical Tables*, Inprint Limited, Brisbane, table 14, p. 16.

The Medicare Benefits Advisory Committee (MBAC) advises the minister on changes to the MBS. The Committee is comprised of eight representatives, five of whom must be medical practitioners. The minister must consult with the AMA or a similar body as the minister considers appropriate on four of the five medical appointments to the MBAC.

In practice, the MBAC's functions are quite limited. The Committee advises on whether MBS fees should be changed and what benefits for medical services of unusual length and/or complexity should be paid. It also plays a role in considering appeals for increased fees.

In late 1989, the minister established a Medical Benefits Consultative Committee (MBCC) comprising representatives from the Department of Health, the HIC, the AMA and the professional groups. The role of this Committee is:

> to negotiate new item structures that were 'cost neutral' within the speciality, that is, overall Medicare benefits were not to increase as a result of movements of fees within the speciality area but the relative values assigned to individual services would better reflect current medical practice (Auditor-General 1991, p. 10).

In addition, MBS fees are adjusted within the annual budgetary/economic statement process where individual or groups of fees may be changed. Most of the amendments to the MBS, however, continue to originate from the MBCC on which the medical profession is in the majority.

The processes for determining MBS fees were recently criticised by the Auditor-General who said that a model MBS would:

> be soundly based on reliable costing of the services, taking into account practice costs, and including, professional net income components which take into account, and provide adequately for, factors such as length of education and training, place of service, inconvenience, necessary experience, skill, complexity, average time required and level of responsibility (Auditor-General 1989, p. 14).

The principles and processes for the determination of the MBS rates are far from transparent. And, the medical profession, mainly through the AMA, seemingly has a great deal of influence on the setting of schedule fees.

The Medical Benefits Review Committee suggested that the lack of independent and public scrutiny, has resulted from earlier experience with a more open process:

> As the Medical Fees Tribunal had proved costly and highly demanding of resources, both the AMA and the department concluded that there was a need for a mechanism which could resolve issues relating the MBS without their having to be decided by an independent body (Layton 1985, p. 50).

Tax rebates for health expenditure

Taxpayers who have out-of-pocket expenses of more than $1000 per year for medical, hospital and pharmaceutical requirements are eligible for a tax rebate of 25 cents in the dollar on expenditure

above the threshold. This is additional to the subsidies provided under Medicare or protection provided by any private insurance arrangements.

C.2 Private health insurance

Private health insurance has long been an important component of the Australian health care system and it continues to play a major role in the current system. Indeed, as Scotton (1990) points out, the ability of the Government to provide benefits through Medicare while maintaining expenditure restraint, depends in large measure on a significant proportion of the population electing to be covered against hospitalisation costs by private health insurance.

Depending on the degree of cover purchased, private health insurance may reimburse the cost of accommodation as a private patient in either private or public hospitals. It also provides benefits in areas not covered by Medicare.

Regulation of private health insurance

Private health insurance is extensively regulated by the Commonwealth Government. The rules governing the provision of health insurance are set out in the *National Health Act 1953*. This Act specifies the type of health insurance that may be provided and the nature of the organisations that can provide insurance. In addition, the Act restricts the information insurers may use when setting premiums.

For Australian citizens and permanent residents, the Act prohibits the conduct of health insurance business by organisations other than those registered with the Minister for Health.[4]

In order to be registered under the *National Health Act* an organisation must:

- be in the form of a health benefits fund;
- provide the minimum level of benefits set down by the minister -- these benefits are referred to as the basic table; and
- set premiums which are community rated. That is, the health insurance fund is not allowed to discriminate on the basis of age, state of health, frequency with which the client has used health services or the benefits the client has previously received.

In addition, registered health funds are subject to prudential regulation.

[4] Health insurance business is defined, in the Act, as the business of undertaking liability by way of insurance to pay fees or charges in relation to the provision, in Australia, of hospital treatment or an ancillary benefit.

Organisations that are registered under the *National Health Act* must seek the minister's approval before they can sell health insurance to foreigners. However, the National Health Act does not restrict the sale of health insurance to non-resident foreigners by organisations that are not registered with the minister.

The *National Health Act* allows two categories of private health insurance.

The first category covers hospital care and treatment and provides two levels of insurance -- basic and supplementary. The National Health Act allows the minister to determine the nature and level of benefits in the basic table. The supplementary table is regulated only in so far as it is influenced by the MBS.

The basic hospital table provides cover for a range of items including treatment by doctor of choice, fees for private patients in public hospital shared ward accommodation, fees for private hospital shared ward accommodation and the 25 per cent gap between the Medicare payment and the MBS fee for medical services provided to private hospital patients.

Benefits available under the basic table are generally less than charges payable by private patients, except for shared ward private patients in recognised (public) hospitals. Consequently, people intending to receive treatment as private patients have an incentive to take out supplementary cover if they are to avoid out-of-pocket expenses.

The supplementary hospital table provides additional hospital accommodation benefits to those provided by the basic hospital table. This help covers charges by private hospitals and for a private room in a recognised (public) hospital. Membership of a basic hospital table is a prerequisite for membership of a supplementary hospital table.

The second category of health insurance covers ancillary health services not subsidised by Medicare. Ancillary tables provide benefits for services such as dental, optical, therapies and other non-accommodation services. Ancillary table membership may be held without any basic table membership. The Commonwealth regulates the provision of insurance for ancillary services through its requirement that insurance be provided by registered health funds and through the MBS.

The registered health insurance funds

Registered health insurance funds can be open or restricted. Anyone can join an open fund, but, members of restricted funds must have an affiliation to certain employment groups, unions, or professional associations.

At June 1990, there were 59 registered organisations in control of 93 approved health benefit funds, 75 of which were operational (see table C.2). All but five of the registered funds operated on a not-for-profit basis. Of the not-for-profit funds, 50 were open to the general public, and 20 were of the

restricted type. In 1989-90, these funds had income from premiums of $3 billion.

Insurance coverage purchased

At June 1990, 44 per cent of the population were covered by basic table private insurance and 39 per cent had obtained additional supplementary cover. About 40 per cent were covered for ancillary expenses.

Table C.2: **Numbers of insurers, membership and persons covered, basic, supplementary hospital and ancillary tables, by State[a], June 1990**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*Aust*
Health Benefits Funds Operating [b] (Number)	23	20	11	7	6	8	75
Basic Table							
Membership ('000)							
Single	538	399	161	136	114	37	1384
Family	745	64	244	183	179	58	1973
Total	1283	963	405	319	293	95	3357
Persons covered	2863	2209	918	709	671	219	7588
% of population covered	**46.8**	**50.4**	**31.6**	**44.4**	**41.0**	**48.0**	**44.4**
Supplementary Hospital Table							
Membership ('000)							
Single	457	358	136	122	106	34	1212
Family	633	509	207	165	168	55	1736
Total	1090	867	343	287	274	9	2948
Persons covered	2421	1991	774	636	628	205	6655
% of population covered	**39.6**	**45.5**	**26.6**	**39.9**	**38.4**	**44.9**	**39.0**
Ancillary Table							
Membership ('000)							
Single	472	285	139	147	132	39	1215
Family	644	415	214	202	203	60	1738
Total	1116	700	353	349	335	99	2953
Persons covered	2532	1646	820	810	771	231	6810
% of population covered	41.4	37.6	28.2	50.7	47.2	50.6	39.9

a) State of registration of organisation, not necessarily State of residence of contributor. There were no health benefit organisations (funds) registered in the ACT or NT.
b) From June 1989 provision was made for organisations to register on a national basis rather than by State. However, a separate health benefits fund must be conducted in each State in which the organisation operates.
Source: Private Health Insurance Administration Council 1990, Annual Report 1989-90, Better Printing Service, Queanbeyan, table 9, p. 50.

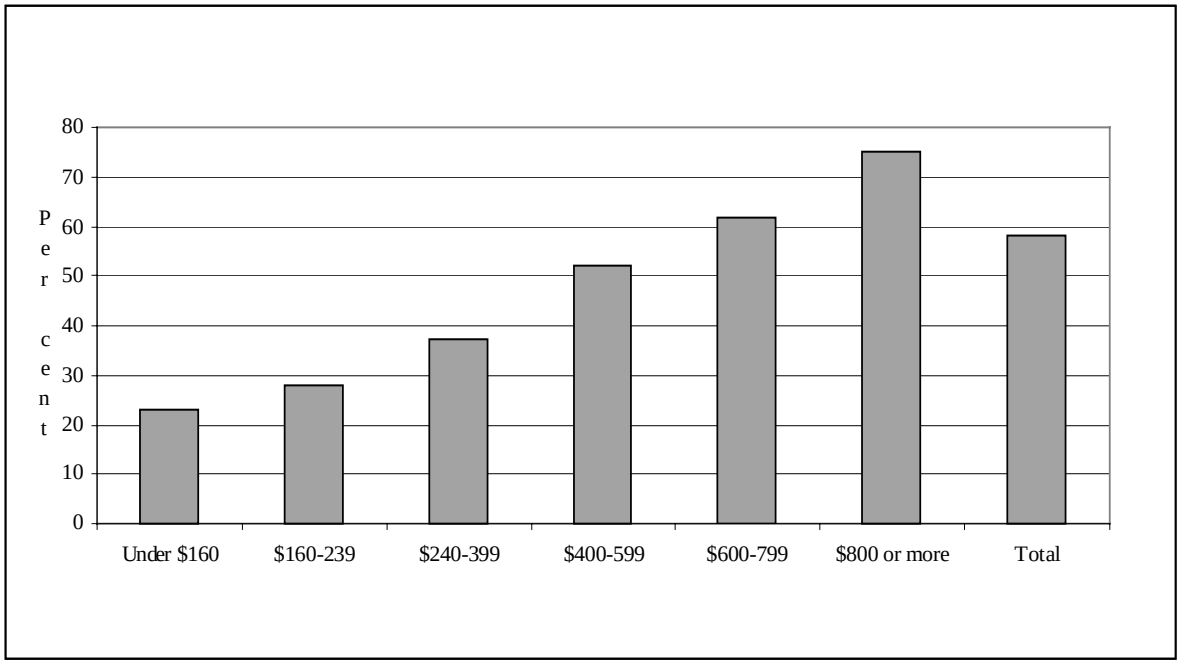
The degree to which private health insurance is purchased varies markedly across the States. At 30 June 1990 only 32 per cent of the population was covered by private health insurance in Queensland while 50 per cent of the population purchased private health insurance in Victoria (see table C.2).

Why do people buy private health insurance?

In a 1990 ABS survey, contributors to private health insurance mentioned the right to doctor of choice, security and peace of mind, and the ancillary benefits available as important factors influencing their decision to purchase private health insurance. Contributors also mentioned the ability to avoid waiting lists, financial considerations, habit and that it was a job requirement to carry personal insurance.

The decision to purchase private health insurance is strongly related to income. The ABS health insurance survey showed that the proportion of people covered by health insurance increases with gross weekly income. According to the survey, 74 per cent of individuals/families with a gross weekly income exceeding $800 had health insurance cover compared with only 23 per cent of individuals/families with gross weekly income less than $160 (see figure C.2).

Figure C.2: **Percentage of contributor units[a] with private health insurance, by gross weekly income, June 1990**



a) The term 'contributor unit', refers to individuals or families as defined by their private health insurance arrangements.
Source: ABS 1990, Health Insurance Survey, cat. no. 4334.0, June.

Age is also an important factor influencing the decision to purchase private health insurance. Those under 25 and over 70 years of age are less likely to purchase health insurance, while those in the 35 to 59 year age groups are significantly more likely to purchase private health insurance (see table C.3).

Effect of government policy on the purchase of health insurance

The introduction of Medicare and the consequent availability of free treatment in public hospitals has been accompanied by a large fall in the number of people with private health insurance. This is true for all but the elderly. Only those aged over 60 have continued to purchase private health insurance at the same rate as before the introduction of Medicare (see table C.3).

Table C.3: **Level of private hospital insurance by age, 1983 to 1990**

Age	*Percentage of contributor units with private hospital insurance*				*% change*
	1983	*1986*	*1988*	*1990*	
15-24	55	29	30	30	-46
25-34	70	46	43	40	-43
35-49	76	56	54	53	-30
50-59	71	56	57	56	-22
60-69	45	42	43	45	0
70 and over	36	32	35	37	+2
Total	**62**	**44**	**44**	**43**	**-31**

Source: National Health Strategy 1991, *A Healthy Risk? Use of Private Insurance*, Background Paper no. 4, Treble Press, Australia, table 9, p. 30.

D REGULATION OF THE MEDICAL AND NURSING PROFESSIONS

Each State and Territory regulates medical practitioners and nurses. Medical practitioners are also self-regulated through their associations and voluntary codes of conduct and ethics. However, the distinction between self-regulation and government regulation is ill-defined as medical practitioners are involved in the main bodies that administer the formal regulations that affect them. In many cases representatives of the medical profession are in the majority on these bodies.

The main case for regulating health professionals hinges on the view that patients do not have as much information about the medical treatment they may require as the practitioners proposing to treat them. Regulations that require health professionals to be accredited can screen out less proficient operators. Accrediting health professionals can also reduce the cost of identifying and arranging the appropriate medical service.

However, regulations can be used to restrict the entry of new service providers as well as reduce competition between existing providers. This can reduce efficiency and raise costs. This issue is further discussed in chapter 6 of the report.

D.1 Regulation of entry into the medical profession

Entry into the medical profession in each State and Territory is controlled by medical registration boards which operate as independent statutory authorities responsible to State Ministers for Health. These boards set standards for the registration and, in some cases, for the conduct and control of the profession.

There are four ways by which a person can qualify to practise medicine in Australia:

- by obtaining a medical degree from an Australian university and then doing the necessary period of internship;

- by holding an overseas medical qualification that is automatically recognised by one or more States;

- by holding an overseas medical qualification and passing the Australian Medical Council (AMC) examination and assessments and then fulfilling any other requirements in the State in which registration is sought; or

- by holding an overseas medical qualification and obtaining a form of limited, provisional or temporary registration for the purpose of practising in a particular situation -- for example, providing medical services in outback areas. Full registration is often granted after a period of

temporary registration. Indeed, this was a fairly common method by which overseas trained doctors gained admission to practise, prior to the introduction of the AMC examination.

Entry through Australian medical schools

Australian medical education is regulated by the AMC, which advises and makes recommendations to the State and Territory medical registration boards in relation to the accreditation of medical schools and of courses leading to basic medical qualifications. The AMC is now in the process of assessing the 10 medical schools in Australia.

The number of medical graduates from Australian medical schools has been limited by student enrolment quotas since the early 1950s. In the early 1970s, the Committee on Medical Schools (Karmel 1973) recommended some expansion of medical education with the consequence that medical graduates completing the Bachelor of Medicine, Bachelor of Surgery (MBBS) course increased from about 1000 in 1973 to nearly 1600 in 1978. However, admission policies were subsequently tightened and the number of medical graduates has since declined to 1235 students in 1991. After 1991, the number of medical graduates is expected to increase by about 100 per year, with a significant portion of this increase comprising overseas students who are not expected to remain and practise in Australia.

Figure D.1 shows the total number of students (including overseas students) who commenced studies at the 10 medical schools in 1991. Though there was a very marginal decline in the total number of Australian students commencing medical studies between 1985 and 1991, there was a significant increase in the number of foreign students enroled over the same period (see figures D.2 and D.3). This followed a 1986 policy change which allowed universities to retain the earnings from full fee-paying overseas students (discussed further in chapter 4).

The decline in admissions of Australian medical students since 1985 reflects a combination of resource constraints, increased course length, and pressure from the Australian Medical Association (AMA) to reduce the intake of students.

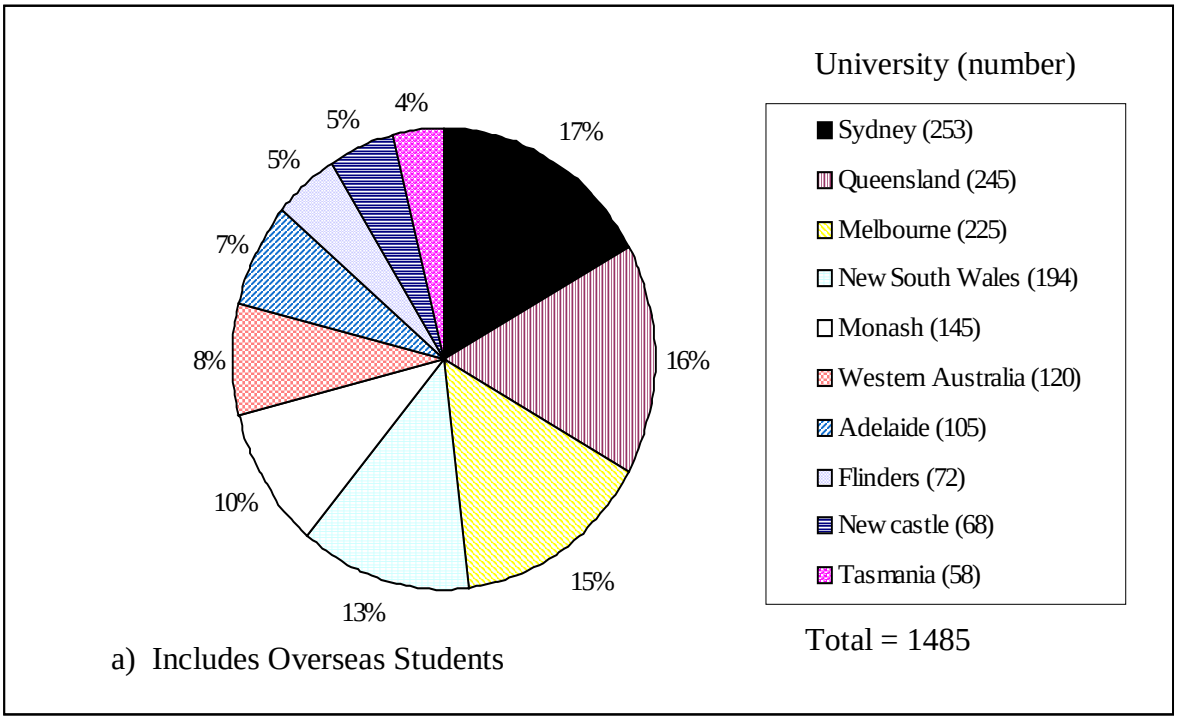
In 1986 some Australian medical schools increased the course length from five to six years. The University of Sydney, Faculty of Medicine stated that:

> In 1985 and previous years the admission quota into the undergraduate medical course was normally 250. In 1986, the Faculty adopted a new six-year curriculum and had no choice but to gradually reduce its intake as its funding from the Commonwealth now had to support a course of a longer duration (letter to Commission).

The Faculty of Medicine of the University of New South Wales stated:

> Faculty and the University also has to be cognisant of the demands from the medical profession, and at times government, to reduce or at least maintain the output of doctors (letter to Commission).

Figure D.1: **Students [a] in Australian medical schools, 1991**



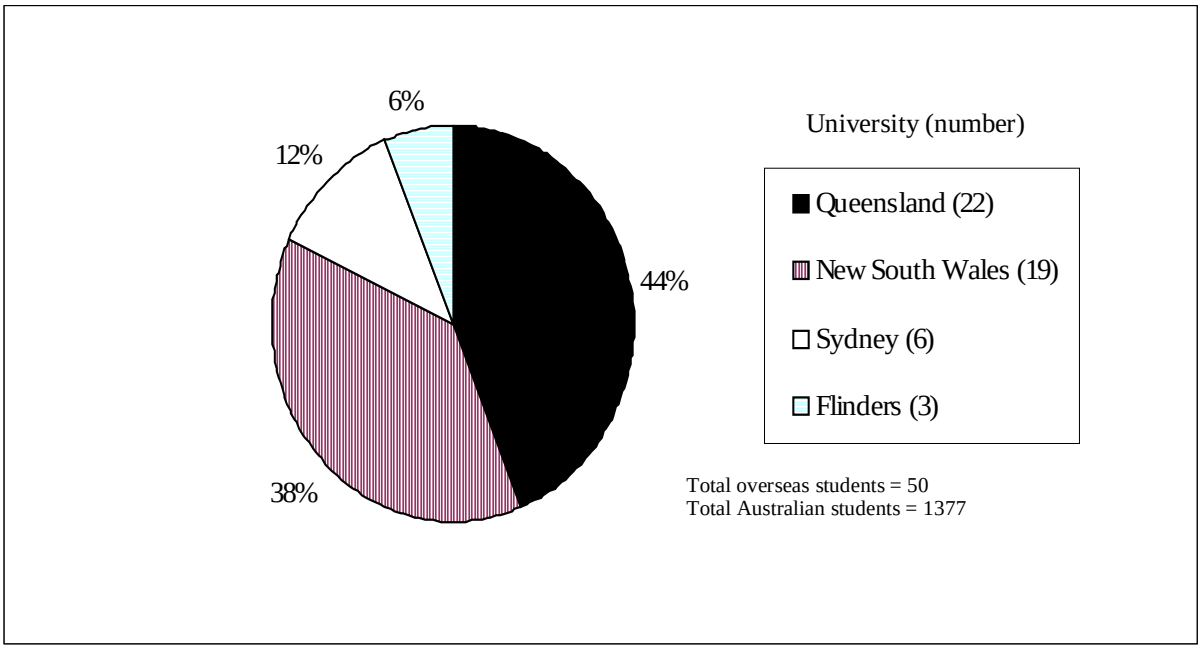
Source: Information provided by medical schools.

The Committee of Inquiry into Medical Education and Medical Work force (1988) assessed that 1250 represented the appropriate intake of medical students and saw 'no need at present for any further reductions beyond those already in train.' It recommended that a Medical Work force Review Committee (now called the Medical Work force Data Review Committee) be set up to review in 1993 the intake of students into the medical schools, 'to ensure that medical school graduations remain appropriate to the overall medical Work force'. The medical profession has a significant representation on this committee.

The AMA has argued for a reduction in medical school intake quotas. It indicated that it has had discussions with the department of health to reduce the annual intake of medical students into the 10 medical schools to overcome the `oversupply' of doctors.

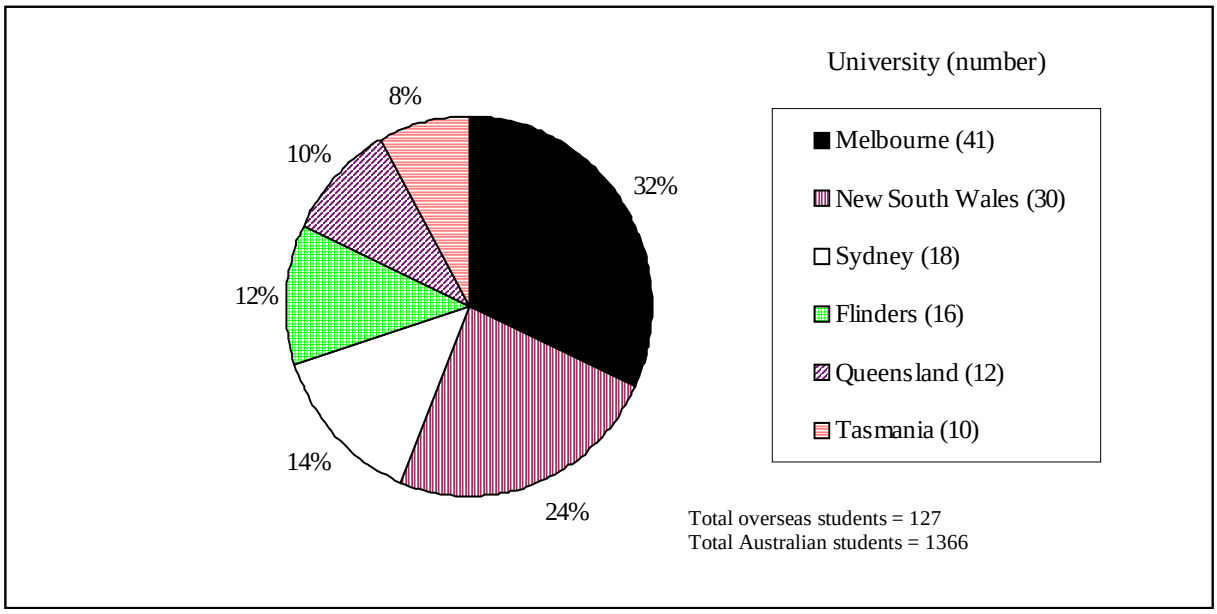
The demand for medical studies in universities far exceeds the available places. The Dean of the Faculty of Medicine of Monash University stated:

Figure D.2: **Overseas students in Australian medical schools, 1985**



Source: Information provided by medical schools.

Figure D.3: **Overseas students in Australian medical schools, 1991**



Source: Information provided by medical schools.

> There is a strict quota for entry of both local and overseas students. These restraints were earlier provided by the Commonwealth Tertiary Education Commission (now DEET) on Work force data. Applications exceed these quotas by the order of 10 times. Each year we review between 1500 and 2000 applicants to select our total entry of 160 students (letter to Commission).

Ratios of applications of about 5 to 10 to every acceptance are typical in Australian medical schools compared with the ratio of about 2 : 1 in the USA (Feldstein 1988, p. 366).

Automatic accreditation on the basis of an overseas medical degree

The conditions for accreditation of foreign trained doctors have become progressively more restrictive over time.

In 1970 doctors trained in 20 countries could obtain automatic accreditation in at least one Australian State or Territory. However, since the early 1970s, each State/Territory medical registration board has taken steps to reduce the range of overseas medical qualifications accorded automatic recognition.

> in the early 1970s, in response to a shortage of medical practitioners in Australia, overseas doctors from a number of countries were permitted to migrate to Australia under a skilled migrant category. There was no registration problem, all state legislation recognising degrees of at least the Commonwealth countries. When the need for medical practitioners in Australia had been satisfied, and as professional bodies representing the medical practitioners began to demand a protectionist approach to recognition of qualifications, state governments began in the 1970s to de-recognise institutions and degrees. The de-recognition occurred largely on a country-by-country basis rather than on an institutional basis (Allars 1988).

As a consequence of this policy shift, by 1990 automatic accreditation only applied to doctors trained in four countries (see table D.1).

More stringent overseas accreditation regulations have been accompanied by a reduction in the immigration of doctors to Australia. Doctor arrivals peaked at 694 in 1977, declined to 90 in 1982-83 (CIMEMW 1988, p. 420). While there has since been an increase in the migration of doctors to 432 in 1989-90 (AIH 1991, table 8), at least a quarter immigrated under the family and humanitarian categories. In contrast to the 1970s, many of these doctors cannot automatically register as medical practitioners.

The overall reduction in the number of foreign medical qualifications granted automatic accreditation seemingly has little to do with maintaining medical standards in Australia. The AMA argued:

> despite the excellence of British medicine and the eminence of British doctors as being amongst the best in the world in clinical medicine, the New South Wales Medical Board ... denied automatic recognition to British graduates ... (submission no. 37, p. 29).

Table D.1: **Automatically registrable overseas medical qualifications by State or Territory, 1970 and 1990**

Country of qualification	*State or Territory*							
	NSW	*ACT*	*NT*	*Qld*	*SA*	*Tas*	*Vic*	*WA*
UK	r	R	R	R	R	R	R	R
New Zealand	R	R	R	R	R	R	R	R
Ireland	r	R	R	R	r	R	R	R
Canada	r	r	r	r	r	r		r
South Africa	r	r	r	r	r	R	r	r
Malta	r	r	r		r	r	r	r
Hong Kong	r	r	r		r	r	r	r
Malaysia	r		r		r	r	r	
Singapore	r	r	r		r	r	r	r
Uganda	r		r		r	r		
Sri Lanka	r	r	r		r	r	r	
India	r		r		r	r	r	
Pakistan	r		r		r	r		
Burma	r		r		r	r		
West Indies			r		r	r		
USA	r							
Puerto Rico	r							
Israel	r							
Lebanon	r							
Sweden	r							

R = registrable in 1970 and in February 1990.
r = registrable in 1970 but not in February 1990.

Source: Iredale R. R. 1987, Wasted Skills: Barriers to Migrant Entry to Occupations in Australia, The Ethnic Affairs Commission of NSW, Sydney, table 6.5 (updated), p. 124.

Move towards a national system of accreditation for health professionals

In March 1991 the Australian health ministers announced a national system of recognition for health professionals, including doctors (Australian Health Ministers' Conference 1991). The national system for doctors will provide automatic recognition in all States and Territories for doctors:

- who were in unrestricted practice throughout Australia in March 1991;
- who are graduates of Australian and New Zealand medical schools and have satisfactorily completed intern training; and
- any overseas doctors who have met the requirements of the AMC.

A working committee will examine the detailed implications of this decision and report to the health ministers with a view to commencement thereafter through legislation in each of the States.

In moving towards a national system for the recognition of qualifications of doctors in all States and Territories, the most restrictive state system -- NSW -- has been adopted as the benchmark. Thus, in practice, the proposed system appears unlikely to free up the movement of practitioners between the States. For example, a practitioner registered in Queensland with his/her primary training in Ireland could still not automatically register in NSW.

The AMC examination

The AMC assumed responsibility from the commonwealth in 1986 for the assessment of overseas trained doctors who seek to practice in Australia.

In order to become accredited, doctors -- both general practitioners and specialists -- trained in overseas countries who are not granted automatic registration must pass the:

- National Office of Overseas Skills Recognition level 3 Occupational English Language Test;
- the AMC multiple choice question written examination;
- the AMC clinical examination; and
- may be required by a medical registration board to undertake a period of supervised practice, usually in a teaching hospital, before being granted full recognition by the board.

The medical registration boards have discretionary powers to allow immediate recognition of overseas trained doctors' qualifications, but these have rarely been used, except in cases of visiting experts seeking temporary registration.

The AMC examination procedures consist of a 3 hour written paper of 150 multiple choice questions and a clinical examination. Candidates may not proceed to the clinical examination until

they have passed the multiple choice exam. Three attempts at the multiple choice exam and two at the clinical examination are permitted.

The AMC examinations and assessment procedures have been extensively criticised by the Overseas Trained Doctors Association (OTDA) and others as being unfair and a device to limit the supply of doctors. The AMC has conducted a review of its examination system and is in the process of revising its assessment procedures (AMC 1990). The OTDA contends that many of the proposed changes are discriminatory.

Dr Con Costa of the Doctors' Reform Society highlighted the restrictiveness of the procedures when he was reported to have stated that 'almost half of the nation's doctors over the age of 45 would fail the AMC exam if they were forced to take it'. The OTDA contends that, as a result of these unreasonably stringent procedures, there is a pool of between 1500 and 1800 overseas trained doctors now resident in Australia who cannot practise medicine.

In response to the draft report the AMC said that:

> The records for the AMC examination ... indicate that there has been a steady increase in the number of overseas trained doctors seeking to enter the medical Work force in Australia. Indeed, the potential pool may be much larger than the examination data indicates. The Table only records those doctors who have actually presented for an examination and obtained a result. The examination data does not include those doctors who have applied to have their qualifications assessed. Whereas the actual number of new candidates presenting for examination rose from some 300 in 1989 to over 500 in 1991, the number of formal applications received for assessment rose from some 900 in 1989 to over 1200 in 1991 (submission no. 41. p. 3).

The AMC also said that:

> Contrary to the views expressed in the Draft Report, the Council considers that one of the factors which has led to the substantial rise in the number of doctors seeking to enter the medical Work force in Australia is the less stringent requirements for registration in Australia compared to other large migrant receiving countries. (submission no. 41. p. 3).

The AMC included in its submission a survey of the entry requirements for doctors in the USA, Canada and the UK.

Limited, provisional or temporary accreditation

Each State and Territory has procedures for granting temporary registration to medical practitioners with overseas qualifications who do not qualify for automatic registration.

Temporary resident medical practitioners must be recruited and sponsored by an employer who has support from the State/Territory health authority. They are not normally allowed to compete with resident private practitioners.

The number of medical practitioners entering Australia under temporary resident visas increased from 116 in 1986-87 to 1255 in 1989-90 (see table D.2). The increased use of temporary

registrations seemingly reflects the tightening of other avenues for entry into the medical profession, together with unmet demand for medical practitioners in the public hospital system.

Table D.2: **Medical practitioner arrivals as temporary residents by region/country of citizenship, 1986-87 to 1989-90**

Region/Country of last residence	*Year* 1986-87	1987-88	1988-89	1989-90
Europe				
UK	58	65	370	735
Ireland	3	2	31	64
Germany	1	12	4	25
Italy	2	-	2	11
Other	12	7	27	26
Sub-total	**76**	**86**	**434**	**861**
Middle East				
Israel	-	-	11	12
Other	1	1	4	2
Sub-total	**1**	**1**	**15**	**14**
America				
Canada	-	12	21	35
USA	2	2	55	127
Other	-	1	1	12
Sub-total	2	15	77	174
Africa	**-**	**-**	**5**	**4**
Asia				
India	1	4	1	23
Japan	17	6	21	15
Malaysia	8	6	• 6	40
Sri Lanka	-	1	10	30
China	9	6	9	55
Other	2	1	12	5
Sub-total	**37**	**24**	**59**	**168**
New Zealand	-	-	-	**34**
All Sources	**116**	**126**	**590**	**1 255**

Source: Information from Department of Immigration, Local Government & Ethnic Affairs.

The NSW Department of Health has negotiated an agreement with DILGEA and DEET to facilitate the temporary entry of 100 foreign medical practitioners to fill resident medical officer vacancies in NSW public hospitals.

Under the agreement, which terminates on 1 June 1993, the doctors will be given temporary residence visas and will be able to stay for up to two years in Australia. The NSW Department has undertaken to take all necessary action to ensure that the medical officers recruited under this agreement will be given limited registration to practise in NSW public hospitals only and will not be permitted, while in Australia to:

- undertake private practice;

- register for the AMC examinations; or

- apply for permanent residents status on occupational grounds (DILGEA and others 1990, p. 2).

The agreement therefore includes a commitment to prevent these temporary recruits from competing with resident private medical practitioners.

The Commission was advised that a similar agreement to recruit 200 overseas trained resident medical officers for Queensland's public hospitals was now being finalised. (For a discussion of the effects of using temporary workers refer IAC 1989, pp. 249-262).

D.2 Regulation of medical specialists

In Queensland and South Australia there is a separate registration system for specialists. In other States, the medical boards have the discretion to register specialists to practise in their particular speciality if they are of a certain professional standing, or have qualifications recognised by the Australian specialist bodies (NSW and Victoria), or have specialist qualifications from the UK (Western Australia).

A National Specialist Qualification Advisory Committee (NSQAC) coordinates between the States and Territories and the Commonwealth to try to ensure that there is uniformity of standards of accreditation for the various classes of medical specialists.

Overseas specialists cannot generally be registered in Australia if they are not automatically registrable as a general practitioner. This means, for example, that in New South Wales, practitioners with registrable specialist qualifications would find it difficult to automatically register as specialists if they gained their first medical degrees in countries other than Australia or New Zealand. There is scope to waive this requirement, but under very restricted conditions:

> Overseas qualified medical practitioners who possess specialist qualifications of ten years standing that are recognised by the NSQAC may be registered to work solely in their area of specialisation. In considering eligibility under this provision applicants are required by the Board to have a firm job offer within the public sector and be permanent residents of Australia (Human Rights and Equal Opportunity Commission 1991, p. 46).

Apparently, however, few overseas practitioners from countries other than New Zealand obtain registration as specialists in NSW even under temporary visa conditions. Some may be admitted

for specialist academic postgraduate medical research but rarely is competition with existing specialists permitted.

There is provision in the *Victorian Medical Practitioners Act 1970* for comparable training to be taken into account for the purposes of gaining registration. The Victorian board may find an overseas specialist, without a medical qualification from a country which is automatically recognised, to be entitled to registration if he/she possesses medical or surgical knowledge, experience and skill which, in the opinion of the board, is of international standing or of such high standing that assessment of professional competence by examination is inappropriate. This provision enables some eminent overseas trained specialists to register as medical practitioners in Victoria. The Medical Board of Victoria, however, stated:

> Many applicants under this section, while possessing a postgraduate qualification appropriate to a specialty and recognised by the National Specialist Qualification Advisory Committee of Australia (NSQAC), do not present any evidence that they have knowledge, experience and skill which are of international standing. The intention of Section 20 is to not permit the registration of all overseas graduates who hold a recognised postgraduate qualification irrespective of their international standing or personal competence. The normal method whereby overseas graduates become eligible for registration is to pass the examination established for the purpose by the Australian Medical Council (Medical Board of Victoria 1988, p. 18).

In 1987-88 the Victorian Board approved only 6 of the 18 applications for registration from overseas specialists.

Training of specialists

Postgraduate specialist vocational training of doctors is provided mainly through professional medical colleges.

However, the medical schools, their clinical departments and the staff of those departments contribute to this vocational speciality training in several ways. The academic research degrees offered by all schools (Doctor of Medicine, Doctor of Philosophy, and Doctor of Surgery) are sometimes considered desirable qualifications for careers in medical research or academic medicine. Some Australian medical schools also offer Masters degrees in various specialities that, although not accepted as registrable qualifications, may meet some of the requirements of the professional colleges. Clinical academics, as clinicians in teaching hospitals and as teachers in the professional colleges, play an important role in vocational training of specialists.

Vocational training of specialists at the colleges typically includes a period of study of the basic science of the speciality, followed by practical experience supervised by specialists. The period of training normally extends over 5 to 10 years. Over time, the training periods required to become a specialist have increased in some specialities. Most specialities require some time to elapse between first qualification (MBBS) and the commencement of specialist training.

There is a generally acknowledged shortage of doctors in some medical specialities. DITAC stated that:

> Specialist training generally takes five years and the positions needed in some specialities are not available because there are insufficient clinical teaching resources (submission no. 10, p. 19).

The Department of Health stated that significant shortages exist in ophthalmology, orthopaedics and cardiac surgery, and this is contributing to increased waiting times for patients requiring specialist treatment. In Victoria, significant waiting times were said to exist for orthopaedics (3.3 months), urology (2.9 months), cardiac surgery (2.7 months), and ear, nose and throat surgery (3.3 months). The Northern Territory Department of Health stated:

> Waiting lists for elective surgery in the specialities of general surgery, orthopaedics, and gynaecology is approximately three months, ophthalmology four to five months and ear, nose, and throat three to four months (letter to Commission).

The Department of Health indicated that the shortage of specialists was associated with restrictions on the number of specialists trained in the colleges. It stated that long training periods contribute to the problem -- for example, the training in the Royal Colleges of Ophthalmologists and Surgeons extends over a period of at least 7 to 10 years after graduation as a medical practitioner.
The general practitioners have argued that:

> The specialities are able to control their numbers through training programs and College-imposed limitations (The National Centre for Epidemiology and Population Health 1991, p. 4).

In regard to the training of overseas doctors as specialists, the Faculty of Medicine of the University of Sydney stated that some of the Royal Colleges do not have sufficient places in their training programmes even to satisfy local demand and that hospitals would also need to be able to accommodate any increase in additional trainees. However, the Faculty indicated that there was potential for alternative training programs for overseas doctors, provided appropriate funding was made available. Such programmes would be aimed at removing any deficiencies in the medical training of overseas students to enable them to undertake postgraduate vocational training.

The OTDA claimed that specialist training facilities are limited and under-represented compared with those of other developed countries. It said that, in several specialities, qualified training cannot be provided and when it is available its standard is not as up to date as that available in certain overseas countries. The Association claimed that this reflects a lag between new discoveries overseas and their application in hospitals in Australia (submission no. 36, p. 1).

D.3 Advertising restrictions

In all States, advertising by doctors to members of the public is only permitted under strict guidelines. This is similar to the position in the United Kingdom but contrasts with that in the USA where the rules of the American Medical Association state that there are no restrictions on advertising by physicians except those that can be justified to protect the public from deceptive practices.

Registered medical practitioners may also be constrained from advertising their individual medical expertise overseas by the regulations on medical ethics and professional conduct, and, in some States, by the laws and regulations under which medical practitioners are registered and practise (see chapter 4).

There are fewer restrictions, however, on advertising between medical practitioners. The Executive Director of the Medical Society of Victoria Inc. and the AMA (Victorian Branch) and the Northern Territory Medical Board stated that their advertising guidelines and regulations do not apply to communications with other doctors. The Registrar of the Medical Board of Western Australia stated that:

> Medical practitioners are permitted to communicate with other practitioners for the purpose of informing them of the particular services performed by them, provided the information is relayed in a sealed envelope (letter to Commission).

The Medical Board of Queensland stated that:

> Specialist practitioners can inform other practitioners of details of their specialist practice and many do so. Complaints about this have been received on a few occasions but the Board would only intervene if there was an element of professional misconduct in the advertising such as false or misleading claims or criticism of other practitioners directly or by implication (letter to Commission).

And, the Registrar of the NSW Medical Board stated:

> In regard to specialist doctors advertising their services to other doctors, the Board has a current policy which does permit this, although it does not strictly comply with the advertising regulations (letter to Commission).

Independent commercial organisations, medical brokers, public and private hospitals and practitioners of alternative medicine are not restricted in advertising their services.

D.4 Regulation of the nursing profession

Apart from the regulation of working conditions and pay under State and Territory awards, the nursing profession is regulated by a range of training and registration requirements.

Registration requirements and procedures

Registration requirements for nurses are determined by the State or Territory nursing registration boards and are based on an examination of a range of criteria which cover most or all of the following:

- the educational process;
- the quality of the educational program;
- the experience of the individual nurse;
- knowledge of health care systems;
- context in which the nurse has worked elsewhere (Northern Territory Board);
- English language proficiency;
- assessment of attitudes and values (in South Australia); and
- completion of a pre-registration supervised experience program (in Victoria).

Registration in one State is currently not recognised in other States or Territories. Thus a qualified nurse must re-register if he/she moves interstate. However, there are proposals to introduce a national registration system. This change is part of a wider set of changes occurring under the award restructuring process. Other changes include the development of clinical career structures and the transfer of nurse education to the tertiary education sector (being phased in over a ten year period ending in 1993).

Registration procedures for overseas trained nurses

Overseas trained nurses are accredited through the Australian Nursing Assessment Council (ANAC). The ANAC comprises a nominee from each of the State or Territory registration boards and two nominees from the National Office of Overseas Skills Recognition. The ANAC's main function is to assess the professional suitability of overseas trained nurses for registration within Australia based on the requirements of the eight State and Territory Boards.

ANAC assessments are advisory only and do not obviate the need for an overseas trained nurse to register with the relevant State registration body. ANAC assessments do not include an examination of an applicant's transcripts to ensure that any required areas of training have been completed. This is done by the registration board.

The procedure for registration depends on which country a nurse was qualified in rather than specific qualifications and experience. The ANAC application form provides the following advice:

> To be considered for registration as a nurse in Australia a person **must have qualified in a country with a health care delivery system similar to that of Australia in terms of culture, technology, licensure and language.** Only the following countries meet this requirement: **CANADA, NEW ZEALAND, REPUBLIC OF IRELAND,**

> **SOUTH AFRICA, UNITED KINGDOM & THE UNITED STATES OF AMERICA**. In certain cases, a nurse who qualified elsewhere, but who has substantial experience as a fully registered nurse, or gained a post-graduate qualification, from one of the countries listed above may be considered for registration (Emphasis in the original).

Nurses from the listed countries can gain immediate registration once their qualifications have been examined. Applicants from other countries must meet other ANAC requirements in order to be eligible for registration. These may include one or more of the following:

- pass an Occupational English exam;
- pass the ANAC nursing exam; and/or
- complete a period of supervised practice in an approved health care institution for a minimum of 3 months, and gain a satisfactory report on completion.

In response to a shortage of nurses, the NSW Nurses Registration Board has recently reviewed its supervised practice requirements. For a 6 month trial period, nurses from Denmark, the Federal Republic of Germany, France, the Netherlands, Malaysia, Singapore, Hong Kong, and Thailand will be required to undertake a 1 month supervised practice period.

Table D.3 below indicates the number of assessments that ANAC performed during 1988-89, and the percentage of successful applicants. The bulk of nurses applying for registration were trained in the UK and Ireland and with few exceptions had their qualifications recognised. However, nurses from the Federal Republic of Germany, Denmark, and Singapore achieved lower recognition rates of 7, 42 and 34 per cent respectively.

From these results the Departments of Labour Advisory Committee Working Party concluded that:

> it appears as if there has been no attempt by the registering authorities to investigate whether overseas qualifications from the listed countries are equivalent to Australian qualifications or to ask ANAC to undertake such an investigation. Consequently, there remains the clear possibility that these restrictive requirements are based primarily on ignorance of other nurse education programs and health care delivery systems and on the unwillingness of registering authorities to extend their registration requirements (Departments of Labour Advisory Committee Working Party 1990, p. 40).

Another barrier to gaining registration in Australia is the requirement for a nurse to complete a period of supervised practice with an accredited health institution. The applicant must find his/her own employment which, according to Anna Fletcher (Acting National Director of the Australian Hospital Association), may be quite difficult to accomplish:

> Indeed, at present ... (supervised training) ... is an almost insurmountable barrier for nurses from overseas who receive a qualified assessment because there is insufficient funding for them to take up positions in the hospitals if they cannot actually work as qualified nurses. There is no spare money around to allow them to work in hospitals

under supervision as unqualified nurses until such time as they meet the registration requirements (transcript, p. 326).

Table D.3: **Results of overseas nurse assessments carried out in 1988-89**

Country of training	*Number of Applicants*	*Recognition rate (%)*
List countries		
Canada	60	92
Ireland	317	100
New Zealand	14	86
South Africa	76	88
United Kingdom	2 252	98
United States of America	86	99
Other countries		
Denmark	12	42
Federal Republic of Germany	15	7
Fiji	36	0
Hong Kong	148	50
India	42	7
Malaysia	86	22
Philippines	127	20
Singapore	29	34
Zimbabwe	13	46

Source: Departments of Labour Advisory Committee Working Party 1990, Background issues paper on the entry of overseas qualified nurses into the Australian Work force, p. 38.

A 1987-88 study of overseas trained nurses in NSW also identified securing supervised employment as a problem (NSW Committee of Inquiry 1989, p. 143). It found that of the 13 respondents who had been prescribed 3 or 6 month periods of supervised practice, none had been successful in obtaining the necessary employment positions.

E THE LABOUR MARKET

E.1 Introduction

The health services industry is labour intensive. Hence, the efficiency with which labour is combined with other inputs to produce health care is an important factor influencing the overall efficiency of service delivery and its international competitiveness. Increased efficiency in the delivery of health care services could provide the resources to reduce waiting lists in public hospitals which constitute a significant impediment to exports and could allow Australian health care institutions, both public and private, to price at levels which are more attractive to foreigners. Further, more efficient service provision to domestic patients offers the prospect of significant savings for the Australian community.

There is evidence to suggest that labour is not used efficiently in some parts of the Australian health services industry.

One source of evidence is the recent EPAC (1990) study which suggests that there are marked differences between the states in the labour they require to produce health services. The findings of the EPAC paper are examined in this appendix and the potential cost savings from adopting best national practice in all States are assessed.

The evidence of inefficiency provided by the EPAC report gains additional support when Australian labour requirements in the health services sector are compared with those in other countries. This comparison shows that labour per occupied hospital bed is much higher in Australia than for other OECD countries for which data was available.

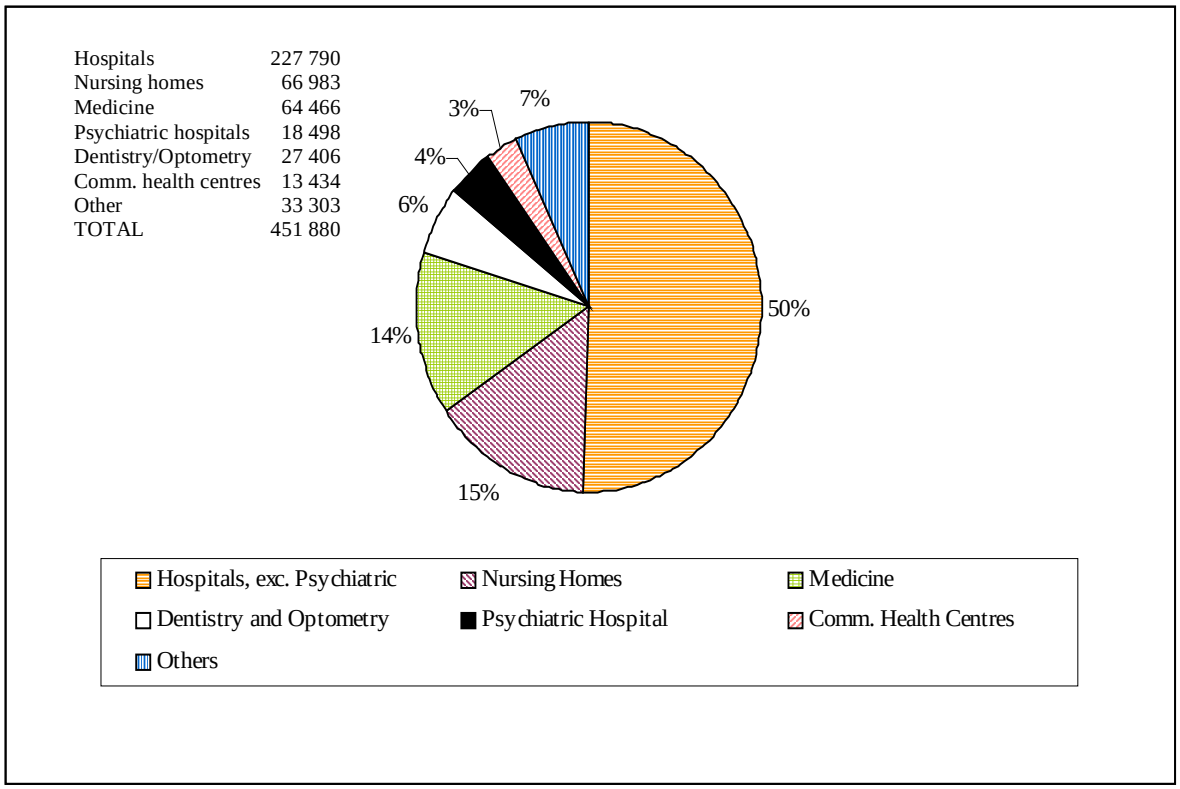
E.2 Key features of the health labour force

The paid health labour force is almost half a million strong, supplemented by many voluntary workers. The sector accounts for almost 7 per cent of the total paid Australian labour force. Overall, labour costs represent

One-half of employment in the health industry is in the hospital sector. Other important employers are nursing homes and medicine, which account for 15 and 14 per cent of total employment respectively (see figure E.1).

Practitioners, nurses and other health personnel account for some 54 per cent of the health labour force, the remainder being administrative and support staff (see figure E.2). The public sector is the major employer, hiring 55 per cent of health industry wage and salary earners.

Figure E.1: **Allocation of personnel to major health industry categories, 1986**



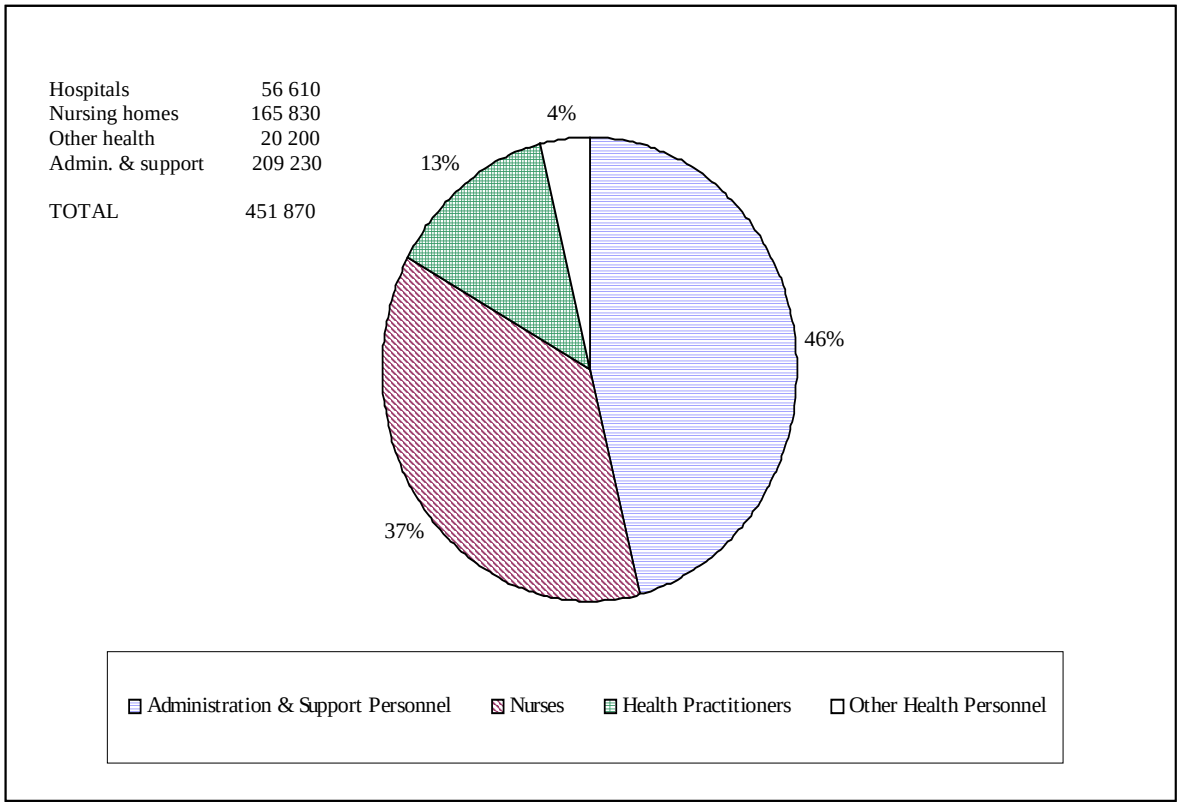
Other includes ambulance services and other health services not specifically defined here.
Source: ABS 1986, census data, microfiche table CX0050.

Three-quarters of the total health labour force are female, but their distribution across occupations vary. Females are in the minority in the medical profession, but comprise the majority in fields such as nursing and occupational therapy, and the non-technical support areas (see table E.1).

E.3 A comparison of State and Territory labour utilisation

Interstate comparisons can provide important insights into the efficiency with which resources in various sectors are used and, in particular, on avenues for improvement in individual States. To this end, EPAC commissioned the Institute of Public Affairs (IPA) to compare how the States provide a range of services including health care.

Figure E.2: **The labour force of the Australian health industry, 1986**



a) Practitioners include: medical and specialist, dentists, pharmacists, occupational therapists, optometrists, physiotherapists, speech pathologists, chiropractors and osteopaths, podiatrists and radiographers.
b) Nurses include: registered, enrolled and dental. Directors of nursing included under administration personnel.
c) Other health personnel includes: medical testing professionals, social workers, counsellors, psychologists, ambulance officers, and medical technical officers & technicians.
d) A further 50 000 persons in health occupations work in other industries.
Source: ABS 1986, cat. no. 4346.0, table 2, p. 6; and ABS 1986, census data, microfiche table CX0050.

Table E.1**:** **Percentage of females in health industry, by major occupation, 1986**

Occupation	*Per cent female*
Medical practitioners	22
Other practitioners	56
Nurses	93
Other health personnel	52
Administration and support personnel	75
Total all occupations	**76**

Source: ABS 1986, census data, microfiche table CX0050.

The findings of the IPA study suggest that, in the case of health care, large cost savings could be made if all states followed the seemingly more efficient labour practices of Queensland. A resume of the IPA study and estimates of these cost savings are provided below.

The IPA Study

The IPA used 1988-89 Commonwealth Grants Commission (CGC) data which showed that the average expenditure per person on general medical services[1] by the States was $589 (see table E.2). However, there was considerable variation amongst the States with, for example, Western Australia spending 50 per cent more per person than Queensland.[2]

Table E.2: **Expenditure per capita on general medical services, by state, 1988-89 (dollars)**

State	*Actual expenditure*	*Cost of a uniform level of service index*	*Standardised expenditure*
	$ per capita		*$ per capita*
NSW	599	0.967	570
Vic	625	0.944	557
Qld	445	1.047	618
SA	608	1.099	648
WA	666	1.071	632
Tas	589	1.076	634
Average	**588.7**		

Source: EPAC 1990, *Background Papers on the Public Sector*, Studies prepared for the Office of EPAC, background paper no. 7, December, p. 27.

However, comparisons based on actual expenditure levels do not account for factors which are likely to lead to differences in the use of health services or the cost of providing such services in individual States. For example, the provision of medical services to remote regions will involve higher per person costs than service provision in more closely populated regions. Accordingly, per person costs in, for example, Western Australia, might be expected to be higher than in Victoria.

1 General medical services includes public hospitals and allied services, nursing homes and psychiatric institutions. Collectively, these services account for 96 per cent of total health expenditure (EPAC 1990, p. 28).

2 The national health strategy (1991, p. 36) also provides per person expenditure levels for major health service programs in 1989-90. Although the relativities between some of the States are different to those in the CGC's expenditure estimates, Queensland is still shown as spending much less per capita than the other States.

Similarly, expenditure requirements are also likely to vary with differences in the age distribution of the population in individual States and, in particular, differences in the proportion of elderly people for whom health services must cater. Such factors imply that there will be differences between the States in the cost of providing a given level of health services.

The CGC attempts to net out such factors in what are termed 'standardised' expenditure levels for each State (see table E.2). These are derived by calculating indices for the cost of providing a given level of service in each of the States (column 2 of table E.2)[3]. These indices indicate that the cost of providing a given level of service should be relatively low in New South Wales and Victoria and relatively high in Queensland, Western Australia, South Australia, and Tasmania. A standardised expenditure level for each State is then calculated by multiplying the average per capita expenditure Australia-wide ($589) by these indices.

According to the IPA study, comparisons between the standardised and actual expenditures per person provide an indication of whether a particular State is operating above or below the average level. Thus Queensland is able to produce its health services at an average cost that is $173 per person lower than would be expected on the basis of the average performance of the States. Victoria, on the other hand, provides its health services at an average cost that is $68 per person higher than would be expected on the basis of the average performance of the States.

Because differences in the cost and use of providing services in individual States have been accounted for, the IPA argues that variations around the mean expenditure of $589 can be interpreted as either differences in the quality of services provided or the efficiency with which those services are delivered.

The IPA could not find evidence of substantial differences between the States in the quality of services and therefore concluded that interstate variations were due to differences in the efficiency of service provision, and in particular to 'human resources policies including staffing levels, staff mix, wage rates and labour productivity' (EPAC 1990, p. vii).

Specifically, the study concluded that Queensland's low level of per capita expenditure on health care is largely a reflection of low non-technical staffing levels, achieved by maintaining a highly centralised public administration system. According to the IPA, there is no evidence to suggest that lower hospital administration costs have been shifted to other public sector areas.

[3] Factors taken into account by the CGC in producing these indices include: the dispersion of the population, age and sex, social composition, the extent to which people move across State borders to obtain services, the scale in administration and super-speciality units (there is a higher cost of provision of services in specialist/teaching hospitals), and the availability of private hospital services.

By contrast, the study found that both Victoria and Western Australia have a high non-technical to technical staff mix. The IPA suggest that this is chiefly a reflection of the success of the hospital employees' unions in pressing for higher non-technical staffing levels. Indeed the IPA's major finding in respect of health care and other essential services was:

> high levels of policy induced differences in State expenditure arise primarily to provide additional benefits to special interest groups, specifically their unionised work force, rather than in providing additional services to consumers (EPAC 1990, p. viii).

Another factor contributing to lower costs is that Queensland's nursing staff still work a 40 hour week compared with 38 hours for nursing staff in the other States. This translates into 5 per cent more productivity for Queensland nursing staff. Also, although salary levels were found to be less important in explaining expenditure variations, the study notes that Queensland does pay lower salaries for all types of staff.

While the methodology underlying the CGC's standardisation exercise should be treated with caution[4], the Commission observes that even if the adjustments are not made, there are large differences in expenditure levels between the states. Thus, in the Commission's view, the questions raised by the IPA study remain valid, notwithstanding any concerns about the methodology employed.

Cost savings from increased efficiency

On the basis of the IPA study, the Commission estimates that, if all States were as productive as Queensland in providing health care, there would be a saving of over $2 billion annually. Retaining the shorter working week for nurses and higher rates of pay for hospital employees in the other States would not greatly reduce this saving. This is because the bulk of the gains would come from better utilisation of labour.

The Commission's estimate of potential cost savings is roughly in line with savings identified by Joni Bessler, Vice President of Booz-Allen and Hamilton (Bessler 1991). Ms Bessler suggests that even within the constraints of the present system, there is the opportunity for a 10 to 15 per cent saving of hospital recurrent expenditure through addressing labour inefficiencies such as:

- overstaffing;
- mismatch between staffing levels and workload patterns;
- inefficient workflow processes;
- operational policies and practices that cause low value resource utilisation;
- inefficient clinical protocols/work practices; and

4 The IPA noted that the CGC is presently conducting a major review of its methodology in assessing cost disabilities. The IPA assume the CGC's method of determining cost disabilities to be the best available at present.

- inefficient organisational structures and job responsibilities.

In order to understand better the differences between the States in labour usage, the Commission examined the ratio of staff to occupied beds in acute care hospitals, psychiatric hospitals and nursing homes (see tables E.3, E.4 and E.5). In each of the three sectors, and for each of the three categories of staff, Queensland requires less labour input than the average for all the States. Indeed, in most cases, Queensland's ratio of staff to occupied beds is the lowest or second lowest among the States. However, the major contributor to lower costs in Queensland is the more frugal use of administrative and support staff. For the acute care hospitals sector, Queensland had 1.17 support staff per occupied bed compared with 1.91 in Tasmania, 1.89 in Victoria and 2.05 in the Northern Territory.

Table E.3: **Number of personnel per occupied bed; acute care public (including repatriation) and private hospitals, 1986**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*Nt*[a]	*ACT*[a]	*Aust*
Nurses	1.57	2.03	1.58	1.80	1.65	2.13	1.86	1.83	1.74
Other Health	0.47	0.46	0.34	0.42	0.43	0.33	0.50	0.57	0.44
Admin/Support	1.60	1.89	1.17	1.57	1.81	1.91	2.05	1.64	1.63
Total	**3.64**	**4.38**	**3.09**	**3.79**	**3.89**	**4.37**	**4.41**	**4.04**	**3.81**

a) includes psychiatric wards in public hospitals.
Source: Commission estimates based on AIH 1989, *Hospital Utilisation and Cost Study*, Volume 1: Commentary, Canberra, table 2.11, p. 40; ABS 1986, census data, microfiche table CX0050; and ABS 1987, cat. no. 3201.0, table 6, p. 22.

Table E.4: Number of personnel per occupied bed; psychiatric hospitals[a] , 1986

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*Nt*[a]	*ACT*[a]	*Aust*
Nurses	0.40	0.80	0.57	1.31	1.43	0.64	..	..	0.64
Other Health	0.07	0.13	0.11	0.26	0.36	0.08	..	..	0.11
Admin/Support	0.44	0.84	0.46	1.44	3.24	0.60	..	..	0.76
Total	**0.91**	**1.77**	**1.14**	**3.01**	**5.03**	**1.32**	**..**	**..**	**1.51**

a) Developmental disability services are included for New South Wales, Victoria and Tasmania but not for other States.
b) The NT and ACT psychiatric wards are incorporated in the public hospitals sector.
Source: Commission estimates based on AIH 1989, *Hospital Utilisation and Cost Study, Volume 1: Commentary*, Canberra, table 2.11, p. 40; ABS 1986, census data, microfiche table CX0050; and ABS 1987, cat. no. 3201.0, table 6, p. 22.

Separate data are not available for staffing levels in the public and private acute care hospital sectors. The Commission is therefore unable to identify whether differences in expenditure between the States are attributable to factors specific to the public hospital sector, or to, say, awards and conditions of employment covering both the private and public sectors in each State.

Table E.5: **Number of personnel per occupied bed; nursing homes, 1986**

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*Nt*[a]	*ACT*[a]	*Aust*
Nurses	0.32	0.56	0.38	0.55	0.38	0.49	0.61	0.49	0.42
Other Health	0.02	0.02	0.01	0.03	0.03	0.02	0.00	0.00	0.02
Admin/Support	0.41	0.49	0.46	0.86	0.68	0.44	0.47	0.31	0.50
Total	**0.75**	**1.07**	**0.85**	**1.44**	**1.09**	**0.95**	**1.08**	**0.80**	**0.94**

Source: Commission estimates based on AIH 1989, *Hospital Utilisation and Cost Study*, Volume 1: Commentary, Canberra, table 2.11, p. 40; ABS 1986, census data, microfiche table CX0050; and ABS 1987, cat. no. 3201.0, table 6, p. 22.

E.4 International comparisons of labour utilisation

International comparisons of labour utilisation provide information on the extent to which Australia as a whole is following best practice in staffing and equipment levels. Of course, such comparisons must be treated with caution because they do not take into account international differences in such things as health care standards and patient mix.

Data from the OECD Health Data File (OECD 1990) show that Australia has by far the highest ratio of hospital personnel per occupied bed (POB) among OECD countries. In 1986, Australia had 3.8 hospital personnel POB. This was 1.3 persons more than Norway which, of the countries listed, had the second highest ratio of hospital personnel to beds. Austria had the lowest hospital staff ratio at 0.7 persons POB. A similar story emerges in the use of nursing staff. Australia's ratio of 1.7 nurses POB was 0.9 persons above Switzerland which had the second highest ratio of nurses to beds. Japan had only 0.4 nurses POB, the lowest ratio of any of the OECD countries listed.

Even accepting the possible qualifications to the OECD data, it seems difficult to avoid drawing the conclusion that the Australian health services industry is highly labour intensive by international standards, and that it could be significantly over-staffed. If this is the case, it will detract from Australia's international competitiveness in the provision of health care services.

The comparisons suggest that moving towards international best practice in staffing could yield significant gains in terms of reduced hospital expenditure additional to those available if all the

States were to adopt best national practice. For example, if Australia's staffing levels POB were reduced to the average of the 13 OECD countries for which data are available, then the Commission estimates that annual savings of almost $3 billion could be generated, over and above the savings made if all States followed Queensland's labour practices.

However, in order to move towards international best practice, considerable expenditure might be needed to upgrade hospitals and other health service facilities. Once this need for additional capital expenditure is taken into account, the realised savings would be somewhat smaller. Further, some of the labour practices that underpin the inefficiencies identified above may be written into industrial awards and state laws. Hence, changes in those areas may need to be made before any savings could be achieved.

F INTERNATIONAL PERSPECTIVES ON HEALTH CARE

Government involvement in health care is extensive in most industrialised countries. While this involvement occurs in different ways, a common feature is that governments fund a high proportion of health care spending. Indeed, health care is one of the largest and fastest growing areas of government expenditure in virtually all developed countries. As a result, the efficiency with which health care services are provided is coming increasingly under the spotlight.

Typically, governments in most developed countries involve themselves in the provision of health care services in order to ensure that all citizens have access to health care at a price which does not impose undue financial burdens. However, the way in which this broad objective is pursued differs significantly between countries. This diversity in approach suggests that changes to Australia's health care system, which would encourage greater efficiency and give greater scope for exports, need not compromise the objective of providing equitable access to medical and hospital services for all Australians.

This appendix examines the main features of the health care systems in some of the major OECD countries. The focus of the discussion is on the arrangements for treating local patients in those countries.

The appendix also looks at differences in total health care expenditures and prices for services in OECD countries and some of the reasons for those differences.

F.1 The role of governments in health care

Government involvement in health care in all OECD countries extends from regulation of doctors, hospitals, and insurance, to direct funding and provision of health care services. On average, public spending accounts for more than three-quarters of total health expenditure (OECD 1990).

Access to basic health care, irrespective of the individual's financial means, is a government objective in most OECD countries. As is apparent from table F.1, public coverage against the cost of inpatient care and ambulatory care is universal or close to universal in the large majority of countries. The USA is a notable exception.

However, there are significant differences in the way in which health care systems are organised and operated to achieve this objective. The OECD categorises health systems into three types:

> the national health insurance model, characterised by universal coverage financed out of general taxation, and national ownership of the health care system;

the social insurance model, characterised by compulsory universal coverage generally within the framework of Social Security, financed by employer and individual contributions through non-profit insurance funds, and public and/or private provision of health care; and the private insurance model, characterised by private health insurance financed by individual or employer contributions with private provision of health care services (OECD 1987, p. 24).

As the OECD state, none of these models provides a wholly adequate description of health care systems in individual countries. Nonetheless, they give an impression of the basic approach taken. The UK and Sweden, for instance, approximate the national insurance model, while Germany adopts the social insurance model. Canada and Japan straddle these two approaches, while in the USA, private insurance plays a large role. The Australian health care system combines a national insurance approach with a private insurance system. Important characteristics of the health care systems in some of these countries are discussed below.

The USA

The health care system in the USA is more market orientated than in other industrialised countries. Nonetheless, government plays a significant role. Federal, State and Local Governments fund approximately 40 per cent of health care expenditures with the Medicare and Medicaid programs accounting for the bulk of this funding. Medicare is run by the Federal Government as a contributory social insurance scheme largely for the elderly. It covers most hospital bills but not long term care. Long term care is available to those covered by Medicaid, a scheme jointly organised by the Federal and State Governments for the poor. It is non-contributory.

In addition to public schemes, private health insurance cover is encouraged through tax deductions available to employers for the provision of insurance to their employees. There is also a major network of veteran hospitals and other facilities available to former members of the armed forces and their dependents and special programs directed at target groups, for example, American indians. Nevertheless, access to health care facilities is not universal with an estimated 10 per cent, or some 30 million people, having no health insurance cover.

Direct charges to patients represent about one-third of total health care expenditure. This is relatively high compared with other countries. Cost sharing for employer provided insurance cover varies widely. Hospitals are paid largely on the basis of retrospective reimbursement, although there is a move towards prospective reimbursement via diagnostic related groups.

Table F.1: **Public contribution to health care costs in OECD countries in 1987**

Country	Public coverage against: inpatient care costs	Public coverage against: costs of ambulatory care	Public coverage against: costs of medical goods	Public share of billing: inpatient care billing	Public share of billing: ambulatory care billing
	per cent of total population covered			per cent	
Australia	100.0	100.0	100.0	79.7	61.2
Austria	99.0	99.0	99.0	90.0	80.0
Belgium	98.0	93.0	93.0	68.0	50.0
Canada	100.0	100.0	34.0	90.6	72.1
Denmark	100.0	100.0	100.0	100.0	76.0
Finland	100.0	100.0	99.0	90.0	70.0
France	99.0	98.0	98.0	92.2	62.1
Germany	92.2	92.2	92.2	98.0	92.0
Greece	100.0	100.0	100.0	90.0	85.0
Iceland	100.0	100.0	100.0	100.0	80.0
Ireland	100.0	37.0	4 0.0	95.0	47.0
Italy	100.0	100.0	100.0	88.7	79.6
Japan	100.0	100.0	100.0	93.0	85.0
Luxemburg	100.0	100.0	100.0	95.0	98.0
Netherlands	73.0	67.0	61.0	82.0	44.0
New Zealand	100.0	100.0	100.0	92.0	47.0
Norway	100.0	100.0	100.0	100.0	-
Portugal	100.0	100.0	100.0	100.0	100.0
Spain	97.1	97.1	97.1	4.0	-
Sweden	100.0	100.0	100.0	100.0	90.0
Switzerland	98.7	98.7	98.1	100.0	85.0
United Kingdom	100.0	100.0	100.0	99.0	88.0
United States	43.0	43.0	10.0	55.0	6.0

Source: OECD 1990, *Health Care Systems in Transition: The Search for Efficiency*, Social Policy Studies no. 7, Paris, pp. 143-47.

Canada

The Canadian health care system is basically one of national health insurance, with responsibility for the provision of health services residing with the provincial governments. As a result there are 10 independent health care plans. Federal and provincial government contributions fund three-quarters of total health care expenditure.

Under these plans, coverage is provided for inpatient care in all general and allied special hospitals. Coverage is universal for both services and people. The level of cost sharing by patients is small. Generally there are provisions for free inpatient (public ward level) and outpatient hospital services

and free physician services, although some provinces require a small patient contribution.

Hospitals, whether publicly or privately owned, are allocated funds from their provincial government on the basis of the previous year's funding allocation. In effect, the hospitals are managed by doctors who work as independent practitioners. They are paid on a negotiated fee-for-service basis.

The United Kingdom

Under the UK's National Health Service, all residents are entitled to receive free hospital and medical care. The scheme is based on the explicit goal of providing social and geographical equality of access to health care services. Individuals cannot contract out of the scheme but can take out insurance cover for additional private services.

The scheme is funded primarily from general taxation revenue. The facilities for providing health care are owned by the State. Thus as well as ensuring that care of a certain quality is available, the government is involved in the delivery of that care.

Although national health care policies are determined and funded by the national government, the provision of insurance and health care is contracted out to regional authorities. Funding at the local area level is determined on the basis of a local needs formula, according to population size, age and sex distribution and an index of health status.

All hospital staff are public sector employees. Doctors in hospitals are salaried while general practitioners are generally paid through capitation payments. Primary care professionals work for the National Health Scheme on a contractual basis. Doctors can work for both the service and the private sector where remuneration is on the basis of fee-for-service.

As noted above, hospital and medical services provided to local residents are free. However, payments are required for drugs and dental and optical treatment. Overall, patient payments account for 3 per cent of total health care expenditure. Children, the poor, expectant mothers and pensioners are among the groups exempt from cost sharing.

There is a small independent, private medical care sector for which full charges are levied. About 7 per cent of the population has private health insurance. Most claims are for elective surgery.

Germany

The German health system provides health care to all residents regardless of income, social status or residence. The system is operated through a statutory social insurance plan. For people below a

threshold level of income, participation in the plan is compulsory.

The statutory insurance plan is administered by some 1150 autonomous funds. In total, the decentralised fund system covers approximately 90 per cent of the population.

Operation of the funds is almost completely independent of the federal and regional governments. Similarly, hospitals are owned and managed by local communities or private physicians. Thus while the government ensures that health care services are available, the provision of that care is independent of government.

The statutory insurance plan is financed by a payroll tax split equally between employees and employers. Financing is therefore independent of the individual's medical and social risks.

Special provisions are made to cover the contributions of the unemployed, elderly, disabled or poor. For example, the federal/regional government may directly pay the contributions.

The insured population is limited by residence and occupation in its freedom to choose a sickness fund. However, the benefit packages differ little between funds.

Patient charges under the scheme are limited to a few items such as dentures, eyeglasses and prescription drugs. There is also a small daily charge for the first 14 days spent in hospital and a daily charge for inpatient rehabilitation treatment. Patient charges are estimated to represent about 5 per cent of total expenditure on services covered by the statutory sickness funds.

In addition to the statutory fund system, there is a small public health service and a factory-based physician service administered and financed by employers in large companies. Private insurers also offer a variety of plans and benefits. However, only persons with incomes above the threshold level may join a private health insurance plan.

Sweden

Provision of health care services in Sweden is based on a national health insurance model. The social insurance plan extends automatic health cover to all Swedish citizens and foreign residents. The system is financed primarily from general taxation.

While the central government is responsible for the administration of the system, county councils play the dominant role in the actual provision of health care services. There are 26 county councils which are responsible for the delivery of health care in their local area. In fact, health care accounts for about 85 to 90 per cent of the operating costs of a county.

The county councils own and operate the hospitals in their area. Each county has at least one general hospital as well as several minor hospitals. There are also nine regional hospitals which service several counties and provide more specialised treatment. Inpatient care is largely financed through county taxes. Hospital staff and publicly employed physicians and dentists are salaried.

Although most health care is publicly provided by the county councils, private health care is available. About 20 per cent of physicians and 50 per cent of dentists are privately employed. However, without an agreement from the local county council, consultations with private physicians are not reimbursed from social insurance. Thus county councils have the power to regulate and control the private health care market.

Direct charges for public health services, prescription drugs and consultations with private doctors approved under the social insurance plan are nominal.

Japan

Japan has a compulsory national health care system that relies heavily on cover arranged in the workplace. Hence it operates principally along the lines of the social insurance model. Health care is financed largely through employer and employee premiums. Quite significant patient payments are required for most services available under public programs -- a 20 per cent contribution towards hospital costs and 30 per cent for all other medical service costs up to a ceiling amount. Special provisions are available for low income patients.

All Japanese hospitals are non-profit bodies. However, over 60 per cent of the hospital beds are privately owned, mostly by individuals or groups of physicians. Both hospital and ambulatory physician services are generally reimbursed on a fee-for-service basis.

F.2 Expenditure on health care

In nearly all developed countries, expenditure on health care has grown at a faster rate than the economy as a whole, so that health care over time has accounted for a larger percentage of national income. For example, in Australia, expenditure on health care rose from around 4.5 per cent of GDP in 1960 to around 7 per cent in 1987, while in the USA, it rose from 5 per cent to over 11 per cent over the same period (see figure F.1).

The same basic trend holds for a much wider selection of countries than shown in figure F.1 and has led to the proposition that, as countries become wealthier (as all developed countries have over the 27 year period), they spend proportionately more on health. This observation is apparently independent of the type of health care system in each country.

Figure F.1: **Total health expenditure as a percentage of GDP for selected countries**
.G.b:\FIGF1.HGL;63.104 p10;46.396 p10;HPGL

Source: OECD 1990, *Health Care Systems in Transition: The Search for Efficiency*, Social Policy Studies no. 7, Paris, pp. 121, 190.

Considerable work has been undertaken to quantify the relationship between health expenditure and GDP. Nearly all studies have found that an increase in GDP prompts a greater than proportional increase in health expenditure (OECD 1990). Culyer's finding (reported in OECD 1990) that a 10 per cent increase in GDP could be expected to increase health care expenditures by 13 per cent is typical.

This relationship has not only been observed over time, but is also apparent in the level of health expenditure in different countries at any point in time. Table F.2 shows the amounts per capita spent on health and per capita GDP in OECD countries. As is apparent from the table, the amount spent on health per capita generally follows a country's GDP ranking.

Table F.2: **Per capita health expenditure and per capita gross domestic product in OECD countries, 1987 (US dollars)**

Country	*GDP*	*Health expenditure*	*Rank in GDP expenditure*	*Rank in health expenditure*
Turkey	4 274	148	24	24
Portugal	6 297	386	23	22
Greece	6 363	337	22	23
Ireland	7 541	561	21	20
Spain	8 681	521	20	21
New Zealand	10 680	733	19	19
Austria	11 664	982	18	11
Belgium	11 802	879	17	15
Netherlands	12 252	1 093	16	9
Italy	12 254	841	15	16
United Kingdom	12 340	758	14	18
Australia	**12 612**	**939**	**13**	**13**
France	12 803	1 105	12	7
Finland	12 838	949	11	12
Japan	13 182	915	10	14
Germany	13 323	1 093	9	8
Denmark	13 329	792	8	17
Sweden	13 771	1 233	7	4
Luxemburg	14 705	1 050	6	10
Norway	15 405	1 149	5	6
Iceland	15 508	1 241	4	3
Switzerland	15 842	1 225	3	5
Canada	17 211	1 483	2	2
United States	18 338	2 051	1	1

Source: OECD 1990, Health Care Systems in Transition: The Search for Efficiency, Social Policy Studies no. 7, Paris, p. 12.

Attention is often focussed on relative expenditures in the UK and the USA because of the widely differing approach to the provision of health care services. At $2051 per capita the USA spends more on health than any other country, and almost three times that of the UK at $758 per capita. These figures have been used to suggest that the USA system is inefficient, or alternatively, that the UK system is drastically underfunded.

As the USA is a much wealthier country than the UK, it is natural to expect that it would spend more on health care services. However, Schrieber and Poullier state that 'US spending exceeds the basic underlying trend relationship by more than $400 per person' (OECD 1990, p. 12).

But, care must be exercised in drawing conclusions about either the effectiveness of this expenditure or the volume of health care consumed by USA citizens. In particular, the comparison

takes no account of the higher price of services in the USA. When allowance for differences in prices are made, Parkin (1989) found that the USA moved from spending a greater amount than would be predicted according to its national income to 'underspending'.

F.3 Health care prices

The fact that health care prices are higher in the USA than in the UK may in part reflect a positive correlation between health care prices and GDP. Parkin states:

> Countries with higher GDPs not only buy more health care, they have higher unit costs for it. In other words, some of their increased expenditure is due to their paying higher health care prices (Parkin 1989, p. 85).

One reason why prices might be higher in wealthy countries is that, in aggregate, health care is a labour intensive service sector. In wealthier countries, labour is expensive relative to other inputs such as capital. Consequently, goods produced by labour intensive industries might be expected to be relatively more expensive in wealthy countries. Along similar lines Parkin notes that the incomes of doctors appear to grow faster than GDP. He concludes:

> for at least one group there is support for the idea of increasing unit labour costs in health care with increasing national income (Parkin 1989, p. 87).

An alternative explanation is that technological innovation in wealthier countries is responsible for the higher price of health care services.

Finally, high prices in the USA are often attributed to features specific to that country -- for example, the market power of physicians and the highly litigious nature of American society.

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