

Community management structures to promote health

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Abstract

This article describes key requirements of effective health service management that emerge from a review of Australian developments in the respective roles of government and the market. From a public interest perspective, community and industry ownership and management of funds appear superior to market-driven health management approaches. The clear separation of public interest-based policy and administrative functions is vital for effective fund management. Greater transparency, more community input to broadly planned service delivery, casemix funding systems and better outcome data are required to tap the potential benefits of this policy-led model. A pooled funding approach to service provision may assist regional communities achieve their health aims, and the service breadth and flexibility which appear to be necessary to support health and related regional goals.

Government pursuit of the public interest and the contracting of services

The term economic rationalism has been used to describe aspects of State and Commonwealth government policy, including the contracting of services. Among others, Muetzelfeldt accuses Australian governments of economic rationalism by downplaying any intrinsically public interest when contracting out services, and using the market not just as a mechanism for implementing policy efficiently, but also as the criterion by which policy objectives should be set (1999, p 156). He primarily cites the Department of Administrative Services' annotated bibliography on competitive tendering and contracting in support of his claims.

In contrast, this article demonstrates that Australian support for public interest-based health policy and related administration has been strengthening and broadening for two decades. It shows that governments have aimed to achieve more transparent and effective management of health funds and related services, and have also used contracting in the service of this aim. A comprehensive, publicly funded health service and pharmaceutical system has been introduced. A national work related health insurance funding model has been developed to replace private sector insurance underwriting. A range of related health and insurance inquiries have been undertaken. These actions have all strengthened the government capacity to apply discipline to fund management and related service delivery, in the interests of the public.

The evidence presented later is that the Australian government direction is not primarily influenced by the market, and that contracting should be understood in the context of an unfinished transparency and accountability agenda. (It is true, however, that one may wonder about areas related to health, such as the Transport Administration Amendment (Rail Restructuring and Corporatisation) Act of 1996, and the recommendations of the Special Commission of Inquiry into the Glenbrook Rail Accident (McInerney 2000). Events in rail administration do not appear to reflect requirements of the European Directive 91/440, the Council of Australian Governments, or the Competition Policy Reform Act, which New South Wales (NSW) rail contracting was supposedly designed to support. Although of vital importance, this matter is considered peripheral to the current discussion of health.)

Effective community regulation, service and subsidy depend upon adequate data

International agreement about the appropriate roles of government and the market has been increasing for some time. For example, at the 1994 Asia Pacific Economic Cooperation (APEC) summit, leaders of the region agreed to creation of an Asia-Pacific free trade zone by 2020, and also supported the protection of health and the natural environment. APEC members have diverse political regimes including, for example, those of Australia, China, Japan, Indonesia and the United States.

The process of achieving national standards and transparent systems that promote protection of health and the environment began in Australia at the beginning of the 1990s, when State and Territory governments commenced legislative review to update their laws and make requirements plain. The Council of Australian Governments (COAG) then agreed to mutual recognition of State and Territory laws, except where national standards would be developed, including for health, the environment, related occupations and training, disability services, social security benefits, and labour market programs (Premiers and Chief Ministers 1991). The expected regulatory role of government was further defined when the recommendations of the Hilmer Report (1993) were implemented by the Commonwealth Competition Policy Reform Act (1995). The legislative review process continued, with the aim of achieving regulation that promotes equal competition between public and private sector service providers on a level playing field of national standards, unless another course of action can be shown to be in the public interest (Fels 1996).

In this emerging regional and national context, the principal role of Australian government ideally appears to be to promote management of the competing provision of goods and services, to effectively meet community aims and standards outlined by legislation. Achieving this goal requires broad access to appropriate and reliable information about comparative service provision, which is still far from easy to obtain. For example, in the NSW Motor Accidents Scheme, the NSW Motor Accidents Authority is required to operate as regulator, in partnership with competing insurance companies that underwrite the scheme and provide its services. In a recent government inquiry into this scheme, representatives of the relevant State and Commonwealth regulators pointed to a general lack of reliable information about the insurance sector and its service provision, including in regard to motor accidents, and stated that as a consequence of this, market disciplines to encourage effective competition have less force. It was also pointed out that information disclosure enhances the natural workings of the market and is less intrusive than other regulatory measures (Standing Committee on Law and Justice 1996, pp 59-73).

The provision of services or subsidy by government is considered most necessary when the market apparently fails to provide adequately to meet community needs. For example, a public inquiry into local government in NSW (2000) asked for identification of those examples of market failure that ought to be addressed by legislation. Local councils are regulated by State government legislation and are responsible for the management, improvement and development of the resources in their areas. They also have the ability to provide goods, services, and facilities, and to carry out activities appropriate to the current and future needs of local communities and the wider public.

Recent reports suggest that the market economy and many current Commonwealth, State and local government programs are poor at ensuring child welfare, prevention of crime, and resolving related family and community health problems (Community Services Commission 2000; Standing Committee on Law and Justice 2000; Select Committee on the Increase in Prisoner Population 2001). The ability of government to achieve its functions effectively depends in large part upon the development of broader and more effective systems of comparative data gathering, in order to determine the grounds on which government should provide or subsidise services, contract them out, or withdraw its support. Currently there is too little reliable evidence about the comparative outcome, quality and cost of the health, disability, and related family or community support services that are managed or provided by public, private or voluntary organizations. This makes all levels of government planning difficult.

Current government policy on management structures to serve the public interest

NSW Health (2000 p 6) has pointed out the need for an effectively integrated and coordinated approach to the management of at least ten NSW government departments, local councils, and a wide range of related Commonwealth and community-based service providers. Alford (2002) has evaluated the outcome of a new

Victorian primary care and community support system, which involved purchasing reforms and a contested selection process between providers in large catchment areas across the State. The following description of current NSW government administrative structures is helpful for establishing management principles which should be appropriate in a range of regional or community-based settings where there is an expectation that industry or public funds should be used primarily in the interests of key stakeholders and the broader community, rather than to support service providers or business shareholders.

Government departments, statutory authorities and state-owned enterprises, primarily conduct the administrative business of NSW government. A government department is fully funded by taxation revenues. It has a regulatory role and its head is therefore fully answerable to the relevant government minister. Creation of a statutory authority is based on the expectation that the organization will not only administer legislated objectives, but will also oversee the provision of services which generate a substantial portion, or all of the income required to administer these objectives effectively. A board of experts, including people drawn from the key stakeholder groups, administers a statutory authority. The board governs with the paramount aim of achieving legislated goals, and its commercial operations must support this. The legislative and policy functions of a statutory authority are the ultimate responsibility of the elected minister, and are clearly separated from the administrative and commercial functions of the board, so that any ministerial directives to the board are transparent (Macdonald 1989; Rich 1989).

The principal objectives of a state-owned enterprise are to be a successful business by operating at least as efficiently as any comparable business, to maximize the net worth of government investment in the corporation, and to exhibit a sense of social responsibility by having regard to the interests of the community and trying to accommodate them when able to do so (State Owned Corporations Act 1989). State-owned corporations are companies operating under the companies' code and shareholding ministers forego all rights to control or manage the business. Social policy outcomes do not emanate from state-owned corporations except where explicit contracts to provide them have been established. The level of accountability which government requires of the board of a state-owned corporation goes far beyond that found in the private sector because the minister is responsible for ensuring that the commercial management of the enterprise is effectively carried out. Privatisation is the sale to the private sector of a government-owned enterprise. Then the shareholders have responsibility for pursuing their business interests on their own account. These basic regulatory principles that govern the operations of the NSW bureaucracy are also relevant in community-based management.

Meeting health needs effectively requires community input and better data gathering

In 1988 the first national health promotion goals for mental health, injury, cancer and cardiovascular disease were established, primarily on the basis of mortality and morbidity data. A national program aimed at improving Aboriginal health was also set up. These developments followed Australia becoming a signatory to the World Health Organization (WHO) Ottawa Charter in 1986. The Charter stated that the necessary supports for world health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity (Wass 1994, p 7). National health service goals are that Australians should have access to a comprehensive range of health care services regardless of financial status, race, culture or language, and that services should be of consistently high quality across the country. Fostering participation of communities and individuals in decision making at all levels of health service planning and delivery is also a major national goal (Commonwealth Department of Community Services and Health 1994).

The separation of policy goals and administrative functions, with the former in the driver's seat, is the essential requirement for effective management in the public interest. Evaluation of reliable performance indicators relevant to these functions is also vital. This has led to government support for purchaser/provider splits and related contractual procedures, in order to achieve the transparency necessary for evaluation of comparative service outcomes, which should in turn guide future policymaking and its administration. This purchaser/provider rationale is well understood in the health industry, but apparently not in some child and family welfare areas (Community Services Commission 2000).

Muetzelfeldt (1999) points out that government contracting usually depends upon strong central control that fixes provider attention on specified tangible outcomes, whilst ignoring less tangible outcomes. Service providers usually have little or no control over the terms that specify the service and results. Hindle (2002a) describes a population-based system for health planning and service delivery in the Australian Capital Territory (ACT) that primarily involves two distinct components. The purchasing agency is the Department of Health, Housing and Community Care Services, and the major provider agency is the ACT Health and Community Care Service, comprising ACT Community Care and the Canberra Hospital. ACT Community Care provides a wide range of services structured as six main programs: child, youth, and women's health; alcohol and drugs; dental health; community rehabilitation; correctional health and disability. The Calvary Public Hospital and other non-government agencies also provide health related services.

An important ACT government goal is reduction of the range of services provided by hospitals through the progressive expansion of community-based services. However, Hindle (2002a, p 127) notes that the ACT has no mechanism for high-level community input to health care planning or policy development, and there is no formal structure whereby the community as a whole can provide the Department with broad policy and planning advice. Hospital funding in the ACT is provided using casemix-based systems, which rely on national estimates of the typical cost of particular episodes of patient care. This style of funding is necessary for more transparent and comparable service delivery, but has yet to be introduced in community-based services such as those related to rehabilitation, palliative care, chronic pain management, convalescence, aged care and various other services. In spite of his support for elements of the current ACT system, Hindle describes a situation which appears to remain focused on bureaucratic and professional management for hospital-based services, and where comparatively little attention has been given to broadening the community input to either the management or delivery of services.

NSW Health (2000, p 14) states that the first condition for achieving the government vision for public health is that each of the seventeen NSW Areas Health Service management authorities, in partnership with its community, other government and non-government organizations, local councils and general practitioners, identify regional public health issues and prioritise responses to those issues. It also seeks community involvement in creating health-enhancing living conditions, specific targets for improvements in the health status of disadvantaged groups, equitable distribution of program funds on the basis of population and specific need, and a public health training strategy which identifies and addresses specific training needs for the public health workforce. The report of the National Sub-Acute and Non-Acute Casemix Classification Study (Eagar et al 1997) and related investigations require broader evaluation in these community-based management and service settings. Supporting research and evaluation programs are also required (O'Donnell 2001, p 13).

A unique patient identifier and electronic health record is currently being established for every individual who accesses the national health care system. This will enable evidence-based health care provision to be developed more effectively for populations and individuals, whether their treatment is delivered free by taxpayer funded public hospitals or in private health facilities that also receive taxpayer subsidy. Priority health care programmes are being developed for people with chronic and complex conditions (NSW Health Council 2000, p 17). The ACT has established a Territory-wide patient master index that facilitates the linkage of care provided in most care settings (Hindle 2002a, p. 127).

A coordinated and effective data gathering approach is required across many related community services, such as those relevant for implementation of the national mental health and injury prevention strategies, and the NSW Disability Policy Framework (2000). This is necessary in order to compare the effectiveness of a wide variety of health and related service provision on the basis of their apparent outcomes. The approach used in the NSW Government Disability Policy Framework appears relevant in other areas, such as child welfare and crime prevention. It calls for a planned, coordinated and flexible approach to policy and service provision for people with disabilities and their carers. It requires the provision of ways for service providers to measure and report on their progress. The model format for disability action plans for state government agencies and participating local councils (Section 3, p 8) may also have broader relevance.

Local councils have recently been invited by the NSW Attorney General to establish crime prevention plans, but lack of funding is one reason that efforts in this area have been comparatively weak. Under national competition policy the COAG provided economic incentives for reform of certain publicly owned utilities such as water, gas and

electricity (Australian Competition and Consumer Commission 1996, p 11). It seems appropriate that a similar policy should be followed with regard to local government management and related service.

How most health services are funded

There is increasing Australian agreement about the importance of clearly separating policy and service administration in order to identify comparative service outcomes more effectively. However, a major debate continues about how competing services should be funded, in order to achieve the best service outcomes for individual consumers and the broader community. There is growing evidence, some of which is discussed later, of a rational preference for public and industry ownership and management of funds by bodies that primarily represent the interests of national and industry communities of stakeholders, in order to achieve the aims of relevant legislation. Such management bodies may subcontract their service provision functions to a competing range of private or public sector organizations, with the aim of meeting the needs of the service consumers increasingly effectively. The common alternative is for individual consumers and service providers to interact in the market, with or without taxpayer subsidy.

For example, the National Health Act of 1953 primarily involved a market-based approach to health care governance. It established a national insurance scheme through provision of government subsidy for health insurance which individuals were expected to take out with insurance companies. In 1984, however, the Medicare system guaranteed universal, taxpayer-funded health care provision, administered by the Health Insurance Commission from general taxation revenues and a levy on taxable incomes. The Commonwealth government additionally provides economic support for individual consumers who choose to purchase extra entitlements to health care services from private sector insurers. From a government perspective the major point of encouraging people to take up additional private health insurance is to increase the overall pool of health funds and public or private facilities available for general use. From a consumer perspective, private health insurance may provide the benefits of earlier access to elective treatment, entitlement to doctor or hospital of choice, and insurer-subsidised ancillary health services (Industry Commission 1997). Potential reforms to inefficiencies in this structure are discussed later.

Under state workers' compensation schemes employers must insure all their employees against work-related injury. Historically, such schemes have operated in a variety of ways but there is now commitment to national uniformity based on the WorkCover managed fund model of service delivery, which was first introduced in 1987 by the NSW government (Heads of Workers' Compensation Authorities 1996). Under this insurance model, the state government and industry own the premium pool and underwrite the scheme. WorkCover is a statutory authority responsible for establishing the level of benefits for injured workers, and the risk rated level of premiums for industries and organisations. It licenses a dozen insurance companies and pays them to collect premiums, administer claims, invest funds, and collect data on its behalf.

This ownership design ensures the benefits of insurer investment are returned to industry and the public. Ideally it also discourages insurer competition for service provision based on premium price, and instead encourages insurer competition based on the provision of effective risk management services. However, better risk management and related outcome data are required to achieve the potential benefits of this ownership structure. Self-employed sub-contractors who are not deemed employees in workers' compensation legislation must make their own insurance arrangements. Forms of 'top-up' or extra insurance and related benefits may also exist (Industry Commission 1994).

Public benefits of industry and community ownership and management of funds

The public benefits of industry ownership of competitively managed funds were acknowledged in the 1986 federal budget through the introduction of award-based superannuation. In 1992 this was supplemented by Commonwealth legislation that introduced a superannuation guarantee. All employers were required to provide superannuation entitlements for all their employees. Industry managed superannuation funds have now become spectacular new investors on behalf of their members. The issue of how these and other funds can best

be managed in an international environment in order to serve individuals, industry and the community, is now of central concern. During the past decade, Commonwealth and/or State inquiries have been conducted into workers' compensation, motor accident, private health insurance, professional indemnity, and public liability insurance. The Senate Economic References Committee inquiry into the impact of public liability and professional indemnity insurance cost increases is currently occurring. Although the detail is complex, the benefits of industry and community ownership of funds are comparatively clear, as long as funds are managed effectively. This requires policy-led management in which administration is focused on evaluation of the comparative achievement of policy related outcomes.

Australian and U.S. health care systems both employ the term 'managed funds' but the fund ownership structures are different. In Australia, the universal coverage of the Medicare system and its integrated private insurance requirements put downward pressure on the prices all providers charge. Private health insurance funds are prohibited from insuring for the total amount the service provider charges the patient, unless this also conforms to government pricing requirements. This structure keeps all provider prices comparatively low. In the U.S., on the other hand, employers may take out private health care insurance coverage for their employees, or individual consumers may purchase it from competing health care funds on their own behalf, if their employer does not carry it for them. The government provides a safety net health care system that applies to a comparatively small and impoverished population group.

In a review of the evidence, Duckett (1997) found the Australian Medicare system outperformed the U.S. health care structure on social indicators related to service access, equity, and cost, but not service quality. Duckett's finding of comparatively poor Australian performance in regard to service quality may appear surprising in the light of the comprehensive national scope that Medicare potentially provides for the collection and analysis of reasonably consistent and reliable health service data. However, a range of recent reports have pointed out the need for better professional and academic organisation and practice in Australia, in order to achieve the transparent outcome data which is necessary for quality management (Review of Professional Indemnity Arrangements for Health Care Professions 1995; Industry Commission 1995 p 32; Australian Health Ministers' Advisory Council 1996; National Expert Advisory Group on Safety and Quality in Australian Health Care 1999).

Before the NSW WorkCover structure was introduced, over forty insurers competed to underwrite workers' compensation business in NSW. Competition on premium price led to five insurance company insolvencies in the mid 1980s (NSW WorkCover Review Committee 1989 p 155). As a result of this, all NSW employers paid, through a levy on premiums, to support injured workers whose employers' insurers had failed. In 1990 an independent actuarial review showed that a return of the NSW WorkCover system to private sector underwriting and competition on premium price would not only turn the investment benefits of the fund over to private hands, but would also increase general administrative costs by around 11% (O'Donnell 2000a). Additional costs would arise partly because of the need for re-insurance, which would be necessary if the large pool of all industry funds was broken up for underwriting by numerous insurance competitors. Re-insurance is an international system, and Australian premium holders could also find their premium costs rising as a result of disasters in foreign parts, over which they have no control. Where private sector insurers underwrite risk and compete on premium price, Australian government would also need to promote and support high levels of insurer profit as insolvency margins. In addition, a multiplicity of insurers competing on premium price would see the return of brokers to the system, adding regulatory difficulties and costs.

The Industry Commission (1994) inquiry into workers' compensation concluded there was a lack of evidence of benefits from private sector underwriting, and so did the joint report of Australian Heads of Workers' Compensation Authorities (1996, p132-133). They argued that other factors, including the quality of scheme administration, provide more important indicators of performance. Under the NSW Motor Accident Scheme the NSW Motor Accidents Authority overlooks a third party accident insurance scheme where insurers underwrite the business. At the public inquiry into the scheme, complaint was heard that the insurers did not distinguish motor accident premiums in any way from other general insurance funds, so the Authority therefore had no basis on which to exercise the powers of financial monitoring provided in its legislation. Whether it is ever possible for government to achieve effective disclosure and monitoring when insurers underwrite the business appears to be a moot question.

The potential for better-coordinated health fund management and related service delivery

There appears to be scope to increase transparency and reduce health care costs through a general investigation of the potential for better national integration between the management and delivery of Medicare, private health insurance and workers' compensation medical, rehabilitation and insurance services. The Industry Commission inquiry into private health insurance (1997) suggested that there is currently little effective competition in some States, and that there are also major administrative inefficiencies attached to current private health insurance underwriting structures. This is partly related to the need, in this community rated health system, to have the Commonwealth act as 're-insurer', in order to provide a buffer against potential insurer insolvency arising from increasing claims by the elderly.

The health care costs incurred under Australian workers' compensation schemes tend to be much higher than the health care costs under Medicare and also tend to rise much faster. For example, between 1987 and 1992 there was an increase in workers' compensation medical costs of 69% in Victoria, compared with an increase in NSW of 246% (Industry Commission 1994, Appendix pD28). On the other hand, Duckett (1997, p 8) found that since the 1970s the health share of gross domestic product in Australia has been relatively stable, hovering between 7.5% and 8% between 1976 and 1990 and increasing marginally to between 8% and 8.5% in the 1990s. This appears to be explained partly by the fact that health care providers may be in a bargaining position to charge more for the comparatively small volume of services provided to injured workers through their employers' insurers. In addition, the evidence is that adversarial court systems, which have historically determined estimates of disability and pain and suffering, are irrational on health and economic grounds. The selection and presentation of evidence by opposing lawyers who each call upon expert medical witnesses has repeatedly been shown to drive up costs as well as undermine rehabilitation (O'Donnell 2000b).

Grellman (1997) found major workers' compensation cost increases were still occurring in NSW as a result of lack of effective risk management at the workplace. Primary cost drivers of the scheme were found to be court payments for permanent impairment and pain and suffering awards; long term duration on weekly benefits; and the cost of commutation, disputes and litigation. NSW WorkCover (2001) has now established a system whereby insurers provide premium reductions if approved auditors find the business has established effective workplace consultation, education and risk management procedures. Initiatives such as this require broader industry and community support and related education, research and evaluation to maximize their potential.

The Premier of NSW has recently discussed the passing of the NSW Civil Liability Act and the need 'to restore personal responsibility and diminish the culture of blame'. He called for 'a fundamental re-think of the law of negligence', and said that there was no precedent for the changes occurring in NSW in this area, 'either in health care, or motor accident law, or in the legislation of other states and territories' (Carr 2002). He later appealed on national television for a major focus on 'the national insurance crisis' and on health and education (Murphy 2002). He has called for a no-fault compensation scheme for all those who are 'catastrophically' injured, which might be funded by a small increase in the Medicare levy, as proposed for Australia's intervention in East Timor (Stephens 2002). He has also said greater powers are necessary for the Australian Competition and Consumer Commission to 'get action' out of insurance companies. The Australian Medical Association President, Dr Kerry Phelps, has supported the Premier's comments, noting that if government did not act urgently on the establishment of a national compensation scheme and state-based tort reform there would be 'increasing chaos' in the health care system (Fabro 2002).

Regionally pooled funding

Australia's population is ageing, and the aim of remaining healthy and independent in one's own home for as long as possible is shared by the elderly and government alike. The National Strategy for an Ageing Australia (2000) identified a number of key areas for promoting healthy ageing and preventing illness. These include maintaining physical and mental health, engaging in physical activity, and preventing falls and other injury. Strategies to maintain wellbeing at older ages must also centre on the development of more flexible employment

patterns, and better coordinated and therefore more effective provision of health and social services, including transport, to meet community need. Flexible employment and related services are required to meet a multiplicity of individual situations. The aim should be to assist everybody to maintain links with work, recreation and community service wherever this is considered beneficial.

Kendig and Duckett (2001) proposed that all Commonwealth and State funds for aged care services should be pooled into a single fund to be managed at the regional level. The funds pool would incorporate residential aged care, home and community care, community aged care packages, and relevant State-funded community health activities. These researchers also suggest that, as occurred in Britain, housing and aged care should be unbundled, with separate funding streams for accommodation, on the one hand, and for living costs and care needs on the other.

This approach appears suitable for broader industry and community application in regional settings. This would allow the supply of care to be coordinated and tailored more effectively to local circumstances, especially in rural areas. Transparent management also requires output-based funding systems that, where relevant, are based upon benchmark pricing for casemix service delivery models (Hindle 2000b). This should also be designed to meet Muetzelfeldt and Hindle's criticisms, outlined earlier, about a lack of effective community input to the design of required contracting and service delivery outcomes. Ideally, implementation should occur across all health, local government, welfare, education and related industry and community contexts.

Conclusion

The role of government is ideally to promote effective management of the competing provision of goods and services so that it meets or improves upon the community standards required by legislation. The provision of government services or subsidies may also be necessary where the market fails to provide adequately. The Australian evidence is that industry and public ownership of funds which are managed so as to encourage equitable and competitive health and welfare service delivery is more cost-effective and fair than a market-driven approach to preventing injury and improving health. However, more community input to broadly planned service delivery, greater transparency and accountability by insurers and other service providers, and casemix funding systems are also required to tap the potential benefits of this policy-led model of fund management. The development of a pooled regional funding approach may assist communities to manage health and related services with more flexibility and also to address transparency and accountability problems.

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