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HOUSE OF REPRESENTATIVES INQUIRY INTO HEALTH FUNDING
SUBMISSION BY THE WESTERN AUSTRALIAN GOVERNMENT

1. BACKGROUND: THE AUSTRALIAN HEALTH CARE SYSTEM

The Australian health care system continues to rank among the best in the world and the Medicare policy provides the framework for the system.

The principle of universality, which underpins Medicare, ensures that people are able to access the health services they need regardless of their ability to pay.

Under Medicare, through the Commonwealth Government's Medical and Pharmaceutical Benefits schemes, people can access services from private doctors and pharmaceuticals at subsidised rates or, in some cases, free of charge.

People requiring hospital care have the option to access public hospital services free of charge if they choose to be treated as public patients. They can also elect to be treated as private patients in private or public hospitals, in which case they receive subsidised treatment.

Few countries maintain comparable standards of quality in training medical practitioners and other health professionals, or have health infrastructure of a similar standard to Australia.

Despite the generous subsidies provided through Medicare, Australia is not one of the highest spending nations on health services. In 2000 Australia spent around 9.0% of our Gross Domestic Product on health, which is less than other countries such as the United States (13.0%), Germany (10.6%) and France (9.5%).

1.1 Pressures on the Health System

While the health system has significant strengths, pressures on the system are evident.

People are on average seeing doctors more frequently and using more prescription pharmaceuticals. Commonwealth expenditure on medical and pharmaceutical benefits is uncapped, growing in response to demand. Despite a variety of measures in recent years designed to limit expenditure growth, expenditure in these areas is continuing to escalate at a rate beyond what would be considered desirable.

In the hospital system, rapid growth in demand is being accompanied by strong wage pressures and increases in costs associated with technological and clinical advances. While expenditure on public hospitals is limited by the funding allocated by governments, hospitals are using all of the funding provided to them and seeking more. Symptomatic of the difficulty public hospitals are having in keeping pace with growing demand are issues such as emergency department by-pass and increasing waiting times for elective procedures.

In summary, expenditure on health services by both the Commonwealth and State governments continues to grow at a rate that outstrips the capacity of governments to finance these expenditures.

The table below presents data on expenditure by the Commonwealth and Western Australian governments over recent years.

	Commonwealth Government (a)		Western Australian Government (b)	
	Expenditure	% Increase	Expenditure	% Increase
2000/01	25,162		2,489	
2001/02	27,461	9.1	2,698	8.4
2002/03	29,400	7.1	2,930	8.6
2003/04	32,355	10.1	3,073	4.9
2004/05	34,986	8.1	3,340	8.7

(a) Extracted from Commonwealth Budget Paper Number 1, various years
(b) WA Department of Health data.
(c) WA Government expenditure data includes all State expenditures (funded from own-source revenues, Commonwealth SPPs and patient revenues.)

The table shows that, for both governments, health expenditure have continued to increase at a rate well above the CPI, which has been growing at around 3% per year.

For the Western Australian Government, the State's Department of Treasury and Finance has estimated that, based on recent trends, health expenditure could rise from around 25% of State Government recurrent expenditures to over 36% by 2012/13.

At a national level, the Commonwealth's National Commission of Audit warned in 1996 that, on current trends, health expenditure as a proportion of GDP would double from 8.5% then to 17% by the year 2041.

All governments and all sides of politics claim to support the Medicare policy continuing to provide the foundation for Australia's health system. To continue with this policy framework it will obviously be necessary for the health system to be made to operate more efficiently if the system is to remain affordable.

2. ROLES AND RESPONSIBILITIES

There is wide recognition that a key issue limiting the efficient operation of the health system is its fragmented management.

With three levels of government and the private sector (commercial companies, charitable organisations and individuals) all having significant roles in designing, funding, managing and delivering health services, the health system is characterised by overlapping responsibilities and decisions by governments and health organisations impacting significantly on one another.

2.1 Division of Responsibilities

The Commonwealth Constitution as originally adopted in 1901 specified a range of Commonwealth Government responsibilities, and provided that all other areas would remain the responsibility of the States. Health was not one of the areas designated a Commonwealth responsibility.

However, part of an amendment passed in 1946 granted the Commonwealth powers in relation to sickness and hospital benefits and medical and dental services. In the period since, the Commonwealth has used this provision to assume a significant direct role in funding and managing health services.

Major current direct Commonwealth Government health roles include:

- subsidising the provision of privately provided medical services and pharmaceuticals;
- funding nursing home services;
- regulating private health insurance; and
- funding medical research.

States have maintained major responsibility for services in areas including:

- public hospital services;
- mental health programs;
- dental health services;
- home and community care;
- child, adolescent and family health services;
- women's health programs;
- public health services;
- rehabilitation; and
- inspection, licensing and monitoring of premises, institutions and personnel.

Although these areas are described as "State responsibilities", the Commonwealth now exercises a substantial degree of control over policy and funding in most State areas of responsibility. This control has been gained largely through the use of its ability to make conditional grants to the States (ie. specific purpose payments (SPPs)).

The 2005/06 Commonwealth Budget papers list 10 *Health* SPPs and two *Social Security and Welfare* SPPs that could be considered as Health. These are presented in the following table.

Specific Purpose Payment	Allocation to WA ($m)	National Allocation ($m)
Hepatitis C Settlement Fund	0.090	3.000
Health Program Grants	0	1.825
Australian Health Care Agreements	822.697	8,366.631
Highly Specialised Drugs	42.415	521.485
Youth Health Services	0.223	2.471
National Public Health	20.929	229.752
Essential Vaccines	10.250	111.663
Repatriation General Hospitals	0	7.286
Western Sydney PET Scanner	0	1.000
Royal Darwin Hospital	0	20.994
Aged Care Assessment	5.659	55.441
Home and Community Care	85.745	857.835
Total	**988.008**	**1,0179.383**

The table shows that the Australian Health Care Agreement (AHCA), through which the Commonwealth provides assistance towards the provision of public hospital services, dominates health SPP funding, accounting for over 80% of total SPP funding.

The situation now is that, across many areas, both the Commonwealth and State governments each have direct roles in funding/managing health programs or services, and through conditions attached to SPPs, the Commonwealth Government exerts a major influence over how State/Territories undertake their role.

The Commonwealth and State governments have increasingly responded to this situation by developing national arrangements that define common objectives, clarify roles and govern how they will operate together. Some examples of such national arrangements include:

- national arrangements for the management and supply of blood and blood products;
- national Aboriginal and Torres Strait Islander framework agreements;
- National Health Priority areas;
- The National Public Health Partnership;
- National regulatory arrangements for food; and
- The National Mental Health Strategy.

2.2 Some Examples of Fragmented Responsibilities

The following is a description of arrangements in just a few areas where there are overlapping Commonwealth and State responsibilities.

Prescription Pharmaceuticals

The approach to the supply of prescription pharmaceuticals provides a good example of the fragmented division of Commonwealth and State responsibilities.

The Commonwealth funds and manages the Pharmaceutical Benefits Scheme (PBS) which subsidises the supply of prescription pharmaceuticals dispensed by community pharmacies. The Commonwealth also regulates community pharmacies. Under the PBS, patients receiving a prescription are required to contribute a co-payment towards the cost of the pharmaceuticals they receive.

However, a significant proportion of prescription pharmaceuticals are supplied to patients in public hospitals, with the hospitals operating their own pharmacies. Under the terms of the AHCAs, the State is required to supply pharmaceuticals to public hospital inpatients and outpatients. The State may, however, charge non-admitted patients and inpatients on discharge for prescription pharmaceuticals at a rate consistent with the Commonwealth PBS co-payments.

The 1998/99 – 2002/03 AHCAs allowed the development of arrangements through which States could charge against the PBS for prescription pharmaceuticals dispensed to outpatients and admitted patients on discharge. Several States are now trialling such arrangements.

The 2003/04 – 2007/08 AHCAs commit the Commonwealth and State governments to explore setting up a single national system for pharmaceuticals across all settings.

Care of Patients with Chronic Disease

There is significant Commonwealth and State overlap in funding and managing services for patients with chronic disease.

For instance, patients with heart failure are usually diagnosed in general practice (which is Commonwealth-subsidised), receives specialist treatment at either public hospitals (State-managed) or private hospitals (where their care is Commonwealth-subsidised) and are then referred back to general practice (Commonwealth-subsidised) and other community-based services for ongoing care.

Rural and Remote Medical Retrieval

The State and Commonwealth share the cost of providing retrieval services to rural and remote communities through the Royal Flying Doctor Service (RFDS). Medical retrieval is the process of sending a clinical team (nurse and/or doctor) out to an accident scene or hospital, stabilising the patient and transporting them back to a higher level facility.

The RFDS is funded from three main sources. The Commonwealth provides around 35% of funding, the State around 50% and the remainder comes from a variety of sources including donations and worker's compensation recoups. The Commonwealth funds primary retrievals ie. retrievals from facilities without a resident doctor or inpatient beds. The State funds secondary retrievals ie. interhospital transfers.

Approximately 80% of flights are interhospital. Because of the dualistic funding arrangements, there is no consistent governance system, nor is there a single contractual approach. Should RFDS require extra emergency funding, for unforeseen maintenance requirements, it is not clear where the responsibility for maintaining the service lies.

Patient Charging

Whilst under the AHCA, State governments have the power to set charges for people treated as private patients in public hospitals, the Commonwealth's power over the health funds through the *National Health Act 1953* significantly distorts the ability of States to recover the true cost of treating these people.

Under Commonwealth legislation introduced in 1995, health insurers and hospitals are able to negotiate contracts that include agreement on the level of benefit insurers will provide for patient accommodation at that hospital. For non-contracted hospitals, the Commonwealth ensures there will at least be some level of coverage by setting a default rate for the use of a shared private room. The default is the minimum rate of benefit insurers are able to provide. Although health funds can recoup at a level higher than the default rate, there is no financial incentive for this to occur.

Currently the default rate understates the true cost of treating this class of private patients by about 75%. The WA Government faces a significant financial risk if it decides to move away from the default rate as the creation of a patient co-contribution will inevitably result in patients nominating themselves as public patients to avoid any "out of pocket" expenses.

Surgically Implanted Prostheses

The Commonwealth Government has recently passed a number of significant amendments to the *National Health Act 1953* in respect to prostheses (assent date of 21 March 2005). The Bill amends the *National Health Act 1953* by requiring health funds to offer a no gap and gap permitted range of prostheses as part of hospital procedures for which a Medicare benefit is payable.

Schedule 1 of the Bill amends the *National Health Act 1953* to allow the Minister for Health and Ageing to determine in writing:

- No gap prostheses – and the benefit amount for each no gap prosthesis; and
- Gap permitted prostheses – and the minimum and maximum benefit amounts for each gap permitted prosthesis

In addition to introducing a distinction between gap and no gap prostheses, the Bill also discriminates between the level of benefit that is payable in a public hospital and a private hospital or day hospital facility. The legislation enables health funds to seek lower charges for prosthetics implanted in public hospitals, on the grounds that the greater purchasing power of the public system should enable lower prices to be charged. This differential treatment of the public and private systems impacts on the State's ability to recover the

costs of prosthetic implants and on the complexity of billing arrangements in the public sector.

Research Infrastructure Funding

The system for funding research infrastructure has evolved in an ad hoc way and has anomalies that make it difficult for research organisations to plan for the long term. The Commonwealth provides the majority of government funding for health and medical research through National Health and Medical Research Council (NHMRC) grant schemes. Basic recurrent infrastructure funding (e.g. telephones and utilities) is provided independently from research grant funding (which explicitly excludes funds for infrastructure) and depends on whether the research is performed in a university, a medical research institute (MRI) or other institution and differs across States.

Infrastructure funding has not kept pace with the increase in funds for research and this has stretched the resources and funding creativity of many institutions. Costs are estimated to be around 50c per $1 of competitive research funding, while the Commonwealth program for this purpose, the Research Infrastructure Block Grants scheme administered by the Department of Education Science and Training (DEST), provides only around 25c and is not directly available to MRIs. In Western Australia the Medical and Health Research Infrastructure Fund (MHRIF) currently provides 24c for eligible researchers in MRIs and 12c for those in hospitals or universities. In other jurisdictions, State Government infrastructure funding is only provided to MRIs or hospitals.

The Commonwealth released the report of the Investment Review of Health and Medical Research Committee in December 2004. It concluded that the current infrastructure funding system is an impediment to the flow of funds to the best researchers and should be addressed by increasing overall infrastructure funding (to 40c per $1) and linking infrastructure funds directly to NHMRC and Australian Research Council (ARC) grants. However this approach also requires an agreement with State governments to maintain their overall HMR investment. This puts pressure on State Government budgets to commit to funding research organisations operating independently of them, and does not resolve the issue of different funding schemes across jurisdictions.

2.3 Issues/Problems Resulting from Fragmented Responsibilities

The split of responsibilities is recognised as giving rise to a number of problems.

2.3.1 Cross-Jurisdictional Implications of Decision Making

As noted earlier, there is a high level of interaction between the parts of the health system managed by different players.

There is incentive for jurisdictions to reduce the financial burden on themselves by changing their own arrangements to shift costs onto programs financed by the other level of government.

An example is the relationship between the availability of after hours private medical services and demands on public hospital emergency departments. During the early 1980s the Commonwealth provided higher rebates for medical services provided after hours, giving doctors an incentive to make available services outside of regular hours. However, in the mid 1980s the Commonwealth removed the incentive, so the same rebate was provided regardless of when the service was delivered. The removal of this incentive led to a reduction in the availability of after hours private medical services. The reduced availability of doctors outside of normal hours led to an increasing number of people obtaining treatment at public hospital emergency departments for problems that might otherwise have been treated by a general practitioner.

Similarly, decision making by State governments about public hospital services can have implications for Commonwealth programs. For example, during the 1980s and early 1990s some States significantly reduced the outpatient services available through their public hospitals. This led to demand progressively shifting to private medical practitioners, consequently increasing claims on the Commonwealth's Medicare Benefits Schedule.

All governments are wary about costs being shifted onto themselves. This concern motivated a decision by the Commonwealth to insert anti cost-shifting provisions into the Australian Health Care Agreements. Clauses 16 and 17 of the AHCAs state:

> *"16. Recognising the co-operative relationship between them, the Commonwealth and [State] agree that they will not institute or sanction arrangements which unreasonably impose an additional financial burden on the other party."*
>
> *"17. Where it can be demonstrated that a change in service delivery arrangements would improve patient care, patient safety or patient outcomes, the Commonwealth and [State] agree to implement such changes in an open and consultative manner and, as appropriate, recompense the other party where costs are transferred to that party."*

The intent of these clauses is commendable. However, the Commonwealth and State/Territory governments have differing capacities to act on concerns about actions by the other that may constitute cost-shifting. If the Commonwealth is concerned that a State Government initiative has led to additional costs for the Commonwealth, then it can simply decide to withhold some of the State's AHCA funding. On the other hand, if a State Government has concerns about Commonwealth actions, then all it can do is voice those concerns, and has no recourse other than to present a request to the Commonwealth that it provide compensation.

2.3.2 Lack of Coordination and Gaps in Service Delivery

The division of responsibilities between the Commonwealth and State governments can also lead to poor coordination and gaps in service delivery.

An example of poor coordination is that the Commonwealth Government has funded "practice nurses" to assist general practitioners in rural areas. While at face value this seems a sound initiative, in Western Australia the main problem has been the absence of private general practitioners in many rural and remote communities. Providing funding for nurses to assist general practitioners is not useful for communities where there is no general practitioner. As a means to address the lack of general practitioners, the Western Australian Government has pursued the development of a nurse practitioner model through which suitably qualified nurses will be able to deliver a limited range of services that might otherwise be delivered by a general practitioner if one was available. Although the Commonwealth's practice nurses model may have been a relevant initiative for larger rural towns in New South Wales and Victoria, it did nothing to advance the nurse practitioner model being pursued by Western Australia.

In terms of gaps, an example is the gap in the availability of assistance for people with continence problems. Persons aged 65 years and over presently receive no assistance towards the purchase of continence aids unless they are a resident of a nursing home.

The Commonwealth funds a Continence Aids Assistance Scheme (CAAS) which provides this type of assistance to a wide group of people. CAAS was originally intended to target people in the workforce, but its eligibility criteria now include other people in younger age groups. People aged 65 years and over are only able to receive assistance if they are in paid work for 8 or more hours per week.

The Commonwealth claims that the responsibility for assistance with continence aids for other people aged 65 years and over is a States' responsibility. It has argued that this responsibility was transferred to States along with funding under a former program, the "Program of Aids for People with Disabilities" (PADP). However, States have responded by arguing that support for continence aids was never included in the PADP and was specifically excluded from PADP criteria.

Regardless of which level of government should be responsible for assisting people aged 65 years and over with incontinence aids, there is clearly a gap and the people affected will not be assisted by the Commonwealth and State governments continuing to point blame at each other.

2.4 Roles and Responsibilities - Reform

A number of high level health system reviews have been undertaken over the past decade.

Separate reviews have been undertaken under the auspices of State Health Ministers and the Council of Australian Governments. The Commonwealth Government's National Commission of Audit and the Commonwealth Senate Inquiry into Public Hospital Funding have also produced reports considering reform options.

All of this work has led to the conclusion that it would be most sensible to eliminate fragmentation in health system roles and responsibilities by bringing the whole system under a single managing authority.

Options for doing so can be summarised as:

(1) Commonwealth-only responsibility for health;
(2) States'-only responsibility; or
(3) the Commonwealth and States jointly determining policy and pooling their funding with a single health management authority.

The Commonwealth's National Commission of Audit identified the first two options, and suggested that States would be best placed to assume responsibility for health given their greater capacity to respond to local and regional circumstances. However, while presenting this suggestion, the Commission's report indicated it was beyond the Commission's scope to firmly recommend the transfer of responsibility for Commonwealth health functions to the States.

Despite all of the work suggesting transferring overall responsibility for health to one level of government (or a single management authority), governments have not pursued this direction and it appears unlikely they will be prepared to do so in the near future.

This leaves governments in the position of having to endeavour to make improvements within the current framework of roles of responsibilities.

In work to negotiate the current AHCAs, the Commonwealth and States established a number of clinician-led working groups. The working groups identified a number of areas where reforms could yield significant benefit and presented Health Ministers with a vast number of reform proposals.

However, the Commonwealth ultimately signalled it was not interested in pursuing reforms in the context of the new AHCAs. Following the finalisation of the AHCAs, the Commonwealth did agree to begin discussing reforms with the States, but advised that it would only be prepared to consider reform proposals that would either result in savings or be cost-neutral to itself.

Work on developing reform options has since been progressing through a Health Reform Agenda Working Group established under the auspices of the Australian Health Ministers' Advisory Council. However, the range of reforms it is able to consider is severely restricted because of the Commonwealth-imposed limitation.

All governments need to recognise that high level reform to improve health services may require some up-front investment.

In addition to the multilateral reform processes, at a bilateral level the Commonwealth and individual States should give priority to improving joint planning processes and seeking to better integrate services at a regional level.

3. SPECIFIC PURPOSE PAYMENTS

By providing grants as SPPs, the Commonwealth exercises significant influence over State service provision, including providing direction on the policy framework, the types of service funded and in some cases even determining which individual services are funded and in what locations. Where SPPs involve matching or maintenance of effort arrangements, the SPP is also influencing the State's financial contribution to the program from its own-source revenues.

3.1 Problems with SPPs

A variety of problems with SPP arrangements have been identified, including:

Lack of Responsiveness to Diverse Regional Needs

Funding provided as SPPs is directed to purposes determined by the Commonwealth.

The concern this creates for States is that the purposes for which an SPP is made available may not align with State priorities. The same funds alternatively might be more usefully applied to a purpose that would be more relevant given the specific circumstances in a State.

The extent of the concern is increased where SPPs impose matching or maintenance of effort requirements that necessitate the State contributing a specified amount of its own funds to the same purpose. In order to meet a matching or maintenance of effort requirement, a State may have to divert funds away from other services that it regards as a higher priority.

The concern often expressed in less populous States is that the Commonwealth determines its priorities to address issues in the more populous States, New South Wales and Victoria. Programs designed to address the situation in those States can fail to adequately take account of issues such as remoteness and Aboriginality, which are often of greater priority in the less populous States.

For example, in the illicit drugs area, the Commonwealth might fund an SPP for programs to combat heroin use to respond to problems it sees in Sydney and Melbourne. At the same time, the larger problem in Western Australia may be petrol sniffing in Aboriginal communities, but the funding by the Commonwealth will not assist in addressing this problem.

Bureaucratic Duplication

Commonwealth involvement in areas of State responsibility means there are two levels of bureaucracy undertaking the same functions, eg. needs analysis, policy development and program evaluations and reviews.

Some SPPs have required funding approvals for individual projects. State and Commonwealth bureaucracies separately develop and provide advice to their respective Ministers on funding under these programs. A current example is the Innovative Services for Homeless Youth (IHSHY) Program. Another previous example was the Home and Community Care Program, where State and Commonwealth approval for each funded project was previously required. For HACC, the requirement for joint approvals for individual projects has now been replaced with a requirement for joint approval on the regional allocation of funding.

Inequities in Funding to Different States

The Commonwealth's allocation of SPP funding to States can be inequitable. Funding may be negotiated on a bi-lateral rather than a multi-lateral basis, which can lead to some States receiving a disproportionately large share of total funds (relative to their population size) and other States a lesser share. This has been the case in the negotiation of some past Medicare Agreements (the predecessor agreements to the current AHCAs). For example, in the 1993/94 – 1997/98 Medicare Agreements, NSW and Victoria negotiated additional special funding titled "Medicare Guarantees", which gave them an additional $1.15 billion over five years. About two thirds of this amount was funded through reductions in financial assistance grants to other States, while the Commonwealth contributed about one third.

Uncertainty

There is no certainty of ongoing funding of SPPs. In a number of instances the Commonwealth has funded new SPPs and then later ceased to provide funding, leaving States with the difficult decision of whether to pick up funding for the program themselves or have the funded services cease.

An example was the Commonwealth Dental Health Program, which the Commonwealth initially funded in 1994/95. The Program was an adjunct to existing State programs providing subsidised dental services for people on low incomes. The then Western Australian Government was required to significantly alter the design of its own program in order to qualify for the funds. The additional Commonwealth funds also significantly raised community expectations about the availability of subsidised services. However, in the 1996/97 Budget the Commonwealth announced its decision to cease funding the Program.

Excessive Cost of Satisfying Reporting Requirements

In specifying SPP reporting requirements, the Commonwealth sometimes does not adequately consider the compliance costs to States. Especially for smaller SPPs, these costs may sometimes be excessive relative to the quantum of funds.

As an example, the Commonwealth provides Western Australia with funding in the vicinity of $200,000 per year for the Innovative Health Services for Homeless Youth (IHSHY) Program. At one point the Commonwealth sought to require States to provide information on other health services accessed by the clients of the non-government services funded through this Program. Establishing a system to track services received by these people would have cost well in excess of the amount of Commonwealth funding and also could have been an unnecessary invasion of personal privacy. Fortunately, in this case, the Commonwealth finally accepted that their proposal was unworkable.

3.2 Reform of SPPs

The problems with SPPs are recognised as applying at a whole-of-government level. Commonwealth and State Treasuries have undertaken considerable work on the reform of SPPs, which in 2001 culminated in the development of a set of "Principles and Guidelines for Specific Purpose Payments", which was endorsed by all State Heads of Treasuries.

The "Principles and Guidelines" document (attached):

- established a set of principles that are basically aimed at encouraging simpler SPP arrangements, increased clarity and improved flexibility;
- provided a set of "Operational Guidelines" on how the principles should be built into SPP agreements; and
- presented a template SPP agreement.

The directions taken in the document are consistent with some directions that have been pursued recently by Commonwealth and State/Territory health agencies. In this regard, for example, the document identifies broadbanding smaller SPPs as a means to improve flexibility and reduce administration costs, and suggests that performance measures should be set in terms of outcomes and outputs. The same principles underpinned the initial negotiation of the Public Health Outcome Funding Agreements.

The Principles and Guidelines could provide a framework for the development of new health SPPs agreements and could also underpin a review of existing SPPs agreements.

4. AUSTRALIAN HEALTH CARE AGREEMENT (AHCA)

The AHCAs, which have replaced the Medicare Agreements, underpin the provision of public hospital services. They are by far the largest health SPP, in 2004/05 accounting for about 90% of the health SPPs received by WA.

4.1 AHCA Shortcomings

For the 2003/04 – 2007/08 AHCAs, like other States, WA was ultimately forced to accept a bad deal. Despite strong growth in health costs WA's AHCA will deliver a lesser Commonwealth contribution to public hospital funding in this State than would have a continuation of the previous 1998/99 – 2002/03 AHCA.

In negotiations, States sought for the AHCAs to be a vehicle for reform, developing suitable arrangements to recognise that general practitioner – type services are being often delivered in public hospitals and that aged persons are frequently accommodated on an ongoing basis in hospitals while awaiting placement in a nursing home. Despite early promise, including agreeing to the establishment of a number of clinician-led working groups to recommend on reforms, the Commonwealth was ultimately resistant to reform.

From a States' perspective, it seems unfair that the Commonwealth is essentially able to fix its funding contribution for the life of the AHCAs, leaving States exposed to all of the risk of growth in expenditure needs beyond the indexation factors. States also recognise that their capacity to fund public hospitals is limited compared to the Commonwealth's.

In negotiating the current AHCAs, States undertook an assessment of expenditure needs and developed a case for a boost in the base level of Commonwealth AHCA funding and also for improved indexation during the period of the agreements.

The Commonwealth failed to respond to the plea for additional funding.

The base level of funding in the first year of the new AHCA was merely equal to the last year with new indexation applied. There was no increase in the base.

For the new AHCA, funding is being indexed in response to three factors – growth in age-weighted population, cost inflation and "utilisation drift". While the other two factors are self-explanatory, utilisation drift is understood to be intended as a catch-all to respond to growth in costs resulting from drivers such as technology advances and rising consumer expectations about services.

The Commonwealth is indexing AHCA funding in response to cost inflation using a wage-cost index (WCI-1), which is a composite of the consumer price index and minimum wage safety net adjustments. WCI-1 is growing at only about 2% per annum, which is vastly inadequate compared to cost inflation in the health sector. The outcomes from recent wage negotiations would suggest that, at minimum, hospital costs are growing in the vicinity of 5% per annum. WA has developed its own hospital output cost index (HOCI), which measures changes between years in the cost of delivering a unit of public hospital services. This has been growing at 7% per annum.

Indexation for utilisation drift has been fixed at 1.7% per annum, and this indexation factor is only being applied to 75% of AHCA funding. Information presented in the recently released Productivity Commission Progress Report for its inquiry into *"Impacts of Medical Technology in Australia"* suggests that the present 1.7% per annum is not adequate to reflect the cost growth associated with new technologies, and the utilisation drift factor needs to be re-examined.

In total, AHCA indexation is resulting in the Commonwealth's contribution to public hospitals increasing by around 6% per annum. Under the terms of the AHCAs, State own-source public hospital expenditures are required to grow at a rate that at least matches growth in Commonwealth funding. In 2003/04, all States have increased their own-source funding by substantially more than the growth in the Commonwealth contributions (in Western Australia's case, the State's own-source recurrent funding grew by about 20%). As a consequence, the Commonwealth's proportional contribution to public hospital funding is declining.

As noted earlier, another important issue with the AHCAs is the uneven position of the Commonwealth and State governments. The Commonwealth Health Minister annually assesses each State's performance in meeting the AHCA principles, and is able to unilaterally decide to withhold funds (for example, if it is believed the State may have undertaken an activity that may have shifted costs onto the Commonwealth). States have no recourse to an independent arbiter if they disagree with the Commonwealth's assessment. Apart from an appeal to the Commonwealth Minister, States also have no recourse if they are concerned about an action by the Commonwealth which they believe has shifted costs onto them.

4.2 Reforming the AHCAs

While believing the current AHCAs have significant and obvious shortcomings, the WA Government has nevertheless signed an agreement and is committed to fulfilling its obligations under the agreement.

The Government also recognises that the Commonwealth is unlikely to be prepared to vary funding or substantively change wording in the current AHCAs. Hence, although it would be desirable to make changes to the current AHCAs, most of the proposals presented here seek changes to be incorporated into the 2008/09 – 2012/13 AHCAs.

Some key changes sought in relation to the 2008/09 – 2012/13 AHCAs are outlined below.

Quantum of Funding

From a States' perspective, public hospital funding is growing at a rate that is unsustainable for State budgets. As noted earlier, in 2003/04, the first year of the current AHCA, the Western Australian Government increased its own-source contribution to public hospital funding by an amount approaching 20% compared to the Commonwealth's 6%. The Western Australian Department of Treasury and Finance has warned that health expenditures could climb from about 25% of the budget to over 36% by the year 2012/13.

Clearly, if the Medicare policy is to continue to underpin the provision of public hospital services, then it will be necessary for the Commonwealth to increase its relative contribution.

There are no formulae or fixed rules for determining how much funding the Commonwealth should contribute to public hospitals through the AHCAs. However, it seems reasonable that there should be some rule developed to ensure equitable contributions by the Commonwealth and State governments.

In the first AHCAs, initiated in the mid-1980s, States agreed to provide free hospital services to people electing to be treated as public patients in return for being compensated for any costs or loss of revenue involved. Compensation was calculated based on the cost of any move from private to "hospital patient" status, on revenue loss from reducing private hospital fees, on the additional cost of medical services to "hospital" patients and on the revenue loss from eliminating outpatient fees.

While the quantum of funding in the first AHCAs was determined based on a set of agreed principles, in more recent times determination of the quantum of funding has become a purely political exercise. Regardless of whether governments go back to the original principles and formula used in the first AHCAs for determining grants, there should be a clear mechanism for determining fair Commonwealth and State financial contributions.

Indexation

As noted earlier, under the current AHCAs the Commonwealth's funding contribution is now indexed using three factors:

(1) growth in age-weighted population;
(2) cost inflation, as measured using a wage-cost index (WCI-1); and
(3) "utilisation drift", set at 1.7% per annum and applied to 75% of the base grant.

Concerns about the use of WCI-1 and the utilisation drift factor were outlined earlier. In summary, as an economy-wide measure of inflation, WCI-1 falls significantly short of reflecting growth in the cost inflation for hospital services, which are largely driven by wage increases. The utilisation drift factor is set too low to adequately respond to cost increases associated with cost drivers such as new technologies, changes in clinical practice and rising community expectations about services.

To address these issues, the Commonwealth and State governments should jointly commission independent work to develop an appropriate measure of cost inflation in public hospitals and also to assess the level at which the utilisation drift factor should be set. This work should provide a basis for indexation in the next AHCAs.

Dispute Resolution

In the current AHCAs the Commonwealth Health Ministers assesses State compliance with agreement provisions and is able to make adjustments to funding as he/she determines, without States having recourse to appeal to an independent third party. States are only able to raise concerns about Commonwealth actions with the Commonwealth Minister. This is a very uneven situation.

The previous AHCAs included provision for States and the Commonwealth to refer matters in dispute to an independent arbiter. This model was superior on justice grounds and it would be desirable to move to re-establish that model for the next AHCAs.

However, a shortcoming of the dispute resolution provisions in the previous AHCAs was that parties were not bound to abide by decisions by the independent arbiter. The next AHCAs should compel jurisdictions to act on an arbiter's findings.

5. WA-SPECIFIC ISSUES

In addition to the broad concerns with Commonwealth/State arrangements outlined above, there are a number of issues of specific concern for Western Australia, some of which may be shared by some other States. These issues are outlined below.

5.1 Low Expenditure on Commonwealth Programs

The Australian Institute of Health and Welfare (AIHW) annually publishes estimates of health expenditure by jurisdiction and by area. Their most recent publication presents figures showing that in 2001/02 the Commonwealth spent $1,466 per person on health services in WA (AIHW, 2004), which was $113 per person or 7% below the national average of $1,579 per person. It was also $250 per person less than the Commonwealth spent in South Australia, the jurisdiction where it spent the most per capita.

Commonwealth Government Health Expenditures by Jurisdiction: 2001/02

Jurisdiction	Commonwealth Outlays ($ million)	Per Capita Commonwealth Outlays ($)
NSW	10,767	1,621
Victoria	7,619	1,670
Queensland	5,663	1,543
Western Australia	**2,813**	**1,466**
South Australia	2,607	1,716
Tasmania	772	1,631
ACT	466	1,444
Northern Territory	255	1,275
Australia	**30,962**	**1,579**

Expenditure data sourced from AIHW, "Health Expenditure Australia 2002-03". Per capita figures derived using ABS population data.

If in 2001/02 the Commonwealth had spent in WA at the national average per capita rate, then it would have spent about $218 million more in this State.

A major contributor to this shortfall in Commonwealth expenditure is below average expenditures on medical and pharmaceutical benefits.

In 2003/04, in WA the Commonwealth spent $419 per person on Medicare benefits, about $68 per person below the national average ($487 per person). For the Pharmaceutical Benefits Scheme, Commonwealth expenditure in WA in 2003/04 averaged $225 per person compared to the national average of $253 per person (Commonwealth Department of Health and Ageing).

Overall, in 2003/04 Commonwealth expenditure on Medicare and Pharmaceutical benefits was around $56 million less in WA than had the Commonwealth spent here at the national average per capita rate.

The low expenditure on medical and pharmaceutical benefits is most severe in remote areas, with expenditure on these programs totalling on average less than $100 per person per year in many rural and remote communities. This is anomalous when the health status of people living in remote areas, especially Aboriginal people, is significantly worse on average than for the remainder of the population.

In contrast to the Commonwealth's low per capita average expenditure on Medicare and pharmaceutical benefits for Aboriginal people, the State spends around three times more per person in providing public hospital services to Aboriginal people than for the remainder of the population.

Low Commonwealth expenditure has led to higher demand on public hospital services. In remote communities, in the absence of private doctors, people rely almost exclusively on State public hospitals to obtain the health services they need.

5.2 Shortage of Doctors in Rural and Remote Areas

A major factor explaining the low per capita Commonwealth expenditure on medical and pharmaceutical benefits referred to above is the low number of doctors in Western Australia's rural and remote areas.

The State has fewer medical practitioners per capita than other States. In this regard, in 2003 the Australian Institute of Health and Welfare (AIHW) Medical Labour Force Survey determined there were:

- 233 clinicians per 100,000 population in Western Australia compared to the national average of 271;

- 79.6 specialists per 100,000 population in Western Australia compared to the national average of 89.7; and

- 90 primary care practitioners (ie. general practitioners) per 100,000 population in Western Australia compared to the national average of 101.

The State's north west provides the most extreme example of the shortage of doctors. There are a total of 44 general practitioners in the Kimberley region and 47 in the Pilbara region. Most of these doctors are either salaried or spend most of their time providing services as visiting medical practitioners (VMPs) on contract to public hospitals. The VMPs may offer private services in addition to their work at a public hospital. However, the total number of general practitioners providing exclusively private services is less than 10, while the region (the Kimberley and Pilbara combined) has a population in excess of 80,000.

The shortage of doctors leaves patients reliant on public hospital emergency departments to access primary care services. In the Kimberley region, for example, the demand from patients requiring general practitioner - type services has led most hospitals to establish an appointments system for people to book to attend their emergency departments.

However, emergency departments are not an appropriate setting for the provision of primary care services. They are geared to respond to acute and urgent health care needs. Their infrastructure makes them an inefficient setting for the provision of primary care services. There is also the risk that the provision of primary care services in emergency departments may hinder their capacity to respond to genuine emergencies.

5.3 Capital Funding for Residential Aged Care

Unlike other State governments, the WA Government is not a major provider of residential aged care facilities. The State has largely withdrawn from having a role as a residential aged care provider such that only two State Government nursing homes are operated by the State.

Nevertheless, the State is a substantial provider of health and community care services for the aged and is situated at the interface between the community, acute care and residential care sector. Consequently, the State is a legitimate stakeholder in planning for the future requirements of the residential aged care sector.

A longstanding issue for WA has been the large number of persons accommodated in public hospitals because there is no place available for them in a nursing home. In 2004, in the Perth metropolitan area at any given time there were an average of 113 people in public hospitals in "Care Awaiting Placement" and another 200 "Nursing Home Type Patients" accommodated in WA country hospitals.

In recent times, the Commonwealth Government has increased the number of nursing home beds which it is prepared to subsidise. However, a significant problem is that nursing home proprietors have not built new facilities or expanded existing facilities to take up the extra places for which subsidies are available.

An underlying problem is the adequacy of capital funding to assist in the cost of upgrading or replacing facilities, particularly small residential aged care facilities in rural and remote regions. Indeed, for a number of existing facilities, their ongoing viability is precarious and some would have difficulty in passing 2008 certification standards.

Following the *Aged Care Act 1997*, the Commonwealth has largely withdrawn from providing capital grants for aged care infrastructure. The lack of access to direct, upfront capital funding, coupled with uncertainty around the legal basis for accessing accommodation payments particularly causes problems in the maintenance of existing, and development of new, residential aged care facilities in rural and remote areas.

This issue was highlighted in the Commonwealth's *Report of the Review of Pricing Arrangements in Residential Aged Care* (the Hogan Report) released in February 2004. The Report noted that:

> *"Given the immaturity of the industry and the degree of Government control, some operators have difficulty raising the capital they need in the capital markets. Equity investors are, not surprisingly, wary of an industry that has little scope to control its operations and that lacks a culture of financial reporting and accountability. This situation has been alleviated, in low care, by accommodation bonds. However, accommodation bonds bring their own difficulties, including the need for strong prudential protections. Bonds also contribute to the immaturity, or at least militate against the maturing of the industry, by providing access to unregulated debt. Moreover accommodation bonds (or their equivalent) are not available generally in high care, exacerbating the capital problem in that sector. The current capital funding arrangements for concessional residents are also inadequate."*

In proposing a solution to this problem the report went on to recommend that:

> *"The concessional resident supplement should be clearly identified as a contribution to the accommodation stream made by the Government (on behalf of residents who cannot afford to make the contribution themselves) to ensure that the capital requirements of the industry are adequate. The accommodation stream requires private capital investment and therefore a clear capacity to provide a return on investment and return of investment.*

Clearly, the current capital raising system is inadequate in meeting the capital needs of the residential aged care industry. Alternative capital raising streams for all providers must be identified, particularly, but not only, for high care places.

5.4 Health Insurance Issues

WA is in a fairly unique situation in terms of having a highly concentrated market (HBF has about 70% market share) and a significant remote population whose access to private health care is very limited.

This situation is largely responsible for the emergence of a number of issues in this State. Because of the Commonwealth's responsibility for health insurance, the State is unable to act, but is instead reliant on Commonwealth actions.

Another issue is that in rural and remote areas health insurers generally refuse to issue provider numbers to ancillary health service providers if they are employed part-time in a public hospital. The consequence is that people with ancillary health insurance cover are unable to claim for services they receive from those providers.

The policy by insurers acts to exacerbate problems with the supply of ancillary service providers in rural and remote areas. It is often the case that there is only sufficient work in a rural/remote town for one ancillary service provider (eg. one physiotherapist) if that person does a combination of private and public sector work. However, with insurers not prepared to issue provider numbers to ancillary service providers employed part-time in a public hospital, their ability to earn private income is curtailed.

Hence, the refusal to issue provider numbers can create a problem for the State in recruiting ancillary service providers to work in rural/remote areas, potentially forcing the State to employ these providers full-time when there is only sufficient work to warrant their part-time work. It also potentially denies communities access to private ancillary services.

5.5 Commonwealth Health Insurance Incentives and Rural/Remote Residents

The lack of availability of private service providers, particularly private hospitals and ancillary health care providers, means private health insurance generally does not represent good value for money for people living in rural and remote areas. However, people in these areas pay the same premiums as metropolitan residents.

There has been a scarcity of initiatives to make insurance more attractive for people in rural/remote areas. For example, insurers might offer assistance with travel and accommodation for people to access private hospital services. However, there have been no initiatives in this direction.

Recent Commonwealth measures designed to increase private health insurance participation are, to some extent, discriminating unfairly against people in rural/remote areas. In this regard:

- The Medicare Levy Surcharge requires people earning above a specified income to pay an additional 1% on their Medicare levy if they do not have health insurance. People in rural/remote areas are subject to the Surcharge despite the fact that they generally do not benefit from insurance.

- Under the Lifetime Community Rating policy people pay higher insurance premiums if they take up health insurance later in life (the premiums increase progressively after age 30 years). People living in rural/remote areas may choose not to purchase insurance because of the lack of benefit while they are living in those areas. They may then move to the city later in life. Once in the city they could potentially benefit from health insurance but, if they purchase insurance, they will have to pay an increased insurance premium.

5.6 Cross-border Arrangements with the Northern Territory

People in the WA's East Kimberley region reside much closer to Darwin than to Perth. Kununurra is approximately 30 minutes flying time from Darwin, where it is around three hours to Perth. Given the close proximity of the East Kimberley residents to Darwin, it would be more efficient and in some cases assist in achieving better patient outcomes if Darwin were to become the regular centre for their care.

There are two types of situations where there would be greatest benefit if patients were transferred to Darwin. These are:

- emergency retrieval, where patients need to be transported in the shortest time possible to where they can obtain required services. In this case, the shorter time to get to Darwin rather than Perth would make Darwin a more sensible destination for emergency transfers.

- elective services, where it may be more efficient to transfer patients to Darwin for elective surgery rather than Perth.

Similarly, it would be sensible for WA's Eastern Desert people to access health services at Alice Springs instead of Perth.

Efforts have been made to negotiate an arrangement between WA and the Northern Territory for patients to be routinely transported from the East Kimberley to Darwin and the Eastern Desert to Alice Springs. Although in-principle agreement has been reached at officer level, the development of a satisfactory arrangement has not yet been possible.

5.7 Addressing WA-Specific Issues

The following are suggestions to address the issues identified above:

Communication and Joint Planning

Communications between the WA and Commonwealth governments tended to occur "as required" and on an ad hoc and piecemeal basis. Within the last one to two years, health agencies from the two jurisdictions have established a high level "bilateral working group" intended to provide a forum for communication on Commonwealth/State issues.

The bilateral working group should function as a forum for joint planning, where the two jurisdictions can raise and discuss problems they are having and look for ways to address those problems cooperatively.

For example, there are a range of options for addressing the issue of lower benefits for renal dialysis in WA. The Commonwealth may be in a better position than the State to exert pressure on health insurers to increase the benefit levels for dialysis services to align with those in other States. Another option would be for the State and Commonwealth to develop an arrangement where the State pays private dialysis providers the "gap" between the dialysis benefit available in WA and that provided in other States. The Commonwealth and State governments need to work cooperatively to explore such options.

As well as one-off issues, under the auspices of the bilateral working group, there might be joint planning undertaken on an ongoing basis on issues such as addressing the shortage of doctors in country areas.

At this stage, there does not seem to have been a strong commitment to the bilateral working group process, with the group so far having met only on one

or two occasions, and little meaningful discussion at the meetings that have occurred. Both jurisdictions need to remain committed to the bilateral committee process.

Cashing Out and Pooled Funding Arrangements

As explained above, low Commonwealth per capita health expenditure in WA is primarily the result of low Commonwealth per capita MBS and PBS expenditure in rural and remote communities. The low expenditure on these programs is often the result of the absence of any private medical practitioner.

Without a private medical practitioner, it is crucial that communities are able to find other types of services to meet their health needs.

Under a program titled the *"Primary Health Care Access Program"*, the Commonwealth has cashed out MBS services in a number of remote Aboriginal communities. Through PHCAP, the funds that would ordinarily be expected to be spent on MBS-subsidised services are used to fund a range of health services tailored to addressing local health issues (eg. Aboriginal health workers, nurses, allied health). In these communities, which typically have the greatest health disadvantage and severely limited access to health services, PHCAP is providing a significant boost to the availability of services to meet health needs. At present, there are a number of PHCAP communities in the Northern Territory, but there are only two in WA.

Under Coordinated Care trials, the Commonwealth and State governments have pooled funding to provide services to persons in a targeted group with chronic and complex needs. A care coordinator, who is also a budget holder, assesses and organises for them the health services they need.

As well as Coordinated Care, patients with chronic and complex conditions can also benefit from a more integrated approach to the delivery of (presently fragmented) State and Commonwealth services. For instance, nurse practitioners working closely with heart failure patients in hospital and in the community have been shown to reduce hospital readmissions. At present there is no means of funding these nurses other than through the State system. A combined Commonwealth/State funding approach or a single funder would be beneficial.

The examples of cashing out and pooled funding arrangements cited above have significant potential to increase the availability of health services and deliver improved health services to targeted population groups, especially in rural and remote areas. The Commonwealth and Western Australian governments should work to significantly expand the PHCAP program in this State and also explore opportunities to better coordinate services under pooled funding arrangements (including Coordinated Care and other models).

Addressing Doctor Shortages

The Commonwealth and State governments share concerns about the shortage of general practitioners in WA, and have been working cooperatively on a number of initiatives. Progress is now being made toward increasing the number of medical school places in this State.

The total number of medical students in WA will increased from 358 in 2004 to 404 in 2005 and will peak at 795 in 2009. The increase in medical student numbers will result in an increased number of graduates entering the health system. In this regard, it is projected that the number of medical interns (post graduate year 1) will increase from 140 positions available in 2005 to 306 in 2010.

Changes to immigration arrangements will enable temporary resident doctors (visa subclass 422) to extend their visa validity from two to four years irrespective of whether the doctors have conditional or unconditional registration.

In addition, where strong efforts made to recruit a doctor to work in a community have proved fruitless, the State is able to declare the area an "area of unmet need", and there is then some relaxation of Commonwealth restrictions on practice by OTDs in that area.

For rural and remote areas, some further initiatives that could be considered to increase the supply of doctors include:

- Introduction of blended payment arrangements under Medicare for rural areas, rather than exclusive fee for service. This will be attractive to general practitioners to even out their income stream and allow practice emphasis to shift more to prevention and promotion efforts currently not rewarded under Medicare.

- Encouragement for the formation of group practices across solo doctor towns to reduce overheads and provide support for individuals. This may include practice management and pharmacy services to be provided through Divisions of General Practice or through other organisations.

- Recognition of rural shire financial contributions to attract rural general practitioners by supporting adjustments to Local Government Grants Commission formulae.

Rural/Remote Care Models

Although the above initiatives would assist in attracting more general practitioners to WA country areas, the stark reality is that it will be impossible to get doctors to work in many towns regardless of the incentives offered.

An opportunity exists for Medicare funding to be provided to the providers of rural and remote hospital based medical services to expand staffing levels, roles and responsibilities and service models in order to deliver well integrated but distinctly different medical service models to the community. There are many locations throughout rural and remote WA where such a model is the only real hope going forward for communities to receive quality and comprehensive medical and health care services.

The WA Country Health Service, in its 2003 Review of the country service delivery system identified a clear agenda for further funding and service integration options to improve the sustainability prospects of medical and health care services in many small to medium sized towns.

Capital Funding for Residential Aged Care

An adequate and sustainable capital funding stream should be established by the Commonwealth in order for residential aged care providers to maintain and develop existing facilities or build new ones.

A need exists for immediate access to a dedicated capital revenue stream to ensure the construction of facilities to accommodate additional beds that have already been approved but are not yet operational.

The recommendations of the Hogan Report around removing perverse financial incentives between high and low care residential aged care places and around concessional residents need to be taken forward.

The residential aged care sector has advocated for a substantial increase in the daily care fee is required to provide a secure and viable capital revenue raising stream. This solution would need to be viewed in the context of community expectations around this issue.

Health Insurance Incentives

As explained above, health insurance is not attractive for people in rural and remote areas. Both levels of government need to acknowledge this and work together to make it a more useful product. The WA Government would be pleased to take a leadership role in convening a working group, reporting to Health Ministers, to devise approaches to making health insurance more attractive for people in rural and remote areas.

WA/NT Cross-border Arrangements

As noted above, although it would be sensible for WA residents in the East Kimberley and Eastern Desert regions to routinely access health services in Darwin and Alice Springs, it has not yet been possible to develop a workable arrangement between the two jurisdictions. WA and the Northern Territory need to commit work earnestly to develop and implement such an arrangement. From a WA perspective, the State recognises that it should pay on a full cost recovery basis for any services the Northern Territory provides to WA residents. However, in accessing services provided by the Northern Territory, WA residents must be given equal priority to Northern Territory residents.

6. CONCLUSIONS

The Australian health care system is framed around a fundamentally sound policy in Medicare. Although the system continues to meet the needs of most people very well, there is evidence of significant pressures on the system. So far the responses to these pressures have been a combination of allocating additional funding (although unevenly across the system) and piecemeal tinkering. More fundamental reform will be required if the system is to remain sustainable into the future, but this must be in the context of maintaining and not dismantling the Medicare policy.

At a national level, the fragmented division of Commonwealth/State roles and responsibilities is a factor impeding the efficient operation of the health system. Accepting that wholesale reform of Commonwealth/State responsibilities is unlikely to occur in the short to medium term, as outlined in this submission, work needs to be progressed to identify areas where there is the potential for benefit to result from change and developing cooperative arrangements to realise those benefits. There also needs to be recognition that desirable reforms may require an initial up-front investment.

This submission has also highlighted general problems with SPPs and particularly the AHCAs. The problems with SPPs are obvious and capable of being fixed relatively painlessly by implementing a common set of principles that already exists in draft form. Change for the AHCAs are primarily about fairness in terms of establishing what the Commonwealth should contribute to public hospitals and creating more of a partnership approach to Hospital Medicare.

At a State level, this submission has raised a range of issues of particular concern to WA. Most of these issues arise because of our relative isolation from other jurisdictions and that we have large remote regions with scattered populations. The issues raised affect a small proportion of Australia's population, but they are nonetheless very important to this State. Addressing them would mainly involve the Commonwealth and WA governments cooperating to make their respective parts of the health system work better together.