GOVERNMENTS WORKING TOGETHER

A better future for all Australians

The Allen Consulting Group

14 May 2004

Hon Steve Bracks
Premier
Parliament House
Melbourne Victoria 3000

Dear Premier

I am pleased to submit to you our report *Governments Working Together: A Better Future for All Australians.*

Our task in writing it was to examine the major ways in which the Commonwealth and State governments affect Australian families' lives, and options for reforms that would produce better outcomes for the community.

Of all areas in which governments provide or subsidise services, none are more important to families' lives than health and education. These are also the two major areas of social policy and programs in which the Commonwealth and the States are both deeply involved – although their approaches are in some respects inconsistent, so that the community is not as well served as it should be.

For a range of reasons, health and education will have even higher priority for the community and for governments in future. Health, in particular, presents daunting challenges, given the ageing of Australian society and other factors driving health care needs and costs.

Hence our report sees these two areas – health and education – as ones in which there is both the imperative for the two levels of government to work together more effectively, and the opportunity to forge the basis of a new and more truly collaborative Federal system.

Our report considers reforms in a 5 to 10 year timeframe. Almost any reform designed to make a real difference will involve significant lead times, not least because there will inevitably be differences of view that need to be resolved. It is thus very important that there is adequate opportunity for discussion and debate. Above all this report is offered as a contribution, and a stimulus, to that debate.

While I and my colleagues take sole responsibility for the content of the report, we were greatly assisted in developing it by the work of expert researchers in health, education and income distribution, by officials of your own and other Victorian Government Departments and those of other States and Territories, and by a distinguished Expert Reference Group chaired by Professor Glyn Davis. The inputs from all of those were invaluable.

Yours sincerely

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Chairman

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This report is the work of an Allen Consulting Group team comprising Mary Ann O'Loughlin, Karen Spindler, Catherine Rooney, Andrew Read and Vince FitzGerald, assisted by Tanya Simonow.

The report represents the views of its authors and does not purport to be a statement of Victorian Government policy or any other Government's policy.

While we take full responsibility for the report, we must acknowledge the extensive and valuable input and feedback we have had from:

- the Policy and Strategy Projects Branch of the Victorian Department of Premier and Cabinet;
- a considerable number of senior officials of other Victorian departments, and counterparts in all other States and Territories – via both the advisory board for the project of which this report forms part and in other discussions;
- a distinguished Expert Reference Group chaired by Professor Glyn Davis AC and including Professor Peter Dawkins, Mr Alan Bansemer, Mr John Menadue AO, Professor Linda Rosenman, Professor Meredith Edwards AM, Dr Martyn Forrest and Dr Louise Watson;
- the authors of the range of related research studies, in health, education and the distribution of income in Australia, commissioned as parts of the same project.

To all of these we express our sincere appreciation for their contribution – while absolving them from any responsibility for the result.

Further Information

This report is part of the Victorian Government's "Shared Future" project. For more information and background, and to provide feedback to the Victorian Government, go to www.dpc.vic.gov.au/SharedFuture

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In order to achieve a new deal for Australian families, the Commonwealth and the States must develop new ways of working collaboratively.

Executive summary

This report

This report focuses on Australian families,[1] and how governments affect their lives, especially in the areas of health and education, but also in other areas such as the distribution of income. Health and education, particularly the former, show up regularly among families' top concerns.

Part I of the report examines the situation of families and identifies major reasons for considering a new approach:

- Problems of affordable and timely access to health and aged care appear to be increasing. With increasing numbers of older people, rising expectations and expensive new technologies, pressures in these areas will grow.
- The education system is failing some families: there are large disparities in both participation in schooling and educational outcomes, with too many children, particularly the disadvantaged, not doing as well as they should.
- The least well off have not done as well in recent times as those on middle incomes. Significant numbers of the least well off also face strong disincentives to improve their own circumstances, and to varying degrees this is true for Australians at all income levels.

A prerequisite for achieving a new deal for Australian families is that the Commonwealth and the States and Territories[2] develop new ways of working collaboratively and efficiently, to maximise what can be achieved. This report aims to identify effective reform options that can be achieved by collaboration.

Part I
How are Families Faring? Assessing the Issues

Changing society, changing expectations

Australian society is changing. Population ageing, together with other factors, will generate a substantial increase in the community's need for health and aged care services, and in their cost. Changes in work and in the economic environment have major implications for education. Schools have a critical role to play in preparing children for successful participation in an increasingly knowledge-based economy, as well as for their participation in society.

Equally important are changes in the nature of work and work participation. Together with economic pressures on young adults, these are causing delays in family formation and changes to the structure of the individuals' life course. It is becoming increasingly difficult to predict who will demand a given government service, and when – implying a need for increased flexibility in service delivery. These trends coincide with people placing increasing value on choice – including in relation to services that government provides.

People want Commonwealth and State Governments to work cooperatively to deliver the services that they value, and dislike conflicts of approach between them. Levels of dissatisfaction with government service delivery are relatively high: generally, Australians think that the quality of education and, in particular, health services has deteriorated. Those who directly receive services tend to be more satisfied.

Equity and incentives: taxes, benefits and the distribution of income

Governments influence the opportunities and quality of life of Australian families in many ways. Prominent among these is the allocation and redistribution of financial resources and other assistance towards families in need. Taxes and social security benefits are the primary tools available to governments for redistributing financial resources. Also important, especially for poorer families, is the subsidised provision of 'benefits in kind' such as school education, public housing and hospital treatment – which are important not only for their immediate redistributive role, but also because they are intimately linked with opportunity.

1 FOR SIMPLICITY OF LANGUAGE, WE REFER TO 'FAMILIES', BUT WE ARE CONCERNED WITH *ALL* AUSTRALIANS, WHETHER LIVING TOGETHER IN FAMILIES OR INDIVIDUALLY.

2 THROUGHOUT THIS REPORT, FOR SIMPLICITY OF LANGUAGE, THE TERM 'STATES' IS USED TO REFER TO STATES AND TERRITORIES AND ALSO (DEPENDING ON THE CONTEXT) TO THE LOCAL AUTHORITIES WITHIN THEIR JURISDICTIONS.

Even after government intervention, of course, significant inequalities among families remain. In fact, there has been a shift over the past decade or so away from support of lower income families, and towards those on middle incomes (through enhanced benefits) and upper incomes (through taxation relief). Taxation and cash benefit systems also affect incentives to engage in economic and other activities, especially employment and education. Australia's marginal tax rates are high by international standards and some families face significant disincentives to increase their working hours because of the combination of these rates and the withdrawal of social security benefits as income rises.

Yet, overall, Australia is a relatively low tax country by OECD standards. The discrepancy between tax rates and revenue raised can be attributed to the proliferation of tax breaks in the system, amounting to a large leakage of revenue.

Australia's health care system: need for reform

There are ever rising cost pressures in health due to technological advances, consumer expectations and, increasingly, ageing. A high proportion of health system resources is used in providing services to people with diseases and health conditions that are known to be preventable.

The complex split in responsibilities for the funding and provision of health care between the Commonwealth and State Governments leads to problems, including poor coordination of planning and service delivery, barriers to efficient substitution of alternative types and sources of care, and scope for cost shifting between governments. Funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting.

Generally, Australians enjoy good health, but there is much scope for improvement, particularly in the health of Indigenous and poorer people. Good access to primary care is becoming increasingly important, with the emphasis on the prevention of ill health, health promotion and disease management. Yet affordable access to primary care is a growing problem, especially for Indigenous people and in outer metropolitan, regional and remote areas.

Public hospital accident and emergency departments are overloaded. A significant component of the load could be more appropriately treated in primary care or other facilities. There are significant delays in access to elective surgery in the public system, while people with private health insurance have increased their access, which raises equity concerns. There is a shortage of institutional aged care places and community-based aged care is underdeveloped, leading to long-stay occupation of acute beds. This, in turn, puts additional pressure back on emergency departments and elective surgery.

There is room for improving the appropriateness of health care. There is evidence of large variations in practice patterns and an over-reliance on acute care. Some people 'fall through the gaps', which emphasises the need for better integration and continuity of care across the care spectrum.

Educating Australia's children

Participation of young people in school education in Australia has risen over the last 20 years and for most groups is relatively high. Australia's learning outcomes are also relatively good by international standards, on average. However, not all groups participate to the same degree and many students do not achieve minimum benchmarks: Indigenous young people and those from poorer backgrounds are much less likely to complete upper secondary schooling and their levels of achievement, on average, are lower in all assessed areas.

These students can be found in schools of all types, but some schools and regions have a higher and increasing concentration of students from disadvantaged families. Unless this trend is checked, the job of these schools will become even harder than it is now, and the result will be a more divided education system.

In Australia, much of the difference in outcomes appears to relate to differences among individual students, but school factors, including the quality of teaching, are also very important. There are high-performing and low-performing schools in all sectors. Features of the current system that contribute to differences in outcomes include: lack of a systematic approach to early childhood development, an inappropriate basis for education funding, substantial funding anomalies and inconsistent or ineffective school performance management and accountability systems.

The present situation is not good enough – there is a clear challenge to improve outcomes for disadvantaged students, and choices of schooling for Australian families generally.

The roles of the two levels of government in social policy and programs

The Commonwealth and the States share responsibility for the government contribution to meeting the needs of Australian families. In the largest and most important social expenditure areas – health and education – both the Commonwealth and the States are actively involved in policy and administration, while the States have the major role in managing service delivery.

In recent decades, the Commonwealth has come to play important roles in more and more areas, especially in social policy. Partly, this reflects the community's desire for a nationally consistent approach in those areas most important to equality of opportunity and equity of social outcomes. However, Australians also want a range of services that suit them and their circumstances. Allowing diversity and responsiveness to local needs is a great strength of our Federal system.

In many cases the way the two levels of government interact does little for the quality of services received by the community, due to duplication, inefficiency and lack of coordination. Australian families want the Commonwealth and the States to cooperate, rather than having inconsistent or conflicting approaches to social programs. The State level of government is generally best placed to respond to meeting particular needs, being closer to local communities, with the Commonwealth having a role in national aspects.

The issue is therefore not whether the Commonwealth and States should both remain involved in the core social programs in health and education, but how. Apart from community preferences, rising cost pressures in areas such as health will make reform of the way governments work together increasingly pressing.

Part II
A Better Future: Options for Reform

Reform principles

Both levels of government should be much less concerned, in considering what roles they should play, with who the service providers are, and more concerned with efficiently achieving the best outcome for Australian families. Equity and efficiency are overarching principles, along with others such as simplicity and clarity, flexibility and choice.

Some well-known principles of good public administration apply to the issue of how the two levels of government should ideally divide roles in social policy between themselves:

- *the principle of subsidiarity*, i.e. a function should be carried out by the lowest level of government able to exercise it effectively; and
- where both levels of government need to be involved in the same area of social policy, they should work collaboratively to resolve national aspects, in the interests of the Australian community as a whole. State Governments have primary roles in identifying the needs of their local communities and developing policy and program responses to them, and in administering programs 'on the ground'. The Commonwealth has primary responsibility for ensuring that all Australians have access to quality services at, at least, minimum national standards.

Provision of health and education services – those which matter most to Australians and their families – should continue to be a shared responsibility between the Commonwealth and the States. But arrangements should comply better with the principles above and embody true collaboration.

Clearly, the major tools for redistribution of wealth will continue to rest with the Commonwealth. The Commonwealth could review the income tax system with the aim of restoring simplicity and lowering the marginal tax rates, while paring back the range of available tax breaks. In social security, there is a need for a simpler and more consistent system.

A new health system for all Australians

The key aims of health reform are to improve:

- affordable access to quality care, and the continuity of care;
- the interface between primary, acute and aged care and the degree of focus on prevention, health promotion and disease management; and
- incentives for primary providers to provide more cost-effective care and reduce the need for acute care.

The formation of a joint Commonwealth–State national body, the Australian Health Commission (AHC), is the essential first step to drive the reform process. The AHC would report to the Commonwealth and State Health Ministers. Its first task would be the development of a framework for an integrated health care system. Under that system, regional health agencies (which could be based on existing entities such as the health care networks of State Health Departments) would control a budget of pooled Commonwealth and State funds for acute, primary and community care, pharmaceuticals and aged care. This approach has many advantages:

- By giving the long term, continuing responsibility for the health of all residents within a region to a single authority, there would be greater emphasis on improving the health status of that community, and increased capacity and incentives for continuity of quality care and service integration.
- Planning could be undertaken across lifetime health problems and needs, disease stages, populations and modalities of care. Possibilities for substitution between more and less cost-effective interventions would be maximised.
- There would be incentives for appropriate cost containment, including through possibilities for substitution between more and less cost-effective interventions.

There is a strong case for beginning the move towards an integrated health care system with reform to primary health care. There is a need for an increasing emphasis on the prevention of ill health, health promotion and disease management – with a consequential increase in the importance of primary care. To gain the benefits of a more integrated, strategic approach to promotion and prevention, the Commonwealth and States could pool their funds to develop local health promotion plans. Funds could be allocated to local GPs, community health centres and hospitals in line with the plan's objectives.

The foundation for better-integrated care for people with continuing care needs is their enrolment with a GP practice taking overall responsibility for care coordination and service integration. People could readily change their enrolled practice, so choice of GP would still be provided. Contracts could be negotiated with GPs to ensure an integrated approach to the management of the health needs of their enrolled populations. This could require the development of primary care teams, referral pathways and more appropriate care models.

Strategies for improving health care developed around primary care obviously depend on good access to primary care. Affordable access to GPs is becoming more of a problem, particularly for people in outer metropolitan, regional and remote areas. It is too early to assess the impact of the MedicarePlus measures to improve access, but further measures may be needed to ensure affordable access to primary care.

Each State could progress to an integrated health care system within its own timeframe and subject to detailed negotiations. Ideally, however, this would be done within broad directions and a framework agreed between the Commonwealth and all the State Governments.

Significant investment in capacity-building by the Commonwealth and the States is needed to prepare and provide support for reform, particularly in the areas of workforce development and information management and technology. Immediate reforms are needed to improve access to primary care, elective surgery and aged care programs. There are a number of options for better use of private hospitals and private health insurance coverage. For example, State Governments could contract for elective surgery for public patients in private hospitals and the Commonwealth could allow private health insurance to cover expenses for facility fees and diagnostic tests at private hospital emergency departments. Options are also available for improving the cost-effectiveness of the funds spent on the 30 per cent private health insurance rebate (for example, by removing the cover for ancillaries or by capping).

An education system for all Australian children

School education plays an important role in helping to build the foundations for economic success and social cohesion in Australia. There is much to be proud of in Australian schools, but there is also much to be done, with some aspects of the system actually contributing to social inequality. The proposed reforms would reverse that, with schools in all sectors contributing to better outcomes for Australian students and their families.

The key aims of reform are:

- to centre funding on students, and on achieving the best outcome for each in an equitable way, with special focus on the disadvantaged;
- to improve information available to families, and school accountability and performance; and
- to promote diversity, innovation and choice while ensuring all schools meet common basic requirements.

The reforms would bring most schools into a new integrated school education system, incorporating the government sector, most Catholic schools and many independent schools. Public funding would only be available to schools within the new system.

Funding of all school education by both levels of government would be administered consistently and fairly across students and schools and would be better related to what the community wants: the best outcome for each student. Where different types of students need different approaches to achieve good outcomes, schools should be provided with different levels of resources so that each child has the same chance of success. Specific actions will be required to support students at risk and to encourage greater participation in early childhood education, especially by children from disadvantaged backgrounds.

Most government funding would be directed to where it is most needed: to schools with students who need the most help and with little ability to raise funds through fees and other means. Government funding would be reduced as schools' private fee income rises and, for those schools charging compulsory fees, as the capacity of parents to pay fees increases. Government funding would not be affected by donations to approved building funds or similar benefactions. Schools within the system would be able to continue their current approaches to fees. The new system would maintain the special character of government schools, including the policy of not charging compulsory fees and a secular approach to education.

Access to the new system would be protected for those who cannot contribute to the cost of their children's education, by ensuring that all schools joining the system participate in access programs.

The proposed arrangements do not mean imposing a high level of uniformity on how schools educate students – quite the opposite. The funding arrangements will give schools more scope to take different approaches and diversity will be strongly encouraged. Performance management, reporting and accountability systems for schools and a performance and development culture for teachers would be integral to the new system.

The States would manage the operation of the integrated system. The Commonwealth and the States together would define the policy, framework and rules for participation and set national objectives and strategies. A new joint Commonwealth–State body should be established to implement the reforms and oversee the coordinated system. Differences in Commonwealth and State funding shares for education in each State vis-à-vis the present situation would be subject to transitional arrangements.

Comprehensively meeting families' needs: a fresh approach to Federal collaboration

Reforms in health and education could be pressed ahead without being accompanied by new overarching arrangements for governments to work together in our Federal system. This would risk failure, however. Maximum prospects of success will require sustained leadership and drive from heads of government, a common broad vision for Australian families and an overarching reform strategy. New arrangements are needed to lock in true collaboration among Australian governments. It is extremely important to put these arrangements in place now, rather than waiting until the present system buckles under the growing pressures on social programs.

In both health and education, this report proposes new integrated funding and other arrangements, and new mechanisms for Commonwealth–State collaboration. While it is desirable that all States implement the reforms, it is not necessary that all do so simultaneously.

Among the most profound influences on how families fare are the major income redistribution instruments operated by the Commonwealth, i.e. income tax and social security. Both need reform, especially to simplify them and to lower marginal tax rates and effective marginal tax rates. The key reform to make that possible would be to stringently cut back the many tax breaks that have proliferated in the tax system. This would also help fund the proposed reforms in health and education.

Comprehensive reform to improve the lot of Australian families can only be effectively driven by institutionalising true collaboration at the highest level of our Federation. We propose a revival and revamp of a concept canvassed several years ago: a new 'Australian Federation Council' (AFC) should replace and transcend the present COAG. The AFC should have regular, fixed meetings, an agreed agenda for each meeting and an independent secretariat.

We envisage that the heads of all Australian governments will develop in the AFC a comprehensive strategy for collaboration to meet Australian families' needs more effectively, particularly in health and education – and indeed to address other national priorities.

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter One
Introduction

Divergences between Commonwealth and State Governments' policy approaches cause significant issues for equity among families as well as for the quality of services they receive.

Introduction

1.1 Background to this report

This report focuses on how Australian families[3] are faring and on how the two major levels of government – Commonwealth and State[4] – can serve them better, particularly in health and education. Governments affect families' standards of living and opportunities in life in many ways – through taxes and benefit payments, and by providing services. For most families, no services are more important than health care and education for their children, and in both of these areas they rely on programs provided or funded by both levels of government.

Generally speaking, the States provide universal and comprehensive services, through government providers, with the Commonwealth contributing funding for some State programs. The Commonwealth, on the other hand, provides most of the public component of funding for health and education services offered by non-government providers. There are, however, some divergences among governments' policy approaches and problems of coordination of their programs, causing significant issues for equity among families as well as for the quality of services they receive.

While government programs greatly improve the lot of many Australian families, there are good reasons for seeking a new approach:

- Problems of affordable and timely access to health and aged care appear to be increasing. As numbers of older people increase, and with generally rising expectations, expensive new technologies etc., pressures in these areas will inevitably grow. Without early changes, the health and aged care system may buckle under these pressures.
- The education system is failing some families: there are large disparities in both participation in schooling and educational outcomes, with too many children, particularly the disadvantaged, not doing as well as they should.
- Overall, the least well off have not done as well in recent times as those on middle incomes. Significant numbers of the least well off also face strong disincentives to improve their own circumstances. To varying degrees, this is true for Australians at all income levels.
- Middle-income families are facing increasing co-payments and charges for services that were formerly low cost or provided free by governments. Their ability to save and plan for the future has diminished.

There is much survey evidence that concerns about these issues are strongly felt across the community. Health and education, particularly the former, show up regularly among families' top concerns.

As this report will discuss, in all of these areas Australia can do significantly better. One of the major impediments to doing so is the way responsibilities have come to be divided between the two major levels of government – often resulting in inconsistency and confusion, wasted resources and dissatisfaction with services. However, the reality is that families care much more about the quality and accessibility of the services available to them than about which level of government does what.

A prerequisite for achieving a 'new deal' for Australian families is that the Commonwealth and the States develop new ways of working collaboratively and efficiently to maximise what can be achieved for the community. Australia is a federation, not a unitary state. While a federation is not as simple, politically or administratively, as a unitary state, a true federal system has some great advantages. One is that it is more democratically responsive to local needs and can deliver services in the way that local communities prefer, while at the same time all of its citizens share a sense of being part of a single national community.

Another advantage is that a federation is intrinsically a better system for promoting improvement in the services provided to the community: by its nature, it encourages diversity, which is a key catalyst for innovation, and that in turn is what leads to improvements in services. In a federation, each State can learn from such improvements made by its neighbours and adapt them to its own community's needs. But achieving those benefits in full measure in our own federation requires our Federal and State Governments to work together cooperatively, sharing information, and ensuring that their policies and programs work smoothly together – from planning and budgeting through to funding and delivery.

This report aims to identify effective reform options that can be achieved collaboratively. We are concerned with long term solutions that may take time to develop and implement, and accordingly this report considers reform options in a ten-year time frame.

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1.2 Approach to the report

The prime focus of this report is on the two core social policy areas in which the two major levels of government extensively share responsibility: health and education. These are also, combined, the largest expenditure areas for Australian governments. Most importantly, they are the two areas that Australian families consistently identify as their highest priorities. For this reason, we have chosen to focus on these priority areas to propose immediate reforms, as well as to provide a model for reform of other areas in which both levels of government are involved.

We envisage that new mechanisms for cooperation among governments could be extended in the future to improving outcomes for families in additional areas outside health and education, e.g. reforming housing programs. There are also implications for policies and programs affecting families that are operated by only one level of government, e.g. tax and social security policies, and indeed for cooperation in areas other than social programs, e.g. transport.

1.3 Introducing some 'typical' Australian families

Real life little resembles the discussions in government policy reports. The enormous significance of health and education to the Australian community lies in the fact that they very directly affect families' lives, choices, and opportunities. The interplay between socioeconomic status, education, health, life opportunities and outcomes is complex and dynamic. To illustrate the way these factors interact to produce different real-life experiences for different types of families, we have constructed five hypothetical families. At various relevant places in the report, we will use these to demonstrate how different families experience current or proposed arrangements in health, education etc.

The case-study families are fictional. However, they have been designed on the basis of Australian Bureau of Statistics information on family types, incomes, location and age and are intended to represent a range of 'typical' family types.

Family 1: Matt

Matt is 25 and lives in Launceston. He left school at 17 without completing Year 12. Since then, he has worked on and off in casual and short term unskilled jobs (such as seasonal work). He has had substantial periods of unemployment or underemployment in that time. Matt earns approximately $20,000 per year. He lives in private rental accommodation and has no assets or savings.

Living in a provincial city such as Launceston limits his options for further training or broader employment options. Matt has a bulk-billing GP and no private health insurance (PHI). Matt is a smoker. He enjoyed his schooling in government schools (but more so at primary school). He now believes he would have had a better chance of securing on-going employment if he had finished secondary school.

Family 2: Don and Yvonne

Don, 70, and Yvonne, 71, are retired and living on the coast. Don was an engineer and Yvonne was a teacher. They are living off combined superannuation benefits. Don and Yvonne own their house in a sought-after coastal location on the Sunshine Coast. The house is their major asset, apart from their super, from which they are now drawing. They are worried about whether they will be able to maintain their lifestyle, contribute to their grandchildren's education costs, and find a pleasant aged care facility that will allow them to live together.

Don and Yvonne's health is generally good, but they are worried about increasing costs as they get older. They have had PHI for 50 years but are increasingly concerned about being able to afford the 'gap' and rising premiums. Don had a heart attack five years ago and is still on medication for it. He is worried by the increasing co-payments required for his blood pressure medications. They do not have access to a bulk-billing GP, nor to many allied primary care services. The nearest hospital is 30 km away. There are no suitable aged care places near their coastal home and they are also concerned about the lack of places for couples. They are hoping to pay outright for aged care place(s) when needed, but they are not sure that there will be places available in facilities close to their adult children or where they can live together.

Don and Yvonne would also like to be able to leave a nest egg for each of their seven grandchildren to assist with their tertiary education costs.

Family 3: Con, Despina, Thea and Ari

Con, 45, owns and runs a newsagency at Glen Waverley shopping centre. Despina, 48, holds a part-time management position in human resources at Myer. Despina also assists Con with human resources decisions relating to the newsagency such as interviewing sales clerks and doing the GST paperwork. Con's small business earns $55,000 per year. Despina earns $28,000; she is often offered overtime but finds that the tax on extra income, combined with loss of family tax benefits, means she has little incentive to work the additional hours. The family does not qualify for any concession cards.

The family lives in a mortgaged outer-metropolitan home. Con and Despina have minimal savings. One of their goals is to be in a position to pay up-front HECS for the children. The family does not have access to a bulk-billing GP, and their 18-year-old daughter, Thea, has juvenile diabetes. Con and Despina have taken out private health insurance for the family, but there are still significant costs as a result of Thea's condition and other out-of-pocket expenses for dental and medical treatments.

The children, Thea, 18, and Ari, 15, attend Catholic secondary schools, which creates extra education costs for the family. Additional outlays include fees, books, excursions and computer access. The family has chosen a Catholic school because of its Christian ethos.

Family 4: Patrice and Jack

Patrice is a single parent with an eight-year-old son. She is 32. She teaches English and Social Studies at a local government secondary school, where she is highly valued and respected. She earns $63,000 a year. Patrice is currently renting a two-bedroom unit in the inner-west of a capital city. She would like to buy a house to increase her financial security, but has not been able to save enough for a deposit.

Patrice currently has private health insurance, but the rising premiums are causing her to consider dropping her cover. The outstanding concern she has is her ability to cover any significant dental work that Jack may need in the future. Jack attends a local state primary school that is renowned for its innovative approach to early learning. He is progressing extremely well, enjoying many extra-curricular activities and excelling in sport.

Family 5: Sally, Bruce, Lucy, Sam and Sophie

Bruce, 29, works as a mechanic earning $45,000 per year. Sally, 26, doesn't work outside the home; she previously worked for Telstra as a call centre operator.

Sally and Bruce have a mortgage on their home in Tamworth. They bought the house with assistance from their parents when they got married; it is too small now they have three children, but as house prices are rising rapidly they are concerned at their capacity to buy a larger one. Tamworth has limited access to many community services; however, they benefit from living in a small community close to their families. Job opportunities for Sally – especially part-time work – are limited, and child care is both limited and expensive. Given Sally's earning potential, she is better off staying at home to look after their two-year-old daughter, Sophie.

There is very little access to bulk-billing GPs in Tamworth and the family does not have PHI. Their doctor used to bulk bill the family but now charges a co-payment. Out-of-pocket expenses for dental and other allied health costs are a problem.

Sam, 5, and Lucy, 6, go to a government school. Sally and Bruce are both closely involved in the school community and attempt to provide as much 'in-kind' labour as they can to make up for their limited capacity to pay the voluntary student contributions for computers and books.

The hypothetical families and the report

As the report considers each of the key policy areas, the impact of current arrangements on relevant families will be outlined. When the reform options are described later in the report, the ways in which the families' current circumstances would be affected will also be sketched. The aim is to make as clear as possible how real families could benefit from the reforms proposed in the second part of the report.

While many of the same factors affecting low- and middle-income families also affect Indigenous families, we recognise that the circumstances of Indigenous families are unique in many ways, and require specific and urgent attention. This report is not able to address those issues in detail. However, we aim to draw attention to the needs and circumstances of Indigenous families, particularly those in remote areas, and highlight the need for further reform.

1.4 Report outline

The body of this report is presented in two parts:

- **Part I: How are Australian Families Faring? Assessing the Issues.** This section begins with an examination of modern Australian society, with a particular focus on families' expectations in relation to the core social programs of health and education. It then looks in detail at the distributional outcomes for families – that is, the combined outcomes from the tax/transfer system, health and education. The report then goes on to examine in detail how well the health and education systems are serving Australian families, identifying current problems, challenges and pressures that may impact on outcomes in future (e.g. ageing, technology). It draws out key issues for reform in each of these areas. It concludes with a discussion of what each level of government does in our Federation, particularly in health and education, and how these roles accord with community preferences.
- **Part II: A Better Future: Options for Reform.** This section outlines a set of principles to guide reform in our Federation. It then discusses reform options designed to provide a 'new deal' for Australian families. The options comprise new ways in which the Commonwealth and State Governments can work together in the areas of health and education to deliver better services to families. They also propose better institutions and processes for cooperation in our Federation generally. In the longer term, these would allow reform to be widened beyond health and education to all major policies and programs affecting families.

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter Two
Changing society, changing expectations

Australian society is changing in ways that have important implications for the type of health and education services that people will need from governments.

Changing society, changing expectations

This chapter examines trends in how Australian society is changing, and their implications for governments. It also looks at the community's expectations of governments, and whether people are satisfied with current social programs.

Key Points

- Australian society is changing. Ageing is a major phenomenon, which – in combination with other factors – will generate a substantial increase in the community's need for health and aged care services and in their cost.
- Changes in work and in the economic environment have major implications for education. Schools play a critical role in preparing children to participate successfully in an increasingly knowledge-based economy.
- Equally important are major changes in the nature of work and work participation, notably by women. Together with economic pressures on young adults, these are causing delays in family formation and changes to the structure of individuals' life courses. It is becoming increasingly important for government to be able to deliver services in flexible ways.
- Other major drivers of change include technological change and globalisation competition and its spread into the public sector. These intersect with people's placing increasing value on choice – including in relation to services provided by government.
- Most Australians recognise and value the role government plays in providing social programs and redistributing income and wealth. Education and health rank very highly as important issues for the community.
- In terms of expectations of social programs, Australians appear to increasingly value the provision of *choice* and the *quality* of service outcomes. People want Commonwealth and State Governments to work cooperatively to deliver the services they value, and dislike conflicts of approach between them.

- In general, Australians are comfortable with the role governments play, but many are concerned about the value currently being delivered by social programs. Levels of dissatisfaction with service delivery are relatively high: generally, Australians think that the quality of education and, in particular, health services, has deteriorated over time. Those who directly receive services tend to be more satisfied.
- 'Gaps' between the current performance of governments and community expectations need to be addressed, especially in health and aged care, where rising pressures on service delivery and on public budgets underline the need for early reform.
- There is scope for a stronger role for the States in developing social policy and managing the delivery of social programs. The States generally appear to be best placed to provide the product differentiation, and information and choice that people now demand.

2.1 The changing Australian society

This section provides an overview of some of the key trends shaping Australian society now and into the medium-term. The next section will examine the implications of these trends for what the community needs from its governments.

Older and healthier

The ageing population

It is well known that Australia's population growth is slowing. The rate of growth of the population has been falling steadily since the post-war baby boom and will continue to do so. This is the inevitable result of sustained reductions in the birth rate, notwithstanding increasing life expectancy.

The ageing of Australia's population will also continue over the next four to five decades. This will have an impact at both ends of the age distribution. The Australian Bureau of Statistics (ABS) projects that between 2002 and 2021, the proportions of the population aged:

- 65 years or more will grow from one in eight to almost one in five – an increase of almost 2 million people; and
- under 15 years will fall from 20 per cent to 16 per cent, a *decrease* of 230,000 people.[5]

The ageing of the population is projected to continue at a broadly similar rate until the middle of the current century.

The ageing of the population is not evenly spread across the country: some regions have older populations than others. Governments will thus need to respond to the demands of the ageing population at both a jurisdiction-wide and a regional level. Overall, regional Australia – especially coastal towns – has older populations than metropolitan areas. In contrast to the main causes of population ageing, the main factor associated with regional ageing in Australia is internal migration. (A regional population will age if relatively large numbers of older people move into an area or if young people leave.[6])

Healthier lives

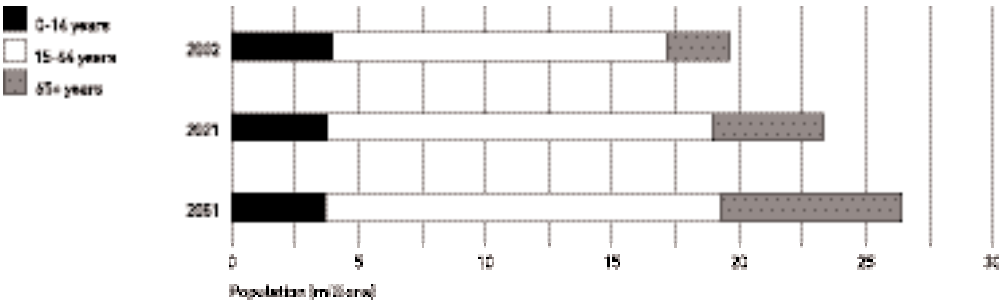
Australians are not only living longer, but also living healthily for longer. Developments in medical technologies and better management of some conditions and disabilities have contributed to improved health outcomes for many people. Aspirations for the quality of care (including, increasingly, preventive care) are also rising.

Between 1981 and 2000, life expectancy at birth increased from 78 to 82 years for women, and from 71 to 77 years for men[7]. Women can expect to live 73 years of their life in full health, while men can expect 70 years. This compares very favourably internationally: Australians can expect to live longer and to enjoy more years of healthy life than people in almost all other countries[8].

A high proportion of Australians of all ages consider themselves to be in good health. Overall, 82 per cent of people rate their health as 'excellent', 'very good' or 'good'. Not surprisingly, mature age people are not as healthy as younger people. The proportion of people in good health tends to fall from the age of 45. But even in the oldest age groups, at least 60 per cent consider themselves to be healthy.[9]

Further discussion of the health status of Australians is provided in chapter 4.

FIGURE 2.1 • AUSTRALIA' S PROJECTED POPULATION: 2002, 2021, 2051



SOURCE: ABS 2003, *POPULATION PROJECTIONS*, AUSTRALIA, 2002–2101, CATALOGUE NO. 3222.0, AUSINFO, CANBERRA.

BOX 2.1 • INDIGENOUS AUSTRALIANS

Indigenous people remain the most disadvantaged group in Australian society, and their experience and needs are largely outside the broad trends evident in the rest of the nation. In contrast to Australia more generally, Indigenous life expectancy is much lower, the birthrate is rising, the population is increasingly young (a large proportion are under 25), and health and education outcomes are bad and getting worse. In remote areas in particular, Indigenous people experience extremely poor health and education service provision, combined with appalling housing, infrastructure, and communication provision.

This report cannot deal adequately with the extent of this national problem, which has been well documented in recent reports by the Productivity Commission,[10] the Commonwealth Grants Commission,[11] and the Senate Community Affairs References Committee.[12] The reforms proposed for the mainstream health and education systems will not address the acute problems experienced by Indigenous people, particularly in remote areas. However, it is hoped that the reforms proposed here will at least provide a platform for the more extensive reform of Indigenous services which is urgently needed.

Delayed formation of smaller families

Changes in the life course

Social changes are altering the ways in which Australians journey through life. In particular, young people are increasingly postponing major life events (marriage, having children etc.). Many young adults are remaining in education for longer, gaining their economic independence later in life and forming long-term relationships at older ages.

For young adults in Australia, leaving home is generally regarded as an important step in the transition from a largely dependent childhood to adult independence. It is becoming increasingly common, however, for young Australians to leave home at a later age. For example, in the decade to 2002, the proportion of 25–34-year-olds still living with their parents rose from 10.5 to 12.7 per cent.[13]

One of the main reasons for young adults' staying at home is that they are studying for longer. In 2003, 37.2 per cent of 20–24-year-olds and 13.4 per cent of 25–34-year-olds were enrolled in a course of study leading to a qualification. Ten years earlier, the respective enrolment rates for these age groups were 25.8 and 9.7 per cent.[14] A decline in affordable housing in the major population centres has made it more difficult for young people to live independently, especially if they are studying full-time.

People are also forming families later in life. Delayed economic independence can slow down the development of long term relationships, and the increased participation of women in the labour force tends to push back the timing of child rearing. These developments have caused the median age at which people first marry and have children to rise considerably in the last ten years. In 2001, the median age of first-time brides and grooms was 26.9 and 28.7 years respectively, compared to 24.3 and 26.5 years in 1990. Almost one quarter of women aged 35 and over who give birth are first-time mothers – nearly twice the rate of a decade earlier.[15]

5
BASED ON THE ABS 'MEDIUM' POPULATION PROJECTION SERIES, SERIES B. ABS 2003, *POPULATION PROJECTIONS, AUSTRALIA*, 2002-2101, CATALOGUE NO. 3222.0, AUSINFO, CANBERRA.

6
ABS 2002, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

7
ABS 2002, *DEATHS, AUSTRALIA*, CATALOGUE NO. 3302.0, AUSINFO, CANBERRA.

8
WORLD HEALTH ORGANIZATION 2003, *HEALTHY LIFE EXPECTANCY, THE WORLD HEALTH REPORT 2001*, WWW3.WHO.INT/WHOSIS/HALE/HALE.CFM, ACCESSED 25 AUGUST 2003.

9
DATA FROM UNITED NATIONS AND ABS CITED IN AIHW 2002, *AUSTRALIA'S HEALTH 2002*, AIHW CATALOGUE NO. AUS25, AIHW, CANBERRA, P. 362.

10
PRODUCTIVITY COMMISSION 2003, *OVERCOMING INDIGENOUS DISADVANTAGE: KEY INDICATORS 2003*, AUSINFO, CANBERRA.

11
COMMONWEALTH GRANTS COMMISSION 2001, *REPORT ON INDIGENOUS FUNDING*, AUSINFO, CANBERRA.

12
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE 2004, *A HAND UP NOT A HAND OUT: RENEWING THE FIGHT AGAINST POVERTY*, AUSINFO, CANBERRA.

13
ABS 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

14
ABS 2003, *EDUCATION AND WORK*, CATALOGUE NO. 6227.0, AUSINFO, CANBERRA.

15
ABS 2002 AND 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

Changing families

Reflecting the above, it is becoming more and more common for Australian men and women to have no partner or to be childless. While most Australians still live in a family that includes a couple, there are an increasing number of Australian adults who live either by themselves or as sole parents. On census night in 2001, there were:

- 2.3 million couples living with children (3 per cent more than in 1986);
- 1.8 million couples living without children (up 33 per cent);
- 760,000 one-parent families (up 53 per cent); and
- 1.6 million people living alone (up 64 per cent).[16]

More jobs and higher incomes – but not for all

Growth through higher productivity

Australia has enjoyed two decades of strong economic growth, with its GDP growing positively in 19 of the last 20 years. Over this period, GDP per capita has grown in real terms by 57 per cent, to its present level of more than $37,000.[17] By this and other similar measures, Australia is one of the most economically prosperous countries in the world. One of the consequences of this is that more Australians can afford to pay for health, education and other services rather than relying on taxpayer-funded services provided by governments.

The main cause of this strong economic performance has been a sustained boom in productivity. Over the 1990s, Australia's productivity growth was about 0.5 per cent higher than that of other OECD countries.[18] There are four main factors that have combined to produce the productivity boom: microeconomic reform; technological improvement; globalisation and its various effects (on competition, specialisation etc.); and more productive workers.

More jobs and higher income, but many still miss out

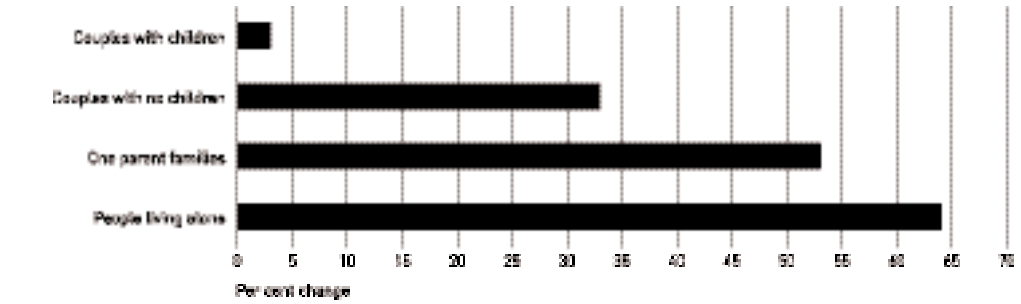
While many Australians are materially better off as a result of the high economic growth of the past 20 years, it is also clear that the benefits have not been equally distributed and that a significant number of families continue to experience entrenched disadvantage.

In the 1980s and 1990s, average household disposable income increased in real terms by 27 per cent.[19] To a large extent, this was caused by an increase in the employment rate combined with higher weekly earnings. In the 20 years up to 2003, the number of Australians who had a job rose by 3.2 million people.[20] The growth was roughly evenly split between part-time and full-time jobs. Over the same period, the number of unemployed people fell by 70,000. Since late 2002, the unemployment rate has been about 6 per cent – the lowest it has been since 1989-90.

While unemployment rates are low by recent standards, Australia still has a significant unemployment problem. In 2003, about 590,000 people were unemployed, 145,000 of whom had been unemployed for 12 months or more. An additional 80,000 people were categorised by the ABS as 'discouraged jobseekers': people not in the labour force who want to work but are not actively looking, because of the difficulties in finding work.[21] A large proportion of discouraged jobseekers gave up looking for work because they felt that employers considered them too old or too young.

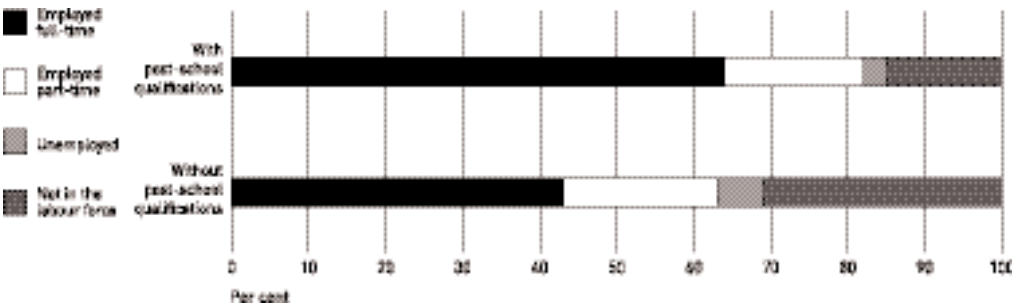
There has also been an increase in income and earnings inequality over the last 20 years. The market earnings and disposable incomes of the wealthiest households increased at a much higher rate than those of the poorest households. Chapter 3 will examine the extent of economic inequality in Australia, and related issues. Chapters 4 and 5, on health and education, will show that people with a lower socioeconomic status are more likely to have poor health and education outcomes.

FIGURE 2.2 • CHANGE IN THE NUMBER OF FAMILIES: 1986–2001



SOURCE: ABS 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

FIGURE 2.3 • EMPLOYMENT OUTCOMES OF 15 TO 64 YEAR-OLDS, BY EDUCATIONAL ATTAINMENT



SOURCE: ABS 2003, *EDUCATION AND WORK*, CATALOGUE NO. 6227.0, AUSINFO, CANBERRA.

Work opportunities for those with skills – but less security

Rise of the knowledge economy

Economic reform, developments in technology and their effects on productivity and cost have caused massive changes in the structure of the labour market and the organisation of the workplace. As in most developed countries, Australia's economy is now dominated by the services sector. Primary industries and 'old manufacturing' are in relative decline.

These shifts mean that employers increasingly require staff who are more highly educated and skilled, and who are willing to learn new skills in order to adapt. Individuals with higher levels of educational attainment have much better labour market outcomes than those with less education: they are more likely to participate in the labour force, more likely to be employed, and their earnings are significantly higher. Figure 2.3 shows that people aged 15–64 years with post-school qualifications are much more likely to be employed full-time than those without qualifications, who are more likely to be unemployed or not in the labour force.

More part-time and casual work

At the same time, service industries have generated many low-skilled, low-paid jobs that, along with some skilled jobs, are often part-time or casual. More and more employers require a flexible workforce. This has been a welcome development for workers who also prefer flexibility, such as parents and students. For many, though, the rise of non-standard employment arrangements has meant underemployment, insecurity and risk. For example, casual workers can face job insecurity, inability to access paid leave, uncertain working time or hours, irregular income, poor access to training, and reduced opportunities for participation in decision making. Reductions in job certainty and security reinforce other factors that are delaying family formation and changing the typical life course.

16
ABS 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

17
ABS 2003, *AUSTRALIAN NATIONAL ACCOUNTS: NATIONAL INCOME, EXPENDITURE AND PRODUCT*, CATALOGUE NO. 5206.0, AUSINFO: CANBERRA.

18
P. FORSYTH 2000, 'MICROECONOMIC POLICIES AND STRUCTURAL CHANGE', IN D. GRUEN AND S. SHRESTHA, *THE AUSTRALIAN ECONOMY IN THE 1990s*, PROCEEDINGS OF A CONFERENCE HELD AT THE H.C. COOMBS CENTRE FOR FINANCIAL STUDIES, KIRRIBILLI ON 24–25 JULY, RESERVE BANK OF AUSTRALIA.

19
SAUNDERS 2002, *THE ENDS AND MEANS OF WELFARE: COPING WITH ECONOMIC AND SOCIAL CHANGE IN AUSTRALIA*, CAMBRIDGE UNIVERSITY PRESS, CAMBRIDGE, P. 30.

20
ABS 2003, *LABOUR FORCE, AUSTRALIA*, CATALOGUE NO. 6202.0, AUSINFO, CANBERRA.

21
ABS 2003, *PERSONS NOT IN THE LABOUR FORCE*, CATALOGUE NO. 6220.0, AUSINFO, CANBERRA.

2.2 Implications for the community's need for services

More flexible and accessible services

There are a number of factors contributing to movement away from what was once considered the 'standard' life course. More women are working and younger people are studying for longer, contributing to a delay in family formation. Changes in the nature of work have seen the end of the 'job for life'. Career progressions are no longer linear, and portable generic skills have become even more important to employers. The need to maintain and update skills is causing demand for lifelong learning and placing a premium on getting a head start in schooling. More and more people will move in and out of education or training more than once in their lives.

In many ways, these forces make service delivery more difficult for governments. It is becoming harder to predict who will require which services and when they will demand them. In addition, technological developments have stimulated awareness of new methods of delivery, particularly on-line provision. Often these are more expensive. The day of the 'one size fits all' approach to service delivery is well and truly past. Government programs will need to be designed more *flexibly*, so as to cater to the needs of the widest possible range of people and provide a range of entry points, and more *accessibly*, so people are able to select the mode of delivery that best suits their lifestyle.

Health and aged care

The trends outlined in the previous section indicate that the health and aged care systems – already straining to meet existing demand – are likely, without significant reform, to become over-stretched in the not-too-distant future. The ageing of the population, rapid developments in health technologies and increased consumer expectations of high quality services will all put additional pressure on government health budgets.

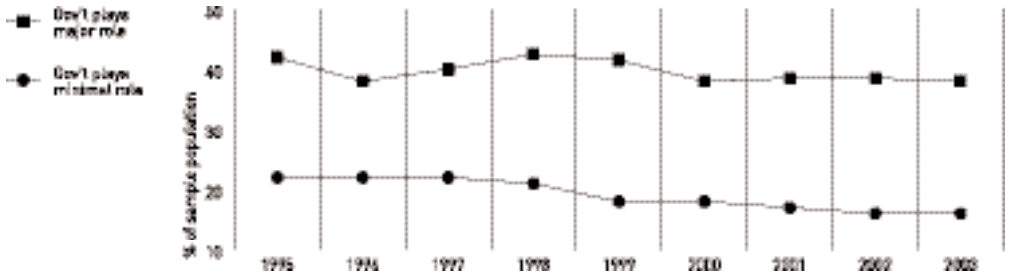
Over the next 20 years, as the baby-boom cohort ages, the number of older Australians will almost double. While most will be relatively healthy for the majority of their years, older people do tend to have a greater need for health services than younger people, and they use those services more often. The impact will be felt across the health sector – from medications, GPs and hospital admissions to more specialised geriatric services, home help and residential aged care.

The impact will be exacerbated by the increasing level of childlessness. It is widely recognised that family members, especially children, contribute substantially to the support and wellbeing of older people. As a growing proportion of older people will have no (or few) children, there is likely to be a reduction in the incidence of informal care, and a corresponding increase in reliance on formal care through government-funded or privately provided programs and services.

At the other end of the age distribution, the declining fertility rate will mean that demand for obstetric and paediatric services will steadily fall. The trend toward childbirth at a later age will also change the nature of maternity-related services that are needed.

Technological advances and rising consumer expectations will combine to compound the pressure on health services. Many new health technologies provide better quality care at a higher cost, rather than providing existing services more efficiently. Consumers increasingly expect and demand the latest and best health care available, whether it be a medical or surgical advance or a new drug.

FIGURE 2.4 • IMPORTANCE OF GOVERNMENT'S ROLE: 1995–2002



SOURCE: QUANTUM MARKET RESEARCH 2002, 'AUSTRALIA SCAN DATA AND TREND REFERENCE BOOK'.

Education and training

Technological developments and changes in employment patterns will continue to impose demands on education systems. Curricula will need to keep pace with ongoing changes in technology, the structure of the economy and consequent labour force demands. The role of schools will be vital in ensuring that all children are able to develop the skills necessary to succeed in an increasingly knowledge-based economy. While this is obviously important for each individual, the continued development of the economy as a whole will also rely on the ability to draw upon a pool of skilled, adaptable workers.

At the post-compulsory level, the decline in the number of children of schooling age will be balanced by higher secondary school completion rates and the increasing demand for higher education and vocational education and training – by both the young and people at later stages of life.

Variation across regions

Each of these trends will impact to varying degrees in different regions, depending on future internal migration patterns. There will, for example, be increasing pressure on the delivery of health services in those coastal areas that attract a large proportion of retired people. Remote regions suffering population loss face many difficulties, such as maintaining critical mass for schools and health facilities, and attracting professionals such as doctors when there is uncertainty about developing and maintaining a practice of viable size.

2.3 What do Australians want from government?

A key issue for this report is what Australian families expect of government and, in turn, how governments should respond to families' needs and expectations.

Role of government

Survey data suggest that Australians recognise and value the role government plays, both ensuring a level of equity and reflecting community aspirations. For example:

- The 2002 Australia SCAN survey (AusSCAN)[22] found that 84 per cent of Australians agree that 'government has an important role'.
- The Australian Election Study in 2001 (AES)[23] similarly found that over 60 per cent of Australians agree that 'government by its nature is the best instrument for promoting the general interests of society'.

Moreover, AusSCAN data over time suggests that while the number of Australians who think that government has a 'major' role has remained reasonably steady, the proportion that think government's role is 'minimal' has declined (Figure 2.4), indicating a possible growth in acceptance of an instrumental role for government in Australian society.

22
QUANTUM MARKET RESEARCH 2002, 'AUSTRALIA SCAN DATA AND TREND REFERENCE BOOK', UNPUBLISHED. DATA WERE OBTAINED OVER THE PERIOD OF OCTOBER TO DECEMBER 2001 USING A NATIONAL FACE-TO-FACE SURVEY OF 1950 AUSTRALIANS.

23
C. BEAN, D. GOW, AND I. MCALLISTER 2002, *AUSTRALIAN ELECTION STUDY 2001*, THE AUSTRALIAN NATIONAL UNIVERSITY. THE SAMPLE SIZE WAS 2010.

Redistribution and service provision

The Australian community generally recognises and values the role of government in providing social programs and redistributing income and wealth. The AES found that 56 per cent of people agree that 'income and wealth should be redistributed towards ordinary working people', while only 18 per cent disagree. In line with this, AusSCAN found that 61 per cent of Australians agree that 'all are entitled to welfare support'.

Further, while many Australians appear to place more importance on governments delivering better services than on reducing taxation levels, they are also conscious of the disincentives generated by the taxation system. The AES found that 60 per cent of Australians would prefer governments – in certain circumstances – to spend more on social services than to reduce taxes. However, the same survey also found that Australians are concerned about the disincentives that are created by high tax rates. Nearly three quarters of the community agree with the proposition that 'high income tax makes people less willing to work hard'.

Education and health are key priorities

Reinforcing the importance that many people place on the government's provision of key services, surveys consistently find that Australians rank health and education as issues that are most important to them. For example, a recent Roy Morgan poll found that health and education were the most important issues to Australians in April 2004.[24] When asked to choose from a list of 11 issues, 'health and hospitals' was chosen by the largest proportion of people (63 per cent), followed by 'improving education' (34 per cent).

Similarly, survey data from Victoria show that education and health rank second and third – behind employment – as the most important issue for a State Government. 20 per cent of Victorians surveyed in 2001 believed education was the most important issue, while 17 per cent listed health/hospitals.[25] Issues ranking well below these in terms of importance include the economy (3 per cent), the environment (3 per cent) and taxation (4 per cent). Around half of all Victorians surveyed chose health or education as one of their top two priorities.

A further indication of both the importance that the community places on education and the redistributive role it expects of government is that 87 per cent of Victorians believe access to the school education that children need should not be limited by income (Figure 2.5).

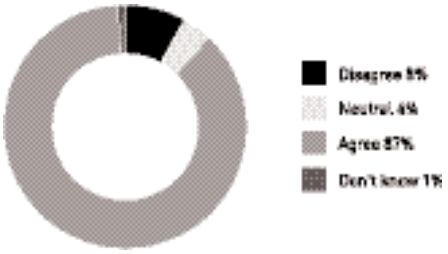
In this and following chapters, the report focuses on the delivery of health and education services, because of the high priority placed on them by the community and the central role they will play in meeting Australians' changing needs.

Community attitudes towards the different levels of government

It is not clear how precisely the general community distinguishes between State and Commonwealth Government roles and responsibilities for funding and delivering services such as health and education. It is apparent, however, that there is widespread support for both levels of government having a role in programs of importance to the community, and general support for something like the current balance of roles. Figure 2.6 provides interesting data on the issue, suggesting a general degree of acceptance of the current balance between the degrees of power exercised by Commonwealth and State Governments, although a significant minority believes State Governments should have more power.

While Australians appear to generally support the notion of having a federal system, and in particular to appreciate the benefits of having governments closer and more responsive to them on bread-and-butter issues, the broader debates between the Commonwealth and the States over funding and service delivery do not resonate widely. Department of Premier and Cabinet (DPC) research indicates that the public does not think that competitive approaches to federalism are productive (Figure 2.7). Rather, as discussed in the next section, issues of quality, choice and information are much more important considerations for the vast majority of people.

FIGURE 2.5 • SHOULD PEOPLE BE ABLE TO ACCESS THE SCHOOL EDUCATION THEY NEED, REGARDLESS OF THEIR INCOME?

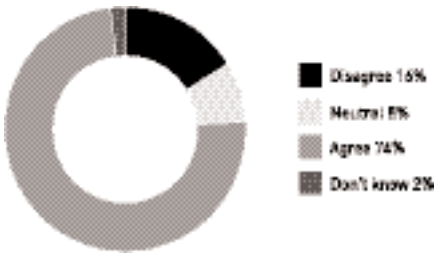


SOURCE: DPC RESEARCH 2004, UNPUBLISHED.

FIGURE 2.6 • SHOULD FEDERAL OR STATE GOVERNMENTS HAVE MORE POWER?

SOURCE: AUSTRALIAN ELECTION STUDY 2001.

FIGURE 2.7 • ARE PEOPLE DISADVANTAGED BY THE SQUABBLES BETWEEN STATE AND FEDERAL GOVERNMENTS?



SOURCE: DPC RESEARCH 2004, UNPUBLISHED.

Informed choice and high quality services

Quality, choice and value for money

Australians now live in an environment in which private provision of essential services has become commonplace and competition has been consciously promoted. This has raised consumers' awareness of the quality of services available from alternative providers, and of the corresponding value for money. The push to increase competition has reinforced attitudes among Australians wanting greater choice in the services they receive.

Not surprisingly, the community is increasingly expecting government services to be of high quality and to provide some consumer choice. Taxpayers are demanding that their tax dollars be used to deliver quality services, especially in core areas such as health and education.

The increasing value Australians are placing on choice has been highlighted in Hugh Mackay's research of social and attitudinal trends:

Choice provides Australians with an increased sense of freedom and power that goes with considering the various possibilities but arguably, an individual is most comfortable when they discover that only one of these possibilities really satisfies their needs.

MACKAY REPORT NO. 89, *CHOICE*, NOVEMBER 1997.

24
ROY MORGAN 2004, 'HEALTH AND EDUCATION STILL TOP ISSUES'. FINDING NO. 3730, APRIL 14, WWW.ROYMORGAN.COM, ACCESSED ON 16 APRIL 2004.

25
DPC RESEARCH 2004, UNPUBLISHED.

The challenge this poses for governments was summarised in a recent report published by the United Kingdom think-tank Demos:

...the ability of public services to deliver in a world of new opportunities, challenges and threats is being put to the test. People are less deferential and rightly demand greater accountability and higher quality of service. Choice is a given not an option, rights only come with responsibilities, and services are decentralising. ...These dynamics are played out against a background where governments are struggling to maintain the trust of their citizens and continually have to demonstrate value for money.

P. STEELS 2004, 'FOREWORD', IN T. BENTLEY AND J. WILSDON (EDS), *THE ADAPTIVE STATE: STRATEGIES FOR PERSONALISING THE PUBLIC REALM*, DEMOS, LONDON.

The desire for choice is somewhat difficult to measure, and there is limited direct quantitative evidence that people now want more choice than they did in the past. In one potentially relevant finding, AusSCAN found that a growing number of Australians do not feel they have sufficient control – which suggests they may not be satisfied with their opportunities to exercise choice about important aspects of their lives. The data show that since 1995 there has been a decline in the proportion of people who say they have 'sufficient personal control' and an increase in those feeling that they do not have enough control (Figure 2.8).

The recent apparent drift away from the public sector and into private health and education services (discussed in chapters 4 and 5) is an indicator of the strengthening of choice as a community value, although current policies have facilitated and encouraged choices of alternatives to standard public services. While some of this shift is undoubtedly due to other factors – including increasing affluence, resourcing in education, and policy inducements in health – factors such as perceived quality and range of services are also likely to be playing a role.

There are indications that the community's desire for choice and quality is increasing – in *Eye on Australia*, Grey Advertising reports that the number of consumers who say they are 'prepared to pay a little extra for good service' rose from 63 per cent in 1993 to 81 per cent in 2002. Similarly, according to the 2002 AusSCAN survey, around half of the Australian community expect the quality of public education, public health care and care for the elderly to get better in the future.

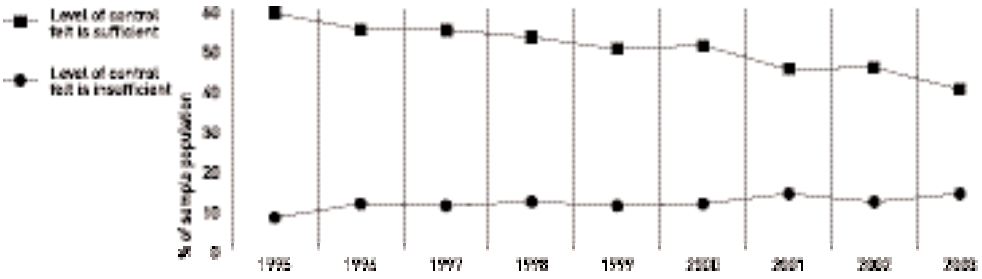
Provision of information

In line with an increasing demand for choice and quality, Australian consumers want access to more and better information about the range and nature of services on offer.

In education, the desire for greater information is reflected in the introduction in recent years of requirements for schools to publish details on class sizes, performance in standardised tests, teacher credentials and student drop-out rates. In many instances, these requirements extend to schools providing annual reports to parents detailing school activities and performance. DPC research indicates that 43 per cent of people believe they do not get enough information about the performance of schools (Figure 2.9).

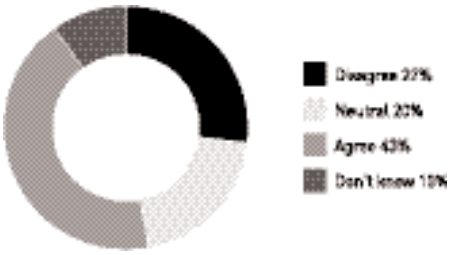
More information is being demanded in the health sector as well. The Consumer Health Information project – conducted by the Health Issues Centre in Melbourne – worked with consumers and a small sample of hospitals to explore the potential for the development of better consumer health information services about quality in acute health care.[26] The project found that consumers currently feel that they have little choice in terms of acute health care services; they are most likely to be directed to services by health care providers, as well as by word of mouth recommendations from friends or family. For this reason, consumers indicated that they would value the systematic availability of quality information, which they could use in conjunction with personal recommendations.

FIGURE 2.8 • 'LEVEL OF CONTROL' FELT BY AUSTRALIANS 1995–2002



SOURCE: QUANTUM MARKET RESEARCH 2002, 'AUSTRALIA SCAN DATA AND TREND REFERENCE BOOK'.

FIGURE 2.9 • 'I DO NOT GET ENOUGH INFORMATION ABOUT THE PERFORMANCE OF DIFFERENT TYPES OF SCHOOLS'



NOTE: SURVEYED POPULATION INCLUDES PEOPLE WITH NO RELATIONSHIP WITH SCHOOLS.
SOURCE: DPC RESEARCH 2004, UNPUBLISHED.

In the residential aged care sector, residents and their representatives have also become much more active in seeking information on relative service quality across providers, and in demanding that minimum standards be more strictly enforced. In response, the Department of Health and Ageing now publishes the accreditation status of residential aged care providers publicly on the Aged Care Standards Agency website. This move reflects a broader international trend to provide consumers of publicly provided health services with information about relative quality, in order to improve both quality and choice in the sector. Box 2.2 illustrates the increasing role of information in driving the service quality in health and aged care internationally.

BOX 2.2 • USING INFORMATION TO DRIVE QUALITY IN HEALTH AND AGED CARE

The OECD recently completed a study of measures used to improve health system performance in OECD countries. According to their report, there have been two related developments in the measurement of quality in health care in recent years:

- **a new field of health research focusing on the measurement of health care quality, and in particular outcomes, and initiatives by purchasers or government agencies aimed at making outcome measurement an integral feature of hospital resource allocation; and**
- **the provision of 'league tables' to the public, by purchasers, government agencies and the popular press, comparing hospitals on the basis of selected indicators.**

The OECD's review of international evidence suggests that the provision of information to consumers on the quality of health, aged care and social services is becoming more widespread:

...publicising comparative results between hospitals, health services and insurance plans would appear to be an irreversible trend...Rationalising resource use in health systems implies reducing the information asymmetry between the players, to the benefit of patients and public or private insurers that speak for them. This publicity is equally justified whether in an American-style competitive system or in public systems that are accountable to their citizens for the quality of tax-funded service.

OECD 2002, *MEASURING UP: IMPROVING HEALTH SYSTEM PERFORMANCE IN OECD COUNTRIES*, P. 269.

26
BETTER HEALTH OUTCOMES NEWSLETTER, SEPTEMBER 1997, WWW.HEALTH.GOV.AU/PQ/BHO/1997/V3N3/WHAT.HTM

The United States has been at the forefront of using information to drive quality in the health care sector, with a range of organisations and 38 states establishing quality indicator databases for hospitals. Quality indicators are also published for other health care providers and for managed care organisations. For example, the Health Care Financing Administration in the United States now requires managed care plans to obtain periodic outcomes measures from a sample of their enrolees. The new performance measure – called the Health Outcomes Survey (HOS) – applies for Medicare recipients who are typically aged over 65. The HOS is the first national measure of quality of life and functional status of Medicare beneficiaries. It aims to produce market forces that favour managed care plans with better results, especially for older people.

Also in the United States, efforts have been made to publish information about relative quality in nursing homes on the Internet. The 'Nursing Home Compare' website provides a good example of this. Clearly, the value of initiatives depends largely on the credibility of the information and assessments they present. To this end, government support for information services that incorporate the components of quality promoted by government (e.g. accreditation) may be useful.

The United Kingdom also publishes regular data on relative hospital performance, although the focus is on service quality measures – such as waiting lists – rather than on clinical outcomes. In 2001, however, a private United Kingdom initiative known as 'Dr Foster' began publishing information on relative mortality rates at public and private hospitals on the Internet. Performance measures for hospitals are also used in Scotland, Canada and France.

SOURCES: OECD 2002, *MEASURING UP: IMPROVING HEALTH SYSTEM PERFORMANCE IN OECD COUNTRIES; OECD 2001*, 'FOSTERING QUALITY HEALTHCARE', OECD *OBSERVER*, WWW.OECDOBSERVER.ORG/NEWS/FULLSTORY.PHP/AID/562.HTML; AND 'NURSING HOME COMPARE' WWW.MEDICARE.GOV/NHCOMPARE/HOME.ASP

2.4 Are the community's wants and needs being met?

Reform of Australia's social programs should consider not just the needs and expectations of the Australian community, but also the extent to which these are being met by current arrangements.

Current views on social programs

Chapters 4 and 5 of this report will present evidence suggesting that there is an urgent and substantial need to improve services and outcomes in both the health and education sectors. This section provides data showing that this need for improvement in the delivery of social programs is also reflected in community views on the quality of services currently provided in these areas.

Schools

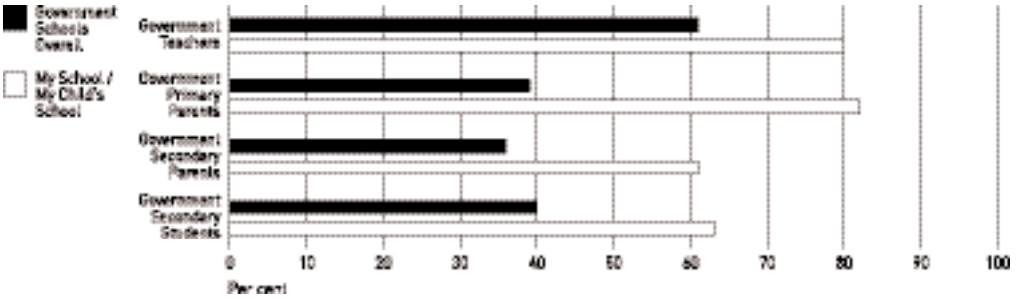
Overall, while most members of the community appear to be satisfied with government-provided school education, there are significant minorities who are not satisfied or believe that service levels are declining. According to the AusSCAN survey, around 70 per cent of people are satisfied with the services provided by state schools, while 30 per cent are dissatisfied (Figure 2.10). Perhaps coincidentally, these figures broadly reflect enrolment patterns, with approximately 69 per cent of school enrolments in state schools and 31 per cent in non-government schools.

Almost two-thirds of the community believes that government school education service levels have stayed the same over time. But, concerningly, 25 per cent believe that service levels have worsened. (Only 11 per cent say services have improved.) Similarly, AES data show that nearly 50 per cent believe that the quality of education (not limited to schools or to the government sector) fell between 1998 and 2001.

FIGURE 2.10 • LEVEL OF SATISFACTION WITH GOVERNMENT SCHOOLS

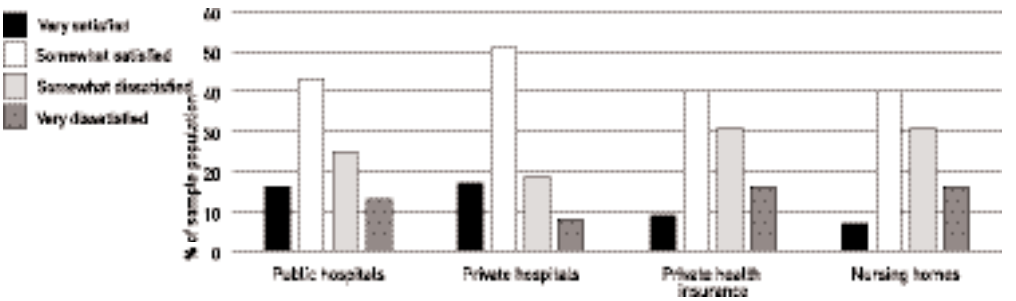
SOURCE: QUANTUM MARKET RESEARCH 2002, 'AUSTRALIA SCAN DATA AND TREND REFERENCE BOOK'.

FIGURE 2.11 • STAKEHOLDERS WHO RATE THE QUALITY OF VICTORIAN GOVERNMENT SCHOOLS AS EXCELLENT OR VERY GOOD, 2003



SOURCE: DPC ANOP RESEARCH 2003, UNPUBLISHED.

FIGURE 2.12 • LEVEL OF SATISFACTION WITH PUBLIC AND PRIVATE HEALTH SERVICES



SOURCE: QUANTUM MARKET RESEARCH 2002, 'AUSTRALIA SCAN DATA AND TREND REFERENCE BOOK'.

FIGURE 2.13 • OVERALL SATISFACTION OF PUBLIC HOSPITAL ACUTE-CARE PATIENTS

SOURCE: TQA RESEARCH 2002, *VICTORIAN PATIENT SATISFACTION MONITOR, ANNUAL REPORT SURVEY* WWW.HEALTH.VIC.GOV.AU/PATSAT/, ACCESSED 17 APRIL 2004.

The DPC ANOP survey examined the perceptions of the quality of government schools that were held by the general public and stakeholders directly involved in the government school system, including teachers, secondary school students and the parents of both primary and secondary students. This research revealed a widespread belief that the distribution of education opportunities across Australians is uneven.[27] Overall, three quarters of people believe that some Australian children are less likely than others to receive an excellent education. On the other hand, 24 per cent of those surveyed thought that all children have an equal opportunity.

Employers and, to a lesser extent, parents are not satisfied with the performance of government schools in preparing students for work. The DPC ANOP survey found that only 10 per cent of employers are satisfied that the education system as a whole is meeting their needs. Parents of secondary school students are also dissatisfied: only 42 per cent believe schools are adequately preparing their children for the workforce.[28]

There appear to be significant differences between people's perceptions and experiences of government school education. The DPC ANOP survey found that there was a widespread tendency for stakeholders to believe that the quality of the school they were directly involved with was higher than that of the average government school (Figure 2.11). This pattern is also observed, but to a lesser extent, in the independent and Catholic school sectors.

Health and aged care

Community satisfaction with health and aged care services follows a very similar pattern to satisfaction with schools. A significant proportion of the general public is dissatisfied with health and aged care services, and there is some evidence that this is increasing over time. But the satisfaction levels of actual clients of health services are considerably higher.

Compared to public schools, a greater proportion of Australians appear to be dissatisfied with the public health system. According to AusSCAN, around 38 per cent of people are dissatisfied with the current public hospital system (Figure 2.12). Dissatisfaction is somewhat lower for private hospitals, but higher for private health insurance.

As with education, there is evidence that dissatisfaction with health services may be increasing over time. AusSCAN found that almost one-third of people believe that the level of service provided by public hospitals has deteriorated over time. Similarly, the AES found that more than 50 per cent of people believed that the quality of health services (not limited to government services) had declined between 1998 and 2001, and half of these people believed that standards had fallen 'a lot'.

The Australian community also appears to be generally dissatisfied with aged care services. AusSCAN found that 47 per cent of people are either somewhat or very dissatisfied with current service provision. Thirty-four per cent believe that services provided by nursing homes have worsened over time.

In contrast, clients of at least some health services appear to be very satisfied with the quality of care they receive. The overwhelming majority (95 per cent) of acute-care patients in Victorian public hospitals were satisfied overall with their hospital stay, with more than seven out of ten (71 per cent) *very* satisfied (Figure 2.13). This finding does not necessarily contradict the dissatisfaction in the broader community, which probably stems primarily from a lack of timely access to affordable health services, such as primary care and elective surgery.

2.5 Emerging themes

This chapter has examined how Australian society is changing and the implications of these changes for the type of services that the community will need from government. It has also reviewed Australians' expectations of their governments and examined how the community believes governments are performing at present.

A number of themes emerge from this analysis:

- Health and education are perhaps the two most important issues that the Australian community expects its governments to deal with.
- A significant proportion of Australians are dissatisfied with the current health and education services provided by government, and this dissatisfaction seems to be growing over time.
- The Australian society is changing in ways that have important implications for the type of health and education services needed from governments:
  - The ageing of the population – in combination with other factors – will generate a substantial increase in the community's need for health services, and in their cost. The health and aged care systems, already straining to meet existing demand, are likely to be stretched beyond breaking point. The pressure on government health service budgets will be exacerbated by the development of costly health technologies and consumers' increased expectations of receiving the highest quality services.
  - In an increasingly knowledge-based economy, young people's chances of securing a good job are becoming ever more closely linked to their skills and educational outcomes. Schools have a critical role to play in preparing children to participate successfully in the world of work. Education curricula will need to keep pace with ongoing changes in technology, the structure of the economy and consequent labour force demands.
- A range of economic and social forces are contributing to a much greater variety in the life courses followed by individuals. As a result, it is becoming increasingly difficult to predict who will require which services and when they will demand them. Government programs will need to be designed to be *flexible*, so as to cater to the needs of the widest possible range of people and provide a range of entry points, and designed *accessibly*, so people are able to select the mode of delivery that best suits their lifestyle.
- Because of technological change and an increased emphasis on competition, people place increasing value on the quality of services, value for money, and the ability to make *an informed choice*. The community is increasingly expecting government services to be of high quality and to make some provision for consumer choice. They also expect sufficient information to allow them to make judgements of value for money.
- There is scope for a stronger role for the States in developing social policy and managing the delivery of social programs. The States generally appear to be best placed to provide the information and choice of services and products that people now demand.

27
DPC ANOP RESEARCH 2003, UNPUBLISHED.

28
DPC ANOP RESEARCH 2003, UNPUBLISHED.

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter Three
Equity, incentives and opportunities: taxes, benefits and the distribution of income

While government services, taxes and benefits significantly reduce income disparities in Australia, considerable inequality remains. That the poorest families have access to good quality health and education services is critical to improving the future opportunities and standards of living of all Australians.

Equity, incentives and opportunities: taxes, benefits and the distribution of income

This chapter examines the taxes and benefits (both cash and in kind, i.e. services) that redistribute financial resources across the community, affecting equity in society and Australians' opportunities in life. It examines the distribution of income in the Australian community and how this is affected by government.

Key Points

- Governments influence the opportunities and quality of life of Australian families in many ways. Prominent among these is the allocation and redistribution of resources towards families in need.
- Taxes and social security benefits are the primary tools available to governments to redistribute financial resources. Also important is the subsidised provision of 'benefits in kind', such as school education, public housing and hospital treatment.
- These systems redistribute money and services in ways that help maintain a cohesive Australian society. For example, they redistribute income from higher income families to those on lower income, from those in the workforce to older and younger Australians, and from the healthy to the sick.
- Even after government intervention, of course, significant inequalities between families remain. In fact, there has been a shift in taxation and the distribution of benefits away from support of lower income families towards those on middle incomes (through benefits) and upper incomes (through taxation).
- *Taxation* and *cash benefit* systems affect incentives to engage in economic and other activities, especially employment. To the extent that these systems are structured so that people are not greatly rewarded for extra effort – taking a job or working overtime – then there are also weaker incentives to increase skill levels on the job or to go back to study.
- Australia's marginal tax rates are high by international standards. Low and middle income families with children, and unemployed people, face significant disincentives to increase their working hours because of the combination of these rates and the withdrawal of social security benefits as income rises.

- Yet, overall, Australia is a relatively low tax country by OECD standards. This discrepancy is caused by the complexity of our tax system and the proliferation of significant tax breaks. These tax breaks tend to cause inefficiencies and inequities, but most importantly represent significant leakages from public revenue. To raise a given level of revenue, higher tax rates are required.
- The necessity of tackling these issues is made more pressing by the issues raised in the previous chapter. For example, given demographic trends, a system in which many low- and middle-income families face significant disincentives to undertake additional work is not desirable for those families or the community. A better system of taxes and benefits will also lay the foundations for providing high quality health and education services.
- *Benefits in kind* to families in the form of service delivery are often overlooked in discussions about the distribution of wealth and income. Yet they make up 24 per cent of the average Australian household's 'final' income after tax, benefits and the value of services received (measured at cost). For the poorest households, benefits in kind make up more than half of their final income. In addition, the value of these services is growing faster than their other sources of income.
- Health and education services are important not only for their immediate redistributive role, but also because health and education are intimately linked with opportunity. It is difficult for families living in poverty to create a better future for their children if they do not have affordable access to quality education, or if there is a chronic or serious illness in the family. High-quality, accessible and affordable health and education services for lower-income families are particularly important when there are significant disparities in income between rich and poor.

3.1 How governments influence Australians' quality of life

Government activities

Governments undertake a range of activities that affect the community in significant ways. For the purposes of this report, these activities can be considered in two categories:

- service provision; and
- taxes and cash benefits.

Service provision

Governments provide a variety of services, many of which are considered to have particular social merits or to generate spillover benefits for the community. Some of these form an important part of the nation's social welfare system (e.g. basic health care), some are provided to people with specific needs (e.g. aged care and disability services), while others are typically used by each person in the community at some stage during their life (e.g. school education).[29] Governments typically deliver such services with the aim of promoting equity in their availability and consumption.

Taxes and cash benefits

To fund the provision of these and other services, governments collect revenue from individuals, businesses and other entities through a variety of taxes and charges. Some of this revenue is returned to families in need in the form of social security cash benefits.

Governments typically attempt to structure taxes and cash benefits so that the distribution of income across families becomes more equal. That is, some households pay more tax than they receive in cash benefits while others pay less tax than they receive in cash benefits. For example, older households and one-parent households are more likely to be net cash recipients from the taxation and benefits systems, while younger couple-only households are likely to pay more tax than they receive in cash benefits.[30]

Redistribution of financial resources

Consuming government services, paying taxes and receiving cash benefits can all have important effects on families' financial standard of living. Reflecting this, we can define a family's 'final income' as a combination of the following:

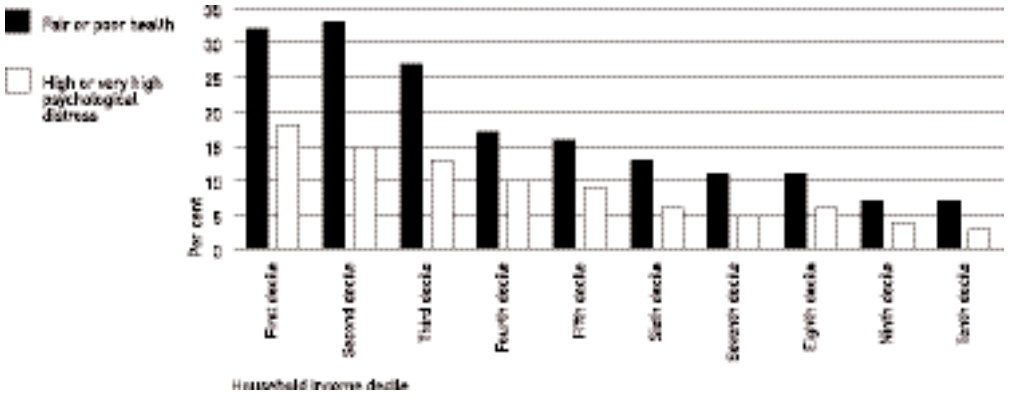
- the family's *private income*, which family members earn in the form of wages and salaries, rents and interest;
- *tax payments*, including both direct taxes (e.g. income tax) and indirect taxes (e.g. the GST);
- *cash benefits*, which again can be both direct (in the form of social security payments) and indirect (e.g. concessions); and
- *benefits in kind*, which include the government-provided services the family consumes at a reduced cost or at no cost.

The importance of health and education

Health, education, and other benefits in kind are often overlooked in analyses of the financial standard of living. Yet they make a very significant contribution to the wellbeing of most families. The National Centre for Social and Economic Modelling (NATSEM) has found that benefits in kind represent 24 per cent of the final income of an average Australian household.[31] For the poorest households, benefits in kind make up more than half of their final income. Health and education services are by far the most valuable benefits, representing 82 per cent of the average family's benefits in kind.

Further, the real value of benefits in kind is growing faster than other sources of final income. NATSEM calculated that for the average household, the value of health benefits in kind grew 41 per cent from 1994–95 to 2001–02, while education benefits in kind grew 32 per cent. In contrast, private income grew 20 per cent and social security benefits 9 per cent over the same period.

FIGURE 3.1 • RATES OF FAIR OR POOR HEALTH AND HIGH OR VERY HIGH PSYCHOLOGICAL DISTRESS AMONG PEOPLE WITH DIFFERENT HOUSEHOLD INCOMES, 2001



SOURCE: ABS 2002, *NATIONAL HEALTH SURVEY*, UNPUBLISHED DATA.

When the impacts on the distribution of financial resources are taken into account, government provision of health and education services can be seen to contribute to families' quality of life in three ways:

- the direct benefits to health and wellbeing, or to knowledge and skills, that accrue from consumption of health and education services;
- the financial cost to families of taxation payments (direct and indirect) that are used by governments to fund the provision of health and education services; and
- the financial benefit to families who consume health and education services that are subsidised by government.

Health and education outcomes and the income distribution

Health and income

Health and education take on even further importance when the linkages between health and education outcomes and the distribution of financial resources are taken into account.

Australians' health is strongly correlated with their level of income. Figure 3.1 shows that people become less likely to have health problems as their income increases.

While it is difficult to determine the direction of causality in the relationship between health outcomes and income, it is likely that it runs in both directions:

- families on low incomes are more likely to become unhealthy, due to a range of factors such as inadequate housing and heating, poor diet and inability to pay for some health services; and
- people with a family member with a chronic or serious illness will find it more difficult to spend time on activities that are likely to help them increase their income, such as study, employment (including working overtime) or looking for work.

Education and income

Educational attainment has a positive impact on employment outcomes, and consequently people with more education tend to have higher incomes. Chapter 2 discussed the growing importance of education and skills to employment outcomes in an increasingly knowledge-based economy.

High-quality education is critical in providing children with opportunities in life, particularly for children from the poorest families. Children from wealthier families tend to have educational advantages, arising from both the families' ability to pay for education and a stronger family history – and expectation – of educational attainment. Again, the relationship between low income and poor educational outcomes is likely to be self-reinforcing over generations.

29
PRODUCTIVITY COMMISSION 2004, *REPORT ON GOVERNMENT SERVICES 2004*, AUSINFO, CANBERRA, P. 1.2.

30
ABS 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

31
A. HARDING, R. LLOYD, AND N. WARREN 2004,*THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET. HARDING ET AL. REFER TO BENEFITS IN KIND AS 'INDIRECT BENEFITS'. THEIR CALCULATION OF FINAL INCOME DOES NOT INCLUDE THE IMPACT OF INDIRECT CASH BENEFITS SUCH AS CONCESSIONS.

3.2 Income inequality

Income is a key factor in determining the quality of life of Australian families: it influences their access to resources and services and their ability to participate fully in society.[32]

In chapter 2 we saw that the disposable income of the average Australian household increased in real terms by 27 per cent in the 1980s and 1990s. This growth was driven by a period of sustained economic expansion, produced by strong productivity growth. However, the benefits of this growth have not been equally shared. There remain significant inequalities in the distribution of financial resources across families.

Current income inequality

The distribution of private income across families in Australia is very unequal. In 2001–02, households in the lowest quintile of the income distribution received little or no private income, averaging just $46 per week.[33] In contrast, households in the highest quintile had an average private income of $2100 per week. In other words, the private income of the richest 20 per cent of households is 45 times higher than that of the poorest 20 per cent.

Government redistribution causes a very significant reduction in income inequality. When taxes are subtracted and benefits added, the incomes of the poorest and richest families are much closer together – though still poles apart. The final income of the lowest quintile was $490 per week, compared to $1510 per week for the highest quintile.

Table 3.1 shows that the amount of taxes paid by households increases with income, while the amount of benefits received decreases. The 40 per cent of households with the lowest incomes (the lowest two quintiles) receive 60 per cent of all government benefits (both cash benefits and benefits in kind) while paying only 13 per cent of all taxes (direct and indirect). The highest quintile pays 50 per cent of taxes and receives 9 per cent of benefits.

The net effect of government redistribution of income is that the poorest 60 per cent of Australians benefit at the expense of the richest 40 per cent.

Figure 3.2 shows how the distribution of income is affected by taxes and benefits. It can be seen that both cash benefits and benefits in kind have a bigger impact on the distribution than the taxation system.

The size and composition of a household play a significant role in determining whether it is a net winner or loser from the impacts of the tax and benefits systems. NATSEM has found that aged households and sole parent families tend to be the biggest winners, while couples without children and single people are the biggest losers.[34] On average:

- *Aged households* pay little tax and receive significant cash benefits through the aged pension as well as considerable benefits in kind, particularly health benefits.
- *Sole-parent families* also pay little tax and are the biggest recipients of cash benefits, primarily in the form of parenting payments. They also receive substantial benefits in kind, via the provision of government schooling and health benefits.
- *Couples with children* are, on average, marginal winners. They receive a large amount of education and health benefits in kind, but these are mostly offset by their direct and indirect tax payments.
- *Couples without children* receive relatively few benefits and pay a much higher amount of tax.
- *Single people* also pay significantly more in taxes than they receive in benefits.

There are, of course, significant variations within household types, depending on the circumstances of individual families. This can be seen by considering the families that were introduced in chapter 1. NATSEM estimates that only Sally, Bruce, Lucy, Sam, and Sophie are net winners from the effects of taxes and benefits (Table 3.2). The four other families have lower final incomes than private incomes, because they pay a higher amount in taxes than they receive in benefits.

TABLE 3.1 • ESTIMATED NET IMPACT OF GOVERNMENT REDISTRIBUTION ON WEEKLY INCOME ($)

	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile
CASH BENEFITS	248.9	231.4	116.1	50.5	12.0
BENEFITS IN KIND	258.9	298.2	263.1	207.8	135.2
DIRECT TAXES	–4.1	–53.0	–153.8	–268.0	–557.6
INDIRECT TAXES	–60.1	–86.1	–114.7	–133.4	–183.8
TOTAL IMPACT	**443.6**	**390.5**	**110.7**	**–143.1**	**–594.2**

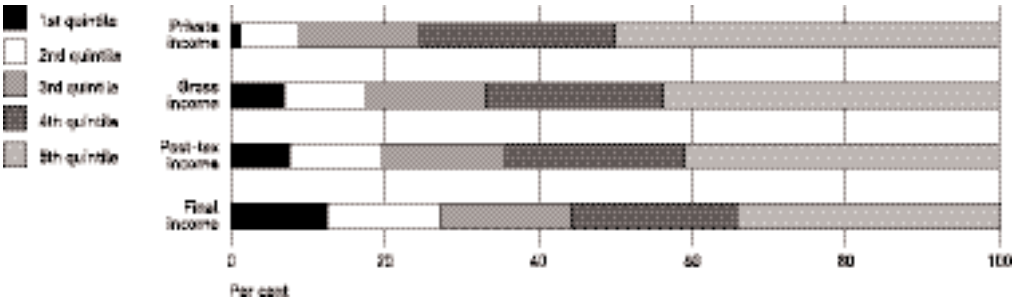
SOURCE: HARDING, A., LLOYD, R. AND WARREN, N. 2004, *THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

TABLE 3.2 • ESTIMATED IMPACT OF TAXES AND BENEFITS ON FAMILIES, PER WEEK ($)

	Matt	Don & Yvonne	Con, Despina, Ari & Thea	Patrice & Jack	Sally, Bruce, Lucy, Sam & Sophie
PRIVATE INCOME	**400**	**1000**	**1596**	**1212**	**865**
BENEFITS					
CASH BENEFITS	0	0	31	57	151
BENEFITS IN KIND					
– EDUCATION	0	0	243	118	237
– HEALTH	48	81	85	46	157
– OTHER	0	106	34	34	34
TAXES					
DIRECT TAXES	54	161	375	345	203
INDIRECT TAXES	62	135	172	117	115
FINAL INCOME	**333**	**891**	**1442**	**1004**	**1126**

SOURCE: NATSEM 2004, UNPUBLISHED DATA.

FIGURE 3.2 • ESTIMATED IMPACT OF GOVERNMENT ON DISTRIBUTION OF INCOME, 2001–02



NOTES: GROSS INCOME IS PRIVATE INCOME PLUS CASH BENEFITS.
POST-TAX INCOME IS GROSS INCOME LESS PAYMENTS OF DIRECT AND INDIRECT TAXES.
FINAL INCOME IS POST-TAX INCOME PLUS BENEFITS IN KIND.

SOURCE: HARDING, A., LLOYD, R. AND WARREN, N. 2004, *THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

For some families, high taxation payments reflect relatively high private incomes. Don and Yvonne – who are self-funded retirees – and Patrice – a senior teacher and sole parent – have substantial private incomes and, as a result, pay more tax and receive little or no cash benefits.

Con and Despina have two children attending a Catholic secondary school. Con runs a small business and Despina has a part time HR management job at Myer. Their private income is relatively high. They receive considerable benefits in kind, but these are easily outweighed by their high tax payments.

Their situation can be contrasted with Sally and Bruce, who have two children attending primary school and an additional child, Sophie, whom Sally cares for at home. The potential cost of childcare outweighs any income that Sally could earn by working. Sally and Bruce's private income is barely more than half of that of Con and Despina. However, the final incomes of the two families are much closer together, because Sally and Bruce receive much higher cash benefits and pay much less income tax.

Matt, who lives alone and has casual employment, has the lowest private income of the five families. Yet he is also one of the biggest losers from the effects of taxes and benefits. His final income is just 83 per cent of his private income. This is because he receives almost no benefits. He is not eligible for any social security payments, rarely uses health services, and does not receive any other benefits in kind.

32
ABS 2003, *AUSTRALIAN SOCIAL TRENDS*, CATALOGUE NO. 4102.0, AUSINFO, CANBERRA.

33
THE INCOME DISTRIBUTION USED IN THIS ANALYSIS IS THE DISTRIBUTION OF EQUIVALENT DISPOSABLE HOUSEHOLD INCOME.

34
HARDING ET AL. 2004, OP. CIT.

Trends in income inequality

Several studies have examined trends in income inequality in Australia in the 1980s and 1990s. The general consensus of this research is that there was an increase in inequality of private income, which was only partly alleviated by government redistribution.

Saunders (2002) reports the trend in income inequality between 1990 and 1999–2000.[35] He found that inequality of both private income and equivalent disposable income[36] (as measured by the Gini coefficient) increased by about 5 per cent over that decade. Over a similar period, Harding and Greenwell (2002) also find that income inequality increased by about 5 per cent.[37] Both Saunders, and Harding and Greenwell, find there was little increase in overall inequality in the second half of the 1990s.

NATSEM has analysed the trend in income inequality between 1994–95 and 2001–02, taking into account the impact of indirect taxes and benefits in kind.[38] It was found that between 1994–95 and 2001–02, the distribution of private income became more equal, with the lower two quintiles gaining a slightly larger share of income (Table 3.3).[39]

The distribution of equivalent final income, however, was virtually unchanged. The two lowest quintiles' increasing share of private income was effectively cancelled out by a decreasing share of the net returns from taxes and benefits. The main cause was a significant redistribution of benefits towards wealthier families. The poorest 20 per cent of households experienced a sharp reduction in their share of total benefits (cash and benefits in kind), from 37.2 per cent in 1994–95 to 34 per cent in 2001–02. The upper three quintiles all increased their share. In addition, the highest quintile paid a lower share of taxes.

The sections that follow examine more closely recent trends in the distribution of the tax burden and the incidence of benefits.

3.3 Taxation

The structure of taxation affects families' opportunities and choices in a variety of ways, and decisions by businesses too. It impacts on consumption and investment decisions and the net income earned through wages and salaries as well as capital investments, and thus on the overall level and pattern of economic activity, including how individuals and families share in that activity.

A number of principles have been accepted as the guides for appropriately developing our tax system. At the broadest level, these 'good design' principles are efficiency, equity and simplicity. A taxation system should be *efficient* in that it does not restrict economic growth or divert resources away from the use that would produce most for the community. The system should be *equitable* in treating everyone fairly and contributing to a more even distribution of income. A relatively simple system aids transparency and makes inequities in the distribution of taxation and unintended inefficiencies in its effects on economic activity less likely.

This section looks briefly at a number of issues related to the tax system:

- how much tax is collected and who pays it; and
- the nature of the tax system – particularly the structure of personal tax rates and the complexity of the system.

TABLE 3.3 • ESTIMATED DISTRIBUTION OF PRIVATE AND FINAL INCOME (% SHARE), 1994–95 AND 2001–02

	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile
PRIVATE INCOME					
1994–95	0.5	7.2	16.1	25.7	50.4
2001–02	1.2	7.6	15.7	25.5	49.9
EQUIVALENT FINAL INCOME					
1994–95	11.0	14.4	17.4	22.6	34.7
2001–02	10.9	14.5	17.6	22.6	34.3

NOTE: EQUIVALENT FINAL INCOME IS FINAL INCOME WHERE THE CASH COMPONENT IS DIVIDED BY THE OECD EQUIVALENCE SCALE AND THE BENEFITS IN KIND ARE DIVIDED BY THE NUMBER OF PEOPLE IN THE HOUSEHOLD. PEOPLE ARE RANKED INTO QUINTILES BASED ON THE EQUIVALENT DISPOSABLE INCOME OF THEIR HOUSEHOLD.

SOURCE: HARDING, A., LLOYD, R. AND WARREN, N. 2004,*THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

TABLE 3.4 • TOTAL TAX REVENUE AS A PER CENT OF GDP, SELECTED OECD COUNTRIES, 2001

Country	Total Tax Revenue as a per cent of GDP	Country	Total Tax Revenue as a per cent of GDP
AUSTRALIA	**30.1**		
CANADA	35.1	UNITED STATES	28.9
JAPAN	27.3	KOREA	27.2
NEW ZEALAND	33.8	FRANCE	45.0
GERMANY	36.8	ITALY	42.0
NETHERLANDS	39.5	SPAIN	35.2
SWITZERLAND	30.6	UNITED KINGDOM	37.3
		OECD (UNWEIGHTED) AVERAGE	**36.9**

SOURCE: OECD 2003, *OECD REVENUE STATISTICS 2003*, OECD, PARIS, WWW.OECD.ORG/SEARCHRESULT/0,2665,EN_2649_201185_1_1_1_1_1,00.HTML.

Tax revenue – how much and who pays?

Total tax revenue collected by all levels of Australian government was $216 billion in 2001–02. The largest component of revenue – over 40 per cent – relates to income tax on individuals.[40]

While government revenue from taxation has increased in recent years, more quickly than the growth in nominal GDP, Australian tax revenue as a proportion of GDP remains relatively low by international standards. As Table 3.4 shows, this proportion is below the OECD average and below that of many industrialised countries.

Research by NATSEM[41] shows that the amount of tax paid by households has risen faster than private incomes in recent years. Between 1994–95 and 2001–02, taxes paid by households rose by 24 per cent in real terms (direct tax by 19 per cent and indirect by 33 per cent), while private incomes rose by 20 per cent.

Over this period, there has also been a shift in the share of tax paid by particular groups of households, with those in the lowest income groups now paying a higher share (lowest 20 per cent of households up from 4.5 per cent to 4.9 per cent, second lowest 20 per cent up from 7.3 per cent to 7.8 per cent) and the highest income households paying a lower proportion (highest 20 per cent of households down from 51.1 per cent to 50 per cent). These changes, although small in terms of shares, are very significant in dollar terms:

- If the top 20 per cent of households had paid the same share (51.1 per cent) in 2001–02 as they had in 1994–95, as a group they would have paid an extra $1.4 billion in direct and indirect tax.
- The higher tax collection for the lowest 20 per cent of households amounts to an increase of $850 each year, or about 6 per cent of their 2001–02 disposable income.

35
SAUNDERS 2002, *THE ENDS AND MEANS OF WELFARE: COPING WITH ECONOMIC AND SOCIAL CHANGE IN AUSTRALIA*, CAMBRIDGE UNIVERSITY PRESS, CAMBRIDGE, PP. 188–93.

36
DISPOSABLE INCOME IS PRIVATE INCOME PLUS CASH BENEFITS, LESS DIRECT TAXES. EQUIVALENT DISPOSABLE INCOME USES THE OECD EQUIVALENCE SCALE TO MAKE HOUSEHOLDS OF DIFFERENT SIZES COMPARABLE.

37
HARDING AND GREENWELL 2002, *TRENDS IN INCOME AND EXPENDITURE INEQUALITY IN THE 1980S AND 1990S: A RE-EXAMINATION AND FURTHER RESULTS*, NATSEM DISCUSSION PAPER NO. 57, JUNE.

38
HARDING ET AL. 2004, OP. CIT.

39
SAUNDERS (2002) ALSO FOUND THAT PRIVATE INCOME BECAME MORE EQUALLY DISTRIBUTED BETWEEN 1997–98 AND1999–2000.

40
ABS 2003, *TAXATION REVENUE 2001–02*, CATALOGUE NO. 5506.0, AUSINFO, CANBERRA, TABLE 1.

41
HARDING ET AL. 2004, OP. CIT.

The changes in distribution of tax collections overall reflect changes in the distribution of both direct and indirect tax between 1994–95 and 2001–02.

- In relation to *direct tax*, low income individuals – on 25 per cent of Average Weekly Earnings (AWE) – are now paying 5.4 per cent of their earnings in tax, up from 4.7 per cent, while those on 150 per cent and 200 per cent of AWE are paying less income tax (as a share of earnings) in the 2001–02 system. The share of income tax paid by the top 20 per cent of income earning households has fallen from 59.4 to 58.4 per cent.
- The lowest income 20 per cent are now paying 20.4 per cent of their gross income in *indirect tax*, up from 17.9 per cent, an increase of $7.40 per week. For the highest income 20 per cent, indirect tax has grown from 7.6 to 8.7 per cent of their gross income. The overall burden of indirect taxation has shifted away from middle and upper-middle-income families towards the high income 20 per cent of households.

Structural issues – high marginal rates at relatively low income

Personal taxation and the rates at which it is applied affect individuals' work, savings, consumption and investment decisions. They therefore affect the level and pattern of economic activity and the distribution of that activity. Particularly, they affect ordinary working Australians in their rewards from, and choices about, work.

Australia's current income tax scale has five brackets, including an initial tax-free area up to a $6000 threshold. A marginal rate of 17c applies to each dollar earned above $6000 and up to $21,600. The rate increases to 30c for each dollar earned between $21,601 and $52,000, 42c for each dollar of income between $52,001 and $62,500 and 47c for each dollar earned above $62,500. (In addition, there is a Medicare levy of 1.5c in the dollar, with an exemption for those on low incomes, up to approximately $15,000 in 2002–03,[42] the exemption being shaded out at 20c in the dollar above that.)

As this report was being finalised, the Commonwealth Government announced changes to the income thresholds at which the two highest tax rates apply. From July 2004, the 42 cent rate will apply between $58,001 and $70,000 and 47 cent above $70,000. From July 2005, the 42 cent rate will apply between $63,001 and $80,000, and the 47 cent rate above $80,000. The changes are subject to passage by the Parliament.

In 2003, full-time adult average weekly ordinary time earnings (AWOTE) equalled $48,452.[43] Therefore, the top marginal rate of 47 cents applies to incomes just under 130 per cent of AWOTE. The second highest marginal tax rate of 42 cents applies to incomes only just above AWOTE (107 per cent of the 2003 figure). The Medicare levy lifts these top two marginal tax rates to 43.5 per cent and 48.5 per cent.

The tax structure thus applies quite high marginal tax rates at relatively low levels of income. International comparisons underline that conclusion. In a recent Federal Budget submission, the Business Coalition for Tax Reform presented broad international comparisons of top marginal tax rates and the personal incomes to which they applied (see Table 3.6). The top marginal tax rate in Australia is well above that in many countries but similar to the rate in Germany and parts of Canada. However, those rates apply at income levels significantly higher than the threshold for the top marginal rate in Australia. Countries such as the United States and the United Kingdom have substantially lower top marginal tax rates that apply only at levels of personal income well above the Australian threshold.

These high marginal tax rates reduce the rewards and incentives for earning extra income, affecting participation in the labour market and decisions about steps to earn additional income, e.g. working overtime or seeking a higher-paid job.

TABLE 3.5 • MARGINAL TAX RATES FOR PAYE EARNERS, 2003–04

Taxable income	Tax on this income
$0–$6,000	NIL
$6,001–$21,600	17c FOR EACH $1 OVER $6,000
$21,601–$52,000	$2,652 PLUS 30c FOR EACH $1 OVER $21,600
$52,001–$62,500	$11,772 PLUS 42c FOR EACH $1 OVER $52,000
OVER $62,500	$16,182 PLUS 47c FOR EACH $1 OVER $62,500

SOURCE: AUSTRALIAN TAXATION OFFICE 2004, WWW.ATO.GOV.AU/INDIVIDUALS/CONTENT.ASP?DOC=/CONTENT/12333.HTM&MNU=5053&MFP=001.

TABLE 3.6 • TOP MARGINAL TAX RATES AND THE PERSONAL INCOME LEVELS TO WHICH THEY APPLY, SELECTED COUNTRIES

	Top marginal rate	Annual income
AUSTRALIA	47	62,501
CANADA (INCLUDING PROVINCES)	39–48.7	123,707
GERMANY	48.5	98,000
HONG KONG	17	26,525
NEW ZEALAND	39	48,954
SINGAPORE	26	439,405
UNITED KINGDOM	40	85,322
UNITED STATES (EXCLUDING STATE TAXES)	35	311,950

SOURCE: BUSINESS COUNCIL OF AUSTRALIA, *BUSINESS COALITION FOR TAX REFORM*, FEDERAL BUDGET SUBMISSION, JANUARY, 2004.

High marginal tax rates also act as a disincentive to personal saving and affect the form in which personal savings and investments are held, e.g. favouring owner-occupied dwellings. This has effects at the individual and economy-wide level. For individuals facing high marginal tax rates, inefficiencies arise in efforts they may make to reduce their personal income tax burdens. Opportunities for tax avoidance and evasion increase real costs for other individuals, firms and governments. This has flow-on effects throughout the economy, as resources are diverted from their most productive uses.

Structural issues – high effective marginal tax rates for some

The combination of the tax system and the social security benefits system can have important incentive effects for people in particular situations.

Those receiving social security benefits face losses from two sources when they earn additional income: they pay tax on the income they earn and, usually, at least part of their benefits are withdrawn as their income rises. The combination of these effects is measured by 'effective' marginal tax rates (EMTRs): e.g. an EMTR of 70 per cent means that 70 cents of an extra dollar of income is lost to taxes and reduced benefits. Those who face very high EMTRs have strong disincentives to earn additional income, including by increasing their participation in the labour market.

Beer[44] calculated that 60 per cent of the population faced EMTRs of between 20 and 60 per cent in 2002. Over half of wage and salary earners faced EMTRs of between 20 and 40 per cent, and 11 per cent faced EMTRs above 60 per cent.

As this report was being finalised, the Commonwealth Government announced changes to the structure of the income tax system and changes in the income tests and taper rates for Family Tax Benefit Parts A and B, to apply from July 2004, subject to passage by the Parliament. These changes will affect the EMTRs faced by families.

The main groups that face very high EMTRs are families with dependent children and sole parents. Over half of sole parents with earnings and 20 per cent of families with dependent children face EMTRs of more than 60 per cent. By comparison, only 3 per cent of single people and 1 per cent of couples without children face EMTRs in excess of 60 per cent. The unemployed and families in the middle of the income distribution also face high EMTRs.

42
A HIGHER FIGURE APPLIES FOR SOME GROUPS.

43
THIS FIGURE WAS FOR AUGUST 2003 (ABS 2004, AWOTE, CATALOGUE NO. 6302, AUSINFO, CANBERRA).

44
G. BEER 2003, 'WORK INCENTIVES UNDER A NEW TAX SYSTEM: THE DISTRIBUTION OF EFFECTIVE MARGINAL TAX RATES IN 2002', *ECONOMIC RECORD VOL 79*, SPECIAL ISSUE: SELECTED PAPERS FROM THE 31ST NATIONAL CONFERENCE OF ECONOMISTS, JUNE, PP. S14–25.

Structural issues – tax leakages and complexity

As we saw earlier, Australia's high marginal tax rates do not result in tax revenue as a proportion of GDP being high by international standards. A key reason is the number of tax breaks or 'leakages' from the tax system, which have proliferated in recent times. These leakages are of various types, but the focus here is on 'tax expenditures'.

Tax expenditures are tax measures designed to benefit a defined group or activity, which substitute for overt budget subsidies. They reduce the revenue obtained by governments and add to the complexity of the taxation system, but unlike budgeted outlays, they typically are not subjected to the same regular review against other public priorities. They can distort economic activity, as they are generally applied to particular groups of the population or to particular activities.

Estimates by the Commonwealth Treasury of the value of Commonwealth tax expenditures totalled just over $30 billion in 2003–04, or around 3.8 per cent of GDP (See Table 3.7).[45]

Tax expenditures exist at State level too, although on a smaller scale (approximately $9.5 billion in total in 2003–04).[46] In addition, there are tax breaks that are not counted as tax expenditures, but rather as features of the tax 'benchmark' – including the negative gearing of rental housing, tax deductions for work-related expenses – and some measures that might be termed 'quasi tax expenditures', such as the private health insurance rebate. Together these examples cost the public purse well over $8 billion.[47]

The caveats noted at the foot of Table 3.7 are important – in particular the caveat that some tax expenditures reflect (or partly reflect) only timing differences vis-à-vis the tax benchmark. Clearly, also, many of the activities or groups assisted are ones that governments would wish to assist, if not in this way, then via other means.

Nevertheless, tax expenditures and other tax breaks have a large impact on the budgets of the Commonwealth and the States. They represent an increasing portion of total government expenditure (including revenue forgone) and are an important part of the explanation for our high marginal tax rates. Moreover, not only are they a growing source of complexity in the taxation system, but there is the strong sense that many, if not most, families would be better served by a simpler system with lower tax rates than by a system of many tax breaks and high tax rates. This theme is taken up in chapter 10.

3.4 Benefits

Governments provide a range of benefits to households: both cash benefits, paid through the social security system, and benefits in kind, made available through subsidised government services such as education and health services.

The taxation and social security systems are the main tools available to governments for changing the distribution of resources among groups within the community. Substantial sums are involved – cash benefits are estimated to be around $60 billion in 2003–04, or around one-third of the Commonwealth's budget – and these payments (and concessions) make a big difference to the quality of life of many Australian families.

However, as we discussed in Section 3.1, benefits in kind also have an important effect on families' standards of living. This is especially so for the poorest families, for whom benefits in kind make up over half their final income, and provide the opportunity for a better future and a way out of poverty. The resources devoted to providing these services are very large.

This section looks briefly at two key issues related to government benefits:

- how government benefits – both cash benefits and benefits in kind – are distributed across households; and
- the nature of the cash benefits system – particularly the complexity of the system and the incentives it creates.

The nature of the health and education systems is examined in detail in chapters 4 and 5.

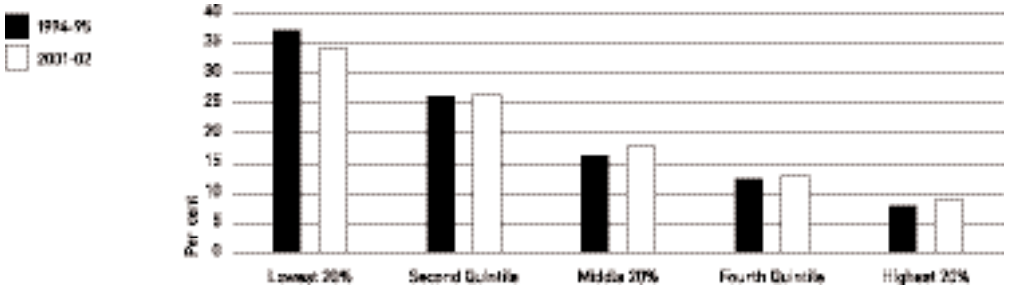
TABLE 3.7 • TAX EXPENDITURES AND SIMILAR BUDGET LEAKAGES, 2003–04

Tax Expenditures, Tax Breaks and 'Quasi' Tax Expenditures	Value ($m)
COMMONWEALTH TAX EXPENDITURES	
LARGE POSITIVE (a) MEASURED TAX EXPENDITURES, COMMONWEALTH	
CONCESSIONAL TAXATION OF FUNDED SUPERANNUATION	10,490
EXEMPTION OF FAMILY TAX BENEFIT, PARTS A & B, INCLUDING EXPENSE EQUIVALENT	2,560
CAPITAL GAINS TAX 50 PER CENT DISCOUNT FOR INDIVIDUALS AND TRUSTS	2,360
SENIOR AUSTRALIANS' TAX OFFSET	1,670
APPLICATION OF STATUTORY FORMULA TO VALUE CAR BENEFITS	1,070
EXEMPTION OF CERTAIN INCOME SUPPORT BENEFITS, PENSIONS OR ALLOWANCES	960
TAX OFFSET FOR RECIPIENTS OF SOME SOCIAL SECURITY BENEFITS, PENSIONS OR ALLOWANCES	930
EXEMPTION OF 30 PER CENT PRIVATE HEALTH INSURANCE REFUND, INCLUDING EXPENSE EQUIVALENT	850
EXEMPTION FROM EXCISE FOR 'ALTERNATIVE FUELS'	830
CONCESSIONAL TREATMENT OF NON-SUPERANNUATION TERMINATION BENEFITS	780
CONCESSIONAL RATE OF EXCISE ON AVIATION GASOLINE AND AVIATION TURBINE FUEL	750
EXEMPTION FROM INTEREST WITHHOLDING TAX ON WIDELY HELD DEBENTURES	650
OTHER MEASURED COMMONWEALTH TAX EXPENDITURES	6,546
TOTAL MEASURED COMMONWEALTH TAX EXPENDITURES	**30,446**
STATE TAX EXPENDITURES (ESTIMATE PROVIDED BY VICTORIAN DTF) SELECTED IN-BENCHMARK TAX BREAKS (b)	**9,500**
NEGATIVE GEARING, OF RENTAL HOUSING (BASED ON ESTIMATE MADE BY PARLIAMENTARY LIBRARY RESEARCH STAFF FOR SENATE COMMUNITY AFFAIRS COMMITTEE, 1997, HERE UPDATED IN LINE WITH GDP) (c)	2,300
WORK-RELATED CAR EXPENSES (SOURCE: ATO) (COST ESTIMATE ASSUMES 30 PER CENT MTR PLUS MEDICARE LEVY)	1,100
OTHER WORK-RELATED EXPENSES – UNIFORMS, MEALS, SELF-EDUCATION EXPENSES ETC. (SOURCE: ATO) (COST ESTIMATED ASSUMES 30 PER CENT MTR PLUS MEDICARE LEVY)	2,800
TOTAL SELECTED IN-BENCHMARK TAX BREAKS	**6,200**
'QUASI' TAX EXPENDITURES	
PRIVATE HEALTH INSURANCE REBATE (COST AS ESTIMATED FOR 2003–04 BY SENATE SELECT COMMITTEE ON MEDICARE) – NOW TREATED AS AN EXPENSE	2,260
TOTAL 'QUASI' TAX EXPENDITURES	**2,260**
TOTAL TAX LEAKAGES LISTED HERE	**48,406**

(a) SOME CALCULATED EXPENDITURES MAY BE NEGATIVE IN A GIVEN YEAR E.G. ACCELERATED DEPRECIATION PROVISIONS (NOT SHOWN HERE), WHICH ALTER ONLY THE TIMING (RATHER THAN THE AMOUNT) OF TAX COLLECTIONS. MUCH OF THE CALCULATED TAX EXPENDITURE FOR FUNDED SUPERANNUATION IS OF THIS CHARACTER.
(b) ESTIMATES OF VALUE ARE APPROXIMATE.
(c) THE AUSTRALIAN TAXATION OFFICE HAS ALSO STATED THAT IT BELIEVES THAT THE $12.4 BILLION OF RENTAL PROPERTY EXPENSE DEDUCTIONS CLAIMED IN 2001–02 MAY BE SIGNIFICANTLY INFLATED; AUDITS ARE PLANNED IN THIS AREA (ATO MEDIA RELEASE NAT 03/55).

SOURCES: COMMONWEALTH DEPARTMENT OF TREASURY 2004, *TAX EXPENDITURES STATEMENT 2003*, CANBERRA, WWW.TREASURY.GOV.AU; SENATE COMMUNITY AFFAIRS COMMITTEE; AUSTRALIAN TAXATION OFFICE; SENATE SELECT COMMITTEE ON MEDICARE; VICTORIAN DEPARTMENT OF TREASURY AND FINANCE.

FIGURE 3.3 • ESTIMATED SHARE OF GOVERNMENT BENEFITS RECEIVED BY HOUSEHOLDS ACROSS THE INCOME DISTRIBUTION, 1994–95 AND 2001–02



SOURCE: A. HARDING, R. LLOYD AND N. WARREN 2004, *THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, NATIONAL CENTRE FOR SOCIAL AND ECONOMIC MODELLING, UNIVERSITY OF CANBERRA, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

45
COMMONWEALTH DEPARTMENT OF TREASURY 2004, *TAX EXPENDITURES STATEMENT 2003*, CANBERRA, WWW.TREASURY.GOV.AU

46
VICTORIAN DEPARTMENT OF TREASURY AND FINANCE ESTIMATE.

47
SEE CHAPTER 10 FOR SOURCES OF ESTIMATES.

Distribution of government benefits

Research by NATSEM[48] shows that in 2001–02, the average Australian household paid $322 a week in direct and indirect taxes (within the scope of the study) and received $360 a week in government benefits – $135 a week in cash benefits and $230 a week in selected benefits in kind. Between 1994–95 and 2001–02, the value of cash benefits to households (in real terms) grew by almost 9 per cent; the value of benefits in kind grew four times faster, making them increasingly important influences on families' final income.

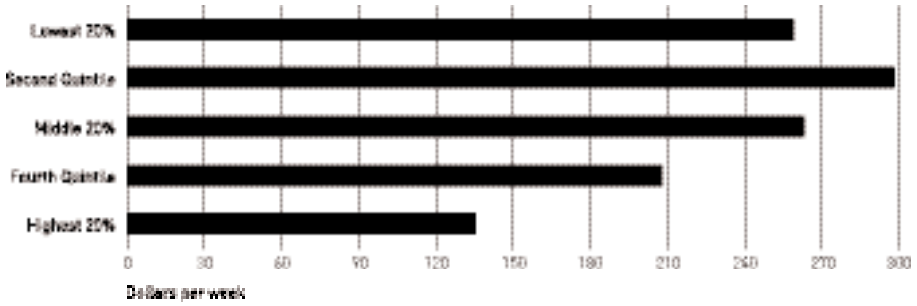
The distribution of government benefits across households has changed in recent years, with the share of benefits received by the lowest-income households falling markedly, from 37.2 per cent in 1994–95 to 34.0 per cent in 2001–02. Households across the rest of the income distribution increased their share of benefits over the same period, with those in middle-income groups benefiting most (see Figure 3.3).

The distribution of both cash benefits and benefits in kind contributed to these changes, but the changing distribution of benefits in kind was a particularly important influence.

- The average value of cash benefits *fell* for households in the top 40 per cent of the income distribution between 1994–95 and 2001–02; as a result, the share of benefits going to this group also fell, from 10.7 per cent to 8.8 per cent. The average value of cash benefits rose for households in other parts of the income distribution, most strongly for middle-income households. The value of benefits going to households in the lowest 20 per cent of the income distribution rose modestly, but their share of total cash benefits fell, from 46.8 per cent to 45.1 per cent.
  - Analysis by NATSEM suggests that some of these changes may have occurred because families with children and older people have moved out of the bottom 20 per cent of households, to be replaced by single people and couples of working age.
- The average value of selected government benefits in kind (health, education, housing and welfare) rose for all household-income groups between 1994–95 and 2001–02. The *distribution* of benefits changed, though, away from those at the bottom end of the income distribution: those receiving the lowest 20 per cent of income saw their share of benefits in kind fall from 30.1 to 27.5 per cent. The share of benefits received by households in the top 60 per cent of the income distribution rose, with middle-income earners benefiting most. As a result, while the distribution of benefits in kind was progressive across most of the income distribution in 2001–02, households in the lowest 20 per cent of the income distribution received less on average than those in middle-income groups (see Figure 3.4).

Government *health services* are particularly important for the poorest families, who are more likely to experience poor health, as discussed in Section 3.1. These services are also critical 'insurance' for families in lower and middle-income groups who do not have significant savings. Health services make up around 45 per cent on average of benefits in kind, and higher proportions for some groups (as much as 71 per cent for those in older households). Health benefits grew by 40 per cent in real terms for the average household between 1994–95 and 2001–02.

FIGURE 3.4 • ESTIMATED AVERAGE WEEKLY GOVERNMENT BENEFITS IN KIND RECEIVED BY HOUSEHOLDS ACROSS THE INCOME DISTRIBUTION, 2001–02



SOURCE: A. HARDING, R. LLOYD AND N. WARREN 2004, *THE DISTRIBUTIONAL IMPACT OF SELECTED GOVERNMENT BENEFITS AND TAXES, 1994–95 AND 2001–02*, NATIONAL CENTRE FOR SOCIAL AND ECONOMIC MODELLING, UNIVERSITY OF CANBERRA, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

The share of health benefits received by different groups of households has shifted markedly, and is an important driver of the overall shift in indirect benefits. The value of health benefits for all income groups rose between 1994–95 and 2001–02, but the share of health benefits received by the poorest 20 per cent of households fell substantially, from 31.7 per cent to 27.7 per cent. All other groups maintained or increased their share. Important influences for the poorest group were:

- a sharp fall in their share of hospital care (from 37.5 per cent to 30.7 per cent), which makes up around half of all health care benefits for this group; and
- lower than average benefits from a small item, the private health insurance rebate ($3 per household per week, compared with over $8 per household per week at the top of the income scale).

Part of this change may be related to fewer children and older people being in the lowest income group in 2001–02.

Education is a key influence on the future standard of living of families. It will become more important as technological change and globalisation increase the premium on skills and knowledge. School education is critical, providing the basis for all later learning, but vocational education and training, tertiary education and, increasingly, lifelong learning are all essential components of a vibrant education sector.

Education services make up a significant part of benefits in kind provided by governments to Australian households: 36 per cent for the average household, and 56 per cent for households with dependent children.

The NATSEM study shows that the value of education services rose between 1994–95 and 2001–02 for households in all income groups. There was no clear trend in the distribution of these benefits, with the poorest households increasing their share of education benefits, the highest income group reducing its share, and mixed changes for middle-income groups. Looking at school education alone (that is, excluding tertiary education), however, the share of benefits going to the bottom 40 per cent of the income distribution fell from 49.1 per cent to 46.2 per cent, while the shares of all other groups rose. This suggests that changes in the composition of income groups form part of the explanation, together with broader trends in education, including the shift of students to the non-government sector and trends in government funding for government schools, non-government schools and tertiary education.

48
HARDING ET AL. 2004, OP. CIT.

Structural issues – complexity and incentives in social security

This section looks briefly at the nature of the social security system and the incentives it creates. Structural issues in the provision of health and education services are not considered here, but are examined in detail in chapters 4 and 5.

Under Australia's social security system, payments are highly targeted to those most in need. Eligibility for benefits is dependent on a range of indicators of need, such as the level of income and assets, the presence of dependants, and level of disability.

The system is complex. Most importantly, in Australia there is a distinction between pensions and allowances: pensions were originally for people who needed long-term income support for retirement or because of a profound disability. Allowances were for people who were temporarily unable to work because they were unemployed or sick. But increasing diversity within payment categories often means that the differences between people on pensions and allowances are no longer clear.[49] Nevertheless, significant differences remain in the payment rates, income and assets tests, and active participation requirements (e.g., in looking for work or training), which can have unintended effects and encourage benefit 'shopping'.

For instance:

- better conditions for pensions create incentives for people to go on pensions rather than allowances, and reduce their focus on seeking paid work;
- sole parents who reconcile with their previous partner or find a new partner can, in some circumstances, have a cut in household income, despite the extra adult in the household. This means that sole parents may be discouraged from reconciling or re-partnering, or not tell Centrelink when they do so;
- some people with a mild or moderate disability may downplay their abilities to qualify for the Disability Support Pension rather than an allowance; and
- as discussed in the previous section, the interplay of the tax and benefits systems can have important incentive effects. Some people will receive only a small increase in their income from quite a large increase in employment earnings, creating strong disincentives for benefit recipients to take up part-time work.

Furthermore, over the decades, more types of pensions and allowances have been added to Australia's social security system and eligibility rules have changed. This has created an unnecessarily complex system that people can find hard to navigate and comply with.

The Commonwealth Government has acknowledged the need for a simpler, more consistent welfare system and is pursuing change through its welfare reform agenda. In the discussion paper for consultation on reform to the structure of social security payments, the Government has put forward a number of design principles, including 'simplicity and fairness':

People with similar circumstances get similar levels of financial assistance and any differences are based on actual differences in need or different levels of participation. People with similar capacity for paid work face similar requirements. Administration is transparent, easy to navigate and cost-effective.

DEPARTMENT OF FAMILY AND COMMUNITY SERVICES 2002, *BUILDING A SIMPLER SYSTEM TO HELP JOBLESS FAMILIES AND INDIVIDUALS*, COMMONWEALTH OF AUSTRALIA, CANBERRA, P. 9.

3.5 Conclusions

Governments in Australia have a substantial impact on the distribution of resources across the community, and on the standard of living of poorer families in particular. Redistribution occurs not only through the tax system and the social security system, but also through benefits in kind received as a result of the consumption of subsidised government services.

The importance of benefits in kind to households' 'final' income has grown rapidly in recent years. Education and health are the most important services – making up around 80 per cent of the value of government services for the 'average' family. Education and health outcomes are also important for their linkages with financial wellbeing. Both educational attainment and health status are closely correlated with income.

While government services, taxes and benefits significantly reduce income disparities in Australia, considerable inequality remains. The final income of the best-off 20 per cent of households is still more than three times the final income of the poorest 20 per cent.

And, in recent years, governments have done less to reduce that inequality. In 2001–02, the poorest households received a substantially smaller share of government benefits (cash and benefits in kind) than they did in 1994–95. Middle and high income households now receive a larger share of government benefits, and the highest 20 per cent pay less tax. These changes have counteracted some of the advantages of strong economic growth for the poorest families.

The continued prosperity of Australia depends on the ability of employers to draw on a growing pool of adaptable, skilled workers, and on the stability of communities being maintained by a strong level of social cohesion. Both of these would be threatened by the emergence of a group of households with persistently poor labour market, health and education outcomes. The poorest families having access to good quality health and education services is critical to enhancing the future opportunities and standards of living of all households, especially those currently in poverty.

Australia's tax and social security systems are complex. They contain a number of features that can provide incentives for people *not* to earn additional income and to arrange their affairs so that they can access particular government benefits. High marginal rates for personal tax can be a disincentive to work additional hours, to look for work, or to undertake further education. For some people, especially parents with dependent children and people re-entering the labour force, this effect is magnified by the combination of marginal tax rates and the tapered withdrawal of benefits.

Despite high marginal tax rates, the tax 'take' is not high in Australia by international standards, because of extensive tax breaks and leakages from the tax system. These leakages represent an increasing portion of total government expenditure (including revenue forgone) and are a growing source of complexity in the taxation system.

The health and education systems in Australia are examined in detail in chapters 4 and 5. We revisit issues related to the tax system in chapter 10.

49
DEPARTMENT OF FAMILY AND COMMUNITY SERVICES 2002, *BUILDING A SIMPLER SYSTEM TO HELP JOBLESS FAMILIES AND INDIVIDUALS*, COMMONWEALTH OF AUSTRALIA, CANBERRA, PP. 3 AND 6.


OWEN

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter Four
Australia's health care system: need for reform

Because of the complexity of the health system, it is difficult for people to identify the services they require and arrange to receive those services. Affordable access to general practitioners is becoming more of a problem for many people.

Australia's health care system: need for reform

This chapter assesses the need for reform of Australia's health care system. It looks at the equity and efficacy of Commonwealth and State funding arrangements. It also considers the health status of Australians, their access to essential medical services, and the appropriateness of care they receive.

Key Points

Sustainability and cost-effectiveness of health care funding

- There are ever-rising cost pressures in health due to technological advances, consumer expectations and, increasingly, ageing.
- A high proportion of health system resources are used to provide services to people with diseases and health conditions that are known to be preventable.
- There are equity and cost-effectiveness concerns about the 30 per cent private health insurance rebate.
- The complex split in responsibilities for the funding and provision of health care between the Commonwealth and State Governments leads to problems, including poor coordination of planning and service delivery, barriers to efficient substitution of alternative types and sources of care, and scope for cost shifting between governments.
- Funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting.

Health status of Australians

- Generally Australians enjoy good health, but there is much scope for improvement, particularly in the health status of Indigenous people and of people from disadvantaged backgrounds.
- About 70 per cent of the total burden of disease in Australia and 78 per cent of all deaths have been attributed to six disease groups: cardiovascular problems, cancers, injuries, mental problems, diabetes mellitus, and asthma.
- For each of the six groups, a certain amount of disease can be prevented, or its impact reduced, through improved health promotion and prevention strategies.

Access and equity

- Good access to primary care is becoming increasingly important for the health and wellbeing of people, with the emphasis on the prevention of ill health, health promotion, and disease management.
- Affordable access to primary care is becoming more of a problem, especially for people in outer metropolitan, regional and remote areas.
- Public hospital accident and emergency departments are overloaded; a significant component of this load could be more appropriately treated in primary care facilities. Part of the overload is also a result of the lack of available acute care beds.
- There are delays in access to elective surgery in the public system, while people with private health insurance have increased their access to elective surgery, raising equity concerns.
- There is a shortage of institutional aged care places and community-based aged care, leading to long-stay occupation of acute beds.

Appropriateness of care

- There is evidence of large variations in practice patterns (incidence of procedures and treatments), indicating a high incidence of questionably appropriate care.
- There is an over-reliance on acute care when alternative care options would not only be more appropriate but also more cost-effective.
- To effectively meet the needs of older and chronically ill people, there needs to be a better focus on integration and continuity of care across the care spectrum.

All Australians want to be healthy and to keep healthy. They also want good access to health care if they need it, and to the right kind of care to help them get better, or best live with a continuing illness.

This chapter looks at how well the Australian health system is meeting the needs of families. We consider the health status of Australians, their access to essential medical services, and the appropriateness of care they receive. We also look at the funding arrangements for health care and the problems that arise for families through the way in which health care is funded. Ways to reform the health care system to tackle these issues are put forward in chapter 8.

Before considering ways to reform health care, we need to be certain that reform is needed. The answer depends on our view as to the seriousness of the current and future problems and the possibility of effectively addressing them. This chapter discusses the main problems facing our health care system, beginning with the pressure on health care funding.

4.1 Increasing expenditure on health care

In 2001–02, Australia spent $66.6 billion on health care. The amount of money spent on health care has been steadily increasing, with a real average annual growth rate of 5.4 per cent between 1997–98 and 2001–02. Health expenditure is accounting for more and more of the total value of the nation's goods and services. As a proportion of GDP, expenditure on health care has increased from 8.1 per cent in 1991–92, to 8.6 per cent in 1997–98, and to 9.3 per cent in 2001–02.[50] In comparison, the OECD average was 8.4 per cent of GDP in 2001.[51]

Another way to view the growth in spending on health is in terms of expenditure per person. By removing the influence of changes in the size of the population, this better highlights the significance of the growth. In 2001–02, on average $3292 was spent on health care per person in Australia. This can be compared with a figure of $2357 per person in 1991–92, a real increase of 40 per cent in ten years.[52]

Over the 1990s, real growth in recurrent health expenditure was concentrated in three areas:

- hospitals, which accounted for 25.7 per cent of the growth (public hospitals 20 per cent and private hospitals 5.7 per cent);
- pharmaceuticals, which accounted for 24.3 per cent of the growth; and
- medical services, which accounted for 15.8 per cent of the growth.

In contrast, expenditure on residential aged care only accounted for 4.3 per cent of the growth.

Over the most recent year for which data are available (2001–02), there was continued strong real growth in expenditure on pharmaceuticals (9.7 per cent), private hospitals (9.7 per cent), and public hospitals (5.3 per cent).[53]

Generally, there are a number of reasons for the steadily increasing expenditure on health care, the main ones being:

- rising consumer expectations;
- technological advances offering improved outcomes at higher cost, which help drive those expectations;
- cost factors such as labour costs, medical equipment and supplies, and liability and insurance issues; and
- increasingly in future years, ageing in combination with all of the above.

The most important single reason for the increase in health care expenditure in Australia over the past few decades, and projected into the future, is increased demand for and supply of health services driven by technological change and the rising consumer expectations it has stimulated. After accounting for population growth and ageing, increased demand for or supply of services driven by technological change comprises almost two-thirds of projected expenditure growth in Australia.[54]

As has been observed:

The forces that have driven up health costs over the long haul are, if anything, intensifying. The staggering fecundity of biomedical research is increasing, not diminishing. Rapid scientific advance always raises expenditure, even as it lowers prices.[55]

Medical technology is not only increasingly a driver of health care costs, but also of health care improvement. Over the 20th century, only about five of the 30 years of increased life expectancy could be attributed to better medical care. But the contribution of medical care to life expectancy rose in the latter part of the century and is likely to continue to do so as technology is better able to address health care needs.[56]

There is also evidence that the effectiveness of medical intervention is improving.[57] The premise that more medical care could have substantial benefits has been referred to as an 'evolving belief'. This represents a major change from the past, when the evidence suggested that, among people with access to good health care, there was only a marginal gain from additional health service usage and non-medical factors were far more important determinants of health status.

This shift in belief suggests that the developed world might be entering a period of renewed health care cost pressures, sustained largely by a leap in the ability of medical care to provide better and longer life for many people:

...the overriding pressures on future costs will be due to the demand-side of the health care market. Undoubtedly, supply factors also play a role... But the major drivers of increased future costs are very likely to be the ability of medical care to improve health, coupled with rising consumer expectations that these treatments should be available.[58]

Against this background, it is not surprising that spending on health care in Australia is projected to continue to rise significantly over the next 30 to 40 years. For example, it has been estimated that health expenditure as a proportion of GDP could rise to about 17 per cent by 2041.[59]

It is not possible to say whether current or projected expenditure on health care is just right, too little, or too much. The answer depends upon our preferences, the opportunity costs of the expenditure (what else we could buy with the money), and the cost-effectiveness of expenditure – i.e. whether we are getting value for the investment in health care.[60]

What we can say is that real increases in expenditure on health care, which are projected to continue and hence put pressure on the funding of other goods and services, place a particular responsibility on both levels of government, as the major funders of health care, to ensure that expenditure is equitable and cost-effective. It is also important that the way in which governments fund health care supports an equitable, cost-effective health care system. This chapter considers these issues.

50
AIHW 2003, *HEALTH EXPENDITURE AUSTRALIA 2001–02*, AIHW, CANBERRA, P. 9.

51
OECD 2003, *HEALTH AT A GLANCE: OECD INDICATORS 2003*, OECD, PARIS, P. 121; THE OECD AVERAGE IS BASED ON 28 COUNTRIES.

52
CONSTANT FIGURES. AIHW 2003, *HEALTH EXPENDITURE AUSTRALIA 2001–02*, AIHW, CANBERRA, P. 12.

53
AIHW 2003, *HEALTH EXPENDITURE AUSTRALIA 2001–02*, AIHW, CANBERRA.

54
J. RICHARDSON AND I. ROBERTSON 1999, 'AGEING AND THE COST OF HEALTH SERVICES', IN PRODUCTIVITY COMMISSION, *POLICY IMPLICATIONS OF THE AGEING OF AUSTRALIA'S POPULATION CONFERENCE*, PRODUCTIVITY COMMISSION, MELBOURNE; HEALTH AND MEDICAL RESEARCH STRATEGIC REVIEW 1999, *THE VIRTUOUS CYCLE: WORKING TOGETHER FOR HEALTH AND MEDICAL RESEARCH*, COMMONWEALTH OF AUSTRALIA, PP. 83–84.

55
H. AARON, *HEALTH AFFAIRS ON LINE*, JANUARY 2002, AT WWW.HEALTHAFFAIRS.ORG.

56
M.J. McGINNIS, P. WILLIAMS-RUSSO AND J. KNICKMAN 2002, 'THE CASE FOR MORE ACTIVE ATTENTION TO HEALTH PROMOTION', *HEALTH AFFAIRS*, 21(2), P. 93. THE FIGURES ARE FOR THE UNITED STATES.

57
D. M. CUTLER AND M. MCCLELLAN 2001, 'IS TECHNOLOGICAL CHANGE IN MEDICINE WORTH IT?', *HEALTH AFFAIRS*, 20(5); F. LICHTENBERG 2001, 'ARE THE BENEFITS OF NEWER DRUGS WORTH THEIR COST? EVIDENCE FROM THE 1996 MEPS', *HEALTH AFFAIRS*, 20(5); Z. OR 2001, *EXPLORING THE EFFECTS OF HEALTH CARE ON MORTALITY ACROSS OECD COUNTRIES*, LABOUR MARKET AND SOCIAL POLICY OCCASIONAL PAPERS NO. 46, OECD, PARIS.

58
T. RICE 2002, 'ADDRESSING COST PRESSURES IN HEALTH CARE SYSTEMS', IN PRODUCTIVITY COMMISSION AND MELBOURNE INSTITUTE OF APPLIED ECONOMIC AND SOCIAL RESEARCH, *HEALTH POLICY ROUNDTABLE*, CONFERENCE PROCEEDINGS, AUSINFO, CANBERRA, PP. 68–69.

59
H. OWENS 2002, 'OPENING REMARKS', IN PRODUCTIVITY COMMISSION AND MELBOURNE INSTITUTE OF APPLIED ECONOMIC AND SOCIAL RESEARCH, *HEALTH POLICY ROUNDTABLE*, CONFERENCE PROCEEDINGS, AUSINFO, CANBERRA, P. 6.

60
T. RICE 2002, 'ADDRESSING COST PRESSURES IN HEALTH CARE SYSTEMS', IN PRODUCTIVITY COMMISSION AND MELBOURNE INSTITUTE OF APPLIED ECONOMIC AND SOCIAL RESEARCH, *HEALTH POLICY ROUNDTABLE*, CONFERENCE PROCEEDINGS, AUSINFO, CANBERRA.

4.2 Efficacy of funding arrangements

The flow of money around the Australian health care system is complex and is determined by the institutional frameworks in place, both government and non-government. In summary, the following are the main features of Australia's health care system:

- Universal cover for privately provided medical services under Medicare is largely funded by the Commonwealth Government, with co-payments by users where the services are patient-billed.
- Eligibility for public hospital services, free at the point of service, funded approximately equally by the States and the Commonwealth Government.
- Growing private hospital activity, largely funded by private health insurance, is in turn subsidised by the Commonwealth Government through the 30 per cent rebate on members' contributions to private health insurance.
- The Commonwealth Government, through its Pharmaceutical Benefits Scheme, subsidises a wide range of drugs and medicinal preparations outside public hospitals.
- The Commonwealth Government provides most of the funding for high-level residential aged care and for health research. It also directly funds a wide range of services for eligible veterans.
- State Governments are primarily responsible for mental health programs, the transport of patients, community health services, and public health services such as health promotion and disease prevention.
- Individuals primarily spend money on pharmaceuticals, dental services, medical services and other professional services.[61]

Most health care expenditure (68.4 per cent) is funded by governments: 46.1 per cent by the Commonwealth Government and 22.3 per cent by State and local governments. For both levels of government, health funding comprises a significant component of their budgets, and their respective areas of responsibility are under financial pressure. Most recently, this has particularly been the case for Commonwealth expenditure on pharmaceuticals, and State expenditure on public hospitals. As the OECD has pointed out, the major risk to government finances in the long term comes from rising health-care expenditures.[62] This point applies to both the Commonwealth and State Governments.

Cost-shifting

One result of a fragmented funding system under budgetary pressure is cost shifting between governments. Cost-shifting occurs when one level of government seeks to shift the costs of health care to the programs funded by the other level of government.

The current distribution of responsibilities by governments for funding services has the potential to distort services away from the setting that best meets patient needs. With the Commonwealth responsible for subsidising private medical services and States funding public hospital services, there is an incentive for each level of government to design their program arrangements so that services will be delivered in a setting where the other level of government will meet the cost, even though this may result in the patient not being treated optimally. For example:

- public hospitals may refer patients being discharged to their GP instead of providing post-hospital services directly, which leads to a proportion of costs being borne by the Commonwealth;
- on the other hand, if patients encounter difficulty in accessing GP services, they may attend public hospital emergency departments to receive primary care services, leading to additional costs being borne by the State; and

› shortages in the availability of Commonwealth-subsidised residential aged care places are resulting in public hospital beds being occupied on a long term basis by patients requiring residential aged care.

These examples demonstrate a fundamental point about the overlap in responsibility for health care funding between the Commonwealth and State Governments: the manner in which one government funds (or fails to fund) health services can have significant flow-on implications for the health services, and hence health expenditure, of another government.

There are many problems with cost shifting. Most importantly, cost shifting can result in less than optimal health care for patients. Furthermore, cost shifting is an inefficient practice to the extent that valuable resources are expended by both governments seeking to find ways to shift costs to the other level of government.

In an efficient, patient-focused system it should not matter which level of government pays for which services. In the present Australian health system, the question of who pays can be of central concern for some patients. For example, a patient with a foot condition can attend a GP and have the cost paid for by the Commonwealth or attend an accident and emergency department and have the cost met by the State. Depending on the condition, however, a podiatrist may be a more appropriate practitioner to assist the patient, but there is no government funding for this service.

Cost shifting thus potentially distorts services away from the setting that best meets patient needs most cost-effectively. Rather than who bears the cost, the central issue should be which setting will provide the most effective care for the patient.

Continuity of care

Current funding and delivery arrangements also create barriers to continuity of care. Because of the complexity of the health system, it is difficult for people to identify the services they require, arrange to receive those services, and navigate their way through the health system without expert help. For example, health promotion, early intervention, and chronic disease management activities are undertaken through a variety of programs. Care is fragmented and people need to navigate a range of programs with different objectives, eligibility criteria, availability and funding arrangements in order to access services. Treatment tends to be episodic and information systems do not facilitate communication between providers. Patients are also likely to encounter difficulties due to differing rationing arrangements across services, with some services available free of charge, while others require a patient co-payment. Patients may also have to wait to receive some services that ideally should be immediately accessible. These points are illustrated in Box 4.1: patients' experiences of cancer treatment.

BOX 4.1 • CANCER CARE SCENARIOS

A cancer patient's access to cancer treatment services does not always depend on best practice. Rather, it can depend on the funding arrangements for the provision of radiation oncology and other issues such as where the patient lives and the facility's budget constraints. Funding arrangements for radiotherapy are different for the public and private sectors, and these arrangements, rather than patient outcomes, are driving care decisions.

Recent actual cases highlight these anomalies:

- **In the town where a cancer patient lived, radiation oncology services were only offered by a private radiation oncology practice that leased premises at a private hospital. The patient had private health insurance, but this did not cover non-admitted radiotherapy treatment. The patient was forced to travel several hundred kilometres to a public facility because they could not afford the out-of-pocket expenses at the private facility.**
- **Patients are being admitted to public hospitals for services that should be provided on a non-admitted basis (e.g. radiotherapy) so that the treatment is paid for.**

SOURCE: *A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS*, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU.

61
AIHW 2003, *HEALTH EXPENDITURE AUSTRALIA 2001–02*, AIHW, CANBERRA, PP. 1–3.

62
OECD 1999, *ECONOMIC SURVEYS – AUSTRALIA*, OECD, PARIS, P. 144.

Further, while there have been significant changes in clinical practice and health care delivery since Medicare was introduced in 1984, funding arrangements remain largely unchanged and reflect historical practice rather than contemporary models of care and clinical practice.[63] When Medicare was introduced, patients admitted to hospitals usually had multi-day stays and there was a strong focus on care provided in institutional settings. Now, many types of care, including dialysis and chemotherapy, are routinely provided on a same-day basis and often in community-based settings or in the patient's home. Models of care are now quite different. Illustrations of these changes are given in Box 4.2.

BOX 4.2 • CHANGES IN CLINICAL PRACTICE AND THE DELIVERY OF HEALTH SERVICES

Average length of stay in public hospitals has dropped from 6.9 days in 1985–86 to 3.8 days in 2001–02.

In 1984, day surgery centres were virtually non-existent. In 2001–02 there were 246 operating nationally.

In 1987–88, only 20 per cent of people were discharged from hospital on the same day they were admitted. In 2001–02, this rate had more than doubled, to 52.3 per cent.

Now over 80 per cent of lens procedures are done on a day-only basis, and over 99 per cent of all renal dialysis and chemotherapy is done on a day-only or outpatient/ambulatory basis.

Endoscopy was performed largely on an admitted-patient basis in 1984. Today, essentially all endoscopy is performed on an ambulatory basis either at a hospital or in doctors' rooms.

Day-of-surgery admission for overnight-stay surgery was not as common in 1984. The benchmark today is 90 per cent of patients admitted for elective surgery on the day of surgery.

The above factors have contributed to the decrease of 28 per cent since 1984 in the numbers of public hospital beds per 1000, to 2.7 beds per 1000.

Medical specialists were appointed to public hospitals on an honorary basis as Honorary Medical Officers. Now, medical specialists are paid, contracted Visiting Medical Officers.

'Hospital in the home' didn't exist in 1984. Now, hospital care in the home is a viable alternative to in-hospital stay, and health funds are able to offer coverage for it.

SOURCE: *A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS,* SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, PP. 32–3; UPDATED WHERE POSSIBLE FROM AIHW 2003, *AUSTRALIAN HOSPITAL STATISTICS 2001–02*, AIHW, CANBERRA, TABLES 2.1 AND 2.3.

There are significant differences in *how* health care services are funded, which have implications for cost pressures. For example, while funding for public hospitals is capped, funding under the MBS and PBS and for the 30 per cent rebate for private health insurance is uncapped. Further, except in the public hospital system (and to a lesser extent in private hospitals under contract arrangements with health funds), there is an absence of countervailing budget-holder entities.

Under uncapped fee-for-service arrangements, providers have little incentive to control utilisation of health resources, so there is the possibility of supplier-induced demand and decreasing effectiveness and appropriateness of treatments. For instance, a recent review has suggested that there is an increased possibility of 'over utilisation' of private hospital care due to the impact of private health insurance policies in Australia, which have increased Medicare's funding of hospital treatment and decreased health funds' ability to contain utilisation.[64]

4.3 Health status of Australians

A question which follows from the consideration of Australia's increasing expenditure on health care is whether the health system is delivering value for the money invested. Compared with other countries, it can be said:

that Australians enjoy good health, that Australia is one of the healthiest countries in the world, and that the health of its people, by and large, continues to improve.[65]

Nevertheless, there is still scope for considerable improvement. For example, there is increasing awareness of the numerous biological, behavioural, social and economic factors that increase the risk of ill health and that can be prevented or modified. Furthermore, experience of other countries suggests that much lower levels of some diseases are possible in Australia, e.g. in the area of death rates from heart attack. Finally, the poor health of certain groups in Australia indicates that much more needs to be done, most notably to improve the health status of Aboriginal and Torres Strait Islander peoples and of people from disadvantaged socioeconomic backgrounds.

About 70 per cent of the total burden of disease in Australia and almost 78 per cent of all deaths have been attributed to six disease groups (see Box 4.3). These six disease groups account for an estimated 40 per cent of total health expenditure. Australian Health Ministers have identified these groups for special action under the National Health Priority Areas initiative.[66]

BOX 4.3 • NATIONAL HEALTH PRIORITY AREAS

Six disease groups have been identified by the Australian Health Ministers for priority action:

- **cardiovascular problems**
- **cancers**
- **injuries**
- **mental problems**
- **diabetes mellitus**
- **asthma.**

SOURCE: AIHW 2002, AUSTRALIA'S HEALTH 2002, AIHW, CANBERRA, P. 103.

63
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, P. 33.

64
P. DAWKINS ET AL. 2004, *RECENT PRIVATE HEALTH INSURANCE POLICIES IN AUSTRALIA: HEALTH RESOURCE UTILIZATION, EQUITY IMPLICATIONS AND POLICY OPTIONS*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, THE MELBOURNE INSTITUTE OF APPLIED ECONOMICS AND SOCIAL RESEARCH, THE UNIVERSITY OF MELBOURNE.

65
AIHW 1998, *INTERNATIONAL HEALTH: HOW AUSTRALIA COMPARES*, AIHW, CANBERRA, P. 2.

66
AIHW 2002, *AUSTRALIA'S HEALTH 2002*, AIHW, CANBERRA, PP. 103–104.

For each of the six health priority groups, a certain amount of disease can be prevented, or its impact at least reduced, through improved health promotion and prevention strategies.[67]

- Cardiovascular disease is the leading cause of death among Australians, accounting for 39 per cent of all deaths. Its health and economic burden exceeds that of any other disease. Much of the death, disability and illness caused by cardiovascular disease is preventable through better diet, not smoking, and exercise.
- It is estimated that 30 per cent of cancers can be attributed to smoking and 30 per cent to dietary influences. Although some of the risks are unavoidable, risks of particular cancers can be reduced through clinical monitoring of a person and their risk factors, and early treatment.
- Injury contributes significantly to mortality and morbidity and is the leading cause of death of young people. Suicide accounts for the largest proportion of deaths from injury, followed by road accidents. Unintentional falls, mainly by older people, rank third.
- Mental problems and disorders are the leading cause of disability in Australia, accounting for 30 per cent of the non-fatal disease burden. They lead to a large number of hospitalisations. Prevention and early-intervention programs allow us to recognise and manage risk factors, preventing mental problems from developing. Disease-management programs can also reduce the severity of mental problems.
- Diabetes is a long-term, chronic condition that contributes to significant illness, disability, poor quality of life and premature mortality. The incidence of type 2 diabetes increases with body fatness and lack of exercise.
- Asthma is prevalent in Australia, with one of the highest levels in the world. Asthma can be controlled by effective education, appropriate medication, identification of trigger factors and monitoring.

An increased emphasis on the prevention of ill health, health promotion and disease management is not only important for patient care, but also for financial sustainability. A high proportion of public hospital and other health system resources is used to provide services to people with diseases and health conditions that are known to be preventable.[68] For instance, there is evidence that about 90 per cent of type 2 diabetes, more than 50 per cent of cardiovascular disease and at least 50 per cent of cancers are preventable. Hence, there is an important link between prevention activities and the demands on hospitals and health services. To the extent that it is possible to reduce the incidence of preventable disease, it should be possible in the long term to reduce the burden on public hospitals and other health services, and accordingly on future expenditure needs.

The health status of Aboriginal and Torres Strait Islander peoples

The health status of Aboriginal and Torres Straight Islander peoples is significantly lower than the health status of other Australians. This poor level of health is characterised by a wide range of health problems including environmental health problems, high levels of health risk factors such as low birth weight and obesity, and lack of access to primary care (see Box 4.4).

BOX 4.4 • HEALTH INDICATORS FOR INDIGENOUS AUSTRALIANS

Life expectancy for Indigenous Australians is 20 years less than for non-Indigenous Australians.

Aboriginal boys born today have only a 45 per cent chance of living to age 65 (85 per cent for non-Aboriginal boys). Aboriginal girls have a 54 per cent chance of living to age 65 (89 per cent for non-Aboriginal girls).

Over the past forty years, adult mortality in the Aboriginal population has increased, with a large increase in the death rate from diabetes.

Indigenous Australians also have much higher levels of morbidity, with high rates of hospitalisation compared with all Australians in every age group.

Babies born to Indigenous mothers are twice as likely to be of low birth weight and twice as likely to die at birth compared with other babies.

Indigenous people suffer higher rates of infectious diseases, including tuberculosis. There are 15 times more deaths from infectious diseases than expected, based on the rates for all Australians.

Indigenous Australians have higher rates of deaths due to circulatory diseases, injury, respiratory diseases, cancer and diabetes than non-Indigenous people.

Indigenous Australians are more likely to die from mental disorders such as depression and psychosis, self-harm and substance misuse than the non-Indigenous population.

Indigenous people are more than twice as likely to smoke, are significantly more likely to be overweight or obese and, while Indigenous adults are less likely to consume alcohol, those who do consume alcohol are more likely to consume it at risky or high levels.

Many Aboriginal communities have inadequate housing and community infrastructure, with overcrowding, poor water supplies and inadequate sewage systems.

Indigenous people face geographic, language, cultural and financial barriers to accessing health services, particularly primary health care services.

SOURCE: ABS 2003, *THE HEALTH AND WELFARE OF AUSTRALIA'S ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES*, CATALOGUE. NO. 4704.0; AND *A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS*, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, P. 61.

The health status of socioeconomically disadvantaged people

The association between socioeconomic disadvantage and health has been summarised as 'wealthy people are healthy people; poor people have poor health'.[69]

The reason for the relationship between socioeconomic status and health status is not always clear. The mechanisms by which socioeconomic status influences health status are many and varied. However, those most often postulated are diet, health behaviour (including smoking and lack of exercise), education, access to health services (both preventive and treatment), occupational exposures, quality of housing, and psychosocial factors.[70]

Box 4.5 summarises some major findings on the health status of people from socioeconomically disadvantaged backgrounds.

BOX 4.5 • HEALTH STATUS OF SOCIOECONOMICALLY DISADVANTAGED PEOPLE

There are large socioeconomic differences for many causes of death, including ischaemic heart disease, chronic obstructive pulmonary disease, diabetes, asthma and road traffic accidents.

Years of life lost due to premature mortality in the most disadvantaged quintile is 41 per cent higher for males and 26 per cent higher for females than in the least disadvantaged quintile.

Males in the most disadvantaged quintile have 12 per cent higher mortality than all Australian males, and 30 per cent higher than the males in the least disadvantaged quintile.

Men in the bottom quintile of socioeconomic disadvantage have a 40 per cent higher chance of dying between ages 25 and 65 than men in the top quintile.

For females, those in the most disadvantaged quintile have a 16 per cent higher level of mortality than those in the least disadvantaged quintile.

More socioeconomically disadvantaged people make greater use of doctors and outpatient/casualty services, but are less likely to use preventive health services.

SOURCE: AIHW 2002, *AUSTRALIA'S HEALTH 2002*, AIHW, CANBERRA, PP. 212–13.

67
AIHW 2002, *AUSTRALIA'S HEALTH 2002*, AIHW, CANBERRA, CHAPTER 2.

68
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, P. 87.

69
P. SAINSBURY AND E. HARRIS 2001, 'HEALTH INEQUALITIES: SOMETHING OLD, SOMETHING NEW', *NSW PUBLIC HEALTH BULLETIN* 12–(5), P. 117.

70
AIHW 2002, *AUSTRALIA'S HEALTH 2002*, AIHW, CANBERRA, P. 212.

In the families introduced in chapter 1, Matt is currently in reasonable health, but he is at risk of developing health problems in the future. He smokes, is overweight and does little exercise. He feels well and sees no need to change his lifestyle. His GP bulk-bills, but he rarely sees his doctor, so emerging problems are unlikely to be picked up early.

4.4 Affordable access to health care

This section discusses issues of access in three main areas of the health care system: primary care, hospitals, and aged care.

Primary health care

Primary health care is the first point of contact people have with the health system. It provides a range of services that are essential to the health and wellbeing of families and individuals, including general practice services, community health care and population health programs.

Good access to primary care is becoming increasingly important for the health and wellbeing of people. Chronic diseases and conditions dominate the health care needs of the Australian population, accounting for an estimated 80 per cent of the total burden of disease, mental problems and injury in Australia.[71] Hence, there is a need for an increasing emphasis on the prevention of ill health, health promotion and disease management, with a consequential increase in the importance of primary care.

Access to general practitioners is particularly important as GPs both provide essential primary care services themselves and form the gateway to other medical services, such as diagnostic services, specialists and acute care. However, a number of indicators suggest that affordable access to general practitioners is becoming more of a problem for many people. The indicators show:[72]

- shortages of GPs, which are particularly apparent in outer metropolitan, regional and remote areas;
- significantly fewer GPs per capita in rural and remote areas compared with capital cities (see Table 4.1);
- declining out-of-hours and nursing home services;
- a decline in the rate of bulk-billing over the past few years, with rates significantly lower in rural and remote areas compared with capital cities:
  - in the mid–1990s, about 80 per cent of all GP attendances were bulk-billed, compared to 68 per cent in 2003; and
  - the rate for rural areas in 2003 was 55 per cent compared to 76 per cent in metropolitan areas.
- increasing out-of-pocket expenses for GP attendances. In the case of patient-billed services only, average patient contributions have risen from $6.90 to $12.91, an increase in real terms of about 44.7 per cent.[74]

Table 4.1 shows the number and distribution of medical practitioners by geographic location in comparison with the distribution of the population for 1999:

- there were higher percentages of medical practitioners in capital cities (76.8 per cent) and large rural centres (6.2 per cent) than the percentages of population residing in those areas (63.9 and 6.0 per cent respectively);
- for other areas, the percentage of medical practitioners was lower than the percentage of population; and
- the greatest imbalance was in 'other rural areas', where 13.2 per cent of Australia's population resided, but only 4.6 per cent of medical practitioners had their main practice.

TABLE 4.1 • MEDICAL PRACTITIONERS: NUMBER AND DISTRIBUTION BY GEOGRAPHIC LOCATION, 1999

Location	Number	Practitioner distribution %	Population distribution %	Practitioners per 100,000 population
CAPITAL CITY	39,165	76.8	63.9	322
OTHER METROPOLITAN	3,619	7.1	7.6	248
LARGE RURAL CENTRE	3,135	6.2	6.0	277
SMALL RURAL CENTRE	2,035	4.0	6.5	165
OTHER RURAL AREA	2,343	4.6	13.2	94
REMOTE AREAS	672	1.3	2.7	115
TOTAL	**50,969**	**100.0**	**100.0**	**268**

SOURCES: AIHW 2002, *AUSTRALIA'S HEALTH 2002,* AIHW, CANBERRA, P. 270; AIHW 2003, *MEDICAL LABOUR FORCE, 1999,* AIHW, CANBERRA, TABLE 6.

The family of Sally and Bruce, introduced in chapter 1, illustrates the problems with affordable access to primary-care services. Their local GP only bulk-bills concession card holders, and Sally and Bruce are above the income limit for a card. This means that every time one of them goes to a GP they have to pay a co-payment of $12. This can be particularly difficult at times – they have three young children who 'catch everything that's going around'.

Notwithstanding emerging issues, access to general practice is much more equitable than access to other primary care services. Access and utilisation for dental, allied health and counselling services vary significantly with location and income. Those with higher incomes who live in metropolitan areas are more likely to use private providers for these services. For those on lower incomes, publicly provided services are budget-capped and rationed. For example, while people with private health insurance (who tend to have higher incomes) have their dental treatment subsidised by the Commonwealth Government through the 30 per cent rebate, the waiting time for public dental services worsens. About 500,000 people are on waiting lists in Australia, and only about 11 per cent of those eligible for treatment receive it each year.[75] With the effective abolition of the community health program during the mid-1980s, there has been no national framework to address these issues for nearly two decades. As a result, service mix and eligibility criteria vary across jurisdictions.[76]

Access to community-based continuing-care services varies significantly among people with very similar needs, depending on the historical evolution of programs and eligibility criteria. For example, while the Home and Community Care Program has dramatically expanded community support for older people with disabilities, comprehensive national programs for other groups with continuing care needs have not been developed. As a result, people with mental illness, chronic disease, post-acute care needs or alcohol and drug problems, and younger people with physical and intellectual disabilities, have quite variable access to publicly funded primary health and community care services across jurisdictions.[77]

As noted earlier, Indigenous people face special access problems, with geographic, language, cultural and financial barriers to accessing health services, particularly primary health services. Socioeconomically disadvantaged people are also less likely to use preventive health services.

Hospitals

Hospitals are the largest form of provider of health services in Australia. Access arrangements are very different for public hospitals and private hospitals.

Public hospitals

In 2001–02, there were 746 public hospitals with 51,461 available beds, providing 3,968,000 patient admissions and 5,754,666 accident and emergency occasions of service across Australia.[78] Under the Australian Health Care Agreements (AHCAs) between the Commonwealth and State Governments, public hospital services must be provided free of charge to public patients on the basis of clinical need and within a clinically appropriate period, regardless of geographic location.

71
AIHW 2002, *CHRONIC DISEASES AND ASSOCIATED RISK FACTORS IN AUSTRALIA: 2001*, AIHW, CANBERRA, P. 4; NUFFIELD TRUST 2000, *POLICY FUTURES FOR UK HEALTH, 2000 REPORT*, NUFFIELD TRUST, PP. 17–20.

72
SENATE SELECT COMMITTEE ON MEDICARE 2003, *MEDICARE – HEALTHCARE OR WELFARE?*, WWW.APH.GOV.AU/SENATE_MEDICARE, CHAPTER 4.

73
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

74
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

75
QUOTED IN P. DAWKINS ET AL. 2004, *RECENT PRIVATE HEALTH INSURANCE POLICIES IN AUSTRALIA: HEALTH RESOURCE UTILIZATION, EQUITY IMPLICATIONS AND POLICY OPTIONS*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, THE MELBOURNE INSTITUTE OF APPLIED ECONOMICS AND SOCIAL RESEARCH, THE UNIVERSITY OF MELBOURNE, P. 22.

76
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, P. 23.

77
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

78
FIGURES ARE FOR PUBLIC ACUTE AND PUBLIC PSYCHIATRIC HOSPITALS. AIHW 2003, *AUSTRALIAN HOSPITAL STATISTICS 2001–02*, AIHW, CANBERRA, PP. 14, 16 AND 21.

Demand for public hospital services has steadily increased over the past few years. Between 1997–98 and 2001–02:

- separations in public hospitals increased by 5.2 per cent – or nearly 200,000 additional separations a year; and
- occasions of service at emergency departments increased by about 12 per cent – or more than 600,000 additional services a year.[79]

With the increase in occasions of service at emergency departments, concerns have been raised about the capacity of the health system to respond in a timely way. Table 4.2 presents data on the adequacy of access to emergency department services related to the urgency of treatment required (the triage category).[80] The data for Australia as a whole show that very nearly all patients (99 per cent) who are in triage category 1 (resuscitation) are seen immediately, but lower proportions of patients in other triage categories are seen within the time limits set for treatment. For instance, only 60 per cent of urgent cases were seen within the set time limit of 30 minutes in 2001–02. With the exception of category 1, across categories there was considerable variation among the jurisdictions in waiting times.

Difficulties with access to emergency departments are an example of the potential flow-on implications of one government's health policies for another government's health services. According to the AHCA Reference Group, lack of access to affordable primary care leads to an 'ED for GP' substitution effect; or, to put it another way, a State for Commonwealth substitution effect. Public hospitals report significant increases in the number of patients presenting at emergency departments in categories 4 and 5, the semi- and non-urgent cases for which treatment by a GP would often, though not always, suffice. One estimate is that one in five people who attend emergency departments would more appropriately be treated by a GP.[81] A recent analysis of 60 towns in NSW showed that in towns where GPs do not bulk-bill, people use public hospital emergency departments at a rate of around 60 per cent more than in those towns where GPs do bulk-bill.[82]

There are also concerns about the adequacy of access to elective surgery in public hospitals. Table 4.3 presents data on time waited for admission for elective surgery, showing the number of days at which 50 per cent (that is, the 50th percentile) and 90 per cent (the 90th percentile) of patients were admitted, based on the time between when a patient was first included on a waiting list and when the patient was admitted.[83] As the public sector is the major provider of emergency care (both medical and surgical), with the increase in demand for emergency care, public hospitals face difficulties allocating resources for elective surgery. In summary:

- in 2001–02, 50 per cent of patients on a waiting list for elective surgery waited 27 days for admission on average across Australia;
- 90 per cent of patients were admitted within 203 days; and
- the data suggest there has been an increase in long-waits, with, for example, 4.5 per cent of patients waiting more than a year for admission in 2001–02 compared with 3.1 per cent in 1999–2000.

Across the jurisdictions there exists considerable variation in waiting times for elective surgery. For example, 9.0 per cent of patients waited more than one year for admission in Tasmania compared with 3.6 per cent in Queensland.

There are also significant variations in waiting times for elective surgery, depending on the speciality of the surgeon and the procedure. For instance, waiting times for cardio-thoracic surgery and neurosurgery are generally much shorter than the average, while waiting times for ear, nose and throat surgery, ophthalmology surgery and orthopaedic surgery are generally much longer. In 2001–02, only 0.2 per cent of patients waited a year or more for cardio-thoracic surgery; in comparison, 11.9 per cent of patients waited a year or more for ophthalmology surgery.[84]

TABLE 4.2 • EMERGENCY DEPARTMENT WAITING TIME, PUBLIC HOSPITALS, AUSTRALIA, 2001–02

Triage category	Time limits	Patients seen within triage category (%)
1 / RESUSCITATION	IMMEDIATE	99
2 / EMERGENCY	WITHIN 10 MINUTES	76
3 / URGENT	WITHIN 30 MINUTES	60
4 / SEMI-URGENT	WITHIN 60 MINUTES	59
5 / NON-URGENT	WITHIN 120 MINUTES	84
TOTAL		**64**

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2004, *REPORT ON GOVERNMENT SERVICES 2004,* PRODUCTIVITY COMMISSION, CANBERRA, TABLE 9.14.

TABLE 4.3 • ELECTIVE SURGERY WAITING TIMES, PUBLIC HOSPITALS, AUSTRALIA

	1999–2000	2001–2002
DAYS WAITED AT 50th PERCENTILE	27	27
DAYS WAITED AT 90th PERCENTILE	175	203
% WAITED MORE THAN 365 DAYS	3.1	4.5

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, TABLE 9.15.

Ensuring timely access to elective surgery is not just a problem for public hospitals; as it can also impact more broadly on the health care system. The work of the AHCA Reference Group showed that not only may there be high physical and emotional costs to the waiting patient, but the financial costs *to the health system as a whole* of waiting for surgery may actually be higher than the costs of surgery. For example, a person waiting for a hip replacement may incur significant costs for medication to manage the condition, visits to the GP, and a number of community services to assist functioning.[85]

Private hospitals

Over the last twenty years, there has been growth in the capacity of the private sector, both in offering dedicated day-procedure facilities and in offering a more complex range of services. With the exception of some super-speciality services (such as transplantation), some large metropolitan private hospitals now offer comparable services to the major public teaching hospitals.

Intensive care, cardiac surgery, neurosurgery, renal dialysis and oncology are among the services that have become increasingly available in private hospitals. Between 1991–92 and 2001–02 the number of private hospitals with an oncology unit increased from eight to 69, and the number of hospitals with separate coronary intensive care units increased from three to 26. Renal dialysis units were available in 22 hospitals in 2001–02 compared with three hospitals in 1991–92, and neurosurgical units were available in nine hospitals in 2001–02 compared with only one hospital in 1991–92.[86]

While the number of private hospitals has increased over the past decade, it is important to note that private hospitals are not evenly distributed geographically; they are concentrated in metropolitan areas, particularly in higher-income areas. Further, while the capacity of some private hospitals has increased, nevertheless, overall the private hospital sector still concentrates on elective surgery (with little or no focus on medical patients and accident and emergency services) and the average complexity of cases treated in private hospitals is still less than in public hospitals.[87]

79
AIHW 2003, *AUSTRALIAN HOSPITAL STATISTICS 2001–02*, AIHW, CANBERRA, TABLES 2.3 AND 2.5; AND AIHW 1999, *AUSTRALIAN HOSPITAL STATISTICS 1997–98*, AIHW, CANBERRA, TABLE 4.5.

80
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2003, *REPORT ON GOVERNMENT SERVICES 2003*, PRODUCTIVITY COMMISSION, CANBERRA, PP. 9.42-9.44.

81
SENATE SELECT COMMITTEE ON MEDICARE 2003, *MEDICARE – HEALTHCARE OR WELFARE?*, WWW.APH.GOV.AU/SENATE_MEDICARE, P. 51.

82
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU.

83
THIS INDICATOR DOES NOT TAKE INTO ACCOUNT CLINICAL URGENCY DUE TO THE SYSTEMATIC DIFFERENCES ACROSS JURISDICTIONS IN THE JUDGEMENTS APPLIED BY CLINICIANS ABOUT THE URGENCY OF CASES, WHICH SIGNIFICANTLY AFFECTS THE COMPARABILITY OF THE DATA. STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2003, *REPORT ON GOVERNMENT SERVICES 2003*, PRODUCTIVITY COMMISSION, CANBERRA, PP. 9.43–9.46.

84
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2003, *REPORT ON GOVERNMENT SERVICES 2003*, PRODUCTIVITY COMMISSION, CANBERRA, TABLES 9.A18 AND 9A.19.

85
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, WWW.HEALTH.GOV.AU, PP. 46–47.

86
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, WWW.HEALTH.GOV.AU, P. 33, AND ABS 2003, *PRIVATE HOSPITALS 2001–02*, CATALOGUE NO. 4290.0, P. 25.

87
S. DUCKETT 2004, *STRATEGIC ENGAGEMENT BETWEEN THE PUBLIC SECTOR AND PRIVATE HOSPITALS*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, PP. 5, 12 AND 13.

In recent years, the Commonwealth Government has introduced a package of measures to encourage the take-up of private health insurance:

- the 30 per cent rebate on private health insurance premiums;
- an additional 1 per cent tax surcharge for high-income individuals who do not have private health insurance; and
- Lifetime Health Cover, which places a surcharge on premiums for people who wait to take out private health insurance until they are older (over 30 years of age).[88]

The measures (in particular, Lifetime Health Cover) resulted in an increase in the proportion of people with private health insurance coverage, from a low of 30.2 per cent of the population in 1998 to a peak of 45.7 per cent in 2000. (As of March 2004, 43.2 per cent of the Australian population was covered by private health insurance.) There has been a consequential significant increase in access to private hospitals:

- separations at private hospitals increased on average by 7.9 per cent a year between 1997–98 and 2001–02, compared with a 1.3 per cent increase in separations in public hospitals; and
- in 2001–02, private hospitals accounted for 38.0 per cent of patient separations compared with 32.4 per cent in 1997–98.[89]

Private hospitals are becoming the major alternative pathway for people who need elective surgery:

- more than 50 per cent of all elective separations are undertaken in private hospitals (54 per cent in 2001–02); and
- 60 per cent of all hospital admissions of veterans are in private hospitals.[90]

This raises an important issue of equity of access to elective surgery for people who do not have private health insurance, or who do not have access to a private hospital. As noted earlier, private hospitals are concentrated in metropolitan areas, particularly in higher-income areas, and while about 80 per cent of the richest 20 per cent of Australians have private health insurance, only about 25 per cent of the poorest 20 per cent of Australians do.[91] The link between private health fund membership and higher income also raises questions about the equity of the expenditure on the 30 per cent rebate. Research shows that high-income households are the main beneficiaries of the rebate.[92]

Other questions have been raised about the cost-efficiency of the rebate. There are a number of reasons for questioning whether the health care system is obtaining adequate value from the Commonwealth's expenditure on the rebate:

- first, it has been estimated that in most cases the rebate subsidises households that would have purchased private health insurance in any case;[93]
- second, the evidence suggests that 'the cheapest policy did the trick'; that is, that most of the increase in membership of private health insurance funds was because of the introduction of Lifetime Health Cover rather than the 30 per cent rebate;[94] and
- third, the available evidence suggests that the Commonwealth's private health insurance policies have been largely ineffective and inefficient as a means of taking pressure off the public hospital system, with only a small reduction in demand for public hospital services.[95] Part of the explanation for this is that some people with private health insurance avoid using their insurance coverage for hospital admissions because of the risk of high out-of-pocket expenses and excesses (59 per cent of people with private health insurance have front-end deductible products). According to a survey conducted in Victoria in 2001 and a similar survey in South Australia in 2000, about 60 per cent of people with private health insurance admitted to public hospitals choose to be admitted as public patients.[96]

Aged care

Good access to aged care is increasingly important for many families, due to the ageing of the population. The Commonwealth has set targets for aged care services per 1000 people in the population aged 70 years and over: 40 high care places, 50 low care places and 10 community aged care packages (CACPs). In 2003, these targets were met at the national level for high care places and CACPs, but not for low care places. (There were 42 places per 1000 older people, compared with the target of 50 places.) However, the target for high care places was not met in all states.[97]

There are two indicators available for timeliness of access to aged care services. The first is the elapsed time between assessment by an Aged Care Assessment Team (ACAT) and entry into a residential care service. The elapsed time between an ACAT assessment and entry into residential care partly reflects the extent to which aged care services meet the demand for services, but may also reflect applicants' willingness to wait for particular residential services or to defer entry.[98] In summary, in 2002–03:

- on average, 71.8 per cent of people entered residential care within three months of being assessed by an ACAT;
- almost half (44.6 per cent) entered within one month of their ACAT assessment;
- across jurisdictions, the proportion of people who entered care within three months of assessment ranged from 76.9 per cent in New South Wales down to 50.1 per cent in the ACT;
- nationally, a greater proportion of people entering *high care* residential services entered within three months of assessment (81.5 per cent) compared with the population entering *low care* residential services within that time (61.5 per cent); and
- across jurisdictions, the proportion of people entering *high care* residential services within three months of being assessed ranged from 86.0 per cent in New South Wales down to 63.8 per cent in the ACT. The proportion of people entering *low care* residential services within three months of being assessed ranged from 66.1 per cent in Western Australia down to 38.0 per cent in the Northern Territory.

88
COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING 2003, SUBMISSION TO THE SELECT COMMITTEE ON MEDICARE, *INQUIRY INTO THE ACCESS TO AND AFFORDABILITY OF GENERAL PRACTICE UNDER MEDICARE*, WWW.APH.GOV.AU/SENATE_MEDICARE, P. 6.

89
AIHW 2003, *AUSTRALIAN HOSPITAL STATISTICS 2001–02*, AIHW, CANBERRA, P. 16.

90
AIHW 2003, *AUSTRALIAN HOSPITAL STATISTICS 2001–02*, AIHW, CANBERRA, TABLE 6.1 AND TABLE 6.16.

91 A. WALKER, R. PERCIVAL, L. THURECHT AND J. PEARSE 2003, *PUBLIC POLICY AND PRIVATE HEALTH INSURANCE: DISTRIBUTIONAL IMPACT ON PUBLIC AND PRIVATE HOSPITAL USAGE IN NEW SOUTH WALES*, PAPER PRESENTED AT THE INTERNATIONAL MICROSIMULATION CONFERENCE ON POPULATION AGEING AND HEALTH, CANBERRA; AVAILABLE AT WWW.NATSEM.CANBERRA.EDU.AU

92
P. DAWKINS ET AL. 2004, *RECENT PRIVATE HEALTH INSURANCE POLICIES IN AUSTRALIA: HEALTH RESOURCE UTILIZATION, EQUITY IMPLICATIONS AND POLICY OPTIONS*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, THE MELBOURNE INSTITUTE OF APPLIED ECONOMICS AND SOCIAL RESEARCH, THE UNIVERSITY OF MELBOURNE.

93
P. DAWKINS ET AL. 2004, OP. CIT.

94
J. BUTLER 2002, 'POLICY CHANGE AND PRIVATE HEALTH INSURANCE: DID THE CHEAPEST POLICY DO THE TRICK?', *AUSTRALIAN HEALTH REVIEW*, 25(6), PP. 33–41.

95
L. SEGAL 2004, 'WHY IT IS TIME TO REVIEW THE ROLE OF PRIVATE HEALTH INSURANCE IN AUSTRALIA', *AUSTRALIAN HEALTH REVIEW*, 27(1), PP. 3–15, AND P. DAWKINS ET AL. 2004, OP. CIT.

96
VICTORIAN DEPARTMENT OF HUMAN SERVICES, UNPUBLISHED PAPER.

97
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, TABLE 12A.10.

98
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, P. 12.25.

The second indicator of access is the elapsed time between an ACAT assessment and the receipt of a community care service. This partly reflects the extent to which aged care services meet the demand for community care services. This indicator is reported using CACP data.[99] In summary:

- on average, 67.2 per cent of all people receiving a CACP during 2002–03 had received it within three months of being assessed by an ACAT;
- 37.7 per cent of people had started receiving a CACP within one month of their ACAT assessment; and
- across jurisdictions, the proportion of people who received a CACP within three months of assessment ranged from 76.8 per cent in Western Australia down to 42.9 per cent in the ACT.

These data clearly indicate problems with access to aged care across Australia, with some jurisdictions experiencing very significant problems. Relatively long waits for aged care services can impact on the effective and efficient running of the health system as a whole by increasing older people's need for other, and potentially less appropriate, services. For example, without timely access to aged care, older people remain in hospitals for extended periods.

The family of Don and Yvonne, introduced in chapter 1, may face problems with access to aged care in coming years. They are reluctant to leave the coastal region where they have an extensive network of friends, but there are no suitable aged care places nearby. Even if they were to move, the likelihood of being able to find an aged care facility that could place both of them is slim. They have a good relationship with their children, who would be keen to help if one of them fell ill, but all live in capital cities and have busy lives of their own, so they would not be in a position to provide care unless Don and Yvonne moved closer to them.

Interface between aged and acute care

The interface between the public hospital sector and the aged care sector is complex. A number of issues impact on the effective and efficient functioning of these sectors.

Particularly under the case-mix model of funding, acute care is more focused on efficient management of specific medical and surgical crises. Interventions are heavily dependent on technology, they are highly scientific and targeted in method and approach, and length of stays is kept to a minimum. This can be at odds with older peoples' needs, including their requirement for a multidisciplinary approach to deal with their multiple co-morbidities, social and psychological issues, and their more intense rehabilitation needs and slower recovery time.[100]

In the absence of appropriate alternate service models, growing numbers of older people are remaining in hospitals for extended periods after an acute episode. This is exacerbating capacity pressures being felt by the acute sector, manifested by emergency access blockages and increasing elective surgery waiting lists.

The impact on public hospital admissions of waits for residential aged care has been analysed recently:

- on average, a person who is assessed in a hospital as needing residential aged care waits 20 days before admission to a residential aged care facility;
- with an average length of stay for overnight patients of 6.4 days, this delay in moving to residential care has an opportunity cost in terms of three admissions to the public hospital that are not possible; and
- in 1999–2000 over 18,000 assessments were done in hospitals for people subsequently admitted to residential care, yielding a total opportunity cost of over 50,000 admissions compared with a more efficient interface between acute and residential care.[101]

The aged care sector has undergone significant changes with the introduction of accreditation for residential care facilities, 'ageing in place' (under which different levels of care are available for a person in the one facility, as he or she grows older), and greatly expanded community care. However, older peoples' expectations have also altered, with more people wanting to be cared for in the community for longer. This has increased demand for more complex and intensive community-based forms of care and support, including Home and Community Care (HACC). As a consequence, residents of aged care facilities tend to be older, frailer and sicker and have higher levels of dependency; that is, there is increasing demand for high care places with a stronger emphasis on medicalised care.

There are indications of a growing need for alternative care options, including sub-acute and transition care for older people with complex needs for whom neither acute care nor residential care is the most appropriate form of care.

These issues are complicated by the boundaries in funding responsibilities between the Commonwealth and States, and between public and private health sectors. Collaborative work at the interface between hospitals and long-term aged care has always been challenging, but it has the potential to deliver more appropriate care options and better health outcomes for older Australians as well as improved demand management for hospital and aged care services.

4.5 The right kind of care

Appropriateness of care pertains to the question: is the right thing being done? This topic includes the issues of the most appropriate level and mix of health care services, and the links between them.

There is substantial evidence of large *variations in practice patterns* that are unrelated to patients and their health conditions, suggesting problems with the level of care provided. Studies have shown highly significant variations between and within States for a range of procedures. For instance:

- A Victorian study investigated the average annual use of 15 well-defined hospital procedures and found that the use generally varied across geographic areas by 400 to 600 per cent, and sometimes more. For example, after standardising for age and sex, the rate at which coronary angiography was provided in different geographic areas within Victoria varied by 700 per cent.[102]
- The Steering Committee for the Review of Government Service Provision also reported significant differences across States in the use of certain procedures. The procedures were selected for their frequency and for being elective and discretionary (given the availability of alternative treatments). They included tonsillectomy, hysterectomy, caesarean section, hip replacement and endoscopy. For example, rates for caesarean sections varied from a low of 22.6 per 100 births in the ACT to a high of 29.2 per 100 births in South Australia.[103]
- Another study investigated the likelihood of a patient receiving a revascularisation procedure (coronary artery bypass graft, angioplasty or stenting) in the eight weeks following an initial emergency admission for a heart attack. The study compared the likelihood of patients in private hospitals receiving one of the procedures to the likelihood patients in public hospitals. In 1996, the likelihood of receiving one of the procedures was significantly greater for patients admitted to a private hospital than for people admitted as public patients to public hospitals (4.9 and 6.7 times greater for men and women respectively).[104]

99
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION 2003, *REPORT ON GOVERNMENT SERVICES 2003*, PRODUCTIVITY COMMISSION, CANBERRA, TABLE 12A.37.

100
S. DUCKETT 2002, 'AGED CARE SYMPOSIUM: OVERVIEW', *AUSTRALIAN HEALTH REVIEW*, 25(5).

101
S. DUCKETT 2002, 'AGED CARE SYMPOSIUM: OVERVIEW', *AUSTRALIAN HEALTH REVIEW*, 25(5), P. 130.

102
J. RICHARDSON 1998, 'FUNDING AND FUTURE OPTIONS FOR THE REFORM OF MEDICARE', CENTRE FOR HEALTH PROGRAM EVALUATION, *WORKING PAPER 79*.

103
STEERING COMMITTEE FOR THE REVIEW OF COMMONWEALTH–STATE SERVICE PROVISION 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, PP. 9.31–33.

104
J. RICHARDSON 1998, 'FUNDING AND FUTURE OPTIONS FOR THE REFORM OF MEDICARE', CENTRE FOR HEALTH PROGRAM EVALUATION, WORKING PAPER 79, P. 4.

Such findings do not indicate whether patients are over-serviced or under-serviced. But the significant differences found in all the studies do raise questions about whether Australians are receiving the appropriate level and mix of health services.

Appropriateness of care also pertains to *models of care*, or to the question of how well health care services are meeting the needs of patients. There is evidence that Australia has an over-reliance on acute care when alternative care options would not only be more appropriate but also cost-effective. For example, technological advances enable hospitals to provide more complex services in home and community settings, such as hospital-in-the-home programs and dialysis. Sub-acute and transition care offer more cost-effective and appropriate care for older people with complex needs for whom neither acute care nor residential care is the most appropriate form of care.

Not only should patient care be provided in the most appropriate setting, but services should also be seamless from the patient's perspective. A patient-centred health care system must emphasise and support *continuity of care*:[105]

- Most people who receive inpatient services in hospitals have received a variety of services prior to their admission, and receive other hospital and non-hospital services after they are discharged. Consequently, care provided within hospitals should be seen as part of a continuum of care, with elements including prevention, diagnosis and ongoing treatment, acute care and rehabilitation.
- Similarly, non-admitted services are often part of a continuum of care, with general practitioners and other service providers referring patients to hospital outpatient or emergency departments for treatment.
- In the case of emergency department services, presentation to emergency often leads to an inpatient episode of care or to identification of a range of ongoing health service needs. While they are outpatients, people may continue to receive services from their referring practitioner and return to the care of their practitioner after they cease to be outpatients.
- In particular, the care of people with chronic and complex problems requires a fundamental rethink of the delivery of health services. People with chronic health conditions – such as diabetes, ischaemic heart disease, chronic obstructive pulmonary disease, asthma and arthritis – require a range of services to meet their needs and appropriate service planning. Hospitals play a vital role in the management of acute illnesses and emergencies, but general practice and community health services have a significant role in the management of patients with chronic disease.

Thea (aged 18), in the family of Con and Despina introduced in chapter 1, has juvenile diabetes. Juvenile diabetes has many symptoms and complications that need constant management. The range of care Thea needs includes help with the most appropriate medication, diet and exercise regime, eye care, foot care and daily monitoring of blood sugar levels. It has been a battle for Despina to coordinate the range of services and providers required and to feel confident that she is on top of Thea's condition and needs, which have been changing through adolescence.

4.6 Conclusions

This chapter began by pointing out that, before considering ways to reform health care, we need to be certain that reform is needed. The chapter has discussed a number of problems with the health care system, including concerns about the equity and efficacy of expenditure on health care. It has considered the health status of Australians, their access to essential medical services, and the appropriateness of care they receive. It has indicated some areas where more resources are needed, particularly for primary and preventive care, aged care and elective surgery. The poor health of certain groups in Australia also indicates that more needs to be done, most notably to improve the health status of Aboriginal and Torres Strait Islander peoples and of people from disadvantaged socioeconomic backgrounds.

These issues raise questions about the adequacy of funding for health care. However, particularly given the significant real increases in health funding over the past decade and projected into the future, it is just as important to consider the cost-effectiveness of funding. In other words, it is not just a question of the amount of funding, but also of how the money is spent: what gets funded, where, and how.

As the major funders of health care, both levels of government have a particular responsibility to ensure health expenditure is equitable and cost-effective. As discussed, the complex split in responsibilities for the funding and provision of health care between the Commonwealth and State Governments leads to problems, including poor coordination of planning and service delivery, barriers to efficient substitution of alternative types and sources of care, and scope for cost shifting. The funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting. There is a lack of focus on prevention, health promotion and disease management.

Options for reform of Australia's health care system in order to address these issues are put forward in chapter 8.

105
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, 'CONTINUUM BETWEEN PREVENTATIVE, PRIMARY, CHRONIC AND ACUTE MODELS OF CARE', SEPTEMBER 2002, WWW.HEALTH.GOV.AU.


Funny
Always helps me
Tells me what to do
Earns money for my Holidays
Really loves me
Dear Dad,
Happy fathers day
I love you a lot
and your the best dad
in the world because
you try and and
love
Lots :- love

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter Five
Educating Australia's children

Different students need different approaches to achieve good results. Schools are not always using approaches that are innovative enough, partly because they do not have the funds to do so, and this results in disparity of student outcomes.

Educating Australia's children

This chapter provides a broad overview of Australia's school education system and what students are achieving. It explores possible reasons for differences in achievement including features of the system itself, such as anomalies in funding, which are likely to be contributing. It points to ways forward, as a precursor to a more detailed discussion of reform options for education in chapter 9.

Key Points

- Australian school *enrolments* have grown by around 11 per cent over the last 20 years, with almost all of that growth occurring in the non-government sector. Most Australian students still attend government schools, but a significant and increasing proportion attend non-government schools.
- States provide the greater part of government recurrent *funding* for school education, most of which goes to government schools. The Commonwealth provides the bulk of government funding to non-government schools. Growth in government spending on schools over the past decade has been disproportionately directed to non-government schools, even allowing for different rates of enrolment growth; significant anomalies in funding have arisen.
- *Participation* of young people in school education in Australia has risen over the last 20 years, and for most groups is relatively high. However, not all groups participate to the same degree – Indigenous young people and those from poorer backgrounds are much less likely to complete upper secondary schooling. Girls are more likely than boys to complete Year 12, as are those living in capital cities.
- Australia's *learning outcomes* are relatively good by international standards, on average. However, many students do not achieve minimum benchmarks, and particular groups persistently achieve poorer outcomes than the general student population. Indigenous students and those from poorer socioeconomic backgrounds attain, on average, lower levels of achievement in all assessed areas.
- There are such students in schools of all types, but there is a higher and increasing concentration of students from disadvantaged families in some schools and regions. Unless this trend is checked, the job of these schools will become even harder than it is now, and the result will be a more divided education system.

- The *reasons for differences* in educational outcomes for students can occur at different levels – system, sector, school, classroom and individual – and are likely to be interrelated. In Australia, much of the difference in outcomes appears to relate to differences among *individual students*, but *school factors*, *including the quality of teaching*, are also very important. There are high performing and low performing schools in all sectors.
- Some important *features of the current system* contributing to differences in outcomes include: the lack of a systematic approach to early childhood development, an inappropriate basis for education funding (the notion of a 'standard' education, rather than a more individual approach) and the presence of substantial funding anomalies, and inconsistent and in some cases ineffective school performance management and accountability systems.
- The fact that there is little consistent information available on school performance, and that funding anomalies exist, inhibits the ability of families to exercise *choice*.
- The present situation is not good enough: there is a *clear challenge* to improve outcomes for disadvantaged students and choices of schooling for Australian families. The imperative to address this issue will intensify as Australia's social and economic environment changes, placing an even greater premium on skills and education.
- The focus of reforms to education must be on moving to a system that is better suited to *meeting individual students' needs*, supported by better preparation for school and more robust and consistent funding and accountability systems.

Education is the foundation of the economic, cultural and social wellbeing of individuals, as well as of nations.

For students, the main purposes of school education are to assist in:

- attaining knowledge, skills and understanding in key learning areas;
- developing their talents, capacities, self-confidence, self-esteem and respect for others; and
- developing their capacity to contribute to Australia's social, cultural and economic development.[106]

More generally, higher levels of education deliver a range of lifetime benefits. People who complete more years of schooling are more successful in the labour market, earn higher salaries, have lower rates of unemployment and experience better health and wellbeing. Critically, high-quality education provides opportunities for a better future, particularly to children from poorer families. Not surprisingly, Australian families put a premium on high-quality education services and the ability to choose a school that meets the needs of their children.

For nations, both the social cohesion of populations and the competitiveness of national economies depend increasingly on a solid foundation of knowledge and skills. In this context, education and training, though not the sole providers of knowledge and competence, are key elements in strategies to ensure economic prosperity, social cohesion and a broad participation of people in processes of sociocultural, economic and technological development.[107]

While education includes many different sectors and experiences, this report focuses on *school education*, which provides the cornerstone of learning. This is where change is most urgently needed. It is clear that good links between school education and other sectors, particularly VET, are vital if the education system is to serve students well: the key is to provide students with the 'pathway' that suits them best and to ensure that the education system helps, rather than hinders, their progress. While we do not examine this issue in detail here, the education reform options outlined in chapter 9 have been designed with a view to strengthening the links across education sectors wherever possible.

The aim of this chapter is to give a broad view of Australia's school education system and the achievements of school students. It has four main sections:

- Section 5.1 describes briefly *the shape of the system* – the enrolment patterns in Australian schools and the funding provided by Commonwealth and State Governments;
- Section 5.2 looks at key *indicators of educational outcomes* – participation, student retention and the learning achievements of students in Australia;
- Section 5.3 discusses the reasons for *variations in student achievement*, which can help guide policy responses, and examines some *features of the Australian education system* that are likely to be contributing to differences in student outcomes; and
- Section 5.4 looks at the *imperative for change* and *where we should be heading* in school education, as a precursor to a more detailed discussion of reform options in chapter 9.

TABLE 5.1 • FULL-TIME SCHOOL STUDENTS BY SECTOR, 1984 AND RECENT YEARS

Year	Sector			Total
	Government	Catholic	Independent	
1984	2,241,250	566,051	186,110	2,993,411
2000	2,248,287	641,631	357,507	3,247,425
2001	2,248,219	648,760	371,198	3,268,177
2002	2,257,337	656,990	387,449	3,301,776
2003	2,254,632	660,591	403,397	3,318,620
PER CENT CHANGE 1984–2003	+0.6	+16.7	+117.8	+10.9
SHARE OF STUDENTS IN 1984 (%)	74.9	18.9	6.2	
SHARE OF STUDENTS IN 2000 (%)	69.2	19.8	11.0	
SHARE OF STUDENTS IN 2001 (%)	68.8	19.9	11.4	
SHARE OF STUDENTS IN 2002 (%)	68.4	19.9	11.7	
SHARE OF STUDENTS IN 2003 (%)	67.9	19.9	12.2	

SOURCE: S. LAMB, M. LONG, G. BALDWIN 2004 FORTHCOMING, *PERFORMANCE OF THE AUSTRALIAN EDUCATION AND TRAINING SYSTEM*, A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 40; ABS 2002, 2001, 2000, *SCHOOLS AUSTRALIA*, CATALOGUE NO. 4221.0, DATA CUBE TABLE 4; ABS 2003, *SCHOOLS AUSTRALIA 2003*, CATALOGUE NO. 4221.0, TABLE 9.

5.1 The 'shape' of the system

The Australian school system has expanded over the last twenty years and will continue to do so during much of this decade. Primary and secondary school enrolments increased by 10 per cent from 1984 to 2002.[108] There are about 3.3 million students currently enrolled in primary and secondary schools in Australia.

While both the Commonwealth and State Governments have important responsibilities for school education, the State Governments have constitutional responsibility to ensure the delivery of schooling to all children of school age. They determine curricula, regulate school activities, and provide most of the funding. State Governments are directly responsible for the administration of government schools, for which they provide the majority of government funding. Non-government schools operate under conditions determined by State Government registration authorities and receive significant Commonwealth and State Government funding.[109]

School enrolments

Most students attend government schools, but a significant and increasing proportion of students attend non-government schools. At a national level, government schools have seen very little change in overall enrolments in the last 20 years. Non-government schools have been the main beneficiaries of the 11 per cent growth in school enrolments over that period (see Table 5.1):

- the number of full-time government school enrolments increased by less than 1 per cent between 1984 and 2003;
- over the same time, enrolments in Catholic schools grew by 16.7 per cent; and
- enrolments in independent schools grew by 117.8 per cent.

These national data mask some differences across jurisdictions. For example, enrolments of full-time students in government schools rose strongly in Queensland, Western Australia and the Northern Territory from the early 1980s to 2003, but fell in other jurisdictions. However, the growth in non-government school enrolments was consistently stronger in all jurisdictions than the growth in government school enrolments.[110]

106
STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION (SCRGSP) 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, P. 3.1.

107
S. LAMB, M. LONG, G. BALDWIN 2004, FORTHCOMING, *PERFORMANCE OF THE AUSTRALIAN EDUCATION AND TRAINING SYSTEM*, A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 1.

108
LAMB ET AL. 2004, FORTHCOMING, OP. CIT., P. 39.

109
SCRGSP 2004, OP. CIT., P. 3.3.

110
ABS 2003, *SCHOOLS AUSTRALIA 2003*, CATALOGUE. NO. 4221.0, TABLE 6.

As a result of these trends, the share of students attending government schools has fallen from 75 per cent in 1984 to 68 per cent in 2003. The share attending independent schools has risen from 6 to 12 per cent and the share attending Catholic schools has risen slightly to 20 per cent. The rise in independent schools' share of enrolments and the fall in the share of the government sector have been particularly marked in the last few years.

The drift to the non-government sector has, in some areas, exacerbated the effect of demographic trends on government school enrolments – this is likely to continue under the current arrangements. Enrolment projections by the Victorian Department of Education suggest that the government schools' share of enrolments will continue to fall in that State. This is likely to have different effects on individual government schools, with successful schools maintaining enrolment levels but less successful schools experiencing disproportionate reductions in enrolment numbers.

Over the last 20 years, the largest change in enrolment shares has occurred in secondary schools, although patterns of drift suggest that the movement has been occurring at earlier year-levels more recently. In terms of *secondary school* enrolments:

- the government secondary school share of enrolments fell from 72 per cent in 1984 to 63 per cent in 2003;
- Catholic schools' share increased from 19 to 21 per cent; and
- independent schools' share rose from 9 to 16 per cent.

In some regions the share of upper secondary students attending Government schools is lower than the overall figure. As we discuss below, students from high socioeconomic backgrounds (and often living in high income areas) are less likely to be attending government schools than students from lower and middle income backgrounds.

Enrolment shares in *primary schools* have also changed, with the independent sector share rising from 4 to 9 per cent and the government sector share falling from 77 to 72 per cent. The share for the Catholic sector has remained much the same at 19 per cent.

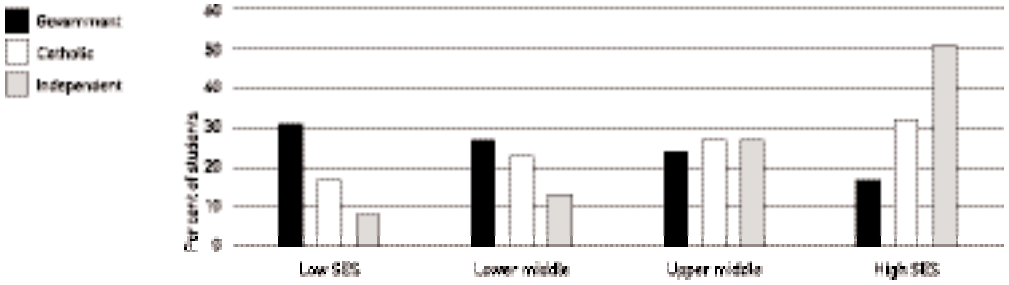
The size of the non-government school sector in Australia is large by comparison with other OECD countries. Only the Netherlands, Belgium and Spain have larger shares of enrolments in non-government schools. The average percentage of enrolments in non-government schools at the primary school level among OECD countries in 2001 was 10.5 per cent. At the junior secondary level, it was 13.2 per cent. Australia's rates of enrolment in non-government schools in 2001 were 27.6 and 29.8 per cent respectively.[111]

Student profile

The socioeconomic profiles of students are very different in the government and non-government school sectors (see Figure 5.1). Government schools have significantly higher concentrations of students of low socioeconomic status (SES) than either type of non-government school: 58 per cent of students in government schools come from the bottom half of the income distribution, compared with 40 per cent in Catholic schools and only 21 per cent in independent schools.[112]

The social intake of schools also appears to be related to school size – within the government system, schools with higher socioeconomic intakes are more often larger schools, whereas schools that serve lower socioeconomic populations are more often small to medium sized.[113] Table 5.2 shows the distribution of secondary students in high and low SES bands across Victorian government schools of different sizes. (The distribution of students in several medium SES categories is not shown in the table.)

FIGURE 5.1 • SOCIAL PROFILE OF YEAR 9 STUDENTS BY SECTOR, AUSTRALIA, 1995



NOTE: THE FIGURES ARE BASED ON A SAMPLE SIZE OF 13,530 YEAR 9 STUDENTS WEIGHTED BY STATE, SECTOR AND GENDER TO PROVIDE NATIONAL POPULATION ESTIMATES.

SOURCE: DERIVED BY STEPHEN LAMB FROM Y95 COHORT OF THE LONGITUDINAL SURVEYS OF AUSTRALIAN YOUTH, IN L. WATSON AND R. TEESE 2004 (FORTHCOMING), *GOALS AND PURPOSES OF EDUCATION AND TRAINING,* A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 40.

TABLE 5.2 • SOCIAL BACKGROUND OF STUDENTS AND SCHOOL SIZE, VICTORIAN GOVERNMENT SECONDARY SCHOOLS, 2002

School size	Per cent of high SES students attending schools of different size	Per cent of low SES students attending schools of different size	Per cent of all students attending schools of different size
SMALL	9.1	30.6	19.1
SMALL–MEDIUM	6.8	41.7	19.9
MEDIUM	22.7	11.1	19.9
MEDIUM–LARGE	25.0	5.6	20.3
LARGE	36.4	11.1	20.7
TOTAL(a)	**100.0**	**100.0**	**100.0**

(a) COLUMNS MAY NOT ADD TO 100 BECAUSE OF ROUNDING.

SOURCE: CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING 2004, COMPILED FROM UNPUBLISHED DATA FROM SCHOOL CENSUS 2002.

There is some indication of a growing concentration of students of particular socioeconomic status in certain regions and schools. A recent study of the affordability of Catholic schools in Victoria[114] found that trends in enrolments of students from poor families differed from school to school. For Victoria as a whole, the study concluded that there had been a shift in enrolments in Catholic primary and secondary schools away from students from low-income families and towards students from high-income families, and it suggested the level of fees was part of the explanation. However, schools in poorer areas had *maintained or increased* their proportion of students from low-income families. The study concludes:

While there can be reasons associated with demographic changes in the surrounding areas, the different patterns for different schools may be an expression of separation and residualisation in an increasingly competitive market for students – that students are increasingly segregated in terms of family background by attendance at schools with different recruitment patterns. One consequence is an increased concentration of students from low-income families in particular schools.

MONASH UNIVERSITY CENTRE FOR THE ECONOMICS OF EDUCATION AND TRAINING AND CATHOLIC EDUCATION COMMISSION OF VICTORIA 2004, *THE AFFORDABILITY OF CATHOLIC SCHOOLS IN VICTORIA*, CATHOLIC EDUCATION COMMISSION OF VICTORIA, MELBOURNE, WWW.CECV.MELB.CATHOLIC.EDU.AU/FUNDS/BODY.HTM, SECTION 9, P. 1.

The drift of students both across and within school sectors in recent years means that this trend is unlikely to be restricted to the Catholic school sector, or to Victoria. There is strong anecdotal evidence, for example, that families with resources are increasingly seeking to move into the catchment areas of government schools that have built up a reputation for academic excellence. The result is often an increasing proportion of more affluent families in these schools and regions and an increasing concentration of disadvantaged families in other areas. In some cases, the special nature of government schools – open to all students – means that there can also be a greater concentration of 'difficult' students with behavioural problems in some schools.

111
OECD 2003, *EDUCATION AT A GLANCE, OECD INDICATORS*, OECD, PARIS, P. 270.

112
L. WATSON AND R. TEESE 2004 FORTHCOMING, *GOALS AND PURPOSES OF EDUCATION AND TRAINING*, A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 40.

113
S. LAMB, D. JESSON, R. RUMBERGER AND R. TEESE 2004, *SCHOOL PERFORMANCE AND VALUE-ADDING: RESULTS FROM ANALYSES OF SCHOOL EFFECTIVENESS*, A DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, MARCH, P. 17.

114
MONASH UNIVERSITY CENTRE FOR THE ECONOMICS OF EDUCATION AND TRAINING AND CATHOLIC EDUCATION COMMISSION OF VICTORIA 2004, *THE AFFORDABILITY OF CATHOLIC SCHOOLS IN VICTORIA*, CATHOLIC EDUCATION COMMISSION OF VICTORIA, MELBOURNE, WWW.CECV.MELB.CATHOLIC.EDU.AU/FUNDS/BODY.HTM.

Funding

Total government recurrent expenditure on school education was $25.3 billion in 2001–02 (see Table 5.3). Expenditure on government schools was 80.1 per cent of the total.

Nationally, State Governments provided 91.2 per cent of total government recurrent expenditure on government schools in 2001–02, and the Commonwealth Government provided 8.8 per cent. In contrast, government expenditure on non-government schools in that year was mainly provided by the Commonwealth Government (71.8 per cent), with the States providing 28.2 per cent.

The growth in government spending on schooling over the past decade has been disproportionately directed to non-government schools. Enrolment drift to the non-government sector does not fully account for the differences in rates of growth in government funding between the school sectors.

The increase in funding to non-government schools and the shift in balance of funding arrangements has been driven mainly by the Commonwealth Government.

These trends are seen in per student funding for school education. Table 5.4 compares what schools received per student from governments, in 2002 prices, in 1992, 1997 and 2002. In summary:

- between 1992 and 2002, per student real spending by governments on *government schools* increased by 30 per cent, to $7847 per student in 2002;
- growth in real spending by governments on *non-government schools* over the same period was considerably higher: $5239 per student for Catholic schools in 2002, a real increase of 57 per cent since 1992, and $4049 for independent schools, a real increase of 64 per cent;
- the Commonwealth Government increased its per capita real spending on *non-government schools* at a much faster rate (69 per cent for Catholic schools and 88 per cent for independent schools) over this period[115] than did the States (31 and 26 per cent respectively); and
- the Commonwealth Government increased its per capita real spending on *government* schools at a slower rate (24 per cent) over this period than did the States (31 per cent).

Taking account of (estimated) non-government income as well as government funding (see Table 5.5), we find:

- At the secondary level, nationally, independent schools on average have the highest total income per student, followed by government schools and then the Catholic sector. On a State-by-State basis, this is also the case in New South Wales, Victoria, Queensland and South Australia, but not in Western Australia, where government schools and Catholic schools are better resourced on average than independent schools. (Data were not available for all sectors in Tasmania, the Northern Territory and the ACT.)
- At the primary level, national data suggest that government schools are, on average, better resourced than independent schools, although this is not the case in Victoria, New South Wales or the ACT. Catholic schools have the lowest level of resources per student at the primary level, both nationally and in every jurisdiction.

The data in Table 5.5 need to be heavily qualified: they are estimates only. It is also worth noting that there is substantial variation in the circumstances of individual schools within sectors that underlie the *average* picture here.

More detailed aspects of current school funding arrangements, and their implications, are discussed in Section 5.3.

TABLE 5.3 • GOVERNMENT RECURRENT EXPENDITURE ON SCHOOL EDUCATION, 2001–02

	$m	%
GOVERNMENT SCHOOLS		
COMMONWEALTH FUNDING	1,776	8.8
STATES FUNDING	18,460	91.2
TOTAL GOVERNMENT FUNDING	**20,235**	**100.0**
NON-GOVERNMENT SCHOOLS		
COMMONWEALTH FUNDING	3,612	71.8
STATES FUNDING	1,422	28.2
TOTAL GOVERNMENT FUNDING	**5,034**	**100.0**
ALL SCHOOLS		
COMMONWEALTH FUNDING	5,388	21.3
STATES FUNDING	19,882	78.7
TOTAL GOVERNMENT FUNDING	**25,270**	**100.0**

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION (SCRGSP) 2004, *REPORT ON GOVERNMENT SERVICES 2004,* PRODUCTIVITY COMMISSION, CANBERRA, P. 3.4.

TABLE 5.4 • SCHOOL INCOME PER STUDENT FROM GOVERNMENT SOURCES, 1992, 1997 AND 2002(a)

	1992(a) $	1997(a) $	2002(a) $	Real % increase, 1992 to 2002
COMMONWEALTH FUNDING				
GOVERNMENT SCHOOLS	676	749	840	24.3
CATHOLIC SCHOOLS	2267	2904	3833	69.1
INDEPENDENT SCHOOLS	1495	1913	2815	88.3
STATES FUNDING				
GOVERNMENT SCHOOLS	5366	6031	7007	30.6
CATHOLIC SCHOOLS	1071	1244	1406	31.3
INDEPENDENT SCHOOLS	977	1070	1234	26.3
ALL GOVERNMENT FUNDING				
GOVERNMENT SCHOOLS	6042	6780	7847	29.9
CATHOLIC SCHOOLS	3338	4148	5239	57.0
INDEPENDENT SCHOOLS	2472	2983	4049	63.8

(a) DATA FOR GOVERNMENT SCHOOLS ARE FOR THE FINANCIAL YEARS 1991–92, 1996–97 AND 2001–02, IN 2002 PRICES, AND EXCLUDE DEPRECIATION, USER COST OF CAPITAL AND PAYROLL TAX.

SOURCE: G. BURKE AND P. WHITE 2004, *SCHOOL EDUCATION FUNDING*, A DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, MARCH, APPENDIX 3.

TABLE 5.5 • ESTIMATED REVENUE OF SCHOOLS BY SECTOR, 2001–02 AND 2002, $ PER STUDENT

	Australia		
	Primary ($)	Secondary ($)	All(a) ($)
GOVERNMENT(b)	7,387	9,636	8,256
CATHOLIC(c)	5,739	8,806	7,225
INDEPENDENT(c)	7,269	11,884	10,268

(a) INCLUDES COMBINED SCHOOLS.
(b) DATA FOR 2001–02, 2002 PRICES. EXCLUDES DEPRECIATION, USER COST OF CAPITAL AND PAYROLL TAX AND INCLUDES AN ASSUMED AMOUNT OF PRIVATE FUNDS OF 8 PER CENT OF ADJUSTED GOVERNMENT FUNDS.
(c) DATA FOR 2002. VARIOUS EXCLUSIONS, SUCH AS FOR AMOUNTS RELATED TO BOARDING FACILITIES.

SOURCE: G. BURKE AND P. WHITE 2004, *SCHOOL EDUCATION FUNDING*, A DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, MARCH, APPENDIX 3.

5.2 Education outcomes for Australian families

The outcomes, or results, of school education for Australian families can be considered in three main ways. We can assess:

- the extent to which children participate in education;
- what they learn while they are at school; and
- how easily their parents can make informed choices about the type of school education best suited to them.

This section looks at a number of indicators of both participation and learning outcomes, and discusses how easily families can make informed choices about schools in Australia.

115 THE COMMONWEALTH GOVERNMENT RECENTLY ANNOUNCED THAT CATHOLIC SCHOOLS WOULD JOIN THE SOCIOECONOMIC STATUS FUNDING SYSTEM THAT DETERMINES THE COMMONWEALTH FUNDING OF INDEPENDENT SCHOOLS. THE CHANGE WILL OCCUR FROM 2005 ONWARDS AND WILL INVOLVE CATHOLIC SCHOOLS RECEIVING ADDITIONAL COMMONWEALTH FUNDING OF $362 MILLION, ABOVE INDEXATION, OVER FOUR YEARS. (THE HON DR B. NELSON 2004, *ANNOUNCEMENT OF CATHOLIC SCHOOLS TO JOIN SES FUNDING SYSTEM*, MIN 633/04, 29 FEBRUARY, WWW.DEST.GOV.AU/MINISTERS/MEDIA/NELSON/2004/03/N6330304.ASP).

Participation in education

Access to and participation in education are key influences on individual and national wellbeing. For individuals, the benefits of successfully completing more years of schooling are particularly significant, including a lower risk of unemployment and the likelihood of higher earnings.[116]

There are three broad indicators of involvement in education: participation in school education, retention rates from year to year and Year 12 completion rates.

These measures are by no means ideal. They do not take into account the fact that staying in school education will not be a 'good' outcome for everyone: some of those who leave are taking the right course for them, particularly if they leave for vocational training or for a job that they will find satisfying over a long period. The picture is also blurred by the breaking down of traditional distinctions between schooling and other avenues of education in Australia, including VET, and the absence of good data on participation in these alternatives.

There may also be cases where apparently different rates of participation in the post-compulsory years of school – for example, for boys and girls – can be partly explained by their participation in other parts of the education system. Boys who leave school before Year 12 are estimated to be about twice as likely to study at a TAFE as girls, although the proportion of early school leavers not engaged in education remains relatively high for both boys and girls, at 62 and 78 per cent respectively.[117]

These qualifications need to be kept in mind in interpreting the data in following sections.

Overall, the various measures suggest that the participation of young people in school education in Australia has risen over the last 20 years and for many groups is relatively high.

However, the data also show that not all groups participate to the same degree: Indigenous young people and those from poorer backgrounds are much less likely to complete upper secondary schooling (and the participation of Indigenous students is lower than that of non-Indigenous students even at middle secondary level). Girls are more likely than boys to complete Year 12, as are those living in capital cities compared to students living elsewhere.

Participation rates

Nationally, 50 per cent of 15 to 19-year-olds were enrolled in schools in 2002. Participation rates varied by age and gender:

- participation rates declined significantly as students exceeded the maximum compulsory school age; and
- participation rates were generally higher for females than for males.[118]

Participation in education by 15 to 19-year-olds has risen over the last 20 years by around 15 percentage points.[119]

Apparent retention rates

Apparent retention rates estimate the percentage of full-time students who continue from a specified year level to a higher year level.[120]

Apparent retention to Year 12 is an indicator of the extent to which students progress to their final year of schooling. As noted above, it will be affected by the rate at which students leave school to take up other education opportunities, as well as by the numbers who leave the education system altogether. There are some significant problems with apparent retention data. For example, no account is taken of transfers between sectors, migration, or students repeating year levels. These factors generally affect retention rates for Government schools more than rates for schools in other sectors.

TABLE 5.6 • APPARENT RATES OF RETENTION FROM YEAR 10 TO YEAR 12: 2002

	Retention rate (%)
INDIGENOUS STUDENTS	
GOVERNMENT SCHOOLS	43.1
NON-GOVERNMENT SCHOOLS	60.4
ALL SCHOOLS	45.8
NON-INDIGENOUS STUDENTS	
GOVERNMENT SCHOOLS	73.2
NON-GOVERNMENT SCHOOLS	86.2
ALL SCHOOLS	77.8
ALL STUDENTS	
GOVERNMENT SCHOOLS	72.2
NON-GOVERNMENT SCHOOLS	85.9
ALL SCHOOLS	77.0

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION (SCRGSP) 2004, *REPORT ON GOVERNMENT SERVICES 2004*, PRODUCTIVITY COMMISSION, CANBERRA, TABLE 3A.32.

Apparent retention rates to Year 12 increased strongly in Australia during the 1980s (by around 40 percentage points for both girls and boys) but levelled off or fell slightly during the 1990s. During that 20-year period, the gap between retention rates for girls and boys widened, to the point where the rate for girls is now around 10 percentage points higher than that for boys.[121]

The retention rate for all students in all schools from Year 10 to Year 12 was relatively high at 77 per cent in 2002, but Table 5.6 shows that this was not a good guide to the participation of all groups of students in higher secondary education. In addition to the gap between girls and boys:

- the retention rate for students at government schools (72.2 per cent) was lower than the rate at non-government schools (85.9 per cent);
- nationally, the retention rate for Indigenous students was 45.8 per cent, or 32.0 percentage points lower than the rate for non-Indigenous students; and
- the difference in retention rates between government and non-government schools was even more marked for Indigenous students: Indigenous students at government schools had a retention rate to Year 12 of 43.1 per cent compared with 60.4 per cent at non-government schools.

116
WATSON AND TEESE 2004 FORTHCOMING, OP. CIT., P. 29.

117
SCRGSP 2004, OP. CIT., P. B.15.

118
SCRGSP 2004, OP. CIT., P. 3.19.

119
LAMB ET AL. 2004 FORTHCOMING, OP. CIT., P. 46.

120
THE TERM 'APPARENT' IS USED BECAUSE NO ADJUSTMENTS ARE MADE FOR MIGRATION, STUDENT MOVEMENTS BETWEEN JURISDICTIONS OR STUDENTS REPEATING YEAR LEVELS (SCRGSP 2004, OP. CIT., P. 3.20).

121
LAMB ET AL. 2004 FORTHCOMING, OP. CIT., P. 46.

Apparent rates of retention from the commencement of secondary school to Year 10 highlight the serious issue of Indigenous students' involvement in school education. Apparent retention rates for all students were commonly 95 to 100 per cent across jurisdictions in 2002, with a national proportion of 98.1. High rates are to be expected, because normal year-level progression means students in Year 10 are generally of an age at which schooling is compulsory. The national retention rate for Indigenous students to Year 10 was 86.4 per cent, or 11.7 percentage points lower than that for all students.[122]

Year 12 completion rates

Year 12 completion rates measure the proportion of young Australians who obtain a Year 12 (or equivalent) certificate as a percentage of the potential Year 12 population.

In 2002, there was a national Year 12 completion rate of 69 per cent, but again this was not representative of the experience of all groups of students (see Table 5.7):

- the most important difference in completion rates reflects socioeconomic status:
  - the completion rate for students from a high socioeconomic background was 80 per cent;
  - completion rates for students from low and medium socioeconomic backgrounds were 17 and 15 percentage points respectively below those for students from a high socioeconomic background;
- completion rates were higher for female students than for male students (by 12 points); and
- completion rates were generally higher in capital cities than in other areas.

International comparisons

International comparisons of participation in education are difficult, because different institutional arrangements mean that the age of completing schooling differs from country to country. Lamb et al. argue that a better measure of school completion and post-compulsory effort is educational attainment. On this type of measure, Australia's performance is improving, but is still low by international standards (see Table 5.8).

Australian upper-secondary completion rates are higher for those in younger age groups than for previous generations, but Australia's rates remain below the OECD average for all age categories and below the rates for almost all of the major industrial countries and those countries culturally similar to Australia. Seventy-one per cent of 25 to 34-year-olds in Australia have completed upper secondary education, compared with an OECD average of 74 per cent and rates around 80 per cent or more for most of the countries in Table 5.8.

Student learning achievement

A 'good' education will fit a child well for the rest of his (or her) life – by helping him to acquire knowledge and skills, an understanding of himself, self-confidence and resilience, an understanding of and trust in others, a degree of comfort in groups, and so on. The results or 'outcomes' of education are very broad and impossible to measure comprehensively.

In trying to assess educational outcomes, we are necessarily limited to narrow measures: student learning achievements in areas such as literacy and numeracy. This section looks first at learning achievements for Australian school students, and then compares Australia's outcomes with those of other OECD countries.

TABLE 5.7 • YEAR 12 ESTIMATED COMPLETION RATES BY SOCIOECONOMIC STATUS, GENDER AND LOCALITY, 2002

Student characteristic	Completion rate (%)
LOW SOCIOECONOMIC STATUS	63
MEDIUM SOCIOECONOMIC STATUS	65
HIGH SOCIOECONOMIC STATUS	80
MALE STUDENTS	63
FEMALE STUDENTS	75
CAPITAL CITY	71
OTHER METROPOLITAN	62
RURAL CENTRES	65
OTHER RURAL AND REMOTE CENTRES	66
ALL STUDENTS	**69**

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION (SCRGSP) 2004, *REPORT ON GOVERNMENT SERVICES 2004,* PRODUCTIVITY COMMISSION, CANBERRA, TABLES 3A.33 AND 3.13.

TABLE 5.8 • PROPORTION OF POPULATION WITH UPPER SECONDARY EDUCATIONAL ATTAINMENT, BY AGE COHORT, 2001

	25-34	35-44	45-54	55-64
AUSTRALIA	71	60	55	44
OECD AVERAGE	**74**	**69**	**60**	**49**
CANADA	89	85	81	67
FRANCE	78	67	58	46
GERMANY	85	86	83	76
ITALY	57	49	39	22
JAPAN	94	94	81	63
NEW ZEALAND	82	80	75	60
UNITED KINGDOM	68	65	61	55
UNITED STATES	88	89	89	83

SOURCE: OECD 2003, *EDUCATION AT A GLANCE: OECD INDICATORS,* OECD, PARIS, P. 41.

TABLE 5.9 • STUDENTS WHO ACHIEVED LEARNING BENCHMARKS, AUSTRALIA, 2001 (%)

	Male	Female	Indigenous	All students
YEAR 3 READING	88.4	92.3	72.0	90.3
YEAR 5 READING	87.8	92.0	66.9	89.8
YEAR 3 WRITING	86.4	92.7	67.8	89.5
YEAR 5 WRITING	91.9	96.2	79.9	94.0
YEAR 3 NUMERACY	93.7	94.3	80.2	93.9
YEAR 5 NUMERACY	89.5	89.8	63.2	89.6

SOURCE: STEERING COMMITTEE FOR THE REVIEW OF GOVERNMENT SERVICE PROVISION (SCRGSP) 2004, *REPORT ON GOVERNMENT SERVICES 2004,* PRODUCTIVITY COMMISSION, CANBERRA, TABLES 3.6–3.11.

Overall, Australia's learning outcomes appear to be good by international standards in two important respects: Australian students score well on standardised tests; and the difference in scores between the highest and lowest achievers is narrower in Australia than in OECD countries on average for mathematical and scientific literacy. However, Australia has a wider dispersion of scores in reading literacy than almost all OECD countries.

Both Australian and international data show that there are significant proportions of students who do not achieve minimum benchmarks in core competencies and that there are particular groups who achieve persistently poorer educational outcomes than the general student population. Indigenous students and those from poorer socioeconomic backgrounds attain, on average, lower levels of achievement in all assessed areas and boys do significantly less well than girls in reading and writing. As seen in chapter 2, this is widely understood by the public, with three quarters of people believing that some Australian children are less likely than others to receive excellent education.

122
SCRGSP 2004, OP. CIT., P. 3.20.

Australian outcomes

For Australia, nationally comparable data on learning outcomes are available for reading, writing and numeracy for 2001. Data for students in Years 3 and 5 relate to agreed national *minimum* benchmarks developed to assess student performance at these year levels. An indicator of performance is the proportion of students who reach a benchmark standard.

Table 5.9 shows the percentage of assessed Year 3 and 5 students in Australia who achieved the reading, writing and numeracy benchmarks in 2001, reported by gender and Indigenous status.[123] In summary:

- while nationally the vast majority of students in Years 3 and 5 achieved the minimum benchmarks, a significant minority (about 10 per cent) failed to do so;
- Indigenous students had significantly lower achievement levels in all three assessed areas; in fact, by Year 3, 20 to 30 per cent of Indigenous children had already fallen below learning benchmarks; and
- a higher proportion of female students than of male students achieved the benchmark standard at both Year levels in reading and writing.

Table 5.9 also provides some evidence that gaps in achievement can *increase* as young people progress through school, at least for reading and numeracy. The proportion of students meeting the minimum standards for reading and numeracy falls between Years 3 and 5 (though only slightly for reading) and the gap in achievement between Indigenous students and the general student population grows. Attainment data from Victoria also show that the proportion of students with the poorest skills rises across the school years, including into secondary school.[124]

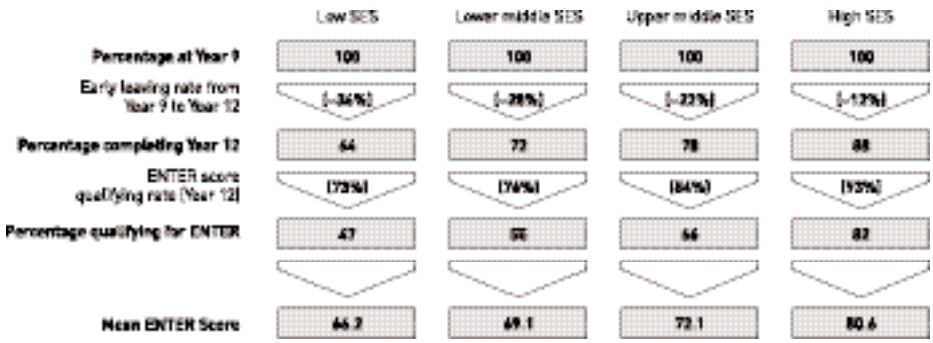
There are sharp contrasts in school achievement in Australia according to the socioeconomic status of students. This is illustrated by comparing the progression through secondary school and the average university-entrance scores for low, middle and high SES students (see Figure 5.2):

- between Year 9 and Year 12, 36 per cent of students from low–SES background leave school, compared with only 12 per cent of students from high–SES;
- of those who commence Year 12, 73 per cent of students from low–SES achieve a university-qualifying rank, compared with 93 per cent of high–SES students; and
- the average university-entry score for low–SES students is 66.2, compared with 80.6 for high–SES students.

International comparisons

International comparisons of student achievement are a way of evaluating how effectively Australian schools are working to develop the foundations for future economic and social prosperity. This section compares Australian student achievement with that of other OECD nations in the Programme for International Student Assessment (PISA). PISA assesses skills of 15-year-olds in areas considered 'essential for full participation in twenty-first century society' – reading, mathematical and scientific literacy.[125] (See Box 5.1 for more information about PISA.)

FIGURE 5.2 • RATES OF YEAR 12 COMPLETION, ENTER SCORE QUALIFYING RATE AND MEAN ENTER SCORES, BY SES QUARTILE (%)



NOTE: FIGURES DERIVED BY STEPHEN LAMB FROM THE Y95 COHORT OF THE LONGITUDINAL SURVEYS OF AUSTRALIAN YOUTH.

SOURCE: S. LAMB, M. LONG, G. BALDWIN 2004 FORTHCOMING, *PERFORMANCE OF THE AUSTRALIAN EDUCATION AND TRAINING SYSTEM*, A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 65.

BOX 5.1 • PROGRAMME FOR INTERNATIONAL STUDENT ASSESSMENT

The Programme for International Student Assessment (PISA) is an initiative of the OECD. The first international assessment was carried out in 2000 on more than a quarter of a million 15-year-old students from 32 countries. About 6200 students from 231 schools participated in Australia.

The domains of learning chosen for assessment in PISA are reading, mathematical, and scientific literacy. Assessment focuses on young people's ability to apply their knowledge and skills to real-life problems and situations, rather than on how much curriculum-based knowledge they possess. The emphasis is on whether students, faced with problem situations that might occur in real life, are able to analyse, reason, and communicate their ideas, arguments or conclusions effectively. The term 'literacy' is attached to each domain to reflect the focus on these broader skills.

SOURCE: J. LOKAN, L. GREENWOOD AND J. CRESSWELL 2001, *THE PISA 2000 SURVEY OF STUDENTS' READING, MATHEMATICAL AND SCIENTIFIC LITERACY SKILLS: 15-UP AND COUNTING, READING, WRITING, REASONING... HOW LITERATE ARE AUSTRALIA'S STUDENTS?*, AUSTRALIAN COUNCIL FOR EDUCATIONAL RESEARCH, MELBOURNE, PP. 201–202.

In summary, Australian students overall acquitted themselves very well in all three assessment areas.

- As Table 5.10 shows, the average results for Australian students were significantly above the OECD average in all areas.
- Taking statistical significance into account, only Finland performed better than Australia in reading literacy, only Japan did likewise in mathematical literacy, and only Korea and Japan outperformed Australia in scientific literacy.[126]

Table 5.10 also presents data showing the differences or gaps in students' performances. The difference between the scores of students at the 75th and 25th percentiles of the performance distribution is often used as a measure of equality in learning outcomes.[127] Also shown are the differences between students' scores at the 5th and 95th percentiles. The less disparate the results between groups of higher and lower performing students are, the closer a country is to the goal of achieving equality of outcomes.

These results show that Australia has a wider dispersion of scores in reading literacy than the OECD average, but lower dispersions for mathematical and scientific literacy.

For reading literacy, only Belgium, Germany and New Zealand had higher levels of dispersion then Australia (using the gap between the 75th and 25th percentiles).

123
PERFORMANCE AGAINST THE BENCHMARK IS ALSO AVAILABLE FOR LBOTE STUDENTS BUT THEIR RESULTS WERE GENERALLY SIMILAR TO THOSE FOR ALL STUDENTS (SCRGSP 2004, OP. CIT., PP. 3.38–3.46).

124
R. TEESE 2003, *PATTERNS OF OUTCOMES AND TRENDS IN EDUCATIONAL OUTCOMES*, REPORT PREPARED FOR THE VICTORIAN DEPARTMENT OF EDUCATION'S 'KEY INFLUENCES ON EDUCATIONAL OUTCOMES PROJECT', EDUCATIONAL OUTCOMES RESEARCH UNIT, UNIVERSITY OF MELBOURNE, IN LAMB ET AL. 2004 FORTHCOMING, OP. CIT., P. 61.

125
J. LOKAN, L. GREENWOOD AND J. CRESSWELL 2001, *THE PISA 2000 SURVEY OF STUDENTS' READING, MATHEMATICAL AND SCIENTIFIC LITERACY SKILLS: 15-UP AND COUNTING, READING, WRITING, REASONING...HOW LITERATE ARE AUSTRALIA'S STUDENTS?* AUSTRALIAN COUNCIL FOR EDUCATIONAL RESEARCH, MELBOURNE, P. 1.

126
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 203.

127
OECD AND UNESCO INSTITUTE FOR STATISTICS 2003, *LITERACY SKILLS FOR THE WORLD OF TOMORROW–FURTHER RESULTS FROM PISA 2000*, EXECUTIVE SUMMARY, OECD, PARIS, P. 6.

The spread for mathematical literacy was significantly less than the OECD average and below the spread for most of the major industrial countries, suggesting progress in Australia in bringing mathematical skills of the lowest-achieving students closer to those of higher achievers.[128]

In PISA, five levels of proficiency in reading literacy are defined and used for reporting purposes: Level 5 is the highest proficiency level, while Level 1 is the lowest level at which students are able to deal with only the least complex reading tasks.

Table 5.11 compares the proficiency levels of Australian students with the OECD average. Australia showed high levels of proficiency in reading, with 43 per cent of Australia's students achieving the highest two levels of proficiency, compared with the OECD average of 32 per cent. The proportion of Australian students with low reading proficiency is lower than the OECD average and the proportion of students at level 2 or below (31 per cent) is lower than that in all but five OECD countries (Finland, Canada, Ireland, Korea and Japan).[129]

However, the proportion of students not achieving good reading proficiency is still worryingly substantial. In its assessment of the PISA results, the Australian Council for Educational Research (ACER) comments: 'It seems likely that the group not reaching Level 2, and probably some of those who did reach Level 2, will experience difficulties in their lives beyond school unless they can be helped to improve their reading literacy skills.'[130]

Analysis of the PISA results on the basis of gender, Indigenous status, language background, location and socioeconomic status showed:

- in every country, *girls significantly outperformed boys* in reading. While part of the explanation may be differences in patterns of development, the results also reinforce current concerns about the literacy achievements of boys. In Australia, boys are substantially over-represented at the lowest proficiency levels and under-represented at the highest level. There was no significant difference between males' and females' scores on mathematical or scientific literacy;[131]
- on average, the *Indigenous* students' performance was more than one proficiency level below the performance of non-Indigenous students in each assessment area in Australia. Indigenous students were over-represented in the group of students who did not reach Level 2 in reading proficiency. However, 40 per cent of Indigenous students demonstrated skills at least at proficiency Level 3 and some achieved very high results;
- the 17 per cent of students whose *home language was not English* performed at an equivalent level in mathematical literacy to the students whose home language was English, but at a slightly lower level in reading literacy and a lower level in scientific literacy;
- students in *provincial cities* performed on a par with students in major urban areas in all three assessment areas, but students in *more remote areas* performed less well than their urban and provincial counterparts in reading and scientific literacy; and
- in all OECD countries, *socioeconomic status* was significantly related to achievement in all three assessment areas[132]. Table 5.12 presents average scores according to socioeconomic status for Australian students and compares them with the OECD average as well as with results for reading in selected individual countries. For both reading and mathematical literacy;
  - Australia has a bigger difference in mean scores between the top and bottom SES quarters than the OECD average, although in both cases Australia's mean score for the lowest quarter is substantially above the OECD mean;
  - compared with a number of major industrialised or culturally similar countries, the difference in mean scores between the top and bottom SES quarters in Australia is larger than in some (such as Canada, France and Italy), similar to New Zealand's, and smaller than the difference in Germany, the United Kingdom and the United States.

TABLE 5.10 • SUMMARY OF RESULTS FROM THE PROGRAM FOR INTERNATIONAL STUDENT ASSESSMENT (PISA), 2000

	Reading literacy	Mathematical literacy	Scientific literacy
AUSTRALIA			
MEAN SCORE	528	533	528
DIFFERENCE BETWEEN SCORES AT 75TH AND 25TH PERCENTILES	144	120	133
DIFFERENCE BETWEEN SCORES AT 5TH AND 95TH PERCENTILES	331	299	307
OECD AVERAGE			
MEAN SCORE	500	500	500
DIFFERENCE BETWEEN SCORES AT 75TH AND 25TH PERCENTILES	136	136	141
DIFFERENCE BETWEEN SCORES AT 5TH AND 95TH PERCENTILES	328	329	325

SOURCE: OECD AND UNESCO INSTITUTE FOR STATISTICS 2003, *LITERACY SKILLS FOR THE WORLD OF TOMORROW – FURTHER RESULTS FROM PISA 2000,* OECD, PARIS, TABLES 2.3A, 3.1 AND 3.2.

TABLE 5.11 • PROFICIENCY LEVELS FOR STUDENTS IN READING LITERACY: 2000 (%)

Proficiency level	Australia	OECD average
BELOW LEVEL 1	3	6
LEVEL 1	9	12
LEVEL 2	19	22
LEVEL 3	26	29
LEVEL 4	25	22
LEVEL 5	18	10

SOURCE: J. LOKAN, L. GREENWOOD AND J. CRESSWELL 2001, *THE PISA 2000 SURVEY OF STUDENTS' READING, MATHEMATICAL AND SCIENTIFIC LITERACY SKILLS: 15-UP AND COUNTING, READING, WRITING, REASONING... HOW LITERATE ARE AUSTRALIA'S STUDENTS?,* AUSTRALIAN COUNCIL FOR EDUCATIONAL RESEARCH, MELBOURNE, P. 66.

TABLE 5.12 • PERFORMANCE ON PISA ACCORDING TO SOCIOECONOMIC STATUS: MEAN SCORES

	Bottom quarter	Second quarter	Third quarter	Top quarter	Difference between bottom and top quarters
READING LITERACY					
AUSTRALIA	490	523	538	576	86
OECD AVERAGE	463	491	515	545	82
CANADA	503	529	545	570	67
FRANCE	469	496	520	552	83
GERMANY	427	471	513	541	114
ITALY	457	581	494	525	68
NEW ZEALAND	489	523	549	574	85
UK	481	513	543	579	98
US	466	507	528	556	90
MATHEMATICAL LITERACY					
AUSTRALIA	495	527	545	578	83
OECD AVERAGE	465	491	513	542	77
SCIENTIFIC LITERACY					
AUSTRALIA	498	522	531	571	73
OECD AVERAGE	465	490	512	543	78

SOURCE: OECD AND UNESCO INSTITUTE FOR STATISTICS 2003, *LITERACY SKILLS FOR THE WORLD OF TOMORROW – FURTHER RESULTS FROM PISA 2000,* OECD, PARIS, TABLES 6.1A, 6.1B AND 6.1C.

128
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 31.

129
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 66.

130
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 204.

131
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 36.

132
SES WAS DETERMINED FROM PARENTS' OCCUPATIONS CLASSIFIED ACCORDING TO THE INTERNATIONAL STANDARD CLASSIFICATION OF OCCUPATIONS.

Making choices

Education is an important influence on an individual's future prosperity. It is therefore an area where Australian families are keen to make the right choices for their children – that is, to choose a school that suits the child and provides them with the best opportunity for success.

Australian families currently have, and exercise, different levels of choice about schooling, influenced by:

- the extent to which alternative options are available – in some areas, particularly rural and remote areas, only one school is within reasonable distance;
- resources – some but not all families can afford to contribute to the cost of their children's education directly, or by moving into a catchment zone for a high-performing government school;
- information – some families will not have sufficient information about how well the various schools that are open to them perform; and
- attitude – parents engage in their children's education to varying extents – often driven by their own experiences in the education system decades earlier.

A school system such as Australia's, which includes a mix of government and private schools, with very different funding arrangements, cannot provide an equal degree of choice to all. However, institutional arrangements *can* be designed to maximise the choice available to families. This is increasingly being recognised. In some areas, for example, there is a greater emphasis on firstly providing good information to parents, including on school performance and student achievement, and secondly encouraging and supporting schools with particular strengths to develop their specialisations even further, while still providing a broad education for their students.[133] Both these strategies improve the capacity of families to choose the school that best suits their children.

However, in two important respects, the current arrangements in Australia are not maximising choice:

- government funding for schools is inequitable:
  - funding does not recognise that different types of students need different approaches – and different levels of funding – to achieve good outcomes;
  - this mismatch of needs and resources is exacerbated by a range of substantial funding anomalies both across school sectors and within them; and
- the barriers between the various school sectors mean that there is little consistent information available to families about school performance, to use as a basis for making informed choices for their children. News about school, principal and teacher performance in different sectors typically travels by word of mouth among those with a good network, but some will find the information difficult to access.

Both of these issues are discussed in more detail in the next section.

5.3 Understanding differences in achievements

Education research

The factors explaining differences in educational outcomes can occur at different levels, and are likely to be interrelated. They include:

- school- sector- and system-related factors such as hours of school time, number of teachers, resources available to the school, school or sector policies, school performance and the mix of students at the school;
- classroom-related factors – principally, the quality of teaching; and
- student-related factors – particularly the socioeconomic and cultural and language background of students.

Educational research has no definitive answers; it suggests that factors at each level can be important. This report touches only briefly on the extensive work done on these topics, drawing principally on reviews of the literature by others.

System, sector and school factors

Lamb, Long and Baldwin suggest that international comparisons of achievement differences (and Australian findings) point to *systemic* factors, such as quantity of school time, being important to outcomes. Other systemic factors thought to be important are the emphasis on and support for homework, a belief among teachers and schools that all children are able to acquire certain core skills in core subjects,[134] and the system-wide staffing situation (with shortages of teachers having an impact on achievement).[135]

As in other areas of government activity, requiring those who provide education to be accountable for the outcomes of the system is a major factor. Research in the United States shows that states with education accountability systems achieved larger improvements in student performance than those without, and those with 'tough' systems achieved bigger improvements than those with 'soft' systems.[136]

At the *school* level, schools themselves have pointed to shortages of instructional resources (such as computers) as having an impact on achievement.[137] Research suggests that school organisation and policy may help to explain differences in outcomes.[138] The use of mixed-ability classes in the early years, the use of specialist teachers, the possibility of teachers working collaboratively with each other and the frequent testing of students' skills may all be important.[139]

Research in the United States and recent work by the OECD suggest that the nature of the school population may also be important. The results for the Programme for International Student Assessment (PISA) 2000 survey of reading, mathematical and scientific literacy show that in all but three countries (Norway, Finland and Iceland), there was a clear advantage in attending a school whose students are, on average, from more advantaged backgrounds. The OECD suggests that the advantages conferred on schools by students from higher SES backgrounds include a range of economic, cultural and social factors that have an impact on the resources, policies and practices of individual schools which in turn contribute to higher levels of student achievement.[140]

ACER analysis of PISA results found that a positive school disciplinary climate was also a significant factor, as was the amount of time devoted to homework, in explaining the variance in results in reading, mathematical and scientific literacy.[141]

In the families introduced in chapter 1, Con and Despina's son, Ari, is unhappy at his Catholic school. Ari's interest in school has waned and he is talking about leaving school and getting a job as a shelf-stacker in the local supermarket. Con and Despina recently met the principal of the local government school through mutual friends and were impressed by her commitment to making education work for each student, no matter what their interests. She convinced Con and Despina that her school's Year 10 teachers, and the special program the school had developed for 'at risk' students, could keep Ari engaged, and she promised to take a special personal interest in his progress. Although Con and Despina like the Christian ethos of the Catholic school Ari is attending, they are very keen for him to complete Year 12 and are seriously considering moving him.

133
SEE, FOR EXAMPLE, THE HON. L. KOSKY 2003, *BLUEPRINT FOR GOVERNMENT SCHOOLS*, DEPARTMENT OF EDUCATION AND TRAINING, MELBOURNE, WWW.DEET.VIC.GOV.AU/DEET/RESOURCES/BLUEPRINT.HTM.

134
LAMB ET AL. 2004, P. 67.

135
J. LOKAN, P. FORD AND L. GREENWOOD 2001, *MATHEMATICS & SCIENCE ON THE LINE: AUSTRALIAN MIDDLE PRIMARY STUDENTS' PERFORMANCE ON THE THIRD INTERNATIONAL MATHEMATICS AND SCIENCE STUDY (TIMSS AUSTRALIA MONOGRAPH: NO. 1)*, AUSTRALIAN COUNCIL FOR EDUCATIONAL RESEARCH, MELBOURNE, IN LAMB ET AL. 2004, OP. CIT., P. 67.

136
THE BROOKINGS INSTITUTION 2003, *NO CHILD LEFT BEHIND? THE POLITICS AND PRACTICE OF ACCOUNTABILITY*, BROOKINGS BRIEFING, 11 DECEMBER.

137
LOKAN, FORD AND GREENWOOD 2001 IN LAMB ET AL. 2004, OP. CIT., P. 67.

138
S. LAMB AND S. FULLARTON 2000, 'CLASSROOM AND TEACHER EFFECTS IN MATHEMATICS ACHIEVEMENT: RESULTS FROM TIMMS', PUBLISHED IN *MATHEMATICS EDUCATION BEYOND 2000*, CONFERENCE PROCEEDINGS OF THE TWENTY-THIRD ANNUAL MEETING OF THE MATHEMATICS EDUCATION RESEARCH GROUP OF AUSTRALASIA, FREMANTLE; AND S. LAMB AND S. FULLARTON 2002, 'CLASSROOM AND SCHOOL FACTORS AFFECTING MATHEMATICS ACHIEVEMENT: A COMPARATIVE STUDY OF AUSTRALIA AND THE UNITED STATES USING TIMSS', *AUSTRALIAN JOURNAL OF EDUCATION*, 46:1, IN LAMB ET AL. 2004, OP. CIT., P. 67.

139
LAMB ET AL. 2004, OP. CIT., P. 67.

140
OECD 2002, *EDUCATIONAL POLICY ANALYSIS*, OECD, PARIS, CHAPTER 2.

141
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., P. 207.

Classroom factors and teacher quality

Rowe and Rowe[142] point to a range of research that suggests the *classroom*, especially the quality of individual teachers, is a key influence on differences in outcomes. Many of these studies conclude that much of the variation in outcomes between schools is, in fact, due to classroom differences and especially variation in the quality of teaching.

...such findings serve to emphasize that it is at the level of the classroom that learning takes place and that there can be very substantial differences in the progress made by students in different classes within the same school. Indeed, teachers make a difference – regardless of student gender, intake or other background characteristic! [authors' emphasis]

K. J. ROWE AND K. S. ROWE 2002, WHAT MATTERS MOST: EVIDENCE-BASED FINDINGS OF KEY FACTORS AFFECTING THE EDUCATIONAL EXPERIENCES AND OUTCOMES FOR GIRLS AND BOYS THROUGHOUT THEIR PRIMARY AND SECONDARY SCHOOLING, SUPPLEMENTARY SUBMISSION TO HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON EDUCATION AND TRAINING: INQUIRY INTO THE EDUCATION OF BOYS, MAY, P. 14.

Estimates of the contribution of teacher quality to differences in outcomes vary, but many studies suggest that it is substantial. Hattie estimates that teachers account for about 30 per cent of the variance in student achievement, second only to the ability that students bring with them (which is estimated to account for around half of the variance).[143]

What makes an effective teacher? Students say that good teachers:[144]

- know, understand and are enthusiastic about their subject;
- treat all students as individuals, care about them, encourage them and treat them fairly;
- make learning the core of what happens in the classroom; and
- manage distractions that disrupt and prevent learning.

Work by the OECD suggests that the main determinants of teacher quality are: incentives such as relative pay and the opportunity for promotion; other aspects of the attractiveness of teaching such as working conditions, flexibility, job security and job satisfaction from working with students; the number of teachers available relative to needs; matching of teachers to schools; teacher education and professional development; and school processes that foster the effectiveness of teachers.[145]

Individual factors and early childhood development

At the *individual* level, students have different abilities, their circumstances at home are different (and are likely to influence how well and how quickly they learn) and they come to school with different levels of preparation. As we saw in Section 5.2, school achievement varies with socioeconomic status and cultural background and, for reading and writing, with gender. While some of these factors are intrinsic, many of them are amenable to policy intervention.

There is also a growing body of research showing the importance of quality early-learning experiences to children's short term cognitive, social and emotional development, their long term success in school and in later life,[146] and their mental health, behaviour and physical health throughout life.[147] The development of neural pathways in the brain is affected by environmental factors. Many of the critical periods for brain development occur before the age of six, and there is evidence that children who do not receive the nutrition and stimulation needed for development in their early years will have great difficulty overcoming these deficits later in life. These children are more likely to develop learning, behavioural or emotional problems during their lives.[148]

Promoting early childhood development has been shown to have benefits for both individuals and the community in four key areas: education, health, social capital and equality. Those reviewing the evidence report that the evidence for the education, health and equality pathways is strong; the social capital pathway is suggestive rather than strong. The research findings are summarised in Table 5.13.

TABLE 5.13 • BENEFITS OF EARLY CHILDHOOD DEVELOPMENT

Pathways	Benefits for children (immediate)	Benefits for adults (long term)	Benefits for society
EDUCATION	HIGHER INTELLIGENCE; IMPROVED PRACTICAL REASONING, EYE AND HAND COORDINATION, HEARING AND SPEECH; READING READINESS; IMPROVED SCHOOL PERFORMANCE; LESS GRADE REPETITION AND DROPOUT; INCREASED SCHOOLING	HIGHER PRODUCTIVITY; INCREASED SUCCESS (BETTER JOBS, HIGHER INCOMES); IMPROVED CHILD CARE AND FAMILY HEALTH; GREATER ECONOMIC WELLBEING	GREATER SOCIAL COHESION; LESS POVERTY AND CRIME; LOWER FERTILITY RATES; INCREASED ADOPTION OF NEW TECHNOLOGIES; IMPROVED DEMOCRATIC PROCESSES; HIGHER ECONOMIC GROWTH
HEALTH	LESS MORBIDITY, MORTALITY, MALNUTRITION, STUNTING AND CHILD ABUSE; BETTER HYGIENE AND HEALTH CARE	IMPROVED HEIGHT AND WEIGHT; ENHANCED COGNITIVE DEVELOPMENT; FEWER INFECTIONS AND CHRONIC DISEASES	HIGHER PRODUCTIVITY; LESS ABSENTEEISM; HIGHER INCOMES
SOCIAL CAPITAL	HIGHER SELF CONCEPT; MORE SOCIALLY ADJUSTED; LESS AGGRESSIVE; MORE COOPERATIVE; BETTER BEHAVIOUR IN GROUPS; INCREASED ACCEPTANCE OF INSTRUCTIONS	HIGHER SELF-ESTEEM; IMPROVED SOCIAL COMPETENCE, MOTIVATION, ACCEPTANCE OF NORMS AND VALUES; LESS DELINQUENCY AND CRIMINAL BEHAVIOUR	IMPROVED UTILISATION OF SOCIAL CAPITAL; ENHANCED SOCIAL VALUES
EQUALITY	REDUCED DISADVANTAGES OF POVERTY; IMPROVED NUTRITIONAL STATUS; COGNITIVE AND SOCIAL DEVELOPMENT AND HEALTH	EQUALITY OF OPPORTUNITY, EDUCATION, HEALTH AND INCOME	REDUCED POVERTY AND CRIME; BETTER SOCIETAL HEALTH; INCREASED SOCIAL JUSTICE; HIGHER SUSTAINABLE ECONOMIC GROWTH

SOURCE: J. VAN DER GAAG 2002, 'FROM CHILD DEVELOPMENT TO HUMAN DEVELOPMENT: INVESTING IN OUR CHILDREN'S FUTURE', IN *HUMAN DEVELOPMENT*, ED. M. E. YOUNG, WASHINGTON, THE WORLD BANK, QUOTED IN NSW COMMISSION FOR CHILDREN AND YOUNG PEOPLE AND COMMISSION FOR CHILDREN AND YOUNG PEOPLE (QLD) 2004, *A HEAD START FOR AUSTRALIA: AN EARLY YEARS FRAMEWORK*, WWW.KIDS.NSW.GOV.AU/PUBLICATIONS/EARLY_YEARS.HTML, P. 6.

Early childhood education can play a vital part in children's development, promoting positive attitudes, skills and knowledge, building social skills and confidence and strengthening cultural identity, family and cultural networks.[149] Research also shows, not surprisingly, that children from disadvantaged backgrounds gain the most from quality early childhood education programs; the benefits for children 'at risk' are greater if intervention occurs very early, from birth.[150]

What explains differences in achievement in Australia?

The causes of differences in education achievement are clearly complex, interrelated and difficult to separate. For example, a child from a poor background may face a number of disadvantages before and throughout his or her school life: less access to early childhood education, parents who may be less able to provide support at home, and a school with a high proportion of socially disadvantaged students, which is less well-resourced, and with less experienced teachers who may have lower expectations of him or her.

In trying to sort out where the balance lies, the analysis of the PISA results by the Australian Council for Educational Research concludes that in Australia, while there are important differences between schools, these are not large by international standards – variance between schools accounted for about 17 per cent of the total variance in reading literacy, which is relatively low compared with many other OECD countries (e.g. the figures for the United Kingdom, the United States and Austria are 22, 30 and 59 per cent respectively). However, Australia has a relatively high level of variance *within schools* – that is, between individual students.[151]

The importance of individual factors in explaining differences in outcomes is also highlighted in a recent analysis of the performance of Victorian schools, although school factors remain an important part of the picture.

Lamb et al.[152] have found that around 55 to 75 per cent of the variation in student performance (measured in different ways) was related to individual factors such as family background, place of residence, attitudes and outlook. The remaining 25 to 45 per cent were estimated to be related to school factors. Individual factors were more important in explaining school completion and the transition from school to further education and training (explaining around 90 per cent of the variation).

142
K. J. ROWE AND K. S. ROWE 2002, *WHAT MATTERS MOST: EVIDENCE-BASED FINDINGS OF KEY FACTORS AFFECTING THE EDUCATIONAL EXPERIENCES AND OUTCOMES FOR GIRLS AND BOYS THROUGHOUT THEIR PRIMARY AND SECONDARY SCHOOLING*, SUPPLEMENTARY SUBMISSION TO HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON EDUCATION AND TRAINING: INQUIRY INTO THE EDUCATION OF BOYS, MAY.

143
J. HATTIE 2003, *TEACHERS MAKE A DIFFERENCE: WHAT IS THE RESEARCH EVIDENCE?*, AUSTRALIAN COUNCIL FOR EDUCATIONAL RESEARCH, OCTOBER.

144
VARIOUS SOURCES QUOTED IN ROWE AND ROWE 2002, OP. CIT., P. 19.

145
OECD 2004, *THE QUALITY OF THE TEACHING WORKFORCE*, POLICY BRIEF, FEBRUARY, WWW.OECD.ORG.

146
OECD 2001, *STARTING STRONG – EARLY CHILDHOOD EDUCATION AND CARE*, OECD, PARIS, P. 13.

147
NSW COMMISSION FOR CHILDREN AND YOUNG PEOPLE AND COMMISSION FOR CHILDREN AND YOUNG PEOPLE (QLD) 2004, *A HEAD START FOR AUSTRALIA: AN EARLY YEARS FRAMEWORK*, WWW.KIDS.NSW.GOV.AU/PUBLICATIONS/EARLY_YEARS.HTML, P. 2.

148
IBID, P. 2.

149
IBID, P. 35.

150
VARIOUS REFERENCES QUOTED IN WATSON AND TEESE 2004, FORTHCOMING, OP. CIT., P. 62.

151
LOKAN, GREENWOOD AND CRESSWELL 2001, OP. CIT., PP. 178–79.

152
LAMB ET AL. 2004, OP. CIT., PP. 50–60.

At the school level, Lamb et al. have shown that there is considerable variation in performance among schools in all sectors, once adjustment is made for the nature of their student bodies: some in each sector are clear under-performers and others are much more effective than average. They find that factors such as the socioeconomic composition of the student body, school size, school sector, quality of teachers, the extent of innovation in teaching style and the 'academic climate' in a school (behaviour of students, aspirations, peer group culture) are some of the reasons for differences in outcomes between schools, once individual student characteristics are accounted for.

The importance of individual factors in explaining outcomes, combined with the distribution of students from different backgrounds across school sectors in Australia, helps to explain apparent differences in performance across those sectors. At first glance, independent schools appear to outperform Catholic schools, which appear to outperform government schools on indicators such as VCE results and ENTER scores. However, these apparently clear differences in the study are explained to a considerable extent by:

- differences in the nature of the student population – government schools have the highest proportion of students from low socioeconomic backgrounds and independent schools have the lowest (see Section 5.1); and
- factors such as school size (some of which are likely to be correlated with levels of funding).

After the student populations the schools serve are taken into account, there remain some differences in the spread of performance across sectors, but the analysis shows that the overall performance of the three sectors is similar and that many government schools are performing very well compared with private schools.

There are two clear implications from this research:

- the current Australian education system is not coping well with individual differences between students; and
- there is scope for reducing the differences in outcomes between schools.

This is not surprising when we consider some important features of the system that are likely to be having significant effects on educational outcomes.

Early childhood education

Early childhood development programs are not provided on a systematic basis in Australia, so children arrive at school with very different levels of preparedness for education. Around 30 per cent of 4-year-olds appear not to participate in pre-school programs at all, and a further 30 per cent participate only in informal or family day care. Participation in formal child care is linked to the parent's labour force status: in families where the father is unemployed, 21 per cent of children participate in formal child care or pre-school; the proportion is 36 per cent for children in families where the father is employed. Australia's commitment to pre-primary education[153] seems to be low by international standards:

- Australia's rate of enrolment of 3-year-olds in pre-primary education (16.4 per cent) is in the bottom third of OECD countries; our rate of enrolment of 4-year-olds (50.1 per cent) is in the bottom quarter of OECD countries; and
- expenditure on pre-primary education in education institutions as a percentage of GDP is the lowest in the OECD, at 0.09 per cent compared with an OECD average of 0.44.[154]

Funding

Funding for Australian schools is not based on what schools need to educate the students they have, but in loose terms (at least within school sectors) on the notion of each child receiving the same 'standard' education. The educational research clearly shows that different students need different approaches to achieve good results: some will need more support, some more intensive coaching, some a narrower or wider program, some highly experienced teachers. Some schools are not currently using approaches that are differentiated or innovative enough, partly because they do not have the funds to do so, and this is reflected in the disparity of student achievements.

Those schools with a high proportion of disadvantaged students are in a particularly difficult position: they have a need for tailored, individual approaches for many of their students and, at best, have a very standard budget with meagre supplementary funds to finance additional effort for these students and little scope to add much to resources from parent contributions. The distribution of students from different backgrounds across schools means that many of the schools facing this problem are in the government sector, but there will also be some in the non-government sector, and many of them will be small schools. In some cases they are facing an *increasing* concentration of students from disadvantaged backgrounds, as those parents who can afford to look for other options for their children.

An examination of the total funds available for Victorian schools with different proportions of students from poor backgrounds shows:[155]

- Even though the government and Catholic school systems allocate some extra funding for schools with poorer students, the proportion of poorer students in the school accounted for little of the variation in total funding per student:
  - Part of the reason is likely to be the very small amount available for this purpose, at least in the government sector – only 1.2 per cent of School Global Budget funds;
  - Another reason is the difference in funds that schools can raise from parents and their community;
- In the independent sector, schools serving poorer communities are more likely to be low-fee schools and to have relatively low resources available per student, while schools serving more affluent communities are more likely to be high-fee schools.

In one of the families introduced in chapter 1, Sally and Bruce's daughter, Lucy, is not yet old enough to have been tested against national learning benchmarks, but she has had some learning problems which suggest she may be in the group who finds it difficult, if not impossible, to reach minimum standards in the critical areas of literacy and numeracy. Lucy did not attend pre-school so her learning problems have been picked up only recently. Her teacher does his best to give her additional help, but cannot do much as he has a large multi-year class to teach. Sally and Bruce do what they can at home to help Lucy's progress but they cannot afford extra coaching or assistance for her.

153
'ORGANISED CENTRE-BASED PROGRAMMES DESIGNED TO FOSTER LEARNING AND EMOTIONAL AND SOCIAL DEVELOPMENT IN CHILDREN FROM 3 TO COMPULSORY SCHOOL AGE.'

154
WATSON AND TEESE 2004, FORTHCOMING, OP. CIT., PP. 64–66. THE EXPENDITURE FIGURE MAY NOT INCLUDE EXPENDITURE ON EDUCATION IN CHILD CARE FACILITIES.

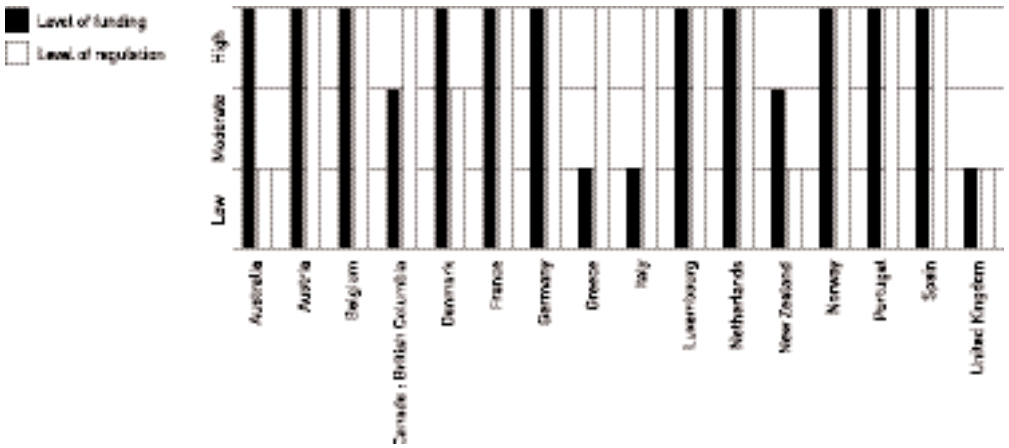
155
G. BURKE AND P. WHITE 2004, *SCHOOL EDUCATION FUNDING*, A DRAFT REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, MARCH, PP. 65, 69.

This mismatch of needs and resources is exacerbated by a range of *substantial funding anomalies* both across school sectors and within them, which means that schools in similar situations, and with a similar job to do, have access to very different levels of funding. For example:

- Watson and Teese[156] point out that the Commonwealth's use of the Average Government School Recurrent Costs (AGSRC) to adjust funding for non-government schools advantages these schools compared with the government sector. The adjustment is intended to compensate non-government schools for changes in *costs*, but the AGSRC in fact captures much more. Instead of the cost of a constant basket of goods or services, it measures changes in total recurrent expenditure of government schools divided by the number of students – and so reflects 'real' changes in expenditure in the government school system as well as rising costs. The index has risen rapidly in recent years (37 per cent between 1995 to 2001). In addition, the Commonwealth has made additional funds available to many non-government schools in recent years, on top of AGSRC adjustments, both before and during the introduction of the SES index as the basis for funding independent schools;[157]
- until very recently, government schools in Victoria[158] with high salary profiles received supplementation to accommodate their higher than average salary bill, amounting to a total of almost $9 million in 2003. The supplementary payments were funded in part by paying below-average amounts – $6 million in total in 2003 – to schools with low salary profiles. Schools with high salary profiles were those where teachers stayed for long periods, and tended to be in the wealthier areas of Melbourne. Schools with low salary profiles tended to be those less sought-after by teachers, and therefore staffed by less experienced teachers, in the western and northern suburbs of Melbourne and country areas. In general, then, the supplementary payments transferred a substantial amount of funding from poorer schools to wealthier schools within the government sector; and
- the existing funding arrangements take very imperfect account of the extent to which schools have differing levels of access to external funds through fees, so that the total resources available for individual students vary enormously, even within school sectors:
  - for example, those government schools in Victoria raising the most external funds add $2000 or more per student to the resources they have available, compared with the average of around $500 to $700 per head (State Government funding is not currently adjusted for the size of this fundraising);[159] and
  - some independent schools in Victoria raise around $15,000 per student per year from parents and communities, while others raise as little as $3000 or less; there are also large differences in the government funds available for independent schools, especially from the Commonwealth, but total resources per student still vary by up to $9000 per student.[160]

These anomalies not only distort the resources available for the education of individual students, and have clear implications for the outcomes that can be achieved, but in some cases also limit the choices of Australian families, as discussed in Section 5.2.

FIGURE 5.3 • LEVELS OF PUBLIC FUNDING AND REGULATION OF PRIVATE SCHOOLS



Levels of Funding:

High – private schools are eligible to receive a maximum government subsidy that is greater than about 66% of per-pupil allocations to public schools.

Medium – private schools are eligible to receive a maximum government subsidy that is greater than about 33% but no more than 66% of per-pupil allocations to public schools.

Low – private schools do not generally receive government subsidies, except in very limited situations, or the maximum government subsidy to private schools is less than about 33% of per-pupil allocations to public schools.

Levels of Regulation:

High – government regulates curriculum, some aspects of admissions, and teacher salaries or working conditions; public authorities register and regularly inspect schools.

Medium – government regulates curriculum (with opportunities for flexibility) and various other areas, such as tuition fees, staff qualifications, admissions or testing; public authorities register or inspect schools to some degree.

Low – government holds schools to basic criteria, such as compliance with broad curricular goals, financial requirements, or testing procedures; may require some type of registration or certification.

SOURCE: N. KOBER 1999, *LESSONS FROM OTHER COUNTRIES ABOUT PRIVATE SCHOOL AID*, CENTER ON EDUCATION POLICY, WWW.CTREDPOL.ORG.

School performance management and accountability

School performance management and accountability systems are not consistent across sectors and are not always effective where they exist. As a result, schools do not always have the best incentives to do the most with the resources they have, under-performing schools do not always get the help they need, and Australian families have little consistent information on which to base decisions about their children's education.

In a study of the amount of public funding received by private schools and levels of regulation applied to those schools by government, Kober[161] found that in most countries where private schools accept significant levels of public funding, they are required to comply with a relatively high degree of government regulation. This helps to ensure accountability for the funds they receive but also tends to make them less distinctive and more like public schools.

Australia is an exception to this pattern, along with New Zealand, providing a high level of public funding to private schools but imposing only low to moderate regulation (see Figure 5.3).

Most of the regulations imposed on private schools in Australia, such as the requirement to keep financial and attendance records, submit to independent audits and spend government grants for the intended purpose, are designed to ensure financial propriety. Aulich[162] points out that private schools in Australia are not required to report, subjected to performance audits, or to make financial records of public funds received and spent publicly available.

156
WATSON AND TEESE 2004, FORTHCOMING, OP. CIT., PP. 44–45.

157
BURKE AND WHITE 2004, OP. CIT., P. 12.

158
A NUMBER OF SPECIFIC EXAMPLES IN THIS SECTION ARE DRAWN FROM THE VICTORIAN EXPERIENCE. THIS REFLECTS THE NATURE OF THE INFORMATION AVAILABLE TO THE AUTHORS OF THIS REPORT AT THE TIME OF WRITING AND THEY ARE INTENDED TO BE ILLUSTRATIVE EXAMPLES ONLY. THEY ARE NOT MEANT TO SUGGEST THAT THE SITUATION IN VICTORIA IS SIGNIFICANTLY WORSE THAN CIRCUMSTANCES IN OTHER STATES – INDEED, WE ARE AWARE THAT A NUMBER OF THE UNDESIRABLE FEATURES OF THE VICTORIAN SYSTEM ARE CURRENTLY BEING REFORMED.

159
BURKE AND WHITE 2004, OP. CIT., P. 23, APPENDIX 3.

160
BURKE AND WHITE 2004, OP. CIT., P. 28.

161
N. KOBER 1999, *LESSONS FROM OTHER COUNTRIES ABOUT PRIVATE SCHOOL AID*, CENTER ON EDUCATION POLICY, WWW.CTREDPOL.ORG.

162
C. AULICH 2002, *GOVERNANCE MODELS FOR PUBLIC FUNDING OF PRIVATE SCHOOLS*, PAPER COMMISSIONED BY THE ACT INQUIRY INTO EDUCATION FUNDING, WWW.EDUCATIONFUNDINGINQUIRY.ACT.GOV.AU/PAPERS.HTM.

In general, private schools are subject to considerably fewer regulations and accountability requirements than are government schools.

This does not mean that the accountability systems in place in government school sectors are always effective. For example, arrangements in Victoria are now changing, but in the past, planning processes have been underdeveloped, there were few links between funding and broader planning and reporting systems, and only limited information on outcomes and how schools achieved them was publicly available and easily obtainable.

It is clearly not desirable to over-regulate any school sector, or to impose the same requirements on different sectors. As Aulich points out, different arrangements make sense where the role of the government is different: both funder and provider in the government school sector, versus purely the funder in the non-government sector.

However, it is clear that there is room for improvement, especially in public accountability for public funds spent by private schools and in the effectiveness of accountability arrangements more generally. One important benefit of better arrangements would be the availability of more comprehensive information on school performance for parents.

Workforce, industrial relations and administrative issues

Current arrangements do not always get the best results from the resources available – especially from the *education workforce* – and do not consistently support high quality teaching.

Teachers' *pay scales* in some sectors do not help to attract and retain excellent teachers. Inexperienced teachers receive a reasonable starting salary of $35,000 to $40,000, but teachers at the top of the scale – and therefore at the top of their profession (other than principals) – do not receive a high premium for their experience, receiving around $60,000 in most States.

OECD data suggest that there has been a significant compression of pay relativities within the teaching profession in Australia in recent years: real starting salaries increased by 31 per cent between 1996 and 2001, whereas the salaries of teachers with 15 years' experience and at the top of the scale increased by only 2 per cent in real terms over that period.[163] A similar change did not occur in other OECD countries (where data are available). While differences in definition across countries make these comparisons difficult – e.g. a number of Australian jurisdictions have special teacher classifications above the top of the base incremental scale, which may not be the case elsewhere – the data shows that the real pay of more experienced teachers has not increased at the same rate as that of their less experienced colleagues.

The effect of compressed pay scales is exacerbated where promotions and pay are more related to length of service than to performance. There is resistance in some areas to building a *performance and development culture*, including the measurement of student outcomes, which could be an important lever for helping to achieve and maintain high standards. Recent research on teacher evaluation programs and processes in schools and education systems in Australia found that performance management systems for teachers in Australia are relatively new and their impact is not yet strong:

It is approximately thirty years since the systems of inspection used to evaluate teachers during the preceding hundred years, were jettisoned. In those thirty years, most Australian teachers have had little or no experience of formal scrutiny of their work. Cultural norms of privacy and individualism remain strong, especially in some secondary schools.

E. KLEINHENZ, L. INGVARSON AND R. CHADBOURNE 2002, *EVALUATING THE WORK OF TEACHERS IN AUSTRALIAN SCHOOLS: VISION AND REALITY*, PAPER PRESENTED AT THE AARE ANNUAL CONFERENCE, BRISBANE, WWW.AARE.EDU.AU/02PAP/KLE02231.HTM.

A detailed review of the performance and development processes for teachers in Victorian government schools supported this conclusion, finding that the system did not result in constructive feedback that could be used to drive targeted professional development activities or provide support and counselling where performance was unsatisfactory. The outcome of the review process – in which 99.85 per cent of teachers were judged to perform satisfactorily – contrasted with principals' perceptions that 10 to 30 per cent of teachers were below-average performers and 0 to 20 per cent were significant under-performers. Systemic improvements were recommended, but the Boston Consulting Group also noted the importance of cultural issues, including 'a general reluctance to admit publicly that not all teachers are equal'.[164] Since this review took place, Victoria has announced the introduction in 2004 of an accreditation scheme to encourage schools to develop a performance and development culture, with accreditation to be a key performance objective for school principals.[165]

Innovation and strong performance by teachers and school leaders need to be encouraged and supported by access to sufficient, high quality *professional development*, including formal training opportunities and learning from peers and those with more experience.

Some teachers have access to excellent professional development opportunities, but this is not always the case:

- a survey of schools and teachers showed that in 1999, 3.6 per cent of schools did not have a professional development program and 6.5 per cent did not have a defined budget for these activities;[166] 17.5 per cent of teachers participated in no professional development or attended it for less than one day in school time and nearly one-quarter did no development outside hours;[167]

163
OECD 2003, *EDUCATION AT A GLANCE*, OECD INDICATORS, OECD, PARIS, P. 383.

164
BOSTON CONSULTING GROUP 2003, *SCHOOLS WORKFORCE DEVELOPMENT STRATEGY*, REPORT FOR THE DEPARTMENT OF EDUCATION AND TRAINING, NOVEMBER, PP. 14–16, 25.

165
THE HON. L. KOSKY 2003, OP CIT., P. 20.

166
D. McRAE, G. AINSWORTH, R. GROVES, M. ROWLAND, V. ZBAR 2001, *PD 2000 AUSTRALIA: A NATIONAL MAPPING OF SCHOOL TEACHER PROFESSIONAL DEVELOPMENT*, COMMONWEALTH DEPARTMENT OF EDUCATION, TRAINING AND YOUTH AFFAIRS, CANBERRA, PP. 122–24.

167
McRAE ET AL. 2001, OP CIT., P. 140.

- the quality of development offerings is an issue, with 16.6 per cent of teachers saying that the activities did not change their professional practice (or they were not sure) and 60.7 per cent saying that the activities changed their practice 'a bit' (22.8 per cent of teachers said that the activity significantly changed their professional practice.)[168] A recent review found that teachers were generally dissatisfied with the effectiveness of much of the professional development offered in the Victorian government sector. In particular, it was not the norm for activities to be targeted at individual teachers' specific needs and the types of learning most highly valued by teachers – peer-to-peer learning and various forms of mentoring and coaching from highly experienced teachers – were rare in practice;[169] and
- opportunities for learning about best practice and worthwhile innovation from other teachers and schools are limited by the institutional arrangements in Australia's education system: the artificial boundaries between school sectors inevitably mean that development activities tend to take place *within* sectors, limiting the flow of information *across* sectors.

And finally, some schools labour under an *unnecessarily high administrative burden and unhelpful restrictions* on how they deliver education, which limit their ability to get the most out of their funding allocations and their staff. For example, in some jurisdictions schools cannot advertise for teachers of specified levels of experience and some do not have the freedom to use options such as large group teaching or lecturing where this may be a suitable method.

In one of the families introduced in chapter 1, Patrice's son Jack has benefited from a dedicated, innovative school leader and high-quality teachers at his government school, as well as a supportive learning environment at home. He has revelled in the flexible environment of his school and learned many core skills quickly through the imaginative play designed for the school's youngest pupils. However, the school principal and two of the school's best and most experienced teachers are leaving to take up better-paid posts in independent schools or, in one case, to leave teaching altogether. All enjoy their existing jobs and would like to stay, but they are also keen to work in an environment that is more supportive of innovation, where they are rewarded better for their experience and outstanding skills and where there is a more systematic approach to handling those who do not pull their weight. Patrice is worried that the school may revert to a more standard approach under the new principal and that Jack's enthusiasm for learning will wane.

5.4 Where to from here?

The imperative for change

While the Australian school education system appears to serve the majority of the community well, it is failing substantial groups of students and their parents. There is a significant minority of young people who fail to achieve even minimum learning benchmarks, and there are clear differences in access to education and learning outcomes between those from high and low socioeconomic backgrounds, Indigenous and non-Indigenous backgrounds and, for reading achievement, between girls and boys. Some parents are in a good position to understand and make choices about schools, but others are not, partly because of features in the system itself and not just their own circumstances.

The causes of these outcomes are complex and include uneven participation in early childhood education, inequitable funding for school education, the failure of some schools and teachers (in all sectors) to do the best for their students, and workforce and administrative arrangements that do not help teachers and schools deliver the best education they can.

Left unchecked, this situation is likely to worsen. The increasing concentration of students from disadvantaged families in some schools and regions is making the job of those schools more difficult. They already have a significantly higher concentration of students from disadvantaged backgrounds and sometimes have more students with behavioural problems. As students move away, the school often loses those families better able to contribute to school life and school resources.

If the proportion of students who come from disadvantaged backgrounds and need more intensive help rises at a school, the culture of the school changes, but the resources needed to get good results for these students are not available, partly because of large funding anomalies. Despite the best efforts of the schools concerned – and research shows that many schools in all sectors, including in poor areas, perform very well indeed when their student populations are taken into account – the result will be a *more* divided education system.

This is not good enough. There is a clear challenge to improve educational outcomes, especially for disadvantaged students, and choices for Australian families. As important as it is to address these issues now, both for the benefit of the individual students not achieving good outcomes and for the broader community, the imperative to address this issue will only intensify in the coming decade as Australia's social and economic context changes, placing an even greater premium on high skills and education.

Globalisation and the diffusion of information and communications technology are changing the way Australia interacts with the world economy. In the global knowledge economy of the 21st century, economic rewards are expected to flow to nations where workers are adaptable, flexible and highly skilled. The OECD has summed up the implications of the impact of globalisation and technological change on skills development:

The large and continuing shift in employment from manufacturing industry to services, the gathering momentum of globalisation, the wide diffusion of information and communications technologies, and the increasing importance of knowledge and skills in [the] production of goods and services are changing the skills profiles needed for jobs. The distribution of employment opportunities is changing, with many unskilled jobs disappearing. With the more rapid turnover of products and services, and with people changing jobs more often than previously, more frequent renewal of knowledge and skills is needed.

OECD 1996, QUOTED IN L. WATSON AND R. TEESE 2004 FORTHCOMING, *GOALS AND PURPOSES OF EDUCATION AND TRAINING*, A REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 21.

While the new economy is rewarding people who have high levels of education, the employment outlook for young people with lower levels of education is bleak. The level of cognitive, technical and communication skills required of all young entrants to the labour market is rising. Most young people today cannot expect to hold the same job or specialisation for life, but are likely to participate in several fields of employment throughout their lifetime. Prospects for promotion out of low-skilled jobs are likely to be more limited as the 'disappearing middle' of the labour market reduces the scope for lower-skilled workers to 'work their way up' the employment hierarchy. The most reliable route to stable lifetime employment for individuals is through attaining higher levels of education.[170]

168
McRAE ET AL. 2001, OP CIT., P. 150.

169
BOSTON CONSULTING GROUP 2003, OP. CIT., P. 15.

170
WATSON AND TEESE 2004 FORTHCOMING, OP. CIT., P. 28.

The implications for individuals and for the economy are clear: an education system that achieves good outcomes for all is the way to prosperity. As Barber points out, it is also increasingly a pre-condition for a socially just and cohesive society:

...a good education system is increasingly important not only to the success of a modern economy but also to the creation of a socially just society. ...The pace of social and technological change has become so much more rapid that any citizen without a good education who is fortunate enough to find work today cannot have confidence that they will still be in work tomorrow. In the emerging global market, every country will seek to match standards elsewhere as a means of attracting business as well as enabling its citizens to succeed in life. The distribution of good education in a population also crucially affects the distribution of income and the degree of social cohesion.

M. BARBER 2003, 'DELIVERABLE GOALS AND STRATEGIC CHALLENGES – A VIEW FROM ENGLAND ON RECONCEPTUALIZING PUBLIC EDUCATION' IN OECD 2003, *SCHOOLING FOR TOMORROW – NETWORKS OF INNOVATION; TOWARDS NEW MODELS FOR MANAGING SCHOOLS AND SYSTEMS*, OECD, PARIS, P. 114.

A strong, inclusive education system is a critical part of our liberal democracy and social wellbeing, while it is also essential for the country's economic prosperity.

The way ahead

Many worthwhile and imaginative initiatives are already under way within school sectors in Australia and further reform can build on these. But the nature and extent of the issues for school education mean that larger, systemic changes are also needed.

The focus of these reforms to education must be on moving to a system that is better suited to meeting individual students' needs, supported by better preparation of children for school as well as more robust and consistent funding and accountability systems for education.

The aim cannot be to achieve the same level of performance for every student – even an excellent education system will not do that. It can be, though, to give every child an equal chance of success, by preparing them well for school and then determining which educational approach works best for them and using it. That is clearly not happening now.

Children arrive at school having had very different levels of preparation. Once they reach school, there is evidence that differences in outcomes *increase* with time at school, rather than decrease: the education system is making things worse, not better. And in some cases, students see school as so irrelevant to them that they leave the system much too early: many studies show that behavioural problems and increased drop-out rates can be traced to the degree to which the most at-risk students consider schooling, classroom teaching and assessable activities to be irrelevant, of no real-world value and fundamentally demotivating.

More change is needed on a number of levels so that:

- education systems encourage the *expectation* of achievement by students, teachers and schools, supported by stronger accountability and performance management arrangements and assistance (but not intrusion) from the centre where it is required;
- students are *treated as individuals*, with educational approaches more geared to what works for each child and updated as new techniques are developed and more is understood about what works well; where students from a particular background or with particular characteristics need more intensive help to achieve good results, this should be provided, and all school sectors should contribute to providing high-quality education for disadvantaged students;
- there are adequate, and equitably distributed, *resources* – including the right teachers, appropriately trained – available to achieve good results for all students; and
- children have fairer access to good *preparation* for school.

Options for reform to achieve these things are explored in chapter 9.

PART I
HOW ARE FAMILIES FARING? ASSESSING THE ISSUES

Chapter Six
The roles of the two levels of government in social policy and programs

The mechanisms that regulate how the two levels of government work together need to be overhauled. Current disconnected and uncoordinated processes should be replaced by approaches that are based on true collaboration.

The roles of the two levels of government in social policy and programs

The central objective of this study is to identify better ways for the Commonwealth and State and Territory Governments[171] to work together to meet community needs, especially social needs. This chapter describes the current responsibilities of the two levels of government, especially in the broad area of social policy and programs. As a prelude to exploring how arrangements should change to create better outcomes for Australian families, it examines how the current arrangements came about, and how well they accord with the community's preferences today.

Key Points

- **The Commonwealth and the States share responsibility for the government contribution to meeting the needs of Australian families. The Commonwealth has the main responsibility for income redistribution, through the tax and social security systems. In the largest and most important social expenditure areas – health and education – both the Commonwealth and the States are actively involved in policy and administration, with the States also having the major role in managing service delivery.**
- **In recent decades, the Commonwealth has come to play important roles in a much wider range of areas, especially in social policy, than those specifically assigned to it by the Constitution. The Commonwealth's style of involvement in areas of primary State responsibility has often tended to be prescriptive rather than collaborative, although this varies across program areas and over time.**
- **Partly, the widening of Commonwealth involvement may be attributed to the financial dominance that the Commonwealth has achieved since World War II. But, in part, it also reflects the community's desire for a nationally consistent approach – in a broad sense – in those areas that are most important to equality of opportunity and equity of social outcomes. That is, it is a widely shared value that all Australians, wherever they live, should have access to services in those core areas to at least a minimum national standard overall.**

- This is not a 'one size fits all' social value. People in every part of Australia want a range of services and ways of delivering those services that suit them. They value it if services in their State and locality are better than the prevailing minimum, and are well suited to their particular circumstances and preferences. Allowing such diversity and responsiveness to local needs is a great strength of our Federal system.
- However, it is clear that in many cases the manner in which the two levels of government actually interact does little for the quality of services received by the community, resulting in duplication, inefficiency and lack of co-ordination. Australian families want the Commonwealth and the States to cooperate, rather than having inconsistent or conflicting approaches to social policy and programs. They want accessible, quality services that meet their particular needs. The State level of government is generally best placed to respond in those respects, being closer to local communities, but the Commonwealth has a proper role in national aspects.
- The issue is therefore not whether the Commonwealth and States should both remain involved in the core social programs in health and education, but how.
- Apart from community preferences, rising cost pressures in areas such as health – driven by the powerful interaction of demographic trends (ageing), increasing use of expensive technology and rising aspirations – will make reform of the way governments work together in these areas an increasingly pressing issue.

171
FOR SIMPLICITY OF EXPRESSION, WHERE THIS REPORT REFERS TO 'STATES', THE REFERENCE SHOULD GENERALLY BE UNDERSTOOD TO BE TO 'STATES AND TERRITORIES', ALTHOUGH (AS HERE) THERE ARE SOME EXPLICIT MENTIONS OF BOTH.

6.1 The increasing role of the Commonwealth

The Commonwealth and the States share responsibility for government's contribution to meeting the social needs of Australian families, although their roles are very different.

The Commonwealth Government has the main responsibility for income redistribution. It has the dominant capacity for raising revenue – collecting around 80 per cent[172] of all taxation revenue – and is now the only level of government to levy income taxes, one of the prime means of redistribution. The Commonwealth also has the major responsibility for providing income transfers to individuals, through the social security system, which is the other major redistributive mechanism. Together, these tools have powerful effects in reducing inequality of income, and inequality of social outcomes, as seen in chapter 3. However, the Commonwealth also has a major involvement in, and provides a substantial share of the funding for, social programs administered by the States, which are of comparable importance for social outcomes.

For the most part, the Commonwealth's involvement in social (and other) programs administered by the States is exercised via its use of tied grants or 'specific purpose payments' (SPPs). These are used to influence policy, how services or benefits are delivered, and to whom, and so on, as well as to contribute to overall funding. These payments, although made on conditions contained in or authorised by Commonwealth legislation, are provided under what are essentially political rather than legally contractual agreements. That is, they generally do not involve referral of powers and do not impinge upon the powers of either level of government under the Constitution. Nevertheless they have a strongly contractual character.

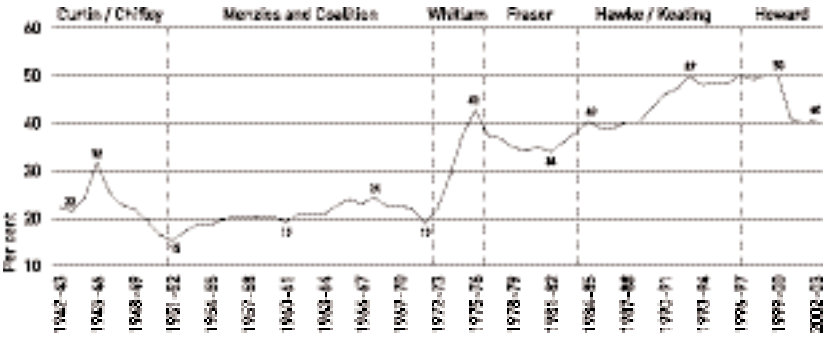
Even with the current general-purpose grants from the Commonwealth based primarily on the GST,[173] the States' general-purpose revenues fall far short of what is required to fund the social programs they administer – particularly in the major fields of health and education. The gap is made up by SPPs paid either directly *to* the States or, in some cases, *through* the States to the ultimate recipients (mainly non-government schools and local government authorities). Clearly, the social programs that these SPPs co-fund could not be delivered without them, at least under the present division of ability to raise public revenues.

Currently, around $20 billion per year of specific purpose payments (under about 120 distinct programs) flow to or through the States. As a proportion of total grants to the States, these payments tied to specific purposes have increased from 22 per cent during the war (1942–43) to as high as 50 per cent in 1999–2000, before falling back to about 40 per cent under the present Commonwealth Government's *New Tax System*[174] (see Figure 6.1).

The Commonwealth employs SPPs for a variety of reasons, including:

- to apply Commonwealth policies in areas of primary State responsibility for service delivery;
- to establish national standards in certain areas e.g. making public hospital services free at the point of use throughout the country, or ensuring that national training standards or qualification frameworks apply throughout in vocational education and training;
- to ensure compliance with international obligations; or
- as agency-type arrangements, where the States are reimbursed or compensated for the cost of carrying out activities on behalf of the Commonwealth e.g. migrant education.

FIGURE 6.1 • SPPs AS A PERCENTAGE OF TOTAL PAYMENTS TO THE STATES



SOURCE: COMMONWEALTH GOVERNMENT (BUDGET PAPERS, VARIOUS YEARS).

TABLE 6.1 • SPECIFIC PURPOSE PAYMENTS (SPPs) BY FUNCTIONAL AREA, 2003–04

Function	Current $m	Capital $m	Total $m	%
SPPs 'TO'				
HEALTH	8209.0	0.0	8209.0	50.6
EDUCATION	3094.0	249.0	3343.0	20.6
SOCIAL SECURITY AND WELFARE	1867.8	44.0	1911.8	11.8
TRANSPORT AND COMMUNICATION	43.9	1015.5	1059.4	6.5
HOUSING AND COMMUNITY AMENITIES	23.9	892.4	916.3	5.7
OTHER PURPOSES	325.3	1.4	326.7	2.0
AGRICULTURE, FORESTRY AND FISHING	264.7	9.8	274.5	1.7
PUBLIC ORDER AND SAFETY	130.0	0.0	130.0	0.8
FUEL AND ENERGY	25.4	14.3	39.7	0.2
TOTAL 'TO'	**13,984.0**	**2226.3**	**16,210.2**	**100.0**
SPPs 'THROUGH'				
FUEL AND ENERGY	0.0	1.8	1.8	0.0
EDUCATION	4263.5	97.8	4361.3	74.0
LOCAL GOVERNMENT	1505.4	0.0	1505.4	25.5
HOUSING AND COMMUNITY AMENITIES	0.0	26.9	26.9	0.5
TOTAL 'THROUGH'	**5768.9**	**126.5**	**5895.4**	**100.0**
ROYALTIES	351.0	N/A	351.0	N/A
TOTAL SPPs	**20,103.9**	**2352.8**	**22,105.7**	**100.0**

SOURCE: COMMONWEALTH GOVERNMENT.

The current arrangements for specific purpose payments – or rather, the manner in which the two levels of government work together where they apply – are not a model of good and efficient public administration. As the Review of Commonwealth–State Funding (*Final Report*, chapter 5) discussed in detail, while practice varies across the areas funded, Commonwealth conditions are often inimical to efficient administration and the quality of services because, for example, they:

- impose input controls, such as matching or maintenance of effort conditions which cut across the objective of pursuit of efficiency (by contrast with outcome or output-based funding); or
- prescribe rigid rules for approval of projects or grants, intrusive reporting requirements, Commonwealth-imposed criteria for access to programs, and so on, any or all of which may conflict with State equivalents even where States provide the bulk of the funding and the delivery, and which reduce flexibility.

172
ABS 2003, *TAXATION REVENUE 2001–02, AUSTRALIA*, CAT. NO. 5506.0, TABLE 2.

173
TOGETHER WITH SOME SMALLER ELEMENTS, PRIMARILY COMPETITION PAYMENTS.

174
SEE GARNAUT AND FITZGERALD, REVIEW OF COMMONWEALTH–STATE FUNDING, *FINAL REPORT* (2002) P. 63, ESPECIALLY FIGURE 5.2.

The Commonwealth has, through its use of SPPs, come to play very important roles in a wide range of programs primarily administered by the States, especially in social policy. The national government now exercises a range of responsibilities that is far more extensive than those *specifically* assigned to it by the Constitution. Other provisions of the Constitution, notably the power given to the Commonwealth to make grants to the States for almost any public purpose on almost any terms, have facilitated this. The Commonwealth's emergence as the financially dominant level of government has also been very important, providing the means and leverage for it to extend its influence across the spectrum of public administration. How the Commonwealth's role has evolved to be far more extensive than envisaged at Federation is described in Appendix A.

6.2 The Commonwealth's current involvement in programs with the States

One indicator of the current extent of the Commonwealth's involvement across the range of policy areas is the now very large number (120) of specific purpose payments, ranging from under $10,000 per year for the smallest, up to the $5–10 billion per year range for the largest. Some SPPs pass 'through' the States to end recipients (e.g. non-government schools), but most are 'to' the States (see Table 6.1). The ten largest SPPs 'to' the States are shown in Table 6.2.

As Table 6.1 shows, the two major social policy areas, health and education, dominate, accounting for 71 per cent of total SPPs 'to' the States and 74 per cent of SPPs 'through' the States.

The Commonwealth provides around 24 per cent of total *education* funding (excluding spending on universities but including specific purpose payments made to the States) and the States over 50 per cent, with around 20 per cent provided from non-government sources.[175]

As well as providing education funding, the Commonwealth's current role in education involves developing agreed national priorities and strategies with the States and representatives of non-government schools and developing policy related to higher education. The States also administer, regulate and deliver education services; in both school education and vocational education and training, the States play the major roles.

The Commonwealth provides a larger share of *health* funding, around 46 per cent (including specific purpose payments made to the States), and the States 22 per cent, with around 32 per cent coming from non-government sources.[176]

As well as providing health funding, the Commonwealth undertakes health policy research and high-level policy co-ordination across the various levels of government. State agencies, however, also develop policy and deliver or arrange for delivery of a wide range of health care services. They play the major roles in planning, administering and managing health care provision.

While the electorate may not have been given many opportunities to directly express a view on which level(s) of government should have which role in particular areas, it can be argued that at least the major involvements of the Commonwealth in social policy have broadly reflected community wishes.

More specifically, it appears to us that there is general support for a national dimension, and hence a Commonwealth role in respect of that dimension, in the major social programs most important to the community in terms of equity and equality of opportunity – notably health and education. We believe that there is a strong sense across the Australian community that every Australian family, regardless of where they live, should have access to services in these core areas to at least a national minimum standard overall.

TABLE 6.2 • TEN LARGEST SPPs 'TO', BY VALUE, 2003–04

SPP	$m	%
AUSTRALIAN HEALTH CARE AGREEMENT	7519.1	46.4
GOVERNMENT SCHOOLS	1784.6	11.0
VOCATIONAL EDUCATION AND TRAINING	1092.5	6.7
ROAD PROGRAMS (MAINLY NATIONAL HIGHWAYS)	928.1	5.7
COMMONWEALTH-STATE HOUSING AGREEMENT	725.2	4.5
HOME AND COMMUNITY CARE	732.4	4.5
COMMONWEALTH-STATE DISABILITY AGREEMENT	548.7	3.4
HIGHLY SPECIALISED DRUGS	376.7	2.3
TARGETED AND JOINT PROGRAMS IN GOVERNMENT SCHOOLS	346.8	2.1
NATIONAL PUBLIC HEALTH	159.7	1.0
OTHER	1996.4	12.3
TOTAL	**16,210.2**	**100.0**

SOURCE: COMMONWEALTH GOVERNMENT.

This is *not* a 'one size fits all' social value. People in every part of Australia want services that suit them, and value it if services in their State or locality are better than the prevailing minimum, and if they are well customised to their particular circumstances and preferences. The fact that it allows such diversity and responsiveness to local needs is a great strength of our Federal system.

However, it is clear that in many cases the *manner* in which the two levels of government interact does little for the quality of services received by the community. It involves much duplication and inefficiency, and indeed causes annoyance in the community at lack of policy and administrative coordination. The Review of Commonwealth–State Funding concluded:

Fixing the current system [of specific purpose payments] would boost States' ability to respond to community needs, increase incentives to improve service delivery, and reduce unnecessary duplication...[177]

Chapters 4 and 5 describe in more detail how the current arrangements across the two levels of government in health and education contribute to less than optimal social outcomes for Australian families.

In short, it is not the fact of Commonwealth involvement in these major social programs, largely administered by the States, that poses issues. Rather, it is the particular mechanisms that are used, and how they are used – as well as the proliferation of detailed Commonwealth involvement into many less central social programs. In many cases it is not obvious that there are any significant national considerations to justify this, particularly where tied grants are used very prescriptively – overriding efforts to deliver programs in ways that best suit local communities, hence inhibiting flexibility, diversity and innovation.

6.3 Pressures on how services are delivered and funded

Multiple pressures for public sector reform

Apart from financial arrangements between the two levels of government, one major factor operating over the past two decades has been the central involvement of the public sector in the wave of micro-economic reform which ran through all facets of the economy over the late 1980s and the 1990s. The Hilmer report on National Competition Policy[178] (NCP) was primarily targeted at the public sector, particularly at the involvement of States in the more commercial kinds of activity such as the operation of electricity, gas and other utilities, transport and financial services and other businesses.

The underlying pressures that NCP responded to trace in part to the opening of the Australian economy to global economic forces through the floating of the exchange rate in the mid 1980s. Industries using public services needed to be able to source efficiently produced inputs of such services in order to compete. They also put pressure on governments to keep taxation levels competitive.

175
STEERING COMMITTEE FOR THE REVIEW OF COMMONWEALTH/STATE SERVICE PROVISION 2002, *REPORT ON GOVERNMENT SERVICES 2002*, PRODUCTIVITY COMMISSION, AUSINFO, CANBERRA, QUOTED IN GARNAUT AND FITZGERALD 2002, P. 209.

176
AIHW 2003, *HEALTH EXPENDITURE AUSTRALIA 2001–02*, HEALTH AND WELFARE EXPENDITURE SERIES NO. 17, AIHW CAT. NO. HWE 24, AIHW, CANBERRA, P. 17.

177
REVIEW OF COMMONWEALTH–STATE GOVERNMENT, *FINAL REPORT*, AUGUST 2002, P. 59.

178
NATIONAL COMPETITION POLICY: REPORT BY THE INDEPENDENT COMMITTEE OF INQUIRY ('HILMER REPORT'), AUSTRALIAN GOVERNMENT PUBLISHING SERVICE, AUGUST 1993.

A closely related driver for efficiency and reformed management structures in the public sector was rising fiscal stress. Governments at both levels over the 1980s and early 1990s experienced considerable difficulty in funding their budgets. Even without the intergovernmental Hilmer reform process, they would have needed to drive efficiencies right across their operations, as to varying degrees all governments did.

Broad-scale public sector reform was pursued under, or reflected, a number of themes:

- fiscal *transparency*, notably the adoption of accrual accounting, thereby bringing all accruing resource usage to account (not merely cash outlay) and clearly distinguishing investment from expense;
- sharpening of *governance,* and *accountability* frameworks – particularly by separating, in the provision of public services, the roles of purchaser and provider;
- moving to purchasing *outputs* (as in the adoption of case-mix funding in hospitals), in the pursuit of explicitly sought outcomes, and moving away from the funding of input costs;
- ensuring *competitive neutrality* among providers of services purchased with public funds; and
- especially in the case of public provision not in competition with private providers, active *pursuit of efficiencies* using techniques such as benchmarking to identify best practice ways of providing services.

These reform themes have now, generally speaking, become norms. But while public finances in Australia are now in much better shape at all levels, public budgets remain perennially 'tight' – in the sense that community needs and aspirations continue to run ahead of the ability to raise public revenues, given the political and competitiveness constraints on taxation levels.

Less extensive reform in social policy areas

Social service provision, although not the prime target of NCP, has been affected by reform trends in the public sector more generally. Where direct competition for funding does not apply (as distinct from competition for clients), indirect supply-side competition through benchmarking and the like has promoted efficiency and some convergence of the performance of public and private providers. However, given the different approaches of the two levels of government to public vs private provision, there are inadequate mechanisms to achieve consistency, rationalisation of scarce resource use, complementarity where appropriate, and so on.

The current mechanisms for Commonwealth involvement in social programs largely administered by the States are, in general, not premised on a collaboration or partnership model focused on achieving the best service outcomes for local communities with the most efficient resource use. On the contrary, they often inhibit both diversity (the ability to deliver programs in ways that suit local communities best) and efficiency – e.g. by imposing minimum State spending on inputs rather than focusing on outputs, or, ideally, outcomes.

Again, the conclusion is not that the Commonwealth should disengage from any involvement in social programs (although it could focus its detailed involvement on far fewer programs than now, with the States reporting in nationally consistent ways in respect of all programs affecting families).

Rather, the conclusion is that the *mechanisms* for the two levels of government to work together need to be overhauled. Disconnected processes of policy development, planning and budgeting, and prescriptive approaches to intergovernmental interactions need to be replaced by approaches that are based on, and seek to 'lock in', true collaboration. That is, with each level of government maintaining its respective roles, mechanisms are needed to ensure that policy development and implementation at the two levels of government proceed with a high degree of communication and consistency, and within a shared broad vision for Australian families.

Given the prospect of rising cost pressures in areas such as health, fiscal pressures alone will be an increasingly pressing reason for seeking more efficient arrangements between the two levels of government for the funding and delivery of public services. Indeed, these prospects make reform imperative. The *Intergenerational Report*, released with the 2002–03 Budget, projects that over the next 40 years, Commonwealth spending in areas where demography is a factor will rise from 13.9 per cent to 19.2 per cent of GDP. This rise will be almost entirely attributable to health and aged care (in that pluses and minuses in other areas are smaller and roughly cancel each other out). Similar work has been done by some State Governments in respect of their future expenditure in such areas, also showing increasing pressures. Victorian analysis indicates that the combination of ageing and rising unit costs of health care will increase budget costs by around two per cent of Gross State Product.

6.4 Where to from here?

The current mix of Commonwealth and State Government responsibilities for social policy is the result of decades of change. The most notable trend has been towards increasing involvement of the Commonwealth in areas of social policy that were originally the responsibility of the States, particularly health and education.

The Commonwealth's involvement in these areas reflects, at least in part, the community's preference for a nationally consistent approach in those areas that are most important to equality of opportunity and equity of social outcomes. However, the *way* that the two levels of government have come to be involved in these sectors is not optimal – and means that Australian families are not getting the best outcomes from the resources used to provide government social services.

The views of Australian families now (see chapter 2) show that the objective of maintaining a nationally consistent approach remains important to them in a broad sense – they want high quality services that are provided in a fair and accessible way, wherever they live, but also want differentiation and responsiveness to local needs. The issue is therefore not, in our view, *whether* both levels of government should remain involved in these areas. Rather it is *how* mechanisms for collaboration between the two levels of government should be developed to meet the needs of the Australian community in the 21st century, flexibly meeting those needs according to local circumstances and preferences.

Part II of this report canvasses options for that overhaul.

PART II
A BETTER FUTURE: OPTIONS FOR REFORM

Chapter Seven
Reform principles

In Australia, the State level of government is particularly responsive to differences in the circumstances and preferences of, say, North Queensland versus Tasmanian families. On the other hand, the Federal Government's role is to ensure that both are treated equitably in the distribution of income and have access to services of a minimum national standard.

Reform principles

This chapter canvasses some guiding principles for consideration of reform to the way in which the two levels of government work together, in social policy areas and generally.

Key Points

- Both levels of government should be much less concerned, in considering what roles they should play, with who the service providers are than with efficiently achieving the best outcome for Australian families. That is, equity and efficiency are overarching principles, along with others such as simplicity and clarity, flexibility and choice.
- Some well-known principles of good public administration apply to the issue of how the two levels of government should ideally divide roles in social policy between themselves:
  - the principle of *subsidiarity*, i.e. a function should be carried out by the lowest level of government able to exercise it effectively; and
  - where both levels of government need to be involved in the same area of social policy, the Commonwealth is naturally best placed to handle issues where a *national perspective* is required, whereas State Governments are more able to identify the needs of their local communities and develop policy and program responses to them. Both have roles in working collaboratively to resolve national aspects of issues in the interest of the Australian community as a whole.
- Reform is about making our Federation work better – unlocking the benefits that only a federal system can generate:
  - maintaining a strong sense of being a single national community in which all families, wherever they live, have access to services at (at least) a minimum national standard overall; but
  - promoting diversity in how policies and programs respond to local needs and preferences – thus promoting service innovation and improvement across the nation.

- Provision of health and education services – those which matter most to Australians and their families – should continue to be a shared responsibility between the Commonwealth and the States:
  - there should be a collaborative approach to the national aspects of policy development, and planning and budgeting for these programs, including minimum national standards and a national reporting framework;
  - each level of government should bear a major share of costs, bear financial risks which it can influence, and share other risks;
  - the Commonwealth has the primary responsibility for ensuring that all Australians have equitable access to quality services at, at least, the minimum national standards; and
  - the States have primary responsibility for identifying local community needs and preferences, shaping responses and driving innovative policy and program solutions to them. The States are also best placed to administer programs 'on the ground'.
- In the area of health, there is a need for new joint arrangements to span virtually all related publicly funded health (including aged care) services.
- In the area of education, there is a need for a single consistent school funding framework for all schools that meet requirements for receiving public support.
- Clearly the major redistributional tools will continue to rest with the Commonwealth. The Commonwealth could review the *income tax* system with the aim of restoring simplicity and lowering the marginal tax rates experienced by ordinary Australians, while paring back the range of available tax breaks. In *social security*, key themes include the need for rationalisation of the different payments, each with different terms of conditions, and ideally, the adoption of a uniform payment based more consistently on needs.

7.1 National objectives and reform principles

Very broad community aims

At the very broadest level, the aim of any reform should be to improve the wellbeing of the Australian community. The two major dimensions of this are:

- efficiency – i.e. providing more or better services that the community values, for the same or less resources; and
- equity – improving fairness and equality of opportunity and reducing disparities in social outcomes.

Along with these two very broad dimensions there are others in which reform can improve things – e.g. simplicity and clarity, flexibility and choice are desirable attributes of all government programs that reform should seek to enhance.

What families want

From the point of view of Australian families and individuals, what is wanted from any changes to the way governments provide services is probably more specific and straightforward. As discussed in chapter 2, they want the two levels of government to cooperate rather than see inconsistent or conflicting approaches:

- in respect of health, they want to be able to access the health care services they need, simply, without experiencing a maze of programs in the two levels of government; to be able to make choices that suit them, and to not be constrained in receiving services they need by any contribution they are asked to make to the cost;
- in education, families want their children to have positive school experiences that develop them socially as well as in the area of learning, and help promote them on the way to a good career. Again, they want fairness and choice, and do not want cost to be a barrier to choosing a school that gives their children a quality education that they are happy with; and
- they want governments to tax them simply and fairly and with a light touch, and to assist them financially when they are in real need, again in a way that is simple and fair and respects their dignity, as well as being adequate for their needs.

All families want to be able to make choices of services that suit them. Particularly in health and education, many will make choices that they expect will require an extra financial contribution from them, and that may involve them receiving less public support.

Reform principles

In considering how the two levels of government should best work together to bring about social outcomes for Australians and their families, some *principles* need to be brought to bear. This is, of course, not a new issue. The general subject of how the two levels of government should work together in our Federal system has been canvassed many times since the late 19th century when the question of Federation – its merits, its shape and how it might work – was beginning to be actively debated in the Colonies.

The context is rather different now, but the issue of how the Federation should work remains very much alive. In recent years there have been periods of very active discussion at the political level – notably in the series of Special Premiers' Conferences initiated by Prime Minister Hawke in 1990, which gave birth (in 1992) to the Council of Australian Governments (COAG). COAG was intended to meet at least annually to discuss issues in the Federation other than finances per se.

Several major expert inquiries have also examined the issue of Commonwealth–State relations in the modern context, as outlined in chapter 6. Among them were the 1996 National Commission of Audit ('the Commission') and the 2001–2002 Review of Commonwealth–State Funding ('the Review'). The Commission paid particular attention to articulating the general principles that should apply to the issue of which level of government should play which roles. The Review focused on the areas where the Commonwealth was involved via specific purpose payments, especially health and education.

The Commission was mainly concerned with the Commonwealth Government's role per se, but with implications for the roles of the States. The Commission noted that the issue extended not only to what the two levels of government should do themselves, but also to how they should, on behalf of the community, engage with service providers, public or private:

It does not follow that because the Commonwealth Government had a role/objective when the program commenced or was expanded that the same role/objective is relevant or appropriate now.

Where government does have a continuing role/objective, this does not of itself require it to continue to deliver services. More efficient and effective delivery could be achieved by way of clearly defined purchase arrangements with other governments, agencies or private providers.

A key point that comes out of these observations by the Commission is that it is necessary to distinguish the intrinsic government roles of strategy and policy-making, planning and public budgeting (in which all public priorities compete for resources), and the high-level provision of funding, from subsidiary roles which may be delegated in some appropriate way. The latter include:

- operational program management and the detailed purchasing arrangements that this entails with providers of the services that government wishes the community to receive; and
- the actual delivery of services.

Both levels of government, especially in the post Hilmer era of National Competition Policy, should be much less concerned with considering what roles they should play, with who the service providers are, than with efficiently achieving the best outcomes for Australians and their families. The aim is to design arrangements so that Australians can readily access quality services that meet their needs and which are delivered efficiently – making good use of the public resources that fund or help to fund them.

Arrangements that favour particular groups of providers, public or private, over others are not justified other than in exceptional cases where they are a means to the end of achieving the best social outcome. In other words, the 'main game' must be delivering the best outcomes for Australian families with the available resources, with competitive neutrality applying among providers, unless achieving best outcomes requires some limits or caveats to that.

Principles guiding the allocation of roles

As for the central question here, of how the two levels of government should ideally divide roles in social policy between themselves, some well-known principles of good public administration readily apply, particularly these:[179]

(i) the principle of *subsidiarity*, i.e. the concept that a function should be carried out by the lowest level of government able to exercise it effectively – and thus as close as possible to the ultimate clients, to allow them choice in how they receive services, noting that in some cases *national considerations* will point to the higher level of government carrying a function (e.g. progressive income taxation), even though it is within the administrative capacity of the lower level;

(ii) functions should thus generally rest with *the lowest* level of government with the appropriate capability, provided that the totality of the responsibilities of each level of government is broadly aligned with its effective command over revenues;

(iii) where *both* levels of government need to be involved in the same area of social policy (as in health and education):

- *both levels of government* need to work collaboratively to resolve national aspects of issues, in the interests of Australia as a whole;
- the States have primary roles in identifying the needs of their communities, and in developing policy and program responses, to them;
- the Commonwealth should have primary responsibility for the minimum standard of services overall that at the very least every Australian family should have access to; and
- appropriate *co-funding and risk sharing* arrangements should apply, i.e. if a particular risk can be better managed or borne by one of the two levels of government, that level should primarily carry the financial consequences of the particular risk; otherwise exposure to risks should be shared as part of financial agreements.

The meeting of Premiers at the end of the Special Premiers' Conference process in November 1991 articulated another principle which they saw as a key to making our Federation work better – the 'Australian nation' principle, i.e. that all governments [should] work together cooperatively to ensure that national issues are resolved in the interests of Australia as a whole.[180]

Advantages of federal systems

Reform is ultimately about making our Federation work better *in ways that make a difference to families*, noting that the term 'families' has been used as a shorthand for 'all Australians'. A federation intrinsically has great advantages over a unitary state in that it allows, and can indeed be structured to actively promote, diversity across and within its sub-national jurisdictions (states, provinces or territories) in what and how services are delivered in response to local needs and preferences.

It is very instructive to note the trend in some unitary states to devolve large areas of policy and administration, particularly in social areas, back to the sub-national level. Nowhere has this movement been more dramatic than in the United Kingdom, where in the past decade a Scottish Parliament and a National Assembly for Wales have been established, along with corresponding executive governments. The Scottish Government on its website[181] lists the following as its top two functions:

- health; and
- education and training.

(Local government, social work and housing are the next three Scottish Government priorities.)

The Welsh Assembly Government lists on its site[182] essentially the same two top priorities, but with somewhat more elaboration:

- developing education, training and lifelong learning in Wales; and
- developing and funding NHS services in Wales.

(The Welsh Government's next three priorities are administering European funds, local government and housing.)

Devolution in the United Kingdom was a response to a number of concerns and aspirations of the Scots and the Welsh, including no doubt the wish to maintain and express their distinct cultural identities and to have governments closer to and more responsive to them. However, it is remarkable that the areas in which those communities now appear to see that local responsiveness as most important are the 'bread-and-butter' core social policy areas of health and education – just as in Australia.

In our own Australian context, the State level of government, being closer to the community, is inherently the more responsive – politically, in the development of policies and programs, and in the way that services are delivered – to differences in the circumstances and preferences of (say) North Queensland versus Tasmanian families. On the other hand, the Federal government may be best placed to ensure that both are treated equitably in the distribution of income and have access to services of at least a minimum national standard overall in those areas that matter most for equity and opportunity in life.

Diversity as a key driver of improvement

Thus it is very important that the concept of a *nationally consistent* approach is not confused with a one-size-fits-all *uniform* approach. On the contrary, it is essential that reform positively promotes diversity in the area of the particular services provided and how they are customised and delivered. Thus the achievement of minimum national standards must be understood and applied *in overall outcome terms*, not by imposing the same detailed policies, program mix or modes of delivery.

This is a very critical point, since diversity is the key to unlocking the potential of our Federal system to serve families best:

- Diversity is a key catalyst for innovation, without which service improvement cannot occur, since if new ways of doing things in different parts of the country are strongly inhibited, innovation can only occur by 'bucking the system'.
- In a collaborative federal model, the benefits of diversity and innovation can be picked up and adapted, or used to prompt new ideas, across the nation. The States have a key leadership role in driving policy and program innovation in this context.

179
THE EXPOSITION OF THE RELEVANT PRINCIPLES HERE BROADLY FOLLOWS THE DISCUSSION OF THEM BY THE NATIONAL COMMISSION OF AUDIT, IN ITS *REPORT TO THE COMMONWEALTH GOVERNMENT*, JUNE 1966, ESPECIALLY CHAPTER 4.

180
R. MATHEWS AND B. GREWAL, *THE PUBLIC SECTOR IN JEOPARDY: AUSTRALIAN FISCAL FEDERALISM FROM WHITLAM TO KEATING*, CENTRE FOR STRATEGIC ECONOMIC STUDIES, VICTORIA UNIVERSITY, MELBOURNE, 1997, P. 558.

181
WWW.SCOTLAND.GOV.UK

182
WWW.WALES.GOV.UK

7.2 Which level(s) of government?

In some areas of social policy the foregoing principles imply that it will be best for a single level of government to take full responsibility for strategy and policy and to be program manager. Some examples are as follows:

- clearly *the major redistributional tools* will continue to rest with the Commonwealth i.e. the Commonwealth will remain responsible for the *income tax*, and the overall mix of direct and indirect taxation, and for the system of *social security payments*[183] which, together with the tax system, perform the major role in redistributing income among Australian families; and
- on the other hand, many 'on the ground' community welfare programs assisting families, children and others (e.g. family support, child protection, juvenile justice etc.) are best managed locally under the full responsibility of the States in respect of policies and programs, although the latter also involve their local government authorities (LGAs)[184] in administration and delivery.

Chapter 6 of this report concluded that the major *core areas of social policy* should be regarded as *areas of shared responsibility* between the two levels of government. Indeed, the discussion there implied that this is the community's preference, and indeed would still be, broadly speaking, even if the relative financial capacities of the two levels of government were significantly different to how they stand today.

- The two major areas in this core sphere are those which matter most to Australians and their families for equality of opportunity, fairness, and equity of social outcomes – namely *health and education*.[185] The Review of Commonwealth–State Funding identified these two areas as the ones in which the present overly-diverse range of Commonwealth specific purpose payments to the States should be concentrated in two *national* (i.e. collaborative) programs, and with the Commonwealth taking prime responsibility for a third national program, Indigenous Community Development, although with the States heavily involved in the development and delivery of that program.

Outside those major areas both the Review and the National Commission of Audit (among others) have identified considerable scope for *transfers of functions* between the Commonwealth and the States – for example in the area of public housing.

There is also much scope for exit of the Commonwealth from smaller involvements in social programs. The Commonwealth is involved in many miscellaneous areas where it appears that limited value is thereby added, but where these involvements do certainly entail duplication, administrative overlap, confusion of the families or individuals accessing the services, and a general degree of inefficiency.

The Review of Commonwealth–State Funding's proposal for reform of the Commonwealth–State interface recommended that outside three national co-operative programs it proposed in Health, Education and Indigenous Community Development, and that with some limited other exceptions, the proliferation of small SPPs should be comprehensively rationalised. That is, most of these SPPs should be terminated, with compensating increases in the resources provided to the States under the three national programs.

The National Commission of Audit noted that in areas which the Commonwealth exited there would still generally be an important community interest in national reporting of outcomes etc. (especially for programs important to families) – but without maintaining any duplicated administration:

...any national policy bodies that are retained should limit their activity to joint work on national coordination and strategic directions and the development of standards, benchmarks and performance measures. They should not be involved in service delivery or approval of projects.[186]

7.3 Efficient governance, efficient delivery, families better served

Essentially, what is needed in the core areas where the community clearly wants both levels of government to be involved is a genuine *partnership*. The two levels of government should allocate responsibilities for strategy, planning, budgeting, program management and delivery between themselves in a way that is clear, efficient and well coordinated.

- This requires '*integrated governance*' arrangements. Such arrangements need to be founded on:
  - agreed goals and objectives;
  - agreed broad policies to achieve them, national minimum standards etc.;
  - agreed *outcomes* to be achieved, but with diversity of approaches to achieving them positively encouraged;
  - an agreed, and clear, allocation of respective roles and responsibilities in pursuing those outcomes;
  - agreement on financing and bearing of risks; and
  - agreed reporting and accountability arrangements.

Such arrangements must be made as transparent as possible to Australian families, who care little about which level of government plays what part in the simple, seamless delivery of quality services that they want.

Nevertheless it is critically important to good governance that the matter of which level plays which part in the process is clearly decided, consistent with the principles outlined earlier (subsidiarity etc.). The Review of Commonwealth–State Funding emphasised the importance of explicitly establishing the following key elements in the core national programs that would be conducted under that compact, and set down explicitly in intergovernmental agreements:

Joint responsibility at the strategic level for setting broad priorities. Outcome objectives and agreed measures to monitor results in the three key areas of health and aged care, education and training, and Indigenous community development.

Administrative responsibility for each of these key areas residing with one level of government. Generally this would be the State level since in the relevant areas they are predominant in service delivery capacity. There would be a single integrated program for these areas and the administering level of government would be free of input controls and micro-management from the other level of government.

Rationalisation of existing functions and funding arrangements. Opportunities would be sought for rationalising functions within or closely related to the three areas between the levels of governments.

183
THE MAJOR SOCIAL SECURITY PAYMENTS INCLUDE THE AGE PENSION, THE DISABILITY SUPPORT PENSION, PARTNERED AND SINGLE PARENTING PAYMENTS, THE NEWSTART ALLOWANCE AND THE YOUTH ALLOWANCE.

184
CONSTITUTIONALLY, LOCAL GOVERNMENT FALLS WITHIN THE JURISDICTION OF THE STATES.

185
AS ELSEWHERE IN THIS REPORT, THESE ARE TO BE UNDERSTOOD BROADLY – EXTENDING TO AGED CARE AND VOCATIONAL EDUCATION AND TRAINING, RESPECTIVELY.

186
NATIONAL COMMISSION OF AUDIT, OP. CIT. P 32.

7.4 Future Commonwealth and State roles in social policy

The Commonwealth's role in income redistribution

As already argued, the Commonwealth Government will have clear responsibility for the key instruments in the redistribution of income in the Australian community – the income tax and the social security payments system. As the National Centre for Social and Economic Modelling (NATSEM) analysis of the impact of governments on outcomes for families shows, these systems of taxation and payments are responsible for, by far, the greater part of the redistribution of incomes and social outcomes influenced by all Australian governments through all their programs combined.

In respect of the *income tax*, a major issue arising out of this study is that the system is unduly burdensome as felt by ordinary Australian taxpayers – even though, overall, taxation in Australia is not unduly high by OECD standards. In part this is attributable to the extensive leakages from income tax collections that have proliferated through deductions, rebates and the like – predominantly those identified in the Commonwealth's annual *Tax Expenditures Statements*.

The income tax system has also been used to administer a variety of elements of social policy including the higher education contribution scheme (HECS) and, in part, the private health insurance (PHI) rebate,[187] as well as some assistance to families.

The aim of income tax reform should be to restore simplicity and to lower the marginal tax rates experienced by ordinary Australians, while severely rationalising the range of tax breaks that have been cumulatively responsible for a substantial leakage of tax revenues. The current situation is analogous to that which existed when the Asprey Committee looked at the income tax system in the 1970s – a time at which deductions and other tax breaks had also proliferated. As a result of the Asprey recommendations, tax rates came down for everyone and, while almost everyone in the community lost the specific benefit of some particular deduction or tax break, the tax-paying community as a whole, and nearly all individual taxpayers, were better off – including in terms of greater simplicity and transparency and perceived fairness in the reformed income tax system.

In the *social security system* the present Commonwealth Government itself has placed major emphasis on systemic reform. Key themes of reform that have been identified include the need for radical rationalisation of the range of different payments, each with different terms and conditions, and ideally the adoption of a uniform social security payment based consistently on real needs.

A difficulty with such a reform is that some people who have been enjoying higher payments than others with the same objective income needs may be losers. Therefore, phasing is likely to be needed, involving a transitional cost. Nevertheless, such a reform would make the social security system fairer, much simpler and more transparent, and would minimise incentives to 'shop' among benefits.

The core social policy areas in which responsibility is shared

Consistent with the principles described in Section 7.3, in health and education the Commonwealth and the States should share responsibility for strategic policy:

- there should be a collaborative approach to the national aspects of policy development, planning and budgeting, including the definition of minimum national standards and the establishment of a national reporting framework; and
- the Commonwealth and the States should enter into, and carry out, agreements that detail the agreed approaches to policy development, planning, funding, program management, and delivery and reporting in respect of national aspects of these policy areas. Neither level of government should intrude into administration of programs by the other; agreements should be in output, or ideally outcome terms, leaving the administering level of government free to determine how results are achieved.

Within this collaborative approach, the Commonwealth and the States should have the following roles:

- the Commonwealth should have primary responsibility for ensuring that all Australians, wherever they live, have equitable access to quality services at, at least, the defined minimum national standards.
- the Commonwealth and the States should both bear a major share of the *responsibility for funding* the core health and education services broadly to those national standards. The Commonwealth should bear financial risks that it can influence (but which the States cannot); conversely, the States should bear the financial exposure to risks that they can influence (but which the Commonwealth cannot). The Commonwealth and the States should share the risks which neither level can readily influence, and in proportion to their overall levels of expenditure. In addition, States should take financial responsibility for any enhancement of services that they choose to provide to their own citizens.
- The Commonwealth should have principal responsibility for identifying national needs and reform directions in these policy areas.
- The States should have principal responsibility for *identifying local community needs and preferences*, shaping responses to those needs, and driving innovative policy and program solutions to them.
- The States should have primary responsibility for efficient program management, purchasing and management of most service provision 'on the ground', including dealing with both government and non-government providers who provide services that receive public support. This role would include reporting within the agreed national framework.

New Commonwealth–State institutional arrangements

The discussion above has been focused on how the Commonwealth and the States should work together in major social program areas where they are both involved. However there is an implied need for reform of the overarching governance structures in our Federation (The Council of Australian Governments, COAG, the various Ministerial Councils etc.), to provide from the top the drive for the new collaborative arrangements. Directions for top level governance reform are canvassed in chapter 10.

187
THE REBATE CAN ALSO BE ACCESSED AS A PREMIUM DISCOUNT OR DIRECT PAYMENT.

PART II
A BETTER FUTURE: OPTIONS FOR REFORM

Chapter Eight
A new health system for all Australians

An integrated approach to health services through funds pooling and local purchasing has the potential to increase medical and technical innovation, reduce costs and improve people's health.

A new health system for all Australians

This chapter sets out reform options for the area of health. It proposes new institutional and funding arrangements to provide quality care for Australian families, seamlessly and more efficiently. It also considers how reform might be implemented.

Key Points

The aims of reform are to improve:

- affordable access to quality care for all Australians;
- continuity of care and service integration;
- the interface between primary, acute and aged care;
- the focus of governments and individuals on prevention, health promotion and disease management; and
- incentives for primary providers to provide more cost-effective care and hence reduce costs for more expensive, acute care.

An Australian Health Commission

The formation of a joint Commonwealth–State national body, the Australian Health Commission (AHC), would be the essential first step to drive the reform process. The AHC would report to and advise the Commonwealth and State Health Ministers.

Directions for reform: an integrated health care system

Under an integrated health care system, regional health agencies would have control over a budget of pooled Commonwealth and State funds for acute care, primary and community care, pharmaceuticals and aged care. Advantages include:

- in the long term, continuing responsibility of one authority for the health of all residents within a region puts the emphasis on improving the health status of individuals and populations;
- increased capacity and incentives for continuity of care and service integration;
- services planning can be undertaken across all health problems, disease stages and target populations, across all modalities of care, and all lifetime health care needs; and
- incentives for appropriate cost containment, including through possibilities for substitution between more and less cost-effective interventions, even where benefits accrue downstream in the future.

First steps: focus on primary health care

There will be increased emphasis on the prevention of ill health, health promotion and disease management, with a consequential increase in the importance of primary care. Two proposals are put forward:

- To gain the benefits of a more strategic approach to prevention and health promotion, the Commonwealth and States would pool their related funds to develop integrated local health promotion plans. Funds could be held by GP Divisions and allocated to GPs, community health centres and hospitals according to the plan's objectives.
- The foundation for integrated care of elderly people and people with chronic diseases is enrolment with a GP practice, giving GPs overall responsibility for care coordination. Contracts would be negotiated with GPs to ensure an integrated approach to the management of health needs (e.g. through primary care teams and referral pathways). Choice between GP practices would remain.

Each State could progress to an integrated health care system within its own timeframe and subject to detailed negotiations. Ideally, however, to ensure a degree of national consistency and commitment, this would be done within broad directions and framework agreed between the Commonwealth and all State Governments.

Capacity building

Significant investment by the Commonwealth and the States through the AHC in capacity building is needed to prepare and provide support for reform. For example, progress is needed in:

- workforce development; and
- a national approach to information management and technology.

Immediate reforms to improve access to care

To improve access to primary care, the priority initiatives are:

- the co-location of primary care clinics adjacent to emergency departments;
- additional funding to improve access to elective surgery for public patients, especially for those facing long waits; and
- additional funding for aged care programs.

Improving the complementarity of public and private care

There are a number of options for better use of private hospitals and private health insurance coverage. For example:

- State Governments could contract for elective surgery for public patients in private hospitals; and
- the Commonwealth could allow private health insurance to cover expenses for facility fees and diagnostic tests at private hospital emergency departments.

Options are also available for improving the cost-effectiveness of the funds spent on the 30 per cent private health insurance rebate (for example, by removing the cover for ancillaries or by capping).

8.1 The case for reform

Simply put, the objectives of Australia's health care system are to provide good care, to all Australians, at a sustainable cost. To do this, there must be easy and equitable access to quality, cost-effective health care.

Chapter 4 considered the case for reform of Australia's health care system. While generally speaking Australians enjoy good health, there is great scope to improve health care, particularly around the issues of access, appropriateness and continuity of care. Also, the poor health of certain groups in Australia indicates that much more needs to be done, most notably to improve the health status of Aboriginal and Torres Strait Islander people and also of people from disadvantaged socioeconomic backgrounds generally. Further, the health care system must be able to respond effectively to the drivers of change that are influencing the future of health care, including significant changes in demographics, in the health needs of the population, in clinical knowledge and practice, and in technology.

The real increases in expenditure on health care, which are projected to continue and hence put pressure on the funding of other goods and services, place a particular responsibility on both levels of government, as the major funders of health care, to ensure that expenditure is equitable and cost-effective. It is also important to ensure that the way in which governments fund health care supports an equitable, cost-effective health care system. Chapter 4 pointed out problems with the current funding arrangements, particularly the complex split in responsibilities for the funding and provision of health care between the Commonwealth and State Governments. This leads to poor coordination of planning and service delivery, barriers to efficient substitution between alternative types and sources of care, and scope for cost-shifting. The funding arrangements do not encourage continuity of care, provision of multidisciplinary care, or provision of care in the most clinically appropriate setting. There is a lack of focus on prevention, health promotion and disease management.

This was the clear message of the Expert Reference Groups brought together to advise Commonwealth and State Ministers in the lead up to the recent renegotiation of the Australian Health Care Agreements:

The current fragmentation of the health system has been identified by all Groups to be the most significant barrier to realising optimal health outcomes for Australians. The system is considered to impose artificial and arbitrary boundaries on consumers and health professionals who need to manage episodes of care in a flexible and coordinated manner.

The overwhelming message from the Groups is that this lack of integration is unsustainable, expensive and detrimental to health outcomes. There is broad agreement that consumers have the right to receive timely, appropriate and quality health care in a seamless environment. The care delivered should be determined by clinical need, not by the limitations or conditions imposed by jurisdictional boundaries or other funding or professional silos.[188]

The Commonwealth and State Governments bear joint responsibility for tackling these issues.

What ability do governments have to reform the system?

Comprehensive reform of the health system would be a very complex endeavour – not least because there are significant limits on the ability of governments (even if working together closely and cooperatively) to address some of the more important issues *directly*. In particular, the Constitution[189] prevents the Commonwealth from making laws that would 'authorise any form of civil conscription', i.e. in this context, laws seeking to impose the terms on which medical and other health practitioners offer their services. General practitioners cannot be compelled to bulk-bill, for example.

Governments can nevertheless influence the system in powerful ways – through financial incentives (by acting as insurers, funders or purchasers of services), by making available services that their own agencies provide or administer, by influencing labour supply in health through the funding of training, and via regulation, persuasion and transparency measures.

In response to the problems created by the situation where both the Commonwealth and State Governments fund health care, many people argue that an important first step in reforming health care is to give responsibility for funding to one level of government. Some people put forward the view that the Commonwealth Government should take responsibility for funding all health services; others propose that the State Governments take full funding responsibility. Recently, for example, the Commonwealth Minister for Health and Ageing, the Hon. Tony Abbott, has raised the idea of the Commonwealth taking over responsibility for all health care.[190]

A good summary of the arguments for and against assigning responsibility for health care funding to one level of government is provided in the Senate Community Affairs References Committee inquiry into public hospital funding.[191] The arguments for a single funder include:

- overcoming cost shifting;
- focusing accountability; and
- shifting the provision of health care to being more responsive to patient needs rather than being based on who pays for a particular service.

In practice, however, it would not be easy to determine which level of government should take the full responsibility for funding. There are advantages and disadvantages with whatever level of government is chosen as the single funder for health care. For example, the Commonwealth has the advantage that it is in the best position to ensure greater consistency of health care provision across Australia; but the States are in a better position to determine the needs of their local populations. Also, it would not be easy to achieve such a result without significant disruptions to the administration of health care.

Given the difficulties, and the unlikelihood that the Commonwealth and the States could reach agreement on the process and on the issues, this paper assumes that both the Commonwealth and States retain joint responsibility for health care. However, there is no doubt that more progress can be made in improving the health care system by the two levels of government working closely together than if they largely operate separately.

188
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, P. 3.

189
THE AUSTRALIAN CONSTITUTION, SUB-SECTION 51 (XXIIIA).

190
QUOTED IN J. MENADUE 2004, *BREAKING THE IMPASSE IN HEALTH: A COALITION OF THE WILLING – A JOINT COMMONWEALTH–STATE HEALTH COMMISSION*, SPEECH TO THE HEALTH CARE REFORM ALLIANCE FORUM, CANBERRA, 21 APRIL.

191
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE 2000, *FIRST REPORT – PUBLIC HOSPITAL FUNDING AND OPTIONS FOR REFORM*, JULY 2000, PP. 71–76; AND OFFICIAL COMMITTEE HANSARD, 18 AUGUST 2000 AND 20 NOVEMBER 2000.

8.2 An Australian Health Commission

The reform proposals put forward here take this last point as a guiding principle for reform: they *require* the two levels of government to work closely together, as this is essential for significant progress to be made in improving Australia's health care system. A comprehensive reform package is achievable in a 5 to 10 year time frame, with intermediate steps along the way. The essential first step is the formation of a joint Commonwealth–State national body to drive the reform process; it will be called here the *Australian Health Commission*, or AHC.

With the formation of the Australian Health Commission (AHC), Commonwealth and State Governments would agree to work together to reform Australia's health care system *for patients*. In the first phase of reform, the AHC would be dedicated to developing and integrating advice on strategic reform in the delivery and management of health care and managing national strategic reform projects.[192]

The rationale for the AHC is based on the recognition that:

- the health sector is under considerable pressure and its sustainability will increasingly become an issue;
- uncoordinated responses by jurisdictions will be inadequate to meet future demand and ensure the provision of comprehensive and contemporary health care; and
- there are great difficulties in exploring opportunities to modify funding and policy parameters in the current funding negotiations between the Commonwealth and States in ways that would make a real difference to families.

The AHC could initially tackle a number of existing issues that require a collaborative approach from the Commonwealth and States, as well as developing and driving a far-reaching reform agenda. The possible role and responsibilities of the AHC are discussed further in Section 8.4.

8.3 Reform directions: an integrated health care system

Many previous studies of the problems of Australia's health system have argued that an essential reform is the *integration* of Commonwealth and State health care programs through funds-pooling and budget-holding. Various models have been proposed, including:

- a Joint Commonwealth–State Health Commission (proposed by John Menadue) in each State, which would receive a negotiated allocation of funds from the Commonwealth and relevant State Government covering acute, primary and community health care services. The Commission would manage the funding and planning of all health services in that State, purchase various services from providers, and monitor performance against agreed targets;[193] and
- managed competition (proposed by Richard Scotton), which would also involve the pooling of Commonwealth and State funds. However, in addition, it would involve more significant structural reform of the health system as it would integrate private sector funding and service provision into a national program.[194]

Approaches with some similarities are being explored or actively implemented in a number of countries comparable to Australia, including the United Kingdom and New Zealand. There is now emerging evidence that closer integration of clinical decision-making and purchasing for enrolled populations through funds-pooling and local purchasing has the potential to increase innovation, reduce costs and improve health.[195]

The key features of these emerging approaches are:[196]

- a regional population model, with a regional health authority, the fundholder, responsible for the health of all residents within a defined geographical region;
- the regional health authority having control over a budget, based on a risk-adjusted capitation payment, and a mandate to purchase (arrange and fund the provision of) all health services for the defined population;
- the health authority negotiating performance-based contracts with providers for health care services; and
- universal coverage, with financing for health care provided from taxpayer funds, at least in the main.

The incentives for the fundholder in this model derive from long term control over the entire health budget for the designated population, given an expectation of low membership turnover tied to residential relocation. The fundholder thus has *continuing* responsibility for the health needs of the enrolled community. This model provides capacity and incentives for continuity of care, service integration, coordination, and innovation. Services planning can be undertaken across all health problems, disease stages and target populations, across all modalities of care, and all lifetime health care needs. Within this, there also strong incentives for public health and population health initiatives.[197]

The long-term focus dictated by low turnover of membership puts the emphasis on improving the health status of individuals and populations through enhanced quality of care. The model thus maximises the possibilities for substitution between more and less cost-effective interventions, even where benefits accrue downstream in the future. Planning across health and other social services is also facilitated.[198]

Details of the approach adopted in New Zealand and England are set out in Box 8.1 and Box 8.2. In both cases district authorities with budgetary, performance and organisational responsibility for the health of a catchment population negotiate contracts with primary care practices for primary care. The focus of primary health reform shifts from traditional, individually-focused general practice to a more integrated population-focused approach.

192
THE IDEA FOR AN AUSTRALIAN HEALTH COMMISSION DRAWS ON A PROPOSAL DEVELOPED BY THE VICTORIAN DEPARTMENT OF HUMAN SERVICES FOR THE AUSTRALIAN HEALTH MINISTERS' ADVISORY COUNCIL TO ESTABLISH A NEW AGENCY, HEALTH DEVELOPMENT AUSTRALIA (HDA). IT WAS PROPOSED THAT HDA WOULD BE DEDICATED TO INTEGRATING ADVICE ON STRATEGIC REFORM IN THE DELIVERY AND MANAGEMENT OF HEALTH CARE, AND MANAGING NATIONAL STRATEGIC REFORM PROJECTS.

193
J. MENADUE 2004, OP. CIT.

194
PRODUCTIVITY COMMISSION 2002, *MANAGED COMPETITION IN HEALTH CARE*, WORKSHOP PROCEEDINGS, AUSINFO, CANBERRA.

195
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

196
L. SEGAL, R. DONATO, J. RICHARDSON AND S. PEACOCK 2002, 'STRENGTHS AND LIMITATIONS OF COMPETITIVE VERSUS NON-COMPETITIVE MODELS OF INTEGRATED CAPITATED FUNDHOLDING', *JOURNAL OF HEALTH SERVICE RESEARCH POLICY*, VOL. 7, SUPPLEMENT 1, JULY, S1:56–64, P. S1:57.

197
IBID.

198
IBID.

BOX 8.1 • PRIMARY HEALTH ORGANISATIONS IN NEW ZEALAND

In New Zealand, District Health Boards have responsibility for health planning, purchasing and performance management for a regional catchment area. They hold budgets and negotiate agreements with providers.

Primary Health Organisations (PHOs) are local groups of providers whose job it is to look after all the people enrolled with them. The group always includes a GP and may also include nurses, pharmacists, dieticians, mental health workers, community health workers and dentists. While primary health care practitioners are encouraged to join PHOs, membership is voluntary.

The essential features of PHOs are:

- their aim is to improve and maintain the health of their populations and restore people's health when they are unwell. They are required to provide at least a minimum set of essential population-based and personal first-line services, including population services to improve health, screening and preventive services, support for people with chronic health problems, and information, assessment and treatment for any episodes of ill health.
- PHOs are required to work with other providers within their regions to ensure that services are coordinated around the needs of their enrolled populations.
- Payments to PHOs are based on a blended combination of capitation, management and other payments:
  - capitation payments are adjusted for age, gender, ethnicity, level of health need and disadvantage. They are made for restorative care, high-needs care, immunisation, and health promotion for enrolled populations, with adjustments for casual attendances;
  - management payments are adjusted for the number of enrolees; and
  - other payments are made for factors such as geographic isolation and the hours the organisation operates for patients.
- PHOs may charge co-payments for specified services but they are required to adhere to fee setting principles and specify their fees as part of the agreement. In effect this provides the District Health Boards with the opportunity to influence PHOs' fees.
- PHOs enrol people through primary providers. Enrolment is voluntary and people are allowed to change their nominated provider without difficulty. As of July 2003, 47 PHOs had been established since 2001, covering a population of approximately 1.7 million New Zealanders (or nearly 50 per cent).
- PHOs are not-for-profit bodies with full and open accountability for the use of public funds and the quality and effectiveness of services.

SOURCE: AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

BOX 8.2 • PRIMARY CARE TRUSTS IN ENGLAND

In England, there are approximately 300 Primary Care Trusts (PCTs) with responsibility for managing all health care for catchment populations. They have three main functions:

- improving the health of the community: PCTs deliver their public health role through community development, service planning, health promotion, health education, commissioning, occupational health and performance management;
- providing and/or securing the provision of services, including primary care, community health, mental health and acute secondary care services; medical, dental, pharmaceutical and optical services; emergency ambulance and patient transport services; and population screening programs; and
- integrating health and social care in the local health and social care community.

Their main features are:

- PCT boundaries are aligned with those of local government and usually have populations of between 100,000 and 200,000 people;
- PCTs have responsibility for community health and general practice services. They employ some staff directly and negotiate standard medical service contracts with independent general practices and also agreements with National Health Service Trusts (acute health providers) to provide services for their catchment population; and
- they receive their funding directly from the Department of Health. In 2002, PCTs controlled around 50 per cent of the NHS budget; in 2004, 75 per cent of the NHS budget will be controlled by PCTs.

PCTs are provided with funds for General Medical Services (GMS) contracts based on their catchment population characteristics. They in turn make payments through the GMS contracts, in line with the specific characteristics of each primary care practice:

- patient registration;
- access and closure arrangements;
- the spread of hours and out of hours arrangements; and
- the nature of the services to be provided (including minor surgery and maternity care), prescribing and dispensing arrangements, records management, service coordination, consumer rights, the quality and performance standards that must be met, and payment arrangements and clinical governance.

Performance-based payments based on the implementation of a quality framework and the achievement of patient outcomes comprise a significant component of practice income. The quality framework includes clinical, organisational and patient experience indicators.

PCTs can negotiate GMS contracts with individuals, partnerships or companies although there is a strong preference for organisationally rather than individually based contracts. In the United Kingdom, services are effectively free to the majority of patients.

SOURCE: AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

8.4 Implementing an integrated health care system

While in theory an integrated health care system would seem an obvious way to go to address Australia's problems of fragmentation of health care funding and delivery, in practice implementing an integrated health care system would be very complex, difficult and time-consuming. It would require significant resources and, most importantly, a great deal of collaboration among the Commonwealth and State Governments. The examples of New Zealand and the United Kingdom indicate that significant governance, system, organisational and workforce development would be needed. Considerable institutional effort would also be required to support change. In the United Kingdom for example, a Modernisation Agency has been established for the NHS.

There are a number of elements that would be important in implementing an integrated health care system in Australia. The key elements are listed in Box 8.3 and discussed in the subsequent sections. It is obvious from the scope of the elements that a new integrated care model could not be introduced overnight as it would require significant change to current Commonwealth–State funding and health care responsibilities. In addition, more careful analysis and broader discussion are required in terms of the specific model for integrated care most appropriate for Australia.

Importantly, this paper does not put forward a specific model for implementation. Our concern is that recommending a specific model for integrated health care would lead to debate about the details of the model, whereas at this stage of the reform process attention should be given to seeking agreement to the directions for reform. If the Commonwealth and States agree to pursue the advantages of an integrated health care system, it is suggested that it would, appropriately, be the responsibility of the AHC to develop a detailed model. The aim of the outline below of the possible elements of an integrated health care system is to open up the issues for discussion by describing a possible approach. Again, this should be viewed as a basis for discussion rather than the only way that integrated care can be achieved.

BOX 8.3 • KEY ELEMENTS OF AN INTEGRATED HEALTH CARE SYSTEM

- Purchasing arrangements:
  - funds-pooling
  - allocation of funds
  - purchasing agency
- Providers
- Service agreements
- Governance arrangements.

Purchasing arrangements

Integrated care aims to facilitate the coordination of patient care, particularly through reforms to arrangements for the purchasing of health care consistent with a strategic purchasing approach. Under strategic purchasing the purchaser becomes responsible for ensuring that the 'required services in the right volume are delivered at the right quality and at the right price'.[199]

There are three important aspects to the new purchasing arrangements: the pooling of health care funds, the allocation of funds, and the agency distributing the funds.

Funds-pooling

An essential component of integrated care is the pooling of funds for health services. Ideally, this would mean pooling of funds across programs (i.e. MBS, PBS, acute care, other public and community health care, and aged care), as well as across jurisdictions. Boundaries between health programs are removed, providing opportunities for substitution of health services, with the aim of improving the coordination and appropriateness of care. Efficiency is improved through reduced program complexities and cost shifting.

The pooled funds are allocated to purchasers who are responsible for 'buying' an appropriate mix of health care services. As all health care services are funded from a single pool, health care becomes more patient-oriented and responsive to individual health care needs. This contrasts with current arrangements under which most funding is determined on a program basis, according to services supplied by providers.

Under funds-pooling arrangements, purchasers of care are accorded greater responsibilities than within the current system. Purchasers are responsible for managing the health care needs of specified population groups. They do this by buying health services from providers, purchased from the pool of funds. Purchasers must carefully consider how patients should be treated and how ultimately they can be kept 'healthy', as they are responsible for deciding upon care within prescribed fund-pooling budgets.

Better-integrated, cost-effective care is encouraged through two central characteristics of pooled funding: responsibility for financial risk, and responsibility for the health of a population.

Through financial risk-sharing, purchasers have an incentive to ensure that services are funded within the constraints of their budget. This encourages the most cost-effective care possible, as purchasers are responsible for the wider flow-on costs of any care prescribed. Purchasers, therefore, have an incentive to manage the health of the people in their population to minimise expensive treatment costs or eliminate them all together through preventive medicine.

Responsibility for the health of a population ensures that purchasers are better able to provide continuity of care. It also enhances the bargaining capacity of purchasers with providers through the weight of numbers covered.

In designing an integrated health care system an early decision must be made about the scope of the health, aged care and community support services to be included. Allocative efficiency (which is concerned with ensuring the best outcome for a given budget) is likely to be promoted if a full range of health care is included. The broader the scope of services included, the greater the opportunities for substitution of health services, continuity of care, and cost control. If the scope is restricted, this creates opportunities for cost shifting.

The scope of services would determine the extent of funds-pooling by the Commonwealth and States. Ideally, the services to be included would be broadly defined as those currently covered under Medicare (MBS and PBS), acute care, other public and community health care services, and aged care programs.

Allocation of funds

In a Commonwealth–State integrated health care system, there would be two levels of funds allocation. First, funds would be allocated to each State. For example, a practical approach would be to base funding on the current allocations of Commonwealth and State funds for health services for a particular State. Alternatively, there might be a common formula, but with an offsetting adjustment to other – for example general purpose – payments to ensure budget neutrality. Growth funding could be made available under the proportional allocations of the Commonwealth and State Governments for each State.

Second, funds would be allocated from the State Government to the regional purchasing agencies within the State. One approach would be for high-level funding to the regional agencies to be based on risk-adjusted capitation payments. The advantage of this approach is that funds would be allocated according to the level of patient need through adjustments for factors such as age, sex, socioeconomic status and location. Hence, revenue can be weighted in favour of the most ill, providing incentives to better cater for their needs. The formula could also build in equity between populations living in different areas. In Australia, this would tend to redistribute payments to rural and remote areas.[200]

Purchasing agency

Under a pooled-funding model, there must be a purchasing organisation or agent responsible for distributing the pooled funds. The purchaser can thus make informed decisions as to the mix of services to be purchased and can utilise and reward different providers in relation to their efficiency and quality.[201] It can thus be a force for encouraging all providers to move towards best practice – that is, employ practices that on solid evidence tend to produce the best outcomes for people, having regard to the resources used.

The combination of responsibilities means that purchasing agencies are more than simply payers. They are organisations that, at their best, bring together expertise in clinical practice, public health, general management, planning, finance, performance monitoring and community participation, and achieve strategic change through the use of their financial and other resources.[202]

199
QUOTED IN PHILLIPS FOX AND CASEMIX CONSULTING 1999, *HEALTH SERVICES POLICY REVIEW DISCUSSION PAPER*, DEPARTMENT OF HUMAN SERVICES, MELBOURNE, P. 42.

200
R. SCOTTON 1998, 'MANAGED COMPETITION', IN G. MOONEY AND R. SCOTTON (EDS), *ECONOMICS AND AUSTRALIAN HEALTH POLICY*, ALLEN & UNWIN, SYDNEY, P. 227.

201
PHILLIPS FOX AND CASEMIX CONSULTING, OP. CIT., P. 82.

202
C. HAM 1997, 'THE UNITED KINGDOM' IN C. HAM (ED.), *HEALTH CARE REFORM*, OPEN UNIVERSITY PRESS, BUCKINGHAM, P. 58.

There are many options for a purchasing agency, but the common characteristic is that it must be able to access the full range of relevant health services for the population covered (i.e. medical services, pharmaceuticals, acute care, other public and community health care services, and aged care).

Under an integrated health care model, each State, together with the Commonwealth, would need to identify appropriate catchment areas for regional health care funding and services and also identify or create agencies which have the capacity to be responsible for the health of all the residents within that defined geographical region (similar to District Health Boards in New Zealand and Primary Care Trusts in the United Kingdom).

In identifying appropriate catchment areas, an important point is that risk, in terms of variations in expenditure, is more easily managed with larger populations. Larger populations also allow purchasers to take advantage of economies of scale and gain better bargaining capacity with providers.[203] According to Segal et al., the task of developing adequate risk adjusters to create fair budgets at the regional level is manageable. It has been estimated that with a scheme membership of 100,000 people there is only a 0.1 per cent risk that actual expenditure will be more than 10 per cent greater than predicted.[204] The risk would decline further for larger populations.

For an integrated care model based on budget-holding for both acute and primary care, Jeff Richardson has suggested that a total of between 18 and 30 regional budget-holders would be appropriate for Australia.[205] Purchasers could be existing entities such as the health care networks of the various States Health Departments or Divisions of General Practice. New entities could also be established to be the purchasing agency.[206]

Providers

Under an integrated health care model, providers of health care services can be private or public organisations that provide a variety of health services to purchasers. The agency would purchase services from the range of public and private health providers relevant to the population's needs. Included would be providers of primary, secondary and tertiary health care and community health and aged care programs.

At the provider level, greater integration of care aims to encourage the facilitation of more seamless service provision for patients to allow health care programs to be more effectively linked. This tends to shift thinking away from 'stand alone' health care provision through hospitals, medical services etc. to a 'network' of health care providers.

With a broad scope of services included within the pooled funding arrangements, the role for coordination of patient care will increase. In Australia, as GPs are traditionally the first point of contact within the health care system, their role as 'gatekeepers' would be strengthened, particularly for patients with complex health needs or chronic diseases. GPs would have a greater case management role in terms of ensuring that health care services are organised for patients to ensure integrated health care. In doing this, GPs, in discussion with their patients, would be able to choose the health care service or provider that was most appropriate for the patient's needs (e.g. specialist, community health services, aged care services), taking account of issues of quality and access.

To facilitate continuity and integration of care, under an integrated health care system people are often either encouraged or required to enrol with a GP practice or primary care organisation. In New Zealand, for example, enrolment with a primary care provider is voluntary and there is a choice of which provider to enrol with. In this approach, it would be necessary for government to address any gaps in primary care services, for example in rural areas.

Service agreements

The development of service agreements or care contracts would be an important element of reform in an integrated health care system. The regional budget-holding agencies would be responsible for negotiating and contracting with providers for the health care needs of the population. They would also develop accountability arrangements and monitor performance. Contracts could be entered into with private GP practices, public hospitals, community health organisations or other bodies such as local governments where appropriate. While payments could be made to individual providers, there could be financial incentives for groups of primary care practitioners (e.g. GPs, nurses, dieticians and physiotherapists) to form primary care organisations as in New Zealand. The primary care organisations would either provide services themselves or make referral arrangements with a range of local practitioners to provide the range of services required.

Contractual care management for defined practice populations has a number of advantages for specifying quality, service characteristics, service levels, service coordination arrangements, consumer access and so forth. Strong, effective agreements with providers (public and private) could also take account of vulnerable and disadvantaged groups by the inclusion of quality, equity, and access requirements into performance contracts. For instance, the contracts could include the requirement that no patient co-payments are permissible, thereby effectively creating bulk billing options where they currently do not exist. The payments could be a combination of capitation, fee-for-service and performance-based payments.[207]

The Australian Council for Safety and Quality in Health Care supports the development of a new accountability for clinical governance underpinned by contractual arrangements to clarify and strengthen responsibilities for patient safety and quality of care.[208] Contract funding of providers, which would be part of the integrated health care model, would provide greater opportunities than traditional fee-for-service to advance quality, safety and appropriateness of care by ensuring 'it is embedded in day to day management and that it is on a par with accountabilities in place for financial management'.[209] This would be similar to the direction in the United Kingdom, where performance-based payments founded on the implementation of a quality framework and the achievement of patient outcomes comprise a significant component of practice income.

203
WORLD HEALTH ORGANIZATION 2000, *HEALTH SYSTEMS: IMPROVING PERFORMANCE: THE WORLD HEALTH REPORT 2000*, WORLD HEALTH ORGANIZATION, GENEVA, P. 105.

204
L. SEGAL, R. DONATO, J. RICHARDSON AND S. PEACOCK 2002 OP. CIT., P. S1:58.

205
J. RICHARDSON 2003, 'FINANCING HEALTH CARE: SHORT RUN PROBLEMS, LONG RUN OPTIONS', *WORKING PAPER 138*, CHPE, MONASH UNIVERSITY, MELBOURNE.

206
SOME COUNTRIES HAVE INTRODUCED COMPETING PURCHASERS ON THE GROUNDS OF OFFERING GREATER CONSUMER CHOICE AND RESPONSIVENESS. HOWEVER, A MAJOR WORLD HEALTH ORGANIZATION REVIEW URGED CAUTION IN ADOPTING COMPETITION BETWEEN PURCHASERS, ARGUING INSTEAD THAT EFFORT SHOULD CONCENTRATE ON REFORMS TO THE DELIVERY OF HEALTH CARE AS THESE HAD DEMONSTRATED GREATER SUCCESS. C. HAM 1997, 'THE UNITED KINGDOM' IN C. HAM (ED.), *HEALTH CARE REFORM*, OPEN UNIVERSITY PRESS, BUCKINGHAM, PP. 14–15.

207
ASSUMING THAT THERE IS A DEGREE OF SUPPLIER INDUCED DEMAND IN AREAS OF HIGH GP SUPPLY, FUNDING FOR CONTRACTS WOULD EFFECTIVELY ADD ONLY MARGINAL COSTS TO COMMONWEALTH AND STATE OUTLAYS. THE GPS REQUIRED TO SERVICE CONTRACTS WOULD MOST LIKELY BE DIVERTED FROM AREAS OF COMPARATIVE WORKFORCE OVER-SUPPLY, AND/OR EXISTING PRACTICES IN AREAS OF WORKFORCE NEED COULD CASH OUT THEIR MBS ARRANGEMENTS THROUGH CONTRACTS. IN EITHER CASE MBS FEE REDUCTIONS WOULD OFFSET FUNDING ALLOCATED THROUGH CONTRACTS.

208
AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE 2003, *SAFETY AND QUALITY AND THE HEALTH REFORM AGENDA*, AT WWW.SAFETYANDQUALITY.ORG, PP. 3–4.

209
AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE 2003, *SAFETY AND QUALITY AND THE HEALTH REFORM AGENDA*, AT WWW.SAFETYANDQUALITY.ORG, P. 4.

What would be the role for private health insurance?

In the context of such significant reform of Australia's health care system, it is relevant to ask what the role would be for private health insurance.

As outlined earlier, there would be universal coverage for all Australians under an integrated health care system and regional budget-holding agencies would have responsibility for the health care needs of all residents in their geographical area. However, it is envisaged that it would still be possible to take out additional private health insurance with the aim of gaining quicker access to elective surgery, wider coverage of services that are not included under the universal system, and access to better amenities in hospitals.

Governance

Clarifying the respective roles and responsibilities, accountability requirements, and reporting relationships of the main players in an integrated health care system would be an important part of designing a new system. There are four main players involved in the integrated health care system outlined above:

- Commonwealth and State Governments;
- the Australian Health Commission (AHC);
- the Regional Health Agencies (RHAs); and
- health care providers.

It is not appropriate at this early stage of outline of a possible new system to define fully the required governance structure and arrangements. If the Commonwealth and States agree to pursue an integrated health care system, there would be a great deal of work needed to set up good governance arrangements to support the specific model developed. The aim of the discussion below of the roles, responsibilities and accountabilities of the main players is to indicate the importance and range of issues to be considered.

Commonwealth and State Governments

As an illustration, the Commonwealth and States would have joint roles and responsibilities in determining:

- the broader health policy framework, including health priorities, within which an integrated care model would fit;
- the overall design of an integrated health care system, including goals and objectives, planning and priority-setting processes, and monitoring and reporting arrangements, such as quality assurance, health outcomes and financial targets;
- the regional purchasing agencies and their roles and responsibilities. The agencies could be based on existing entities such as the health care networks of the various States Health Departments or Divisions of General Practice;
- core service specifications; and
- budgets and the resource allocation formula.

The Commonwealth would also focus on:

- policy leadership in respect of national considerations and national health policy issues; and
- those roles for which significant economies of scale accrue from concerted national action (such as price negotiations on pharmaceuticals).

The States would also be responsible for:

- providing policy leadership relating to cost-effective, flexible and responsive service provision tailored to the needs of their communities; and
- providing public hospital care.

Accountability requirements flow from the roles and responsibilities. Given their joint responsibilities for funding, designing and directing new integrated health system, the Commonwealth and State Ministers would have overall accountability for the effective and efficient operation of the system in each State. State Ministers would retain accountability for public hospitals.

Australian Health Commission

As suggested earlier, a joint Commonwealth–State national body – such as the proposed Australian Health Commission – would be necessary to drive the reform process. The AHC would report to and advise the Commonwealth and State Health Ministers. Given its role as a policy formulation, advisory and monitoring body, the AHC would only need to be a small agency and could be staffed from officers from both the Commonwealth and States.

One of its first tasks would be the development of a framework for an integrated health care system, including national policy, goals and objectives, and planning and priority-setting processes to ensure greater alignment of Commonwealth and State priorities. The AHC would also have responsibility for leading the necessary capacity-building required for successful implementation of an integrated health care system (discussed further below). With the new system in operation, the AHC would advise on national strategic plans, high-level budget allocations and associated performance measures, as well as operating a national reporting framework.

It is essential that all the States and the Commonwealth be involved in the design of the framework for an integrated health care system. Being involved in the development of the framework is important for three reasons:

- both levels of government have unique perspectives to bring to bear that will impact on the successful implementation of the model. For example, the States have better understanding of service management and provision 'on the ground', and can provide policy leadership in designing arrangements which are flexible and responsive to local circumstances, while the Commonwealth has primary responsibility for ensuring that all Australians, wherever they live, have equitable access to quality services;
- this is the only way that all the States can ensure that the model would work for them and their specific conditions and arrangements; and
- all governments will be politically accountable for their roles and responsibilities, including their respective funding of the new system, and hence must shape the directions and arrangements.

It is, however, not essential that all the States implement an integrated health care system within the same timeframe (an idea that is discussed further below).

Regional Health Agencies (RHAs)

RHAs would be responsible for the health of all residents within a defined geographical region. They would:

- purchase the required health services from a given budget of pooled Commonwealth and State funds;
- negotiate and contract with providers for the health care needs of the population; and
- develop accountability arrangements and monitor performance.

The RHAs would be accountable to and report to both the Commonwealth and State Governments because of the joint funding responsibilities. This could be, for example, via an integrated board of governance.

Providers

As is the case under the current health care system, most health care would be delivered by private sector providers (including not-for-profit providers), with the main exception of public hospital care, for which the State Government would remain responsible. Health care providers would be accountable to the RHAs through the service agreements.

8.5 Degree of difficulty

This discussion of the elements of an integrated health care system illustrates some of the advantages of the approach (e.g. improved incentives for continuity of care, service integration, and health promotion) but it also highlights some of the complexities and difficulties (e.g. joint accountabilities, governance arrangements, capitated funding, and determining risk sharing between funders). It is important not to underestimate the challenge and wide-ranging implications of moving towards an integrated health care system in Australia. While Australia can look to the experience of other countries that have taken steps in this direction, there are significant differences among these countries that limit the applicability of these experiences to Australia.

It would take good will, resources, the highest level of collaboration and time to develop an integrated health care system for Australia. It would also take significant investment in reform capacity – in the knowledge, experience and resources of people within the system working together in a productive way to advance health reform. In short, it would require the leadership and resolve of all the Commonwealth and State Governments.

One way to progress the integrated health care reform agenda has been suggested by John Menadue.[210] As noted earlier, Menadue has proposed a Joint Commonwealth–State Health Commission in each State, which would receive a negotiated allocation of funds from the Commonwealth and relevant State Government covering acute, primary, and community health care services. The Commission would manage the funding and planning of all health services in that state, purchase various services from providers, and monitor performance against agreed targets.

However, rather than being dependent on the agreement of all jurisdictions, Menadue has suggested that a Joint Commonwealth–State Health Commission could be established in *any* state where the Commonwealth and a State Government can agree. An outline of the proposed Commission is given in Box 8.4. To ensure a degree of national consistency and commitment by all governments, ideally under this approach all State Governments and the Commonwealth would agree on the broad directions and framework for an integrated health care system developed by the AHC (as discussed above), but each State would progress to the new system within its own timeframe and subject to detailed negotiations.

BOX 8.4 JOINT COMMONWEALTH–STATE HEALTH COMMISSION (JCSHC)

Coverage of JCSHC

As broad as possible, including:

- State health (including Health Care Agreement)
- Aged care
- Department of Veterans' Affairs
- Home and Community Care (HACC)
- Commonwealth Regional Health Services in rural and remote areas
- Medical Benefits Scheme (MBS)
- Pharmaceutical Benefit Scheme (PBS)
- Aboriginal health
- Local Government health and NGOs (e.g. nursing services).

Providers (e.g. State health, HACC, local government and NGOs) would tender for the provision of services to the JCSHC.

Private hospitals would probably be excluded from coverage as they depend on private rather than direct government funding. But private hospitals could tender to supply services to JCSHC.

Importantly, existing providers would continue to operate and provide services but those services would be purchased by JCSHC as part of a statewide plan.

Funding of JCSHC

The JCSHC would receive a negotiated allocation of funds from the Commonwealth and State Government, which reflects the coverage of programs for which it would be responsible, with appropriate growth and indexation add-ons.

Functions of JCSHC

Shared resource allocation: through the purchase of various services from providers – Commonwealth, State and local government, and NGOs as part of a joint strategic plan. Funding would be allocated with agreed short and long term integrated outcomes rather than program outcomes with specified standards and levels of performance.

Shared performance management: oversight of continuous improvement of the health system, monitoring of progress, and establishing reform targets and timelines.

JCSHC governance

Board of Directors: membership of the board would be high level to enable strategic decision-making, and reflect the broad interests of the whole community. The Board must have clear 'governance' responsibility and not just an advisory role. An independent chair would be appointed by the two Ministers (Commonwealth and State). The Board would approve the strategic plan and budget.

Commonwealth and State Ministers would be responsible for negotiating high-level policy principles, including overall funding, on the advice of the Board. This would help reduce the risk of the Board dividing on Commonwealth/State lines.

The Board would be responsible to the Commonwealth and State Ministers, with one financial report to both.

JCSHC process

In the initial stages, a memorandum of understanding (MOU) between the Commonwealth and State Governments would be agreed upon. The MOU would:

- set out the shared understandings on purpose, roles, responsibilities and obligations;
- describe any agreed decision-making processes;
- outline any agreed conflict resolution processes;
- outline other matters important to the success of the initiative; and
- establish an agreed priority-setting process as one of its first tasks.

As early as possible the MOU would be fully or in part superseded by complementary/mirror Commonwealth and State legislation with appropriate regulations.

SOURCE: J. MENADUE 2004, *BREAKING THE IMPASSE IN HEALTH: A COALITION OF THE WILLING – A JOINT COMMONWEALTH–STATE HEALTH COMMISSION*, SPEECH TO THE HEALTH CARE REFORM ALLIANCE FORUM, CANBERRA, 21 APRIL.

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J. MENADUE 2004, OP. CIT.

Another way to progress the reform agenda would be to take a transitional step and implement the integrated health care model in one or more regional areas (this approach could be agreed to by the Commonwealth and all State Governments, or the Commonwealth and an individual State Government as in the Menadue proposal). This would allow the model to be better understood and further developed on a moderate but meaningful scale before taking on the logistical difficulties of large-scale implementation nation-wide. The ideal pilot area would be a major regional centre with its surrounding catchment. Examples are the regional areas of Wollongong, Newcastle and Geelong. The advantages of these regions are that they are well defined and provide the full range of health care services, from community care to tertiary hospital services, but on an overall scale lower than in the large capital city metropolitan areas.

Coordinated Care Trials

A version of funds-pooling has been trailed in Australia through the Coordinated Care Trials funded by the Commonwealth and States. The experiences of the trials provide an indication of the challenges and difficulties faced in moves towards better integrated health care.

The first round of trials began in June 1997 and was completed in December 1999. The trials focused on people with complex and chronic health needs who required a mix of health care services from a mix of different providers. The aim of the trials was to test whether health care for these people could be improved within existing resources, through better planning and coordination of health care, supported by more flexible funding arrangements. All health care services for the patients were purchased from a trial budget of pooled Commonwealth and State Government funds.

The lessons learned from the coordinated care trials are important to take into account in developing reform proposals in this area. The experience of these trials also highlights the importance of building reform capacity. The following points summarise the relevant key findings of the National Evaluation:[211]

- the models of care coordination developed by the trials shared the common elements of assessment, care planning and services coordination (although there were considerable differences). From the client perspective, the element that seemed to have the most impact was access to a service coordinator, who provided patients with increased assistance and a sense of security;
- trials that included a new 'service coordinator' were more successful compared with trials that relied upon GPs to undertake the coordinator role. The GPs felt that having someone who knew what services were available, and who had the time to link patients with these services, was beneficial to both themselves and their patients;
- service coordination was constrained, as the first round of trials generally excluded nursing home care and services received from the private sector;
- through funds-pooling, trials were able to develop funding models of far greater flexibility than existed elsewhere in the Australian health care system. This mechanism allowed client costs to be monitored across a range of different services, allowed trials to act as purchasers, facilitated interactions between funders and purchasers, and created a significant role for stakeholders. However, the trials' ability to use the fund pool to improve efficiency was constrained by a limited understanding of strategies that would be effective in this context. Further investigation of the benefits of restricted, rather than comprehensive, funds pooling is warranted;

- crucially, there was no financial incentive to target the most cost-effective services. The coordinators did not gain from any savings, as the budgets remained cost-neutral. This does not match the incentives of fund holding, where both gains and losses are sustained;
- generally, there was a lack of mechanisms to link services and finances in an ongoing, iterative manner, and hence trials consistently provided services outside the scope of their available resources. This highlights the need for the development of models that establish clear linkages and processes between clinical and financial decision-making to ensure financial viability and sustainability;
- all the trials had a relatively small population base. The largest trial only had a population of 2,500 and many were considerably smaller. A much larger population base is needed to spread the risk and secure economies of scale; and
- the restrictions to the population and services covered acted to limit the trials capacity to improve allocative efficiency, an important goal of funds-pooling arrangements.

Although there were issues and problems with the first round of Coordinated Care Trials, it is important to acknowledge that they also demonstrated that major reform is possible between the Commonwealth and States. More specifically, the Trials encourage the development of a model of integrated care by showing that:

- funds-pooling between Governments is possible, and that providers can cooperate at a local level to design and develop a radically new approach to health care in Australia;
- the Australian health care system can develop and implement world class information management and care planning systems; and
- major cultural shifts away from the traditional antagonisms and rivalry between different players and toward cooperation are possible.

Interestingly, the Aboriginal and Torres Strait Islander Coordinated Care Trials proved to be some of the most successful trials conducted, with lessons beyond Indigenous health settings, in areas such as rural and remote health care delivery and population health.[212] The trials were located in Katherine (Northern Territory), the Tiwi Islands (Northern Territory), Wilcannia (New South Wales), and Perth/Bunbury (Western Australia). Trial outcomes included:[213]

- enhanced service access, with the financial flexibility provided through funds-pooling enabling trials to either develop or purchase new services and develop population health initiatives for their communities;
- improved service appropriateness, with each trial making a significant investment in the development and implementation of care coordination infrastructure and processes;
- improved individual empowerment, through client involvement in the development and delivery of their care plan; and
- greater understanding of the importance of community involvement and empowerment as a means of driving health service reform.

As an example of more specific outcomes, the Katherine trial achieved a 19 per cent reduction in the number of evacuations to hospital in a six-month period, and a distinct shift from hospital-based services to primary care.

The relevant key lessons of the trials are summarised in Box 8.5.

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DEPARTMENT OF HEALTH AND AGED CARE 2001, *THE AUSTRALIAN COORDINATED CARE TRIALS: SUMMARY OF THE FINAL TECHNICAL NATIONAL EVALUATION REPORT ON THE FIRST ROUND OF TRIALS*, PP. XI – XIII; AND DEPARTMENT OF HEALTH AND AGED CARE 1999, *THE AUSTRALIAN COORDINATED CARE TRIALS: INTERIM NATIONAL EVALUATION SUMMARY*, AT WWW.HEALTH.GOV.AU.

212
THE HON. M. WOOLDRIDGE, COMMONWEALTH MINISTER FOR HEALTH AND AGED CARE 2001, 'FOREWORD', IN DEPARTMENT OF HEALTH AND AGED CARE, *THE ABORIGINAL AND TORRES STRAIT ISLANDER COORDINATED CARE TRIALS, NATIONAL EVALUATION SUMMARY*, AT WWW.HEALTH.GOV.AU.

213
DEPARTMENT OF HEALTH AND AGED CARE 2001, *THE ABORIGINAL AND TORRES STRAIT ISLANDER COORDINATED CARE TRIALS, NATIONAL EVALUATION SUMMARY*, AT WWW.HEALTH.GOV.AU.

BOX 8.5 • KEY LESSONS OF THE ABORIGINAL AND TORRES STRAIT ISLANDER COORDINATED CARE TRIALS

Time and resources: coordinated care requires investment in infrastructure support – information systems development, staff recruitment and training.

Benefits of a selective and targeted approach to coordinated care: trial experiences suggest that full and comprehensive needs assessment may not be necessary and/or appropriate for all clients. A more selective and targeted approach may be more beneficial, enabling scarce resources to be applied to that group of clients for whom coordinated care will provide the greatest benefit.

Population health: the trials demonstrated that there is much potential for disease management and health promotion as part of coordinated care.

Financial mechanisms and infrastructure: the trials demonstrated that with appropriate structures, clear aims and appropriate strategies, equivalent MBS/PBS funding is an important means towards overcoming access barriers to health services.

The funds pool has proved a useful mechanism for encouraging integration between Commonwealth and State funded services, objectives and commitments.

Workforce development: health reform as comprehensive and potent as that evidenced in the trials would require considerable expansion of the workforce and training and retraining of staff. This would require a national strategy.

SOURCE: DEPARTMENT OF HEALTH AND AGED CARE 2001, *THE ABORIGINAL AND TORRES STRAIT ISLANDER COORDINATED CARE TRIALS, NATIONAL EVALUATION SUMMARY*, AT WWW.HEALTH.GOV.AU.

The challenges and difficulties to be faced in moves towards better-integrated health care and the experiences of the coordinated care trials support arguments for at least beginning with smaller-scale reform than a fully integrated health care system. Smaller-scale reform is more easily achieved without the significant transaction costs and unintended and unexpected effects of very large reorganisations of administrative structures and provider arrangements.[214] A number of more immediate steps that could be taken which would both improve health care in Australia and also be consistent with or help progress towards an integrated health care system are discussed below.

8.6 First steps: focus on primary health care

There is a sound case for beginning the move towards an integrated health care system by introducing reform to primary health care.

Good access to primary care is becoming increasingly important for the health and wellbeing of people. As noted in chapter 4, chronic diseases and conditions dominate the health care needs of the Australian population, being responsible for an estimated 80 per cent of the total burden of disease, mental health problems and injury in Australia.[215] Chronic diseases are defined as 'illnesses that are prolonged, do not resolve spontaneously, and are rarely cured completely'. They share a number of common underlying risk factors, most notably social determinants (including poverty and inequality), poor nutrition, inadequate environmental health conditions, physical inactivity, alcohol misuse and tobacco smoking.[216] Hence, there is a need for an increasing emphasis on the prevention of ill health, and on health promotion and disease management, with a consequential increase in the importance of primary care.

Increasing the emphasis on the prevention of ill health, on health promotion and on disease management is not only important for patient care, but also for financial sustainability, as a high proportion of health system resources are used in providing services to people with diseases and health conditions that are known to be preventable.[217] For example, a large-scale study in New Zealand estimated that approximately one third of hospitalisations for people aged 0 to 74 years was preventable. Of these, approximately two thirds were potentially avoidable through more effective primary health care services.[218]

Internationally, there is increasing recognition of the importance of the primary care system for improving health outcomes and managing costs. Stronger primary health systems are associated with better health outcomes and lower costs, particularly for children. Improved primary health and community support also has the potential to prevent hospital admissions. As well, better primary health and community support can prevent inappropriate and unnecessary use of residential care services.[219]

However, a recent review of the strength of primary care infrastructure in 13 OECD countries found that the Australian system performs at only an intermediate level on both system and practice characteristics.[220] This is partly because of the split in roles and responsibilities between the Commonwealth and State Governments. With the current jurisdictional division of responsibilities, the Commonwealth has been mainly interested in general practice and pharmacy issues while the States have been concerned about dental, allied health, community nursing and counselling services. As a result, policy for primary health and community care has been developed through a range of Commonwealth and State initiatives. Many of these overlap and the boundaries are not always distinct. There is little joint planning, funding and development of primary medical, allied health, dental, counselling and nursing services.

Current funding and delivery arrangements also create barriers to continuity of care. Because of the complexity of the health system, it is difficult for people to identify the services they require, arrange to receive those services, and navigate their way through the health system without expert help.

Given the importance of primary care as the first point of contact with the health system and as the gateway to other services, there are significant opportunities to improve the quality, equity and sustainability of the health care system *through* reform to primary care, including by improving:

- affordable access to care for Australians;
- continuity of care and service integration, particularly for those with continuing care needs; and
- the focus of governments and individuals on prevention, health promotion and disease management.

This section puts forward proposals that aim to do this.

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A. MAYNARD 2002, 'BARRIERS TO EVIDENCE-BASED POLICY MAKING IN HEALTH CARE', IN PRODUCTIVITY COMMISSION AND MELBOURNE INSTITUTE OF APPLIED ECONOMIC AND SOCIAL RESEARCH, *HEALTH POLICY ROUNDTABLE*, CONFERENCE PROCEEDINGS, AUSINFO, CANBERRA, P. 40.

215
AIHW 2002, *CHRONIC DISEASES AND ASSOCIATED RISK FACTORS IN AUSTRALIA: 2001*, AIHW, CANBERRA, P. 4; NUFFIELD TRUST 2000, *POLICY FUTURES FOR UK HEALTH*, 2000 REPORT, NUFFIELD TRUST, PP. 17–20.

216
QUOTED IN T. WEERAMANTHRI ET AL. 2003, 'THE NORTHERN TERRITORY PREVENTABLE CHRONIC DISEASE STRATEGY – PROMOTING AN INTEGRATED AND LIFE COURSE APPROACH TO CHRONIC DISEASE IN AUSTRALIA', *AUSTRALIAN HEALTH REVIEW*, 26(3), P. 31.

217
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, AT WWW.HEALTH.GOV.AU, P. 87.

218
QUOTED IN H. SWERISSEN 2002, 'TOWARD GREATER INTEGRATION OF THE HEALTH SYSTEM', *AUSTRALIAN HEALTH REVIEW*, 25(5), 88–93, P. 90.

219
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

220
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

Better health promotion and illness prevention

First, measures are needed that encourage better health promotion and illness prevention. Currently, both the Commonwealth and State Governments fund programs in these areas. To gain the benefits of a more integrated, strategic approach to promotion and prevention, it is proposed that the Commonwealth and States pool their (non-volume) related payments to develop integrated local health promotion plans.[221] The payments would include the Commonwealth's Practice Incentives Program and GP Divisional project funding, and the State's health promotion funding. Given the relatively low level of funding for specific health promotion and prevention programs (currently only about 2 per cent of total government health expenditure[222]), additional funding might be needed in light of the plans developed.

Key participants in the development of integrated health promotion plans would include GPs, community health agencies and hospitals. These agencies would come together through an appropriate coordinating agency, such as Divisions of General Practice (of which there are 120 around Australia). The integrated plans would require local agreement about objectives, strategies, roles and responsibilities, accountability and performance monitoring, and funding arrangements. Funding would be held by the coordinating agency and distributed to collaborating agencies or partners. The partners would be required to align their individual efforts with the local plan as a condition of funding. Performance against process and impact indicators included in the plan would be monitored jointly by the Commonwealth and the States (e.g. referral rates, program participants and behaviour change).

Initially, the plans could build upon the work of the National Public Health Partnership and Joint Advisory Group on General Practice and Population Health, for example in developing a framework and strategies in the four key areas of health promotion: smoking, nutrition, alcohol and physical activity.[223] Integrated health promotion plans could encourage and support comprehensive screening, monitoring and management of at-risk patients by GPs (e.g. of blood pressure, weight, smoking, glucose tolerance and cholesterol). Initiatives could include provision of information, patient education, and behaviour management programs, supported by appropriate referral, reporting and monitoring systems. More broadly, the plans could include initiatives to work with local organisations such as schools, sporting and recreational bodies, and workplaces. (An approach similar to this is currently being implemented in Victoria through Integrated Health Promotion.[224])

Integrated care for people with continuing care needs

Second, there needs to be greater emphasis on continuity of care and service integration. To both better manage illness or disease and to help prevent its progress where possible, there needs to be a shift away from a series of relatively uncoordinated episodes of care, across primary, community, and acute care, to integrated care. However, the lessons of the coordinated care trials point to the benefits of a selective and targeted approach to reform measures, focused on people with continuing care needs, including elderly people and people with chronic diseases.

The foundation for better integrated care for people with continuing care needs is their enrolment with a GP practice or primary care organisation (which would include general practitioners). This would give overall responsibility for care coordination to a GP (preferably a GP located in a primary care centre). Under this proposal, people with chronic diseases (such as diabetes and ischaemic heart disease) and all older people (for example, aged 70 or more) would enrol. Existing patient rights to choice of GP would be protected. While people would be encouraged to enrol, arrangements could be developed to allow patients to enrol with participating practices or choose to use standard Medicare-funded GP services. An advantage of this approach is that, as the Commonwealth is the principal funder of general practice, the Commonwealth–State issues involved could be more easily addressed than in a fully integrated health care system.

Once this foundation is laid, there is potential to develop systems which are directed at improving the quality of care for the elderly and chronically ill. For example, primary care contracts for an enrolled chronic disease patient population could be developed. Building on the experience of coordinated care trials, capitation and performance-based payment arrangements for these patients could be negotiated with GPs to ensure an integrated approach to the management of their health needs. This could require the development of primary care teams, referral pathways and more appropriate care models.[225] Price, quality and performance for the enrolled patient group would be ensured through the contract negotiation and management process. Contracts with primary care organisations (including GP practices) might also include provision for extended-hours services, home based care and palliative care to meet the needs of this patient group.

Patients enrolled in integrated care programs would have access to a broader range of services to meet their needs. Current Enhanced Primary Care arrangements for care planning and additional services could be extended to ensure enrolled patients have access to appropriate allied health, dental, nursing, personal care, and health education and self-management programs in line with care plans. These additional services could be delivered either through primary care teams within an integrated primary care organisation, or through brokerage arrangements between providers.

Better access to primary care

To make an obvious point, strategies for improving health care developed around primary care depend on good access to primary care. As discussed in chapter 4, affordable access to general practitioners is becoming more of a problem for many people. The Commonwealth Government has introduced measures (MedicarePlus) that aim to improve access, particularly for concessional patients and children under 16. It is too early to assess the impact of the measures on access but concerns have been raised about the potential effectiveness of the measures. It has been suggested that the measures are unlikely to reverse the decline in bulk billing rates for non-concessional patients and in rural areas.[226] It may be that further measures are needed to ensure affordable access to primary care (e.g. an increase in the MBS rebate for GPs to stabilise and reverse the decline in bulk-billing).

8.7 Capacity building

Successfully implementing an integrated health care system would require significant investment in capacity building to prepare and provide support for the reforms. This would be a major responsibility of the AHC. The necessary preparatory work would include a range of issues, such as the development of performance indicators, payments systems and funding allocation models. However, two issues are highlighted here because of their significant potential to either hinder, or alternatively to advance, reform of Australia's health care system: workforce issues and the use of information technology.

Workforce development

An adequate, properly trained and well-distributed workforce would be critical to achieving an integrated health care system. There are a number of current problems in this area that would hinder progress, including:

- shortages across the health workforce, particularly in rural and remote areas and in the Aboriginal and Torres Strait Islander health workforce, and among mental health workers; the health industry is not always staffed to operate effectively on a 24/7 basis;
- problems recruiting and retaining health workers, and barriers to retraining and re-entry of workers who have left the field;
- lack of systematic planning at a national level, and of coordinated or consistent health workforce planning across States; workforce planning is also impeded by the lack of timely, quality data;

221 AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

222 AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

223 NATIONAL PUBLIC HEALTH PARTNERSHIP 2001, *PREVENTING CHRONIC DISEASE: A STRATEGIC FRAMEWORK. BACKGROUND PAPER*, AT WWW.NPHP.GOV.AU, AND JOINT ADVISORY GROUP ON GENERAL PRACTICE AND POPULATION HEALTH, *IMPROVING POPULATION HEALTH OUTCOMES THROUGH PARTNERSHIP WITH GENERAL PRACTICE*, AT WWW.HEALTH.GOV.AU/PUBHLTH.

224 AT WWW.DHS.VIC.GOV.AU/PHD.

225 AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

226 AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

- the roles and responsibilities/scope of practice of the health workforce are prescribed by a range of regulations, industrial awards and agreements, and professional standards and competencies. These impact on the development of new or flexible workforce roles and responsibilities, and the development of education and training responsive to the workforce needs of the health system; and
- traditional roles and responsibilities also impact on responsiveness to the utilisation of the new health care technologies and systems.

At the recent Australian Health Ministers' Conference, Health Ministers agreed to an agenda for workforce reform[227]. The centrepiece of the agenda is, for the first time, a National Health Workforce Strategic Framework, providing an overarching guide to national health workforce policy and to the investment needed in the health workforce over the next decade. The Ministers announced a number of projects to implement the Strategic Framework, including:

- work to identify best practice approaches to recruitment and retention as a resource to help attract and keep the health workforce;
- work to explore future health workforce challenges, and identify solutions and timeframes for implementation to avoid unmanageable health workforce shortages in the coming decades;
- the establishment of a Health Workforce Clearinghouse to share information about effective health workforce solutions; and
- health workforce data improvements to ensure policy is based on the best possible information.

Ministers also agreed that a National Workforce Action Plan, focusing on national and cross-jurisdictional issues, will be developed for reporting back to Ministers at their next meeting. The AHC could progress this coordinated national approach to health workforce issues.

A national approach to information management and technology

The overall effectiveness of integrated health care will be facilitated by the availability of relevant information for all participants:

- for patients, successful integration of care depends upon the capacity for data gathering, to follow their progress and track outcomes. Patients are treated by a variety of health care professionals and organisations, including general practitioners, nurses, specialist medical practitioners, laboratory technicians, diagnostic technologists and administrative staff. A person can be admitted to one facility, transferred to another for treatment, and then require extended care in the community or at home. In order to provide continuity of care, it is necessary to be able to identify consumers across multiple care settings and providers, and to be able to collect patient information from multiple sources. The ability to exchange personal health information via a secure network would enable better coordination of care, and disease management;
- providers will wish to ensure that they provide services according to 'best practice', as this will encourage future contracts from purchasers. Also, better coordination of different service providers will require better-defined information channels; and
- purchasers will seek to evaluate different available treatment options offered by providers and, in particular, will be seeking to make informed choices as to what represents the most appropriate, cost-effective care. In short, purchasers need to know what works and what works most cost-effectively.

Historically, the investment in information management and technology has been proportionately lower in health than in other information-rich industries, due to competing priorities for funding for clinical service provision. Like many OECD countries, the health sector in Australia is lagging well behind other sectors of the economy in harnessing the power of information technology to make fundamental improvements in quality, service and efficiency. A recent major review of IT and e-health (the use of information and information systems) highlighted four key areas for action highly relevant to progressing an integrated health care system:[228]

- *Governance*: Existing governance arrangements have not succeeded in bringing health information and technology activities under a framework that stimulates innovation, provides strategic direction and drives nationally coordinated action;
- *'Infostructure' development*: The fragmented way that health information is currently collected means it is often unavailable when needed most. Information is embedded in record systems (paper or computer systems) that have limited capacity to share and reuse it. In most cases, health care providers and organisations are free to determine what information is relevant and what form it should take. This reflects the main historical purpose of health records as a highly detailed documentation of a patient's particular *episode* of care. Paper records impede the integration of health care delivery, research, and administration. The wide variety of formats, styles, and organisational systems for paper records frustrates the coordination of care between different providers, and even between departments or providers in the same institution. Enabling information to flow in appropriately structured, secure and unambiguous ways requires an information infrastructure comprising standards and architectural frameworks needed for effective infrastructure investment and interoperable systems;
- *Infrastructure development*: Internet-based initiatives require an adequate IT infrastructure (including telecommunications and computer networks, devices and systems) upon which to deliver a range of clinical, professional development and administrative applications. This is currently hindered by the speed of changes in technology, differing levels of existing maturity across health care, and the substantial change in management involved in implementing and optimising use of new technologies. National collaboration is required to deliver requisite telecommunications and to achieve comparable levels of maturity in applications across the health sector; and
- *Data linkage*: To date, much of the policy debate on e-health in Australia has focused on accessing health information at the point of care and delivering health services electronically. Equal if not greater impacts on health outcomes could be achieved by applying integrated health data to research and manage the health of entire populations. Core administrative data sets suitable for this process include the PBS, MBS, hospital separation data and registers of births and deaths.

Australia's Health Ministers have identified information management and technology as a critical enabler of future reform to the health system. At the recent Australian Health Ministers' Conference, Health Ministers noted the need for increased national capacity to drive forward priorities in the area.[229] They have requested further advice on the possible shape of national capacity, including the option of establishing a new national entity dedicated to reform in this area.

There is a clear need for greater national collaboration in developing information management and technology in health care. This is another area where the leadership and direction of the AHC could help to progress the reform agenda.

227
AUSTRALIAN HEALTH MINISTERS' CONFERENCE 2004, *NATIONAL HEALTH WORKFORCE STRATEGIC FRAMEWORK*, JOINT COMMUNIQUÉ, 23 APRIL, AT WWW.HEALTH.GOV.AU.

228
A REPORT TO THE AUSTRALIAN HEALTH MINISTERS' CONFERENCE FROM AUSTRALIAN HEALTH CARE AGREEMENT REFERENCE GROUPS, SEPTEMBER 2002, *INFORMATION TECHNOLOGY, RESEARCH AND E-HEALTH*, AT WWW.HEALTH.GOV.AU.

229
AUSTRALIAN HEALTH MINISTERS' CONFERENCE 2004, *NATIONAL INFORMATION MANAGEMENT AND INFORMATION COMMUNICATIONS TECHNOLOGY REFORM*, JOINT COMMUNIQUÉ, 23 APRIL, AT WWW.HEALTH.GOV.AU

8.8 Immediate reforms to improve health care

There are a number of reforms to improve health care that the Commonwealth and State Governments can implement in the immediate future including:

- the co-location of primary care clinics adjacent to emergency departments. This would improve access to general practitioners, thereby also taking some of the load off public hospital emergency departments;
- additional funding to improve access to elective surgery for public patients, especially for those facing long-waits; and
- additional funding for aged care programs. This would address the shortage of residential aged care places and underdeveloped community-based aged care. It would also reduce inappropriate long-stay occupation of acute beds and hence help free up the capacity of public hospitals (for both the provision of emergency services and elective surgery).

There are a number of options for better use of private hospitals and/or private health insurance coverage.[230] In some cases, these could both potentially benefit fund members and take some pressure off the public hospital system:

- to help take some pressure off public emergency departments, the Commonwealth could allow private health insurance (PHI) to cover expenses for facility fees and diagnostic tests at private hospital emergency department services;
- access to elective surgery could be improved by better use of the facilities and funding of the private sector. For example:
  - State Governments could (and in some cases, already do) contract for elective surgery for public patients in private hospitals (for example in cases where there are high medical and financial costs for long waits or where it is efficient to encourage provider specialisation and complementarity); and
  - the Commonwealth could give attention to ways to further encourage privately insured patients to use their health insurance to access private hospitals for elective surgery rather than depend on the public hospital system (for example by achieving a more complete solution to the problem of out-of-pocket expenses that continue to be incurred by many privately insured patients, although this potentially increases any problems with over-utilisation of private hospital care due to the fairly limited control by private health funds of health resource utilisation);
- the revenue for public hospitals from privately insured patients should be increased by increasing the charges for hospital accommodation in public hospitals. (Currently, bed-day charges in public hospitals are about half what they are in private hospitals and public hospitals do not charge theatre fees.) This would require action by the Commonwealth Government, since it regulates the level of default benefits payable by health funds to public hospitals;
- to encourage continuity of and the most appropriate care, the Commonwealth could allow PHI to cover services for their members outside the hospital; and
- to encourage health promotion and better disease management, the Commonwealth could also allow PHI to contract with GPs/primary carers for preventive and disease management programs for their members.

A further issue involves the 30 per cent private health insurance rebate, estimated to cost the Commonwealth Government $2.3 billion in 2003–04.[231] Major concerns have been raised with the equity and cost-efficiency of the rebate, as discussed in chapter 4. In the immediate term, the cost of the rebate should be reduced, for example through removal of cover for ancillaries and possibly by capping the rebate payable.[232] In the longer term, it may be possible to remove the rebate and redirect the funding to more cost-effective policies as part of a major reform agenda.

Reform costs

The reforms are aimed at substantially improving the *cost effectiveness* of health care funding, through elements designed to ensure that the range of care provided represents best value for the community for the resources used, including by realising over time the significant potential for technical and allocative efficiencies that many studies have pointed to.

However, this report has also raised questions about the current *adequacy* of funding for health care and has indicated some areas where more resources are needed, particularly for primary and preventive care, aged care and elective surgery. Improving access to essential health and aged care services would require significant additional expenditure. While it is beyond the scope of this report to develop detailed costings, as an indication:

- to reduce elective surgery waiting lists by about 10 per cent would cost about $170 million a year, based on opening up existing beds in public hospitals. An alternative approach would be to establish dedicated elective surgery centres, which would also incur additional capital costs of about $410 million over two years;[233]
- currently, only about 2 per cent of government health expenditure is allocated to specific health promotion and prevention programs. Additional expenditure of about 0.5 per cent a year ($200 million) towards primary care contracts for people with chronic illness would have the potential to significantly improve chronic disease prevention and management;[234] and
- it may be necessary to increase expenditure to ensure affordable access to GPs if the MedicarePlus measures do not lift bulk-billing rates. As an indication, it has been estimated that to increase bulk-billing rates to 80 per cent, an additional $380 million a year would be needed in the form of differentially higher rebates for bulk-billed services and other incentive payments.[235]

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S. DUCKETT 2004, *STRATEGIC ENGAGEMENT BETWEEN THE PUBLIC SECTOR AND PRIVATE HOSPITALS*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

231
DEPARTMENT OF HEALTH AND AGEING 2003, *PORTFOLIO BUDGET STATEMENTS 2003–04*, P. 217, AT WWW.HEALTH.GOV.AU.

232
P. DAWKINS ET AL. 2004, *RECENT PRIVATE HEALTH INSURANCE POLICIES IN AUSTRALIA: HEALTH RESOURCE UTILIZATION, EQUITY IMPLICATIONS AND POLICY OPTIONS*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, THE MELBOURNE INSTITUTE OF APPLIED ECONOMICS AND SOCIAL RESEARCH, THE UNIVERSITY OF MELBOURNE, P. 39.

233
UNPUBLISHED ANALYSIS BY THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

234
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

235
AUSTRALIAN INSTITUTE FOR PRIMARY CARE 2004, *GENERAL PRACTICE AND MEDICARE: OPTIONS FOR REFORM*, DRAFT REPORT FOR THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET.

PART II
A BETTER FUTURE: OPTIONS FOR REFORM

Chapter Nine
An education system for all Australian children

A new approach in schools is required to improve the quality of school education so that outcomes are more consistently high across schools and students.

An education system for all Australian children

This chapter sets out reform options for education. It proposes new institutional and funding arrangements and specific initiatives in some areas to improve education outcomes for Australian families. It also considers how reform might be implemented.

Key Points

Key thrusts of reform

School education plays an important role in helping to build the foundations for economic success and social cohesion in Australia. There is much to be proud of in Australian schools, but there is also much to be done, with some aspects of the system actually contributing to social inequality. These reforms would reverse that, with schools in all sectors contributing to better outcomes for Australian students and their families.

The key aims of reform are:

(i) to centre funding on students and on achieving the best outcome for each in an equitable way, with special focus on the disadvantaged;

(ii) to improve information available to families, school accountability and performance; and

(iii) to promote diversity, innovation and choice while ensuring all schools meet common basic requirements.

The reforms would bring most schools into a new integrated school education system, incorporating the government sector, most Catholic schools and many independent schools. Public funding would only be available to schools within the new system.

A new integrated school education system

- Funding of all school education by both levels of government would be administered consistently and fairly across students and schools and would be better related to what the community wants – the best outcome for each student.
- Where different types of students need different approaches to achieve good outcomes, schools should be provided with different levels of resources so that each child has the same chance of success. This proposal includes additional funding of $500 million to $1 billion for this purpose.

- Most government funding would be directed to where it is most needed – schools with students who need the most help and with little ability to raise funds through either compulsory or generally-applied voluntary fees. Government funding would be reduced as schools' private fee income rises and, for those schools charging compulsory fees, as the capacity of parents to pay fees increases. Government funding of schools would not be affected by donations to approved building funds and similar benefactions. Resources would move to schools with larger numbers of students from disadvantaged groups, especially those operating in poorer socioeconomic areas, giving them the ability to attract some of the best teachers.
- Access to the new system would be protected for those who cannot contribute to the cost of their children's education. The simplest way to achieve this – by excluding schools that charge compulsory fees – runs the risks, however, of reducing private contributions to the cost of education (and thus putting a much larger burden on public funding) and entrenching a two-tier system. Access to the education system can be preserved just as effectively, and other objectives met, by allowing most schools to enter the system – but with funding graduated to need – and ensuring that all schools joining the system participate in access programs.
- Schools within the system would be able to continue their current approaches to fees. The new system would maintain the special character of government schools, including the policy of not charging compulsory fees, and a secular approach to education.
- The proposed arrangements do not mean imposing a high level of uniformity on how schools educate students – quite the opposite. The funding arrangements will give schools more scope to take different approaches for different students and will move school education away from the 'standard' approach that exists in some areas now. Diversity of approaches will be strongly encouraged.
- Schools would have considerable autonomy in how they use the funding they receive but would be accountable for the results of their work. Performance management, reporting and accountability systems for schools and teachers would be integral to the new system.

- Rough estimates suggest that the overall cost of the reforms would be in the region of $1 billion to $2.2 billion (in 2004 terms), including additional funding of up to $1 billion to improve outcomes for disadvantaged groups.
- The States would manage the operation of the integrated school education system. The Commonwealth and the States together would define the policy, framework and rules for participation, and would set national objectives and strategies. A new joint Commonwealth–State body should be established to implement the reforms and oversee the coordinated system.

Specific initiatives

- Specific actions will be required to support students at risk and to encourage greater participation in early childhood education, especially by children from disadvantaged backgrounds.

Implementing reform

- Work can begin before the establishment of the new Commonwealth–State body in several areas – the information needed for designing a robust student-centred funding system, progress on performance management and accountability systems – through existing forums such as MCEETYA.
- While it is highly desirable that all States join with the Commonwealth in designing and putting in place the proposed new system, implementation could commence in some States, with others following later (and taking account of early experience in the pioneering jurisdictions). Implementation could also be staged *within* jurisdictions, at a regional level.
- Differences in Commonwealth and State funding shares for education in each State vis-à-vis present shares could be offset by compensating adjustments to Commonwealth general-purpose payments to the States, akin to the budget-balancing assistance provided to the States in recent years as part of the introduction of the GST and distribution of the resulting revenue. Those States that would receive a lower share of Commonwealth payments for school education under the new system than they receive now would receive a 'top up', phasing out over time; where States receive a higher share under the new system, their benefit could reduce over time.

9.1 The issues for education reform

Chapter 5 showed that the school education system in Australia achieves relatively good outcomes for a large part of the community, but that it is failing some families.

There are large inequalities in both student participation in schooling and educational performance, some of which increase with time spent at school. Students from low socioeconomic and Indigenous backgrounds are more likely to leave school early and to achieve poorer learning results; boys in general are less likely than girls to achieve good literacy standards. The reasons for differences in educational achievement are complex, can occur at different levels – system, sector, school, classroom and individual – and are likely to be interrelated.

Inequities and inconsistencies in school funding and inconsistent information about school performance are limiting the ability of Australian families to make the best education choices for their children.

Left unchecked, this situation is likely to worsen. As discussed in chapter 5, the increasing concentration of students from disadvantaged families in some schools and regions is making the job of those schools more difficult. A growing proportion of their students needs more intensive help, but the increased need is generally not responded to with sufficient resources. Despite the best efforts of the schools concerned, the result of this trend – if unchecked – will be a *more* divided education system.

This is not an acceptable situation. While staying at school until completion of Year 12 or equivalent is not the best path for all, there are significant numbers for whom early leaving or poor educational achievement means wasted talents and a less satisfying life. Employment prospects are bleak for those who emerge from school with a poor education and without basic abilities such as persistence, confidence, being organised and having the ability to get along with others. The distribution of good education in a population affects not only individual and national economic fortunes, but also the degree of social cohesion in a community. A strong, inclusive education system is a critical part of our liberal democracy and social wellbeing, as well as essential for maintaining economic prosperity.

Reform of education must focus on achieving high standards for *all* students. The complex web of reasons for differences in outcomes means that change is needed on a number of levels, so that:

- education systems encourage the *expectation* of achievement by students, teachers and schools, supported by stronger accountability and performance management arrangements and assistance (but not intrusion) from the centre where it is required;
- students are treated as *individuals*, with educational approaches geared to what works for each child and updated as new techniques are developed and more is understood about what works well. Where students from a particular background or with particular characteristics need more intensive help to achieve good results, this should be provided, and all school sectors should contribute to providing high quality education for disadvantaged students;
- adequate, and equitably distributed, *resources* – including the right teachers, appropriately trained – are available to achieve good results for all students; and
- children have fairer access to good *preparation* for school.

Many worthwhile initiatives are already under way within school sectors in Australia and further reform can build on these. But the nature and extent of the issues for school education mean that larger, systemic changes are also needed. In particular, the current division of responsibilities for education between the Commonwealth and the States clearly is not consistent with the community's aspirations for school education. The following sections explore both the issues and two broad reform directions:

- a change in the institutional and funding arrangements for school education to achieve greater consistency and equity; and
- a stronger focus on the outcomes of school education.

The focus is on *school education*. *Higher education* is now firmly established as a Commonwealth responsibility (although States have interests) and it is appropriate that *vocational education and training* remain under State administration, with Commonwealth input to national policies and to funding, coordinated via the Australian National Training Authority (ANTA). As noted in chapter 5, good links between school education and other sectors are vital if the education system is to serve students well. The education reform options have been designed with a view to strengthening the links across sectors wherever possible.

The following issues are examined in the rest of this chapter:

- The divided nature of Australia's school education system is considered in Section 9.2.
- Selected overseas experience is outlined in Section 9.3.
- The scope of the proposed new integrated school education system is discussed in Section 9.4.
- The key features of the proposed new system are explained in Section 9.5.
- More detail is provided in Section 9.6 on the funding and other arrangements that are designed to improve education outcomes.
- The need for specific initiatives in two areas – students at risk and early childhood education – is outlined in Section 9.7.
- The benefits of reform are discussed in Section 9.8 and implementation issues in Section 9.9.

9.2 Divided responsibilities

All schools in Australia are currently required to comply with basic registration, curriculum and assessment regimes applied by public authorities, although these differ somewhat from State to State and across school sectors. They are not, though, subject to a broad institutional framework that defines funding, reporting and accountability arrangements. In particular, Australia is unusual in having such a strong divide between 'government' and 'non-government' schools. This divide creates artificial barriers, even between schools in very similar situations, including:

- *inequities and inconsistencies in funding* across schools. The two systems of government funding are different and clearly inconsistent – significant anomalies exist in the funding of otherwise similar schools,[236] and substantial Commonwealth funds go to independent schools that have access to high levels of fee and other income:
  - this contributes to inequitable outcomes for students; and
  - the relative funding of the different sectors is likely to be part of the reason for increasing numbers of people choosing to send their children to non-government schools. There are also inconsistencies within school sectors;
- restrictions on *information flows* and *limited accountability* in some sectors:
  - schools and teachers learn about best practice and worthwhile innovation from each other, but the artificial boundary between sectors inevitably limits this flow of information and therefore limits what schools can achieve; and

– while schools provide detailed information to their respective government funding bodies, there is relatively little information publicly available about school performance. This is true of all sectors, including government school sectors, although change is under way in some, and *consistent* information across sectors is even scarcer, limiting the ability of families to make well-based choices about schools.

The artificiality of this barrier is clearest in the distinction that exists between *government* schools and some schools in the *non-government* sector. Government schools clearly have a special role in the system – welcoming all students and providing a secular education without compulsory fees. However, many non-government schools have similar characteristics to government schools, including:

- welcoming students of any social background;
- charging only moderate fees, and providing many students from disadvantaged backgrounds with fee reductions or exemptions;
- conforming to a common syllabus with their government counterparts; and
- being substantially publicly funded.

In particular, and contrary to public perceptions, there are many children from low and middle income families in non-government schools that operate on very low levels of resources. An equitable school funding policy must take this into consideration.

9.3 Overseas experience

Arrangements in other countries do not necessarily provide a model for reform in Australian education – our system has some distinctive features and new arrangements need to take account of them. However, overseas experience can provide a pointer to possible directions for change.

Other countries have a much less rigid delineation between schools in different provider sectors, at least as far as mainly publicly funded schools are concerned. For example, in New Zealand government and government-dependent Catholic schools are treated in similar ways by government (see Box 9.1). Similar arrangements exist in a number of European countries (see Box 9.2 for a description of the arrangements in the United Kingdom).

BOX 9.1 • SCHOOL EDUCATION IN NEW ZEALAND

The regulatory and funding framework for education in New Zealand differs depending on whether the school is state, integrated or private:

- **State schools – state-owned schools receive 'full' state subsidies and are extensively regulated by the state. State schools cannot charge fees but can ask for donations.**
- **Integrated schools – an 'integrated school' in New Zealand is a private school that has opted to integrate into the public system. These schools receive equivalent per-student operational funding rates to state schools, but must fund some of their own capital expenditure. Integrated schools cannot charge fees (but can charge 'attendance fees' to fund capital works). These schools must provide education of a special character within the framework of a particular religion or philosophical belief, and draw a certain proportion of their students from within this religion or belief. They are required to teach the national curriculum. The majority of integrated schools are run by the Catholic education office: approximately nine per cent of students in New Zealand attend the 190 Catholic primary schools and 48 high schools in that country.**
- **Private schools – privately-owned schools receive lower government funding and are subject to fewer regulations than either state or integrated schools. Private schools receive government funding at a rate of about 30 per cent of the per pupil rate provided in state schools. Private schools can charge fees as they see fit and are not required to follow the national curriculum.**

SOURCES: MINISTRY OF EDUCATION (NZ) 2003, *AN EDUCATION WITH A SPECIAL CHARACTER: A PUBLIC DISCUSSION PAPER ON THE CONSOLIDATION OF THE PRIVATE SCHOOLS CONDITIONAL INTEGRATION ACT 1975 INTO THE EDUCATION ACT*; INDEPENDENT SCHOOLS OF NEW ZEALAND 2002, *FUNDING ARRANGEMENTS FOR INDEPENDENT SCHOOLS IN NEW ZEALAND.*

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FOR EXAMPLE, SOME NON-GOVERNMENT SCHOOLS RECEIVE MORE GOVERNMENT FUNDS IN TOTAL THAN NEARBY AND SIMILAR GOVERNMENT SCHOOLS.

BOX 9.2 • SCHOOL EDUCATION IN THE UNITED KINGDOM

There are three categories of schools in the United Kingdom:

- Maintained schools – these are publicly funded primary schools or secondary schools in England and Wales. They include community schools, foundation schools, voluntary aided schools and voluntary controlled schools. These schools are funded by Local Education Authorities (LEAs). No fees are payable.
- Voluntary aided schools – these are a subset of maintained schools at primary and secondary levels. They were established by voluntary bodies (mainly the Catholic church and the Church of England) and the school's land and buildings are normally owned by trustees or a charitable foundation. They receive their revenue funding from the LEA, and the majority of their capital funding from central government but must contribute 15 per cent to capital costs. The school governing body employs the school staff and has primary responsibility for admission arrangements.
- Private schools – there are also a small proportion of private primary schools, and a larger number of private secondary schools. These schools receive no government funding and charge fees for tuition.

A recent United Kingdom government initiative – 'Building Schools for the Future' – suggests that that government is looking to make better use of private resources in education. The initiative provides five billion pounds for rebuilding and refurbishing schools by 2005–06. In return, the government is seeking to institute major reform of the publicly funded education system, encouraging public/private partnerships in the delivery of education by helping LEAs to set up independent academies. Academies will be schools run on independent lines, but will forge strong partnerships – including for funding – with the community.

SOURCES: EURYDICE DATABASE ON EDUCATION SYSTEMS IN EUROPE 2003, WWW.EURYDICE.ORG/EURYBASE/APPLICATION/EURYBASE.HTM; 'PM UNVEILS MASSIVE SCHOOL BUILDING PLAN', 12 FEBRUARY 2004, WWW.OPEN.GOV.UK/NEWS/NEWSARTICLE/FS/EN? CONTENT_ID=4011013&CHK=NYX%2BMX.

9.4 Scope of the new integrated education system

The inequities, inconsistencies and inadequacies of the current school education system explored in chapter 5 call strongly for reform and, particularly, for a more integrated school education system in Australia. Treating similar schools and similar students in similar ways, no matter which school sector provides the service, would improve the quality and fairness of school education. Such a system would better meet the broad community aims for reform of efficiency and equity discussed in chapter 7 and would provide the basis for a genuine partnership between the Commonwealth and States in school education.

The case is clearest for integration within one system of government schools and those non-government schools that share many of the core characteristics of the government sector. But there is a case for Australia to go further. Those independent schools that are not *predominantly* publicly funded, but receive some government money, also educate a substantial proportion of Australian students. And while debate will continue about *how much* government funding they should receive, the reality is that governments are likely to want to continue providing some support to this sector.

There is therefore much to be gained – in consistency of treatment, and thus in the quality and equity of educational outcomes for Australian students – from designing an institutional and funding framework that encourages most of these schools, as well as those that are predominantly publicly-funded – to commit to the basic principles of a new integrated education system.

The diversity within the school system means that the design of a framework for a new system raises the issue of where to draw the line between those inside the system and those outside. Key considerations include:

- What requirements should *all* schools satisfy?
- On what basis should schools receive *public funding*? And how should *other sources of school income*, including fees, be handled?
- What requirements should there be as far as *access* is concerned?
- What should the *system* arrangements be and how much *autonomy* should schools have?

These issues and the broad features of the proposed new integrated education system are discussed in Section 9.5. Some aspects of the proposed new system – especially those designed to improve outcomes directly – are examined in more detail in Section 9.6.

9.5 A single, consistent framework

The clearest, and cleanest, option for change is to create a single, consistent but flexible institutional framework within which all schools would operate *to some degree*. Figure 9.1 presents a simple representation of the broad framework proposed, which includes:

- all schools remaining subject to some requirements, such as for registration;
- most schools *inside* a new integrated education system – these schools receive public funding (although they remain free to raise non-government revenue); they are required to satisfy certain requirements as far as access and reporting and accountability are concerned; and
- a few schools *outside* the integrated education system – these schools receive no government funding.

The following sections explain the framework in more detail.

Requirements on all schools

All schools would continue to be subject to basic *registration, curriculum* and *assessment* requirements.

There is also a case for requiring all schools to commit to educating children in the basic *values and institutions* of our democracy, while (in the case of those serving members of a particular religion) also being free to include in their programs material on the values of their faith.

Democracy needs nurturing, and schools are one of the few focal points in our society for the sustenance of democratic discourses. This role cannot be limited to encouraging young people to learn about the institutions of democracy through the school curriculum. It also involves learning to practise democracy. Schools are places where young people from different backgrounds and experiences can learn democratic habits and capacities of liberal citizenship, including the habit of civility and the capacity for public reasonableness.

A. REID 2003, *PUBLIC EDUCATION AS AN EDUCATION COMMONS*, DISCUSSION PAPER, AUSTRALIAN COUNCIL OF DEANS OF EDUCATION, P. 3.

Decisions to establish *new schools* would be the responsibility of the various education provider sectors, provided a clear need for the school can be demonstrated and the provider sector can supply or access the initial capital required for establishment.

Government funding

Most schools would receive some public funding and would be required to meet certain conditions attached to that funding (see below). However, some would choose not to participate in the new integrated system.

- Non-government schools that choose to raise substantial private revenues through fees would not qualify for across-the-board public funding.
- Some non-government schools may choose not to comply with the conditions attached to public funding.

Funding of school education by both levels of government would be integrated into a single framework, with the following features.

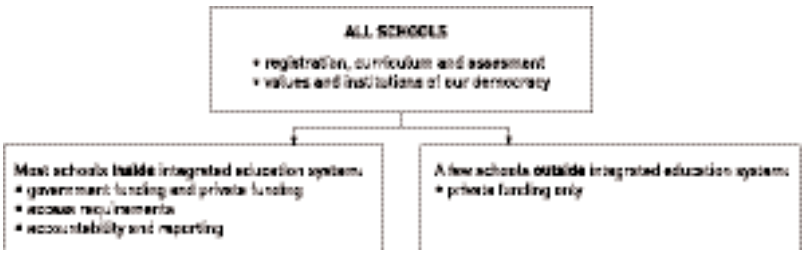
Student outcomes to be the basis of funding

Funding would be more closely related to what the community wants from school education – that is, the best *outcome* possible for each student. As discussed in chapter 5, different students need different approaches to achieve good results and, where different levels of resources are needed, this should be reflected in school funding. We need to move from a world where educational *inputs* are (more or less) standardised to one where inputs are varied and combined imaginatively to suit the particular student, class or school:

Some students need more learning time to achieve high standards than others; that time should be provided. Some need intensive individual tuition; that should be provided. As they get older, some students learn better in workplaces or communities than they do in schools; they should have those options. Different approaches to teaching and learning suit different students; teachers should therefore tailor their pedagogy. To achieve common outputs, the inputs need to be varied in whatever way it takes.

M. BARBER 2003, 'DELIVERABLE GOALS AND STRATEGIC CHALLENGES – A VIEW FROM ENGLAND ON RECONCEPTUALIZING PUBLIC EDUCATION' IN OECD 2003, *SCHOOLING FOR TOMORROW – NETWORKS OF INNOVATION; TOWARDS NEW MODELS FOR MANAGING SCHOOLS AND SYSTEMS*, OECD, PARIS, P. 114.

FIGURE 9.1 • A SINGLE FRAMEWORK FOR SCHOOL EDUCATION IN AUSTRALIA



SOURCE: THE ALLEN CONSULTING GROUP.

To achieve more consistent and equitable educational outcomes, school funding therefore needs to recognise differences among broad groups of students, and so needs to be *student-based*, rather than based on the school's provider sector as is currently the case, and based on *evidence* about what strategies work for particular groups of students.

- The majority of students can achieve good outcomes with approaches funded by relatively *standard payments* per student. This does not mean that the *teaching* of these students should be standardised – boys and girls, for example, may well need different approaches, especially in literacy subjects, and teachers should gear how they teach to these needs – but the level of resources required for these students would not be different.
- But where schools require different levels of resources to achieve good outcomes for different types of students, these should be provided to the school, so the size of payment will be *needs-based* and will vary across types of students.
  - Additional payments would be made to schools for students where special, more intensive approaches are needed to achieve good outcomes, because they are from groups that currently achieve poor outcomes (e.g. those from disadvantaged backgrounds or Indigenous students) or they have characteristics such as physical or learning disabilities.
  - The small amounts currently provided to schools to fund extra help for disadvantaged students and the resulting disparity in education outcomes (see chapter 5) suggest that a substantial injection of *additional* funds will be needed to achieve better results for these students.
  - This proposal includes additional funding of up to $1 billion for this specific purpose.
- Where a school's circumstances are exceptional (remoteness, size) and affect the cost of achieving required educational outcomes, this would also be reflected in its funding.
- This issue is discussed in more detail in Section 9.6.

Distribution across provider sectors

Funding would be *fairly distributed* across schools according to need. Schools and students with similar needs would receive similar amounts of funding.

Taking account of fee income

Chapter 5 showed that school funding currently takes inadequate, if any, account of a school's access to external funds such as fee income. As a result, the total resources available to schools vary enormously, by thousands of dollars per student – and it is likely that this and other sources of funding inequities are contributing to the variability of student achievement.

One of the key objectives of the new funding arrangements must therefore be an equitable distribution of public funds, taking account of schools' access to fee income. Government funding needs to be directed to where it is most needed, with more going to those schools with little ability to raise external funds through fees.

At the same time, there is a need to:

- ensure continued access to the system for all – those who cannot afford to contribute much (or anything) to the cost of their children's schooling must not be excluded from the system – or from receiving the help needed to achieve good educational outcomes;
- preserve private contributions to the financing of education – there is simply not the budgetary scope for governments to take on a much larger share of the cost of education than they are currently carrying, given the range of demands on the public purse; and
- maintain the special character of government schools and, in particular, the policy that government schools do not charge compulsory fees.

Two design issues arise for the new system:

- The boundary issue – on what basis should schools be allowed into the new integrated education system? In particular, should those charging compulsory fees be allowed inside the net?
- The basis for public funding of those inside the system – how should the public funding formula take account of schools' access to external funds?

In relation to the *boundary issue*, one option is to exclude from the integrated education system those schools charging compulsory fees. This has the attraction of creating a 'clean' border around the system and of maintaining integrity, and also a link, with the traditional notion of public education and the special feature of schools in the government sector now – that private contributions are voluntary and no-one is excluded on the basis of inability to pay. It is an option that would ensure access to the system for all.

Developments in school education in recent decades mean, though, that the option of excluding schools from the integrated education system if they charge compulsory fees has important disadvantages.

- The distinction between compulsory and voluntary fees has become less clear. The nature of school fees now varies enormously both across and within provider sectors, and making distinctions on this basis would mean treating similar schools in different, and inequitable, ways.
  - In the government sector, schools are not permitted to charge compulsory fees and many request only relatively small voluntary contributions from families. However, some government schools, especially selective schools and those that have a strong record of academic achievement and where places are highly prized, have significant voluntary contributions. Although not compulsory, there is often a strong expectation that such fees will be paid.
  - In the non-government sector, some schools charge high and 'compulsory' fees. Others, especially those charging lower fees, impose what are termed compulsory fees but provide concessions for those families not able to pay. Even some high-fee schools are prepared to make special arrangements for families in financial difficulty.

- Drawing the border of the system on the basis of compulsory or voluntary fees would create an incentive for schools to abandon compulsory fees so that they could enter the net and receive public funding. In some cases, they would see a drop in their fee income and the public purse would be required to pick up at least part of the reduction in private contributions.
- Some schools that would otherwise join the system would remain outside it and so would not sign up to its principles and requirements. The result would be to entrench a two-tier system, with separate government funding arrangements for these schools, continued inconsistency in treatment and a substantial group of schools not meeting the requirements of the new system, including the provision of access for disadvantaged students.

Exclusion of schools charging compulsory fees would therefore threaten the objectives of a system that is both equitable and sustains private contributions.

An alternative, and effective, way to meet the critical objective of preserving access for those with lower ability to pay is to allow schools charging compulsory fees inside the system – but with funding graduated to need – and to ensure that all schools in the system participate in access programs. This option also maintains private contributions to the cost of education and brings more schools inside the system.

Schools within the system could continue their existing fee arrangements. Schools that currently charge compulsory fees could continue to do so. Nothing in the new model implies that government schools would charge compulsory fees.

The access requirements proposed for the new integrated education system are discussed below, under 'Access'.

To graduate government funding of schools according to need, the arrangements need to take account of schools' access to private fee income.

- The relationship between schools' fee income and government funding would achieve an equitable distribution of public funds for education, encourage schools to continue raising funds through fees from families who can afford to pay them, and maintain compatibility with the policy that government schools do not charge compulsory fees.
- Fee income would include funds raised through either compulsory fees or voluntary fees that are generally applied. This will make the distribution of government funding for education more equitable, by directing more funds to where they are most needed – schools in poor areas – and by encouraging continued private contributions from those who can afford them.
- To encourage schools to continue raising external funds:
  - a school's access to private income could be measured by a combination of *capacity* to raise funds through fees and *actual* fees received;
  - a school's government funding would be adjusted on a sliding scale, although designed to ensure that incentives to raise funds through fees remained; and
  - donations to approved building funds and similar benefactions of capital funds would not affect a school's government funding.
- The policy that government (and possibly some other) schools do not charge compulsory fees would be recognised within the funding model. Schools in this situation would have their fee income measured, but the capacity of parents to pay compulsory fees would not be relevant. Under these arrangements, governments may need to be willing to take on much of the funding of any non-government schools that also opted not to charge compulsory fees (noting the difficulties described above of distinguishing between compulsory and voluntary fees).

Funding – overview

The four key steps proposed for establishing a school's level of government funding are summarised (in simplified form) below and in Table 9.1. The first two steps are *student-based* components of funding (where the school receives the sum of what is provided for each individual student); steps 3 and 4 relate to the *school's* circumstances.

These steps will result in funding levels that are much better aligned with student needs.

- Step 1 – All schools in the integrated education system would initially be allocated a standard amount from public resources for *each student*.
- Step 2 – Schools would be allocated different amounts from governments to enable them to achieve good outcomes for *each student* from a disadvantaged group where education outcomes are currently poor – such as those from poor backgrounds or Indigenous students – or with individual special needs – such as physical or other disabilities.
- Step 3 – Where a *school's* circumstances are exceptional (remoteness, size) and affect the cost of achieving required educational outcomes, it would also be allocated additional funding.
- Step 4 – The *school's* actual government funding would be adjusted to take account of its access to private fee income.

The implications of the new funding model for individual schools and the need to design transition arrangements carefully are discussed in Section 9.8.

Access

Access to the system would be assured for all, and schools in all provider sectors would contribute to achieving better education outcomes for disadvantaged students.

Schools receiving the highest levels of government funding would be required to provide open access to students from the whole community, or a substantial group in the community (e.g. to those of a particular religion), on a non-exclusive basis – that is, no prospective student would be barred by school-instituted academic prerequisites, fees (schools would need to put in place arrangements for exempting families with limited resources from paying fees), or other restrictions.

Schools receiving lower levels of government funding would be required to hold a significant proportion of their places for students who would otherwise be excluded because of an inability to pay fees or other restrictions; selection for these places would be on the basis of an approved access policy.

In addition, all schools within a particular region in the new integrated system could be encouraged to work together to maximise opportunities for all students. This process could allow, for example, schools across different sectors to increase the range of alternative educational options and therefore maximise choice. It could also allow for greater planning to meet the needs of students at risk or students with challenging behaviour and learning needs.

System arrangements, school autonomy and accountability

Consistent with the principles in chapter 7, the States would oversee the operation of the integrated school education system, within a national framework (the division of Commonwealth and State responsibilities is discussed further below). They would be responsible for guiding and supporting schools in the system, whether government or non-government, including by curriculum development, developing policies to meet particular needs (e.g. re-engaging disengaged students), reflecting local priorities, monitoring and sharing best practice information, developing and implementing performance management systems (including responding to poorly performing schools), and developing and supplying curriculum material and professional development options at low cost.

TABLE 9.1 • PROPOSED COMPONENTS OF GOVERNMENT FUNDING FOR SCHOOLS

Step 1 standard per student amount	Step 2 adjustments for student characteristics	Step 3 adjustments for school characteristics	Step 4 adjustment for access to non-gov't funds
	PLUS	**PLUS**	**LESS**
STANDARD PER STUDENT AMOUNT ALLOCATED FOR ALL STUDENTS	ADDITIONAL FUNDING NEEDED TO ACHIEVE GOOD OUTCOMES FOR STUDENTS FROM DISADVANTAGED GROUPS – LOW SOCIOECONOMIC OR INDIGENOUS BACKGROUNDS – AND STUDENTS WITH INDIVIDUAL SPECIAL NEEDS – STUDENTS WITH DISABILITIES ETC.	FUNDING FOR SCHOOLS IN EXCEPTIONAL CIRCUMSTANCES (REMOTE LOCATION, OR SIZE) THAT AFFECT THE COST OF ACHIEVING REQUIRED EDUCATION OUTCOMES	ADJUSTMENT FOR ACCESS TO PRIVATE FEE INCOME, BASED ON(a): › COMBINATION OF CAPACITY TO RAISE FUNDS THROUGH FEES AND ACTUAL FEES RECEIVED (ACTUAL ONLY FOR GOVT SCHOOLS); AND › GOVT FUNDS REDUCED ON A SLIDING SCALE

(a) NOTE THAT IN STEP 4 , 'FEE INCOME' EXCLUDES DONATIONS TO APPROVED BUILDING FUNDS AND SIMILAR BENEFACTIONS.
SOURCE: THE ALLEN CONSULTING GROUP.

Schools would have considerable autonomy in how they use the funding they receive (and the extent to which they use support, such as curriculum material, offered from the centre), but they would remain accountable for the results of their work. All schools receiving government funding would be required to comply with consistent reporting and accountability arrangements and agree to the publication of a minimum set of performance and financial information, but would not be subject to a large administrative burden. The accountability and reporting arrangements would improve the incentives for schools to do the most with the resources they have available and would provide better information on which Australian families could base decisions about their children's education.

The new arrangements would mean considerable freedom for schools that perform well in all provider sectors. Schools not doing so well would receive support and assistance to help them improve their performance. Performance management of schools is discussed in more detail in Section 9.6.

Preserving and promoting diversity and innovation

It is important to emphasise that the proposed arrangements do *not* mean imposing a high level of uniformity on how schools educate students – quite the opposite.

The focus of the proposed changes is educational *outcomes* – that is, student achievements. There is a clear need to improve outcomes, especially for those students currently not being served well by the school education system. The changes proposed here are designed to give schools what they need to do that – and an essential part of reaching the goal will be *more* diversity in how schools approach the education of their students, both across and within different provider sectors.

The funding arrangements described above will give schools more scope to take different approaches for different students, as will the greater flexibility advocated later in this chapter for the administrative and workforce arrangements imposed on some sectors. These changes will move school education *away* from the 'standard' approach that exists in some parts of the system to one where more diverse mixes of 'inputs' are used to attain more consistent student achievements. And the basis for setting per student payments that is discussed in Section 9.6 – a process of benchmarking best practice in school education – will provide continuing incentives for schools to seek out new and more effective ways of delivering education to students.

Part of a more diverse and innovative school system will involve the use of different approaches *within* schools, but there would also be scope to increase diversity of approach *across* schools, including by allowing and encouraging more specialisation in areas of particular strength. Specialisation already occurs in a number of schools which are known to have unusually strong programs in music, art, science, technology etc., and this is being encouraged to develop further in some sectors, as noted in chapter 5. There is scope to build on the current directions, particularly with an integrated system providing more opportunities for schools in different provider sectors to co-operate, especially in the teaching of 'specialist' subjects. In essence, encouraging diversity and specialisation to better meet student needs increases the choice available to all parents, including those who remain within the government school system.

The United Kingdom's experience with specialist schools to date suggests that this can be one strategy for lifting educational standards and encouraging innovation, as well as providing more choice in the nature and style of education for students and their families. United Kingdom specialist schools have a focus on their chosen subject area, but must meet the full national curriculum requirements and deliver a broad education to their students. In a recent review of secondary schools, the Office for Standards in Education found that specialist schools, which were less than half of all schools, made up 64 per cent of 'outstanding' schools.[237]

Respective government roles

A greater degree of collaboration and consultation among governments than exists now would be required to make the proposed system work well, while retaining flexibility and a substantial degree of policy autonomy at a jurisdictional level. In other words, a genuine partnership is required.

The Commonwealth and States together would define the framework and rules for participation in the system and set national objectives and strategies. The Commonwealth would be best placed to operate a national system of performance measurement and reporting and would negotiate with the States on the high level allocation of financial costs and risks.

The States are best placed to take the main responsibility for the integrated school education system, expanding their current involvement to encompass non-government as well as government schools that will together comprise the new, integrated education system. Each jurisdiction would retain considerable autonomy to implement its own approach to pursuing the objectives of the system (e.g. by setting policies relating to lifting school performance, developing teachers and sharing best practice, re-engaging disengaged students etc.) and managing the integrated education system so as to encourage innovation and diversity, reflecting local priorities. Within this framework, schools would have considerable autonomy in how they deliver education.

A new joint Commonwealth–State body should be established to implement the reforms and oversee the coordinated system. The new institution would be a small organisation analogous to the proposed new health reform body and would report to a Ministerial Council. Its first task should be to develop detailed implementation plans for the proposed reforms, including detail on the division of responsibilities between the Commonwealth and States, something that is beyond the scope of this paper.

Once the reforms have been implemented, the new organisation would be responsible for overseeing the implementation by the States of a national policy on schools. It would be logical for this body, in time, to be merged with the Australian National Training Authority (ANTA), which oversees the vocational education and training sector. Combining the two organisations would help to strengthen the vital links between the school education and vocational education and training sectors in the future.

Reform costs

The cost of such an arrangement to government would depend on detailed features of the design of the framework, whose development is beyond the scope of this report. Rough estimates[238] suggest, though, that the overall cost would be in the region of $1 billion to $2.2 billion (in 2004 terms), made up of:

- additional spending of around $1 billion to $1.5 billion to lift per-student funding to non-government schools with little private fee income to the same level as that provided to government schools (this will principally affect funding to Catholic schools that charge low fees);
- reduced or no funding (around $0.3 billion to $0.4 billion) for the wealthier independent schools; and
- additional funding of around $500 million to $1 billion to improve educational outcomes, especially for those groups of students (from disadvantaged backgrounds) who are currently recording lower levels of achievement at school. The amount required would depend on evidence of how much it costs to improve outcomes for these students and the numbers of students involved.

The above would be ongoing costs (additions to Forward Estimates). Some transitional costs would also arise – although these have not been scoped in detail – in order to ensure that no State is worse off in the short term, and also to ensure that any schools that would lose funding under this proposal had time to adjust.

9.6 A stronger focus on results

Alongside this reshaped broad framework, more specific changes are needed to lift performance in school education and particularly to address the wide disparity in outcomes across students and schools.

Government funding and accountability arrangements need to have a stronger focus on educational outcomes. And not just on average, but for each school and each student; a system that serves only part of the community well is not succeeding.

Resourcing to improve outcomes for those falling behind

As discussed in Section 9.5, a clearer focus on outcomes requires a shift from input-based funding for schools to a system where funding is allocated on a *per student* basis and represents a payment for the achievement of student outcomes.

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SPECIALIST SCHOOLS TRUST 2004, *SPECIALIST SCHOOLS DOMINATE OFSTED'S LIST OF 'OUTSTANDING' SCHOOLS*, PRESS RELEASE, 4 FEBRUARY, WWW.SPECIALISTSCHOOLSTRUST.ORG.UK/NEWS/PRESSRELEASE.CFM?ID=91.

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ESTIMATE PREPARED BY VICTORIAN DEPARTMENT OF PREMIER AND CABINET IN CONSULTATION WITH PROFESSOR GERALD BURKE, CENTRE FOR THE ECONOMICS OF EDUCATION AND TRAINING, MONASH UNIVERSITY, MAY 2004.

Per student payments should fund costs which schools themselves manage. With small schools in mind, the per student formula could include a base 'lump sum' amount to cover overheads. Decisions to invest in school capacity, and the financing of that capacity would – as now – be the responsibility of the various education provider sectors, although there is a need for a strengthened process to ensure that these investments are warranted.

Critically, where schools require different levels of resources to achieve good outcomes for different types of students, these would be provided, so the size of payment will vary, with need, across broad types of students.

- Some students need special approaches because they have particular characteristics, such as physical or learning disabilities.
- Some groups of students, such as those from poorer backgrounds and Indigenous students, currently achieve persistently worse outcomes than others, suggesting that new approaches are needed to engage these students and help them learn. Where the best approaches are more expensive – smaller classes, one-on-one coaching, more experienced teachers or additional instruction – schools should receive significantly more funding than they currently do in order to improve results for these students.

As noted in chapter 5, even though the government and Catholic school systems allocate extra funds for schools with poorer and disadvantaged students, the amounts involved are not large enough for *total* funding per student to vary, except weakly, with the proportion of disadvantaged students in the school. A substantial injection of *additional* funds is therefore likely to be required to improve the consistency of education outcomes for Australian families and this proposal includes up to $1 billion of extra funding to meet this need.

Payments may also vary across levels of schooling and with some unusual characteristics of schools (such as remote location) that affect the cost of achieving the required outcomes.

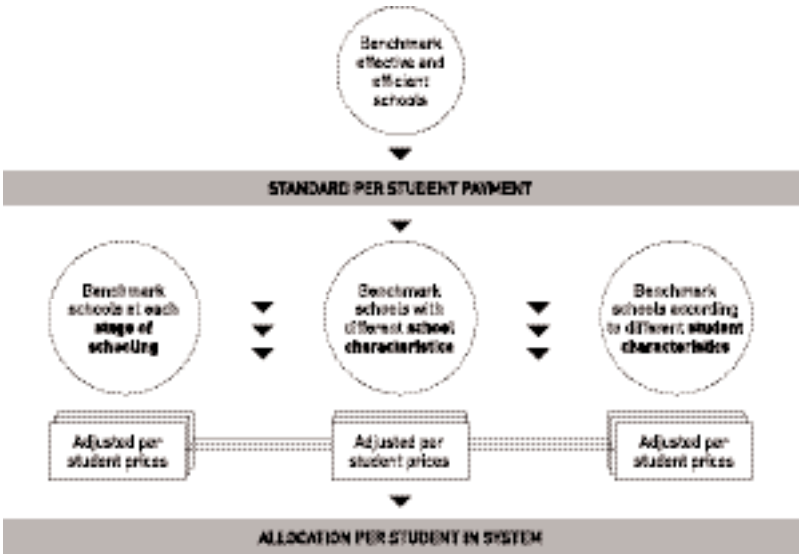
Setting the level of per student payments is not an easy task. It needs to be based on a thorough understanding of student outcomes, how they vary across different groups (carefully defined), the strategies required to improve outcomes where they are poor, and the cost of these strategies.

To encourage innovation by schools, the per student payments need to be based on evidence of what works best for students and what is an efficient use of resources. Schools that do their job well – effectively and efficiently – need to be identified and a benchmarking process used to collect data on how much it costs to achieve good outcomes for a range of different types of students using 'best practice' methods. Payments need to be reset periodically.

The framework for setting the level of per student payments is shown in Figure 9.2.

Determining the level of payments therefore requires an understanding of how various educational inputs are being combined to achieve good results. However, the basis for funding *must* remain very clearly on outcomes. Schools would be funded on the basis of the cost of 'best practice' approaches, but they would not be compelled to replicate those approaches if they could find a different way of achieving the results required. Payments to schools would be payments for outcomes, not for supplying particular combinations of inputs, so schools would have an incentive to innovate and do even better than current 'best practice', while continuing to be responsible for the results of their work. The result, as discussed earlier, would be more diversity in how education is delivered in schools, not less.

FIGURE 9.2 • SETTING PER STUDENT PAYMENTS



SOURCE: THE ALLEN CONSULTING GROUP.

Promoting good performance, focused on the student

Improving the quality of school education so that outcomes are more consistently high across schools and students requires a new approach in schools. Research shows that the quality of school leadership and teaching can be a key driver of student outcomes and productivity improvements in schools. The right teachers and school leaders – able and willing to think imaginatively and pursue information about how best to meet the learning needs of their students – are essential, and they need the right incentives and support to do their job well. Schools and teachers also need to be given the freedom to follow new approaches.

Chapter 5 showed that, while worthwhile change is under way in all sectors, the current arrangements do not always produce the best results from the resources available or consistently support quality teaching:

- School performance and accountability systems are not consistent and not always effective, where they exist. A number of schools in all provider sectors are not performing well.
- Teachers' pay scales in some sectors do not help to attract and retain excellent teachers.
- There is some resistance to building a performance and development culture, including the measurement of student outcomes, which can be an important lever for helping to achieve and maintain high standards. The performance management systems in place can be of limited value.
- Leadership and professional development are excellent in some parts of the school education system, but this is not uniformly the case.
- Some schools labour under unhelpful restrictions on how they deliver education, which limit their ability to get the most out of their funding allocations and their staff and which impose an unnecessarily high administrative burden.

Alongside the resources to achieve good outcomes, therefore, schools need:

- better incentives for good performance, and better support for those schools in difficulty, provided by more robust performance management and accountability systems for schools and teachers that are linked to funding; and
- more flexibility to manage within their funding allocations.

In a number of these areas, reform can and should build on changes already under way in a number of jurisdictions.

The links between funding and performance management and accountability systems are crucial. In particular, it needs to be clear at the start of a funding period what a school is receiving its funding *for*. That is, the outcomes that the school is expected to achieve need to be explicit, so that it can plan its work and allocate funding well, and so that its performance can be measured at the end of the funding period. This indicates a need for a form of agreement to be made between the school and the relevant State authorities at regular intervals as a basis for school performance management and accountability.

A central aspect of all such agreements would be the careful definition of what a good outcome is for the population at each school. These definitions need to recognise the diversity of students within and across schools and the range of pathways open to them – departure from school before Year 12 or equivalent for a job or for a VET course is a good outcome for some students but not for others.

Funding also has an important role to play in the management of school performance – by, for example, the funding of remedial action in poorly performing schools and the funding of innovative measures:

- schools that under-perform (given the characteristics of their students) should be obliged to enter into an agreement with the State authority to address problem areas and lift outcomes; the State agency would advance supplementary resources and other assistance (such as specialist advice) in return for commitment to agreed goals for outcomes, and would monitor results;
- funds should also be earmarked to finance innovations in individual schools designed to 'stretch' performance and inform understanding of best practice for dissemination to all schools.

The direct role of funding arrangements in encouraging good performance by schools is necessarily limited. It is vital, for example, to ensure that under-performing schools are not stripped of the resources they need to improve their performance, although in extreme circumstances of persistent under-performance the State may impose stringent conditions on further public funding. There is a strong need for a performance management system that provides non-financial incentives to encourage improved performance by schools. A consistent system of reporting school performance against agreed outcomes is clearly one element of this system, but in particular cases active support and intervention by education authorities will also be needed.

The issues around teacher pay and performance, professional development and administrative restrictions indicate the need for substantial change in the workforce and administrative environments that many schools operate in. The option for change is a far-reaching review of the full set of arrangements around pay, training and development, performance management and operational flexibility, designed to:

- attract, retain and promote the right people for school education;
- stimulate and maintain a high level of professionalism, creativity and innovation in schools; and
- help teachers and schools to develop a culture which values improvement both in how well and how efficiently they deliver education to Australian families.

9.7 More specific initiatives

Participation of early school leavers

An area requiring particular attention is the early departure from school of significant numbers of students. Early leaving can have serious consequences for young people – early leavers are at greater risk of unemployment or low-paid employment – and costs for the community as a whole, including through forgone economic growth.[239]

Chapter 5 showed that Australia's rate of participation in senior secondary education is poor and is a particular issue for students from poorer families and Indigenous students.

A sharper focus on education outputs, including better meeting the individual learning needs of students, should help to improve the achievements at school of these students and encourage them to keep attending. But more specific action may also be needed. A range of options for action in this area exists at various levels, including system reform (such as ongoing curriculum reform at senior secondary level to diversify choices for students), and initiatives to support individual students at risk, including the use of a case management approach.

Preparation for school – early childhood education

Chapter 5 described the growing body of research showing the importance of quality early learning experiences to children's short-term cognitive, social and emotional development, as well as to their long-term success in school and later life, with children from disadvantaged backgrounds gaining the most from quality early childhood education programs.

While some States have introduced early intervention initiatives, there is scope for Australia both to develop a more systematic approach to early childhood development and to encourage greater participation, especially by children from disadvantaged backgrounds. This will require resolution of a range of issues, including:

- whether participation should be compulsory at a particular age or targeted to disadvantaged children;
- the nature of programs and the extent of national coordination;
- how early childhood development should be linked with the school education system and the range of other services that support families;
- sources and levels of funding;
- scope and responsibility for regulation; and
- workforce issues.

239 L. WATSON AND R. TEESE 2004, FORTHCOMING, *GOALS AND PURPOSES OF EDUCATION AND TRAINING*, A REPORT TO THE VICTORIAN DEPARTMENT OF PREMIER AND CABINET, UNIVERSITY OF MELBOURNE CENTRE FOR POST-COMPULSORY EDUCATION AND LIFELONG LEARNING, P. 30.

9.8 The benefits of reform

The reforms suggested here would clearly take time to have a significant effect – we would probably not see large changes in educational outcomes for a number of years after the institutional changes are made. However, over time there would be significant benefits, both for individual students (and their families) and for schools.

The three key changes that the reforms would bring about for students and their families (summarised in Table 9.2) are:

- better education standards, and the *expectation* of good results, for all students:
  - by making it clear that schools are required to achieve good results – carefully defined – for their students as a condition of receiving public funding;
  - by providing the funding needed to achieve those results;
  - by providing public funding on an equitable basis across students, schools and school sectors;
  - by better systems to encourage good performance – performance management, reporting and accountability systems for schools and teachers; and
  - by improved workforce arrangements, including better support for teachers (through professional development);
- a more *individual* approach for students and more *equitable* outcomes:
  - by providing public funding on an equitable basis and per student;
  - by providing funding according to what is needed to achieve good outcomes for particular types of students, including substantial additional funding of up to $1 billion to improve the results of students in disadvantaged groups;
  - by improved workforce arrangements, including better support for teachers (through professional development);
  - by giving schools more flexibility in how they manage; and
  - by a more systematic approach to early childhood development;
- more and fairer choice for Australian families:
  - by providing public funding fairly;
  - by encouraging diversity and innovation in educational offerings in all school sectors; and
  - ensuring that good information on school performance is available to families making choices about school education.

Most schools and teachers would benefit from the new arrangements too (summarised in Box 9.3). Their task would be clear, they would receive enough funding – based on evidence – to do the job required of them, they would have flexibility to get on with the job in a way that suited their students, they would be given support from the centre, and their performance would be assessed on agreed basis.

The clear winners from the changes in funding would be those schools in both the government and non-government sectors that are currently *under*-funded, given the nature of their student population. These will primarily be schools with large numbers of students from disadvantaged groups, and especially those in poorer socioeconomic areas.
They would receive a substantial boost to their funding, particularly from the additional $500 million to $1 billion to be provided to finance better outcomes for students from disadvantaged groups. As a result, they would have the resources to attract some of the best teaching talent and provide more flexible, tailored learning environments for their students than is possible now.

TABLE 9.2 • BENEFITS FOR STUDENTS AND THEIR FAMILIES

1. Better standards of education	2. Fairer education outcomes	3. More and fairer choice about education
STUDENT ACHIEVEMENT TO BE THE BASIS FOR PUBLIC FUNDING	FAIR PUBLIC FUNDING ACROSS STUDENTS, SCHOOLS, SECTORS	FAIR PUBLIC FUNDING ACROSS STUDENTS, SCHOOLS, SECTORS
ENOUGH FUNDING TO ACHIEVE THOSE RESULTS	FUNDING ON A NEEDS BASIS, INCLUDING UP TO EXTRA $1 BILLION	ENCOURAGING DIVERSITY AND INNOVATION
FAIR PUBLIC FUNDING ACROSS STUDENTS, SCHOOLS, SECTORS	IMPROVED WORKFORCE ARRANGEMENTS	GOOD INFORMATION
BETTER SYSTEMS TO ENCOURAGE GOOD PERFORMANCE	MORE FLEXIBILITY FOR SCHOOLS	
IMPROVED WORKFORCE ARRANGEMENTS	MORE SYSTEMATIC APPROACH TO EARLY CHILDHOOD DEVELOPMENT	

SOURCE: THE ALLEN CONSULTING GROUP.

The changes would better equip many schools to compete in the provision of higher quality education for a range of students, helping to turn around the increasing concentration of disadvantaged students in some schools and regions and so to reverse the development of a divided and unfair education system.

Some schools would ultimately receive less public funding – at least in real terms – than now. Some non-government schools might opt out of the system altogether and not receive any public funding. Schools within the new system would only receive less government funding if they currently receive more than they need to achieve the outcomes required of them, taking account of their student population and their access to private fee income. This is likely to be true of some non-government schools charging high fees; it may also be true of a small number of schools in the government and Catholic sectors that are well-resourced given their student populations.

However, changes in funding would be phased in over a number of years and schools would be supported and assisted to adjust to new levels of government funding during the transition period.

BOX 9.3 • BENEFITS FOR SCHOOLS AND TEACHERS

- **A clear task, carefully defined.**
- **Adequate, and fair, funding.**
- **Additional funding to achieve better outcomes for disadvantaged groups.**
- **Flexibility in how they deliver education.**
- **Support from the centre.**
- **Performance assessed on agreed outcomes.**

SOURCE: THE ALLEN CONSULTING GROUP.

9.9 Implementing reform

As with health, the creation of a *new joint Commonwealth–State body* would be an important step in planning the reform process and driving its principal components, especially the changes to funding and the transition arrangements. As well as working on a broad plan for educational reform, one area that the new body could work on initially would be the development of a national approach to early childhood education, where Australia clearly lags behind many other countries. The new body will be small and focused on its core role of driving reform.

However, even before the creation of the new institution, work can begin in a number of areas through existing forums, such as MCEETYA. In most of these areas, change is desirable regardless of the speed of larger changes in institutional and funding arrangements, and would reap substantial benefits for students on their own. In all these areas, change is critical if the larger reforms proposed in this report are to succeed.

The new *student-centred funding system* needs to be based on:

- a clear understanding of what the (specific) desirable and realistic goals are for school education and how performance is to be measured; and
- sound evidence about differences in student achievements, best practice in meeting the goals of the system, etc.

Although there is material available on these questions in different jurisdictions, and there is substantial work under way as part of the Schools Resourcing Taskforce of MCEETYA, there is relatively little available that has been sponsored *on a national basis*. Starting joint work on these questions would be an essential first step in the reform process.

Chapter 5 showed that there are large inconsistencies and inadequacies in *performance management and accountability systems* for schools and teachers. Individual jurisdictions can start work on improving their own systems, and can work together through a body such as MCEETYA to develop systems and processes along similar lines in order to provide some consistency in the existing conditions around public funding for education as a basis for future development.

Substantial change over the 5 to 10 year reform period envisaged here is needed in the *workforce and administrative arrangements* if schools are to be able to offer more diverse approaches to education for students with different needs and to get more out the resources they have available. Again, individual jurisdictions can work on changing their own arrangements, supported by joint work on identifying where change is most critical.

Changes to *funding arrangements* will inevitably follow some of this earlier work, and will require detailed negotiations across jurisdictions once the relevant evidence is available.

One issue will be how to deal with differences across jurisdictions in Commonwealth and State funding shares for school education. If, as suggested, funds are to be pooled and then distributed to schools on a per student basis, rather than by sector, a critical issue will be the establishment of agreed funding proportions for the two levels of government. One simple approach, where there are differences to present funding shares, would be to offset any such difference through a separate compensating adjustment in other payments that the Commonwealth makes to those jurisdictions.

These adjustments would be made to general purpose payments and would be akin to the budget-balancing assistance provided to the States in recent years as part of the new inter-governmental arrangements associated with introduction of the GST. The adjustments would therefore be made separately from the allocation of GST revenue by the Grants Commission and would not be taken account of in that allocation process. Those States that would receive a lower share of Commonwealth payments for school education under the new system than they receive now would receive a 'top up', phasing out over time; where States receive a higher share under the new system, their benefit could reduce over time.

Where such large changes are proposed, there will inevitably be *differences of view* across jurisdictions. Ideally, all jurisdictions would commit to reform, but the proposals here do not need to wait for unanimity of view about the way ahead or a commitment by all. It would be feasible for reform to occur in some jurisdictions initially, provided the relevant States and the Commonwealth agreed on the broad parameters of the new education system. Change could proceed initially on a bilateral basis or, if several jurisdictions wanted to go ahead, through the formation of a limited scope umbrella organisation of the type proposed above. Implementation could also be staged *within* jurisdictions, at a regional level, starting with those areas where there is a higher concentration of disadvantaged students.

The existing arrangements – with the traditional split of Commonwealth and State funding and other responsibilities – could continue elsewhere, until these jurisdictions were ready to join the new arrangement. No doubt the experience of the pioneering jurisdictions would be of value to those following later.

PART II
A BETTER FUTURE: OPTIONS FOR REFORM

Chapter Ten
Comprehensively meeting families' needs: a fresh approach to federal collaboration

Successful reform to meet the needs of Australians will require sustained leadership and drive from heads of government. New arrangements are needed that are designed to lock in true collaboration among Australian governments, from the top down.

Comprehensively meeting families' needs: a fresh approach to federal collaboration

This chapter broadly discusses reform directions that could be pursued by one or other level of government, or both, in areas important to families outside health and education. It also discusses reform of the overarching governance structures of our Federation.

Key Points

- It is extremely important, given the prospect of growing pressures on social programs over the next few decades – particularly in health, including aged care – that new collaborative arrangements are put in place now, rather than waiting until present arrangements buckle under those pressures.
- Reforms in health, and in education, could conceivably be pressed ahead with, without being accompanied by reforms in other policies and programs affecting families – or by new overarching arrangements for governments to work together in our Federal system.
- However, pursuing reforms in health and education in isolation from reform to the high-level governance of our Federation would risk failure. The proposed reforms in those specific areas are far-reaching and are certain to encounter opposition from some stakeholders. Maximising the prospects of success will require sustained leadership and drive from heads of government, a common broad vision for Australian families and an overarching reform strategy. What are needed are new arrangements designed to lock in true collaboration among Australian governments, from the top down – thereby helping to realise the full potential of our Federal system.
- In each of the areas of health and education we have proposed new integrated funding and other arrangements, and new mechanisms for Commonwealth–State collaboration. While it is desirable that all States participate in implementing those reforms, we have emphasised that it is not necessary that all do so simultaneously.
- Outside health and education, there are some other major social programs in which both levels of government are involved, where outcomes for families could be improved by reform – e.g. housing and disability programs. There are indeed many smaller areas where it would be better for just one level of government to provide administration and funding – but within an overall national strategy for families and associated national reporting framework.

- Among the most profound influences on how families fare are the major income redistributional instruments which the Commonwealth operates – i.e. the income tax and social security systems. Both need reform, especially to simplify them and to lower marginal tax rates and effective marginal tax rates. The key reform direction to make that possible would be to stringently cut back the many tax breaks that have proliferated in the tax system. There would also be scope in this to generate some additional funds for social programs, in particular to help fund the proposed reforms in health and education.
- Such reforms in tax and social security would reinforce the benefits, for families, of the health and education reforms proposed here, by significantly improving incentives for families to be more active economically and to improve their circumstances and their children's prospects. There is strong evidence that individuals' health and education outcomes would ultimately also be improved by this.
- Comprehensive reform to improve the lot of Australian families can only be effectively driven by institutionalising true collaboration at the highest level of our Federation. We propose a revival and revamp of a concept canvassed in the Special Premiers' Conference process of the early 1990s – that a new 'Australian Federation Council' (AFC) should replace and transcend the present COAG. We envisage that the heads of all Australian governments will develop in the AFC a comprehensive strategy for collaboration to meet Australian families' needs more effectively, particularly in health and education – and indeed to address other national priorities. Unlike COAG, the AFC will meet regularly, be open in setting its agenda, and have its own secretariat.

10.1 Widening the reform vision

The proposed reform directions in health and education outlined in the previous two chapters envisage new arrangements between the Commonwealth and the States in those areas. The reforms would integrate Commonwealth and State efforts to meet the needs of Australian families more consistently, effectively and efficiently. Families would enjoy better quality services that are provided more equitably and simply.

It is extremely important, given the prospect of steadily growing pressures on social programs over the next few decades – especially in health (including aged care) – that reforms are pressed ahead with in the near term, rather than delaying reform until programs buckle under those pressures. It is equally important that the way in which reform is pursued maximises the prospects of success.

The proposed reforms in health and education could conceivably be pursued largely independently of reforms in other policies and programs affecting families, or in overarching arrangements for governments to work together in our Federal system.

However, pursuing reforms in health and education in isolation from reform to the high-level governance of our Federation would risk failure. The proposed reforms in those specific areas are far-reaching and certain to encounter opposition from some stakeholders. Maximising the prospects of success will require sustained leadership and drive from heads of government, a common broad vision for Australian families and an overarching reform strategy. What are needed are new arrangements designed to lock in true collaboration among Australian governments, from the top down – thereby helping to realise the full potential of our Federal system.

Outside health and education, there are other social programs and mechanisms such as the tax and social security systems which deeply affect families' lives. A common broad vision for families would encompass all of these in a broad sense, even though in most cases they will be administered by only one level of government.

Tax and social security

The tax and social security systems are fundamentally important to families. For example, these systems combine to create effective marginal tax rates that discourage the least well-off families from being more economically active and improving their circumstances; and in turn those circumstances impair the ability of their children to improve their prospects through education.

This report does not propose specific reforms in tax and social security, which are areas of Commonwealth sole responsibility. However, it is appropriate to discuss here general directions of reform in those areas that would be consistent with, and indeed support, the general aims of the reforms proposed in health and education. Such directions are discussed in Section 10.3.

Other social programs affecting families' lives

There are other social programs in which either the Commonwealth or the States affect families' lives, even if not as fundamentally as do the programs in health and education. Some of these share with health and education the characteristic that at present they are areas in which the Commonwealth and States are both significantly involved at the levels of policy and funding, although generally with the States managing service delivery.

While it is beyond the scope of this report to canvass specific reforms across the range of such programs, it is appropriate to discuss the general directions that reforms would desirably follow – with brief reference to some of the larger programs.

Examples are housing assistance, home and community care and disability programs, which are areas in which the Commonwealth makes major specific purpose payments to the States, although not as large as in health and education (see Table 6.2). There are very many smaller specific-purpose payments in yet other social policy areas. As the Review of Commonwealth State Funding argued, it would reduce much administrative overlap, and improve the quality of services that families receive, if the Commonwealth ceased 'micro-managing' the activity of the States in these detailed areas.

This is not to deny that in social programs generally, there may be a national interest in ensuring that families are able to access at least a minimum national standard of services overall. In terms of the principles outlined at the beginning of Part II of this report, however, it would be far better to establish such national considerations in overarching framework agreements between the Commonwealth and the States, rather than attempting to reflect them through detailed administrative intrusions into State policy-making, program development and management of service delivery.

Need for a fresh federal approach

What these considerations point to is that it is not sufficient simply to identify reform options that would improve the way that the two levels of government work together to assist families in health and education. Rather, such reforms need to fit under a fresh new approach in how the two levels of government in our Federation work together at the top level, combining to develop, in true collaboration, a common national vision of how the community is faring, what its needs are, what are the best broad national strategies for responding to them, and what part each level of government should play.

It is worth noting that these issues apply not only in the social policy area on which this report has concentrated, but also in a range of other areas, not so directly affecting families, in which the two levels of government are both involved. Examples include such major fields as transport, public order and safety, and various areas of industry assistance and regulation e.g. in agriculture. All of those areas are ones in which the Commonwealth is significantly involved and in which there are substantial specific-purpose payments – for example Commonwealth funding for national roads.

All of the areas mentioned above, whether in social policy or in other fields, are ones in which our federal system of government is capable of delivering far better results than would a single 'one size fits all' centrally determined national approach, administered from Canberra. As outlined in chapter 7, by comparison with the unitary state, a well-functioning federation is capable of being much more democratically responsive than a unitary state to the wishes and needs of local communities within the nation, reflecting their particular circumstances and preferences.

Diversity as key driver of innovation

Through the diversity that a federation naturally exhibits in responding to those needs, it promotes innovation, since improvements in policies, programs or service delivery can spread from jurisdiction to jurisdiction, and through adaptation lead to further improvements. Diversity is thus a key driver of improvements in services across the nation as a whole. All this can be achieved while a strong sense of being a single national community is maintained, and families, wherever they live across the nation, remain confident that they will receive quality services to at least a minimum national standard.

Australian governments do meet to discuss issues and coordinate their activities through many channels, but it can hardly be said that at present cooperation is optimal. In the two major areas of health and education, the tradition has been for the Commonwealth to determine its policies and funding proposals essentially unilaterally, albeit typically after considerable consultation. Also, there are few opportunities under present arrangements for government leaders to review and share planning and strategic thinking on how the two levels of government can together produce better outcomes for the community as a whole. What occurs now is cooperation to a degree, but not the true collaboration needed to achieve the full potential of our Federation.

10.2 A fresh approach to collaboration in our Federation

As outlined in chapter 6, in considering better ways for our Federation to work, the issue is not really one of rethinking constitutional roles and responsibilities. The Constitution has only a loose constraining influence on how the two levels of government are involved in major areas of service delivery:

- The Commonwealth, through its grants power and backed by the financial dominance that it has been able to achieve, has the ability to be involved widely across the whole field of public policy, wherever it considers that there is a national dimension.
- Indeed, it seems clear that at least in certain areas, the community wants a national approach to apply, in a broad sense, in respect of those programs which most affect equity among Australian families and their opportunities in life – among which none are more central to families' concerns than health and education. The community wants services to at least a national minimum standard to be available in these areas on a fair and equitable basis to all Australians, wherever they live.
- As argued in chapter 6, this does *not* mean that the community wants a 'one size fits all' approach to social services. On the contrary, the community clearly wants a considerable degree of choice, and wants a range of services and methods of delivery that respond to local circumstances, needs and preferences.
- Most people in the community understand that the Commonwealth, which is the level of government most directly responsible for raising taxes and for the distribution of income, is the level of government that has the financial resources to underwrite a national approach. Most also understand that the States are best placed to deliver public services that respond to local needs and preferences.

Changes to the Constitution are not needed to achieve a new set of arrangements allowing the two levels of government to work together collaboratively in our Federation. Within the Constitution as it stands now, it is demonstrably possible to develop new institutions and processes within which governments can deal collaboratively, effectively and efficiently with all of those issues of importance to the community which have both State and national dimensions.

Previous reform efforts

In the past two decades, there have been a number of very positive attempts to develop such new approaches, although the fruits of those efforts have, in a number of respects, fallen short of their full potential. A meeting of the Constitutional Convention was convened in 1985, which discussed a number of aspects of how the two levels of government work together – including canvassing ideas for a Federal Fiscal Council that would have a role in the raising of public revenues nationally and in utilising them to fund national public programs. Those discussions did not lead immediately to any concrete reforms, but were very fruitful in generating both a focus and productive thinking around reform ideas.

Undoubtedly the most fertile period of discussions between governments on concrete ideas for Federal reform in recent times was between late 1990 and late 1991 in a series of Special Premiers' Conferences, the first of which was convened in October 1990 by Prime Minister Hawke. The last at which the Commonwealth participated was in July 1991 – although the Premiers and Chief Ministers met again without the Commonwealth to continue the discussion of federal reforms in November 1991. Out of that series of meetings came many positive reform ideas, including a proposal for a new 'Council of the Australian Federation', intended to institutionalise the cooperation that the Special Premiers' Conferences achieved – albeit briefly.

The proposed Council was not particularly ambitious. It was envisaged essentially as an information sharing and consensus building body, in which the heads of all Australian governments would meet regularly – at least twice a year – to discuss an unrestrained agenda of issues in which both levels of government were involved and which had a national dimension. Implicitly, it would be an umbrella under which more concrete and cooperative arrangements could be developed.

As described by Mathews and Grewal:[240]

The third major proposal advanced by the Premiers for the November 1991 meeting was directed to making progress on reallocating the roles and responsibilities of the several levels of government, drawing on the reports of the Tied Grants Working Group and the reviews of functional areas. The Premiers emphasised the need for a fully integrated review of all functional areas from a 'whole of government' perspective, so as to facilitate policy and integration, resolve functional issues having regard to the fiscal capacities of governments, and develop a coherent administrative reform package. The Premiers listed a set of principles which the Tied Grants Working Party had developed to guide the allocation of roles and responsibilities. These were:

(1) the Australian nation principle (all governments will work cooperatively to ensure that national issues are resolved in the interest of Australia as a whole);

(2) the subsidiarity principle (responsibility should be devolved to the maximum extent possible consistent with the national interest, so that government is accessible and accountable to those affected by the decisions);

(3) the structural efficiency principle (structural reform in the public sector is necessary to complement private sector reform and remove inefficient Commonwealth–State divisions of functions); and

(4) the accountability principle (the structure of intergovernmental arrangements should promote accountability and the transparency of government).

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R. MATHEWS AND B. GREWAL, *THE PUBLIC SECTOR IN JEOPARDY: AUSTRALIAN FISCAL FEDERALISM FROM WHITLAM TO KEATING*, CENTRE FOR STRATEGIC ECONOMIC STUDIES, VICTORIA UNIVERSITY, MELBOURNE, 1997, PP. 557–558. FOR A FULLER DESCRIPTION OF THE SPECIAL PREMIERS' CONFERENCE PROCESS, SEE PP. 548–559.

The Premiers agreed not only on those reform principles, but also on proposals for financial reform – which have since to a large extent been overtaken by the Intergovernmental Agreement on, among other things, the sharing of the proceeds of the GST.[241] The Premiers also reached agreement in 1991 on a number of specific areas of cooperation such as:

- removal of remaining regulatory impediments to a national market in goods, including development of uniform standards applying to goods, and related 'common market' reforms such as acceptance in all States of registration in any one State of occupations and professions etc;
- a new scheme for State supervision of non-bank financial institutions (since overtaken by the reforms to the financial system recommended by the Financial System, or Wallis, Inquiry in 1997);
- agreements on uniform standards and other aspects of transport policy; and
- endorsement of the need for a national competition policy.

Those were only a part of the list of issues that the States agreed to work on together, but out of that list National Competition Policy and mutual recognition were the only major agenda items in which the Commonwealth subsequently saw advantage in working in federal structures in close cooperation with the States.

Present structures: COAG and other mechanisms

A successor body to the Special Premiers' Conferences, the Council of Australian Governments (COAG) was established in May 1992, and indeed, its main achievement has been the working out of the National Competition Principles Agreement. Related to that Agreement, regulatory reform in a number of the utility sectors (e.g. gas and electricity) has been pursued through follow-up bodies which have gone a long way towards creating national grids and markets in those sectors. There have been demonstrable positive effects on national productivity.

More recently, COAG has had limited effectiveness, and this stems from the fact that the Commonwealth does not at present appear to see major areas (where it has policies and programs) in which there would be advantage to it in high-level collaboration with the States. Over recent years, for example, there has been little discussion in COAG itself of the primary subjects of this report: health and education. The fact that the Commonwealth controls when COAG meets and what is on its agenda is a major weakness in current arrangements, as is the fact that COAG has no independent secretariat or analytical capacity.

Of course it is true that Commonwealth–State discussions occur regularly, at both portfolio Minister and official levels, across a wide range of areas of both State and national interest. But there is no habitual mechanism at the top level for the leaders of all the Australian governments to sit down, share their views of what are the priorities for the community, produce a common strategic vision, and work through how their governments can collaborate to produce the most effective results. Rather, the style is for each level of government to work largely independently, in policy development, planning, budgeting and administration. The style of the Commonwealth, in particular, tends to be unilateral and prescriptive.

That is not to say that there is not a good deal of constructive discussion, information sharing and negotiation (albeit in many cases rather one-sided negotiation in respect of funding). Much of this interplay between the levels of government occurs in Ministerial Councils and associated officials' groups, advisory bodies, task forces and working groups, and some of it bilaterally and/or informally.

- A prime example of relevance to the central areas of focus of this report is the Australian Health Ministers' Council (AHMC) and the associated Australian Health Ministers Advisory Council (AHMAC), which comprises officials and experts from relevant Commonwealth and State agencies, who are in turn able to enlist expertise from within their organisations. AHMAC has done much useful work, e.g. in helping coordinate approaches to health workforce issues.
- In the education and training field, the equivalent body to AHMC has a wider span. It is the Ministerial Council on Employment, Education, Training and Youth Affairs (MCEETYA), which also has its associated official working bodies, including the Australian Education Systems' Officials Committee (AESOC) and a range of expert task forces. In vocational education and training, there is a national body, the Australian National Training Authority (ANTA), governed by its own board, broadly representative of interests in training, but a body about which both levels of government feel ownership. ANTA has successfully led the development of a national approach in training, but one within which the States can pursue diverse approaches in terms of what and how this training is delivered.

The new arrangements in health and education canvassed in the previous two chapters of this report would, in effect, build on those existing coordination arrangements between governments in the areas of health and education.

Need for top level direction and drive

The key point of this chapter, however, is that reforms in the two areas of health and education need to be driven by new arrangements at the top level – to set a strong national vision for meeting the needs of Australian families, and to drive planning and strategy to respond to those needs from the top down. Given the growing pressures that lie ahead, particularly in health and aged care, it is extremely important to set such arrangements in place now, as already argued.

This report proposes that a new and more ambitious version of the 1990s proposal for a Council of the Australian Federation be developed. It is envisaged that a new Intergovernmental Agreement be developed and signed by all governments setting out the scope and charter of an 'Australian Federation Council', including agreed objectives for developing collaborative activities under its umbrella, notably in health and education, and agreed principles on the allocation of roles and responsibilities within those areas of collaboration.

A new 'Australian Federation Council'

The new Australian Federation Council (AFC) should:

- comprise the heads of all Australian governments;
- in principle range across all issues of national significance in which either or both levels of government have a role, but with an initial focus on the needs of families and in particular, on health and education;
- be open in setting its agenda – that is with any head of government being able to nominate issues for discussion;
- have its own small secretariat with adequate analytical capacity;
- meet on a regular schedule; and

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THE FULL TITLE OF THE AGREEMENT IS THE *INTERGOVERNMENTAL AGREEMENT ON THE REFORM OF COMMONWEALTH–STATE FINANCIAL RELATIONS*, SIGNED IN 1999.

- have as regular agenda items:
  - the development of a national strategy focusing on the total situation and needs of Australian families;
  - agreeing on the broad mechanisms for the two levels of government to work together to implement the strategy, in particular the key elements of new collaborative programs and associated bodies, funds-pooling arrangements etc. in health and education;
  - agreeing on broad planning and budgeting guidelines, including principles for sharing financial burdens;
  - agreeing on key outcome and other performance measures; and
  - reviewing progress against the strategy.

In essence the new Australian Federation Council would develop a comprehensive vision and strategy in core social policy – as well as in other areas of national importance involving both levels of government. It would develop measures of achievement and performance through which the community could understand the goals and results of the strategy, and against which all governments would report – facilitating democratic accountability to the electorate at each level. AFC would replace and transcend COAG.

10.3 Further areas for reform

Social programs outside health and education

The 2002 Review of Commonwealth–State Funding reviewed the full range of Commonwealth involvements via Specific Purpose Payments (SPPs) in areas of primary State responsibility, observing that many of these involvements are relatively small in scale and apparently add little value, often creating problems of overlap duplication, inconsistency etc. Many SPPs involve restrictive input controls, disincentives for efficiency, inflexibility, micro-management and duplication.

Under the Review's proposal, many SPPs would be terminated and the funds flows concerned would be concentrated on just three national cooperative programs, two being the core areas of health and education that have also been the focus of this report, and the third being Indigenous Community Development.[242]

Generally, it is proposed that national social policy reforms should take this same approach outside the two core areas – i.e. with one level of government having the sole role in respect of detailed policy and administration in each area. The two levels of government should nevertheless agree to operate in all social policy areas within a broad national framework, and under shared broad goals developed under the umbrella of the new AFC, including:

- agreement on high level objectives, and
- reporting on all such programs within a consistent national framework.

Outside health and education, the most significant area of joint involvement in social policy is in housing. Public housing (i.e. ensuring provision of housing stock) is a 'natural' area for each State to develop its policies and programs independently – not least because costs in local housing markets vary widely between States, between regions within States and even within States' metropolitan regions, as, of course do housing needs. On the other hand, assessing *assistance* needs of families (including for housing) is a natural role of the Commonwealth, which operates the social security system. Consequently, housing is a prime area for collaborative development of reforms. Another such area is disability programs.

Social security also needs reform

While this report does not propose reforms to the social security system (the system of welfare payments or transfers), it is worth noting here that there are issues in that system which also indicate a need for reform. Indeed, the Commonwealth received a major report on this in 2000[243] which is still under consideration.

- Australia's social security system is very tightly means tested. This targets assistance to those most in need and controls costs, but has the consequence outlined in chapter 3 that many of those assisted face high effective marginal tax rates (EMTRs), discouraging them from being more active economically. There has been a proliferation of assistance programs in this system too, i.e. a multiplicity of benefits (e.g. Newstart Allowance or Disability Support Pension) that differ in eligibility conditions, payment levels and indexation arrangements. People can be treated significantly differently when their needs are similar, encouraging some people to 'shop' among the different payments, and helping encourage attitudes of dependency and affecting the perceived fairness and integrity of the system.
- A key reform theme is that via rationalisation and simplification of social security payments, ideally creating a uniform payment, people with essentially the same needs would receive the same benefits.
  - This type of reform could mean that the system costs less in the long run, although a preferred option would be to use most of any savings from rationalisation to lower EMTRs. In either case, however, there would likely be substantial transitional costs; and if benefits were aligned at higher, rather than lower, levels, there could be significant ongoing costs rather than savings. The difficulty of reform in this area is recognised but the issues have been well analysed in the Commonwealth's review and are not further canvassed in this report.

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THE LATTER WAS PROPOSED TO BE ADMINISTERED BY THE COMMONWEALTH BUT WITH EXTENSIVE STATE INVOLVEMENT IN SERVICE DELIVERY. THIS REPORT HAS NOT CANVASSED INDIGENOUS COMMUNITY DEVELOPMENT SPECIFICALLY, BUT WE ENDORSE THE REVIEW'S PROPOSAL IN THAT AREA.

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PARTICIPATION SUPPORT FOR A MORE EQUITABLE SOCIETY, FINAL REPORT OF THE REFERENCE GROUP ON WELFARE REFORM, DEPARTMENT OF FAMILY AND COMMUNITY SERVICES, CANBERRA, JULY 2000 (McLURE REPORT).

Australians need relief from high tax rates (and effective rates)

In the OECD context, Australia is not a high tax country (in terms of total tax raised), and indeed resources available to fund public programs in health, education etc. are perennially tight. Yet ordinary Australians experience relatively high rates of tax and – where means-tested benefits are part of their income – even higher EMTRs – as described in chapter 3.

Those experiencing high EMTRs due to the interaction of the tax and social security systems are of course people on lower levels of income. However, relatively high marginal tax rates (MTRs) on *earned* income are experienced by people on only moderate incomes (but not dependent on social security) through the broad middle of the income range. Australia's top marginal rate is quite high (at 48.5 per cent, including the Medicare Levy) and cuts in at only about 1.5 times average earnings (i.e. at $62,500. As this report was being finalised, the Commonwealth Government announced its intention to raise this to $80,000).

Proliferation of tax breaks or 'leakages' is a major explanation

Chapter 3 also noted a major part of the explanation for this state of affairs. Since the early 1990s, 'leakages' from the income tax have expanded substantially – via both identified tax expenditures and what might be termed 'quasi tax expenditures' such as the private health insurance (PHI) rebate. (The PHI rebate is provided in alternative ways, including as a tax offset, but treated in the Budget as an expenditure.) There are also many tax breaks that are officially regarded as part of the 'normal' tax benchmark.

As well as these tax breaks and related types of concessions, programs on the expenditure side of the Commonwealth Budget delivering benefits to relatively narrow groups have also proliferated, although these are generally scrutinised more regularly in the budget process than are tax breaks. Budget expenditures generally are outside the scope of this discussion, focusing on reforms to the main instruments redistributing cash incomes among families, i.e. tax (and in particular, the income tax) and social security payments.

State taxes and tax breaks

This report focuses on the relevant Commonwealth taxes and transfers because it is the Commonwealth that controls the major instruments of income redistribution. Some of the tax breaks officially identified as tax expenditures, however, are business tax breaks – albeit that their ultimate incidence may spread widely across the community. This raises the issue that it is not only the Commonwealth that raises taxes and gives tax breaks, although given Australia's extreme vertical fiscal imbalance, the Commonwealth collects the great bulk of Australian tax revenues. As noted in Table 3.6, State tax expenditures are correspondingly smaller, in aggregate $9.5 billion per annum currently, or less than one-third of the Commonwealth's, and vary widely but with some common themes (e.g. land tax exemption for principal residence, payroll tax relief for small business). Nevertheless, there should be discussion about these as well as Commonwealth tax breaks.

Broad income tax reform directions

The broad type of reform that can be envisaged to best address the situation outlined above is in the style of the Asprey Committee of the 1970s,[244] whose proposals led to a simpler, 'lighter' income tax. Many special tax breaks were ended, with no particular recipient group singled out, and with nearly all taxpayers better–off on balance – especially due to significantly lower tax rates (and thus improvements to incentives). At the same time, the income tax became fairer, simpler, and more robust in respect of raising future revenues. Reforms in this vein today would be similarly founded on a thorough rationalisation of tax expenditures, 'quasi tax expenditures' such as the PHI and tax breaks which are regarded as in the income tax 'benchmark.'

TABLE 10.1 • SUMMARY OF TAX AND RELATED BUDGET LEAKAGES, 2003–04

Tax measure	Value '$b'
COMMONWEALTH TAX EXPENDITURES	30.5
STATE TAX EXPENDITURES	9.5
OTHER MAJOR TAX BREAKS	6.2
'QUASI' TAX EXPENDITURE: THE PHI REBATE	2.3
TOTAL	**48.5**

SOURCES: COMMONWEALTH DEPARTMENT OF TREASURY 2004, *TAX EXPENDITURES STATEMENT 2003*, CANBERRA, WWW.TREASURY.GOV.AU; SENATE COMMUNITY AFFAIRS COMMITTEE; AUSTRALIAN TAXATION OFFICE; SENATE SELECT COMMITTEE ON MEDICARE; VICTORIAN DEPARTMENT OF TREASURY AND FINANCE.

Prioritising tax breaks for consideration in reform

Table 10.1 summarises the detailed list of tax and related budget leakages shown in Table 3.7. It is suggested that on the face of it, many of these tax breaks and similar concessions are of questionable priority and merit a searching review in relation to the prospect of a major simplification and 'lightening' of the personal income tax as just outlined.

It is important, however, to recognise that from the perspective of assisting families, particularly families at low to middle income levels, not all of the benefits of reform may best be delivered as tax cuts. Indeed, utilising part of the savings from removing tax breaks, and particularly closely related 'quasi tax expenditures', to enhance the health and education systems – although still with the bulk used to reform the personal income tax – is likely to be the optimal way to achieve the greatest overall improvement for Australian families and individuals.

In this context it is important to note that the reforms proposed here are envisaged as being developed and implemented over a 5–10 year timeframe. In that timeframe both levels of government would have available to them the fiscal dividend of economic growth – i.e. real revenues per capita growing somewhat faster (even with periodic return of 'bracket creep' in income tax 'cuts') than the cost of maintaining real per capita program expenditures. This difference is a significant ongoing source of finance for reform of social programs.

10.4 How reform would benefit families

This section of the report shows how reforms to health, education and the tax system would improve the quality of life of Australian families. The reforms – while not a cure-all – will make many people's lives better, in very real and significant ways. To illustrate this, we again draw on the circumstances of the 'typical' families that were introduced in chapter 1.

Some of the ways in which the reforms could help typical Australian families are explored below and summarised in Table 10.2.

Matt

Matt left school when he was 17 without completing Year 12. In the eight years since, he has worked on and off in casual and short term unskilled jobs. He has had substantial periods of unemployment and underemployment. He now believes he would have a better chance of securing ongoing employment if he had finished secondary school.

How reform would help

Life could be better for someone like Matt if he had completed his schooling. Reforms to education funding arrangements would make this more likely. Funding that is better related to student outcomes, combined with special arrangements for students at risk, would mean schools have both more resources and an added incentive to find a way to keep students like Matt engaged in their studies. A more integrated education system could also mean that students like Matt have a more diverse range of course options available to them.

Someone like Matt could also benefit from health reform. Integrated local plans would target key areas of health promotion, including Matt's problems of smoking, poor nutrition and lack of physical exercise.

244 TAXATION REVIEW COMMITTEE, *FULL REPORT*, AGPS, CANBERRA, 1975 (ASPREY REPORT).

Don and Yvonne

Don and Yvonne are concerned about the cost and availability of health services in their area. Don is on medication for a heart attack he had five years ago. They do not have access to a bulk-billing GP or to many allied primary care services. They are worried that they will not be able to find aged care accommodation that allows them to live together.

How reform would help

Under proposed health reforms, older people like Don and Yvonne would enrol with a GP practice, or a similar primary care organisation, to have continuing responsibility for their health care needs – emphasising prevention, disease management, and service coordination. There would also be more residential aged care places available following an increase in funding, and a smoother path from acute care.

Con, Despina, Thea and Ari

In the next few years, Con and Despina want to be able to pay Thea and Ari's HECS fees up-front. Currently, they are able to save very little. While Despina is often offered overtime, this produces very little additional income, due to the combined effects of higher tax and reduced family benefit payments.

Thea's juvenile diabetes has required continuous attention throughout her adolescence. It has been a battle for Despina to coordinate the range of services and providers required, and to feel confident that she is on top of Thea's changing condition and needs. Meanwhile, Ari is unhappy at school. His interest has waned and he is considering leaving. Con and Despina are impressed by the approach taken at a local government school and are seriously considering moving Ari.

How reform would help

Lower marginal tax rates would produce a two-fold benefit for a family like that of Con and Despina. Not only would their current disposable incomes rise, but someone like Despina would also have a greater incentive to take on additional work (especially if social security arrangements were restructured to reduce effective marginal tax rates). The family would be better placed to save the money needed to pay their children's HECS fees.

Under reforms to health, people with chronic diseases like Thea would enrol with a GP practice that would have continuing responsibility for the overall management of their disease and coordination of the relevant services. The family would be relieved of some of the burden of managing the disease.

New funding arrangements in education would mean that schools like Ari's, if they had a number of students 'at risk', may receive sufficient resources to begin their own programs to support these students staying at school. Alternatively, the integrated education system could open up more opportunity for Ari to attend a special course of interest to him (such as a VET course) available at a government school, perhaps while staying based at his Catholic school. Finally, parents like Con and Despina would be much better placed to decide whether to transfer their child to a different school. They would be able to access more and better information about the performance of both schools.

TABLE 10.2 • HOW FAMILIES WOULD BENEFIT FROM REFORM: SUMMARY

Family	Existing challenges	How reform would help
MATT		
	HAVING TROUBLE SECURING ONGOING EMPLOYMENT, PERHAPS DUE TO NOT COMPLETING YEAR 12.	SCHOOLS WOULD HAVE BOTH MORE RESOURCES AND AN ADDED INCENTIVE TO KEEP STUDENTS ENGAGED IN THEIR STUDIES.
DON & YVONNE	SEVERAL HEALTH RISK BEHAVIOURS: SMOKES, IS OVERWEIGHT AND DOES NOT EXERCISE.	INTEGRATED LOCAL PLANS WILL TARGET KEY AREAS OF HEALTH PROMOTION.
	DO NOT HAVE ACCESS TO A BULK-BILLING GP NOR TO MANY ALLIED PRIMARY CARE SERVICES.	PEOPLE COULD ENROL WITH A GP PRACTICE THAT HAS CONTINUING RESPONSIBILITY FOR THEIR HEALTH CARE NEEDS. IN THE SHORT TERM, BULK-BILLING RATES WOULD INCREASE DUE TO THE IMPACT OF MEDICAREPLUS AND/OR INCREASED GOVERNMENT EXPENDITURE ON DIFFERENT REBATES AND INCENTIVE PAYMENTS TO GPs.
CON, DESPINA, THEA & ARI	WORRIED THAT THEY WILL NOT BE ABLE TO FIND APPROPRIATE AGED CARE ACCOMMODATION.	INCREASED FUNDING WOULD MEAN MORE RESIDENTIAL AGED CARE PLACES ARE AVAILABLE, AND A SMOOTHER PATH FROM ACUTE CARE.
	LITTLE INCENTIVE TO TAKE ON MORE WORK DUE TO HIGH EMTRs.	LOWER MARGINAL TAX RATES.
	MANAGING HEALTH SERVICES AND PROVIDERS FOR THEA'S JUVENILE DIABETES HAS BEEN A SIGNIFICANT BURDEN ON THE FAMILY.	PEOPLE WITH CHRONIC DISEASES COULD ENROL WITH A GP PRACTICE THAT HAS CONTINUING RESPONSIBILITY FOR THE OVERALL MANAGEMENT OF THEIR DISEASE AND COORDINATION OF RELEVANT SERVICES.
PATRICE & JACK	ARI HAS LOST INTEREST IN SCHOOL. CON AND DESPINA ARE CONSIDERING MOVING HIM TO ANOTHER SCHOOL.	SCHOOLS WITH SEVERAL STUDENTS 'AT RISK' WOULD RECEIVE ADDITIONAL RESOURCES. STUDENTS WOULD HAVE GREATER OPPORTUNITY TO STUDY COURSES AT OTHER SCHOOLS. PARENTS WOULD HAVE ACCESS TO BETTER INFORMATION ABOUT THE PERFORMANCE OF OTHER SCHOOLS.
	SOME OF THE BETTER STAFF AT JACK'S SCHOOL ARE LEAVING BECAUSE THEY WANT TO WORK IN AN ENVIRONMENT THAT IS MORE SUPPORTIVE OF INNOVATION, AND WHERE THEY WOULD BE BETTER REWARDED FOR THEIR EXPERIENCE AND SKILLS.	A RANGE OF REFORMS WOULD ENSURE THAT INNOVATIONS THAT IMPROVE OUTCOMES ARE ENCOURAGED. A BETTER PERFORMANCE AND DEVELOPMENT SYSTEM FOR TEACHERS WOULD ENSURE THAT ALL SCHOOLS ARE IN A POSITION TO RECOGNISE AND RETAIN EXCELLENT TEACHERS.
SALLY, BRUCE, LUCY, SAM & SOPHIE		
	LITTLE INCENTIVE TO INCREASE WORK, DUE TO HIGH EMTRs.	LOWER MARGINAL TAX RATES.
	THE FAMILY CANNOT ACCESS A BULK-BILLING GP.	GP PRACTICES WOULD BE CONTRACTED TO PROVIDE SERVICES AS PART OF AN INTEGRATED HEALTH CARE SYSTEM. SOME CONTRACTS COULD SPECIFY THAT NO PATIENT CO-PAYMENTS ARE PERMISSIBLE FOR CERTAIN GROUPS. IN THE SHORT TERM, BULK-BILLING RATES WOULD INCREASE DUE TO THE IMPACT OF MEDICAREPLUS AND/OR HIGHER REBATES FOR ALL BULK-BILLED SERVICES.
	LUCY HAS SOME LEARNING DIFFICULTIES. HER TEACHER TRIES TO GIVE ADDITIONAL HELP, BUT CANNOT DO MUCH AS HE HAS A LARGE MULTI-YEAR CLASS TO TEACH.	SCHOOLS WITH MANY STUDENTS FROM POOR BACKGROUNDS WOULD RECEIVE MORE FUNDING TO HELP THEM IMPROVE STUDENT OUTCOMES. SCHOOLS WOULD ALSO RECEIVE FUNDING TO ASSIST STUDENTS WITH SEVERE LEARNING PROBLEMS.

SOURCE: THE ALLEN CONSULTING GROUP.

Patrice and Jack

Jack is thriving at a local government primary school that is renowned for its innovative approach to early learning. However, the school principal and two of the school's best and most experienced teachers are leaving to take up better-paid posts in independent schools, and in one case, to leave teaching altogether. All enjoy their existing jobs, but they are also keen to work in an environment that is more supportive of innovation, and where they would be better rewarded for their experience and skills.

How reform would help

Changes to educational arrangements could mean teachers like those at Jack's school are less likely to want to leave. More robust accountability systems, more flexible and equitable funding and fewer administrative restrictions would ensure that innovations that improve outcomes are encouraged. A better performance and development system for teachers would ensure that all schools are in a position to retain excellent teachers, providing them with appropriate rewards and recognition.

Sally, Bruce, Lucy, Sam and Sophie

Now that Sally and Bruce have three children, their home is too small. But with house prices rising rapidly, they are concerned that they may not be able to buy a larger one. Bruce would like to take on additional work to better provide for his family, but he faces significant disincentives due to high effective marginal tax rates. The family's capacity to save is also hampered by the difficulty of accessing a bulk-billing GP in Tamworth.

Sally and Bruce send Sam and Lucy to a government school. Lucy is six and has some learning difficulties. Her teacher tries to give additional help, but cannot do much as he has a large multi-year class to teach.

How reform would help

Lower marginal tax rates and health reforms would benefit the financial position of families like that of Sally and Bruce:

- The effective marginal tax rate of someone like Bruce would be lower, so there would be a greater boost to disposable income if additional hours were worked.
- In the health system, initial reforms would include incentives aimed at increasing bulk-billing by GPs. In the longer term, under an integrated health care system, GP practices would be contracted to provide services. The contracts would specify quality and access arrangements, such as the requirement that patient co-payments are not permissible.

Finally, schools like Sam and Lucy's, with large numbers of students from relatively poor backgrounds, would receive considerable increases in funding to help them improve student outcomes. The additional funding and added administrative flexibility available might be used by schools to recruit additional teachers or teachers' aides, reduce some class sizes, provide one-on-one coaching, design special intervention programs for those students requiring them and provide more guidance for parents in how best to support students at home. The school would be better placed to give Lucy the additional assistance she needs.

10.5 Conclusion

While the Commonwealth and the States can immediately make a beginning on new approaches in health and education that would go directly to the areas of greatest concern to Australian families, the lives of Australian families can not be improved to the fullest extent that governments can bring about if they work in each of those areas largely independently. What is needed to carry the endeavour forward is an overhaul of the top-level arrangements for governments to allow collaboration in our Federation through the establishment of a new Australian Federation Council.

The AFC would provide the institutional framework within which to develop a national vision for Australian society via which reforms to health, education, and the social security and taxation system would consistently fit and interrelate.

The new mechanisms would not only promote the development of a total picture of families' needs and governments' response to them, but also provide the mechanisms through which governments could collaborate to address the whole range of areas of government activity in which there is a national interest. Both levels of government need to work together to produce the best results for the Australian community.

However, it is not the purpose of this report to canvass specific reforms to Commonwealth or State taxes. Rather, the purpose here is to flag the fact that such reforms would be an important complement and reinforcement to the reforms in health and education that are proposed here. Essentially, the link is that poor people have poorer health than others do, and their children do not do as well in education and hence have poorer job prospects. High EMTRs strongly inhibit them from acting to improve their circumstances and their families' prospects. Tax and social security reforms that address these issues will thus reinforce the effectiveness of health and education reforms.

APPENDIX

Evolution of Commonwealth roles in social programs since Federation

Evolution of Commonwealth roles in social programs since Federation

The original constitutional assignment of responsibilities

At Federation, the Commonwealth was assigned the power to make laws in relation to a specific list of matters. In some of these, such as defence and external affairs, the Commonwealth was intended to be the sole level of government making legislation after Federation, although in others, such as corporations, the States were not excluded from a continuing role subject to the general caveat[245] that where State and Commonwealth laws overlap and are inconsistent, Commonwealth legislation prevails.

Matters where the Constitution did not give the Commonwealth the power to make laws were to remain with the States. In social policy, very few matters were assigned to the Commonwealth. In social security and welfare, the Commonwealth was assigned only invalid and old age pensions.[246]

Thus, at the time of Federation, the States were envisaged as remaining responsible for making laws and delivering public services in all the 'bread and butter' areas – health, education, community welfare, housing, public transport, public safety, and so on. They were seen as the natural level of government to administer most social programs as they then existed, on a considerably smaller scale than is the case today.

Responsibilities for taxation

On the taxation side, the approach in the Constitution was in some sense the reverse of that taken in public administration and attendant expenditure. The Commonwealth was given broad power to raise taxation revenues in almost any form, but exclusive power to raise the then major form of revenue, customs duties. It was also given the exclusive power to levy excise duty on the domestic production of goods.[247] Outside these areas, though, the States retained an unrestricted ability to raise revenues and the possibility was (consciously) created for both levels of government to raise revenue from the same tax base.

The Commonwealth was apparently not envisaged as having a major role in redistributing income via progressive income taxation, any more than through welfare payments. Indeed, the income tax in Australia was pioneered by the States and levied predominantly by them up to World War II. The Commonwealth did not levy an income tax at all for some years after Federation.

The Commonwealth's use of its Grants power

The Commonwealth is today very extensively involved, not only in redistributing income through taxes and transfers, but also to varying extents across the spectrum of public, especially social, services delivered by the States. The Commonwealth was explicitly given additional powers in social (including health) policy in a post World War II constitutional amendment (see below), but over recent decades its involvement has extended well beyond that 'licence'. The primary avenue by which this came about is Section 96 of the Constitution, which allows the Commonwealth Parliament to 'grant financial assistance to any State on such terms and conditions as [it] thinks fit'.

In the decades following Federation, the High Court has allowed a very wide interpretation of Section 96. Coupled with Section 109, which gives Commonwealth laws priority over State laws where they overlap, the High Court's interpretation opened the way for the Commonwealth to become widely involved in public services delivered by the States.

The Commonwealth's financial dominance

The widened involvement of the Commonwealth has of course depended importantly on the Commonwealth's extension of its command over public revenues, far beyond its initial exclusive licence to raise customs duties and to levy excise on the production of goods.

Goods and services taxes

Thanks to High Court decisions interpreting the concept of an excise duty on domestic production very broadly, the Commonwealth has come to have a virtual monopoly on the taxation of goods at any stage after production – denying the States the ability to raise almost any kind of revenue related to production, sale, trading or dealing in, or possibly even use or consumption of goods.

Although the States remained able to tax services, this is inherently more difficult than taxing goods, and only gambling has remained a lucrative field of revenue raising in this broad area for the States. Other kinds of taxes on services such as the NSW 'bed tax' (on hotel accommodation) of the late 1990s have in effect now been 'crowded out' by the Commonwealth's Goods and Services Tax (GST), introduced in 2000. The GST extends Commonwealth indirect taxation across virtually the whole field of 'non-social' services,[248] a significantly larger economic sector these days than goods production.

245
SECTION 109 OF THE CONSTITUTION.

246
SECTION 51 (XXIII) OF THE CONSTITUTION.

247
SECTIONS 86–93 AND 95 OF THE CONSTITUTION.

248
I.E. OTHER THAN HEALTH, EDUCATION ETC.

Under the terms of the 1999 *Intergovernmental Agreement on the Reform of Commonwealth–State Financial Relations*, or IGA, the Commonwealth distributes the GST net proceeds among the States (including the Territories).[249] The GST nevertheless remains a Commonwealth tax, the redistribution of its proceeds to the States being open to the Commonwealth alone to change (by legislation) at any time. Its introduction, accompanied by the States giving up some taxes, thus increased the 'vertical fiscal imbalance' (VFI)[250] in the Australian Federation – although in practice (so long as the IGA remains in force), the States have assured access to a 'growth tax', currently (2003–04) yielding approximately $32 billion per year.

Income taxes

Easily the biggest factor in Australia, having by far the largest vertical fiscal imbalance of any significant federation in the world, has been the Commonwealth's occupation of the income tax base from World War II onwards. As noted above, the income tax was pioneered by the States and was predominantly raised by them up to the eve of World War II. As part of the financial mobilisation for war, however, and to achieve uniformity in what was by then becoming a far more important tax than it had been at Federation, the Commonwealth secured agreement for the States to cease levying income tax for the duration of the war.

After the war, the Commonwealth refused to 'make room' for the States to re-enter the income tax field. They could only do so by levying additional income tax, over and above the national uniform income tax. Had the Commonwealth's position remained at that, some States might well have chosen to levy a supplementary income tax, but the Commonwealth chose to actively prevent this, using its power to attach any conditions it might choose to Section 96 grants.

In subsequent decades, the Commonwealth has shown little willingness to allow the States to re-enter the income tax field, although the Fraser Government, under its 'New Federalism' policy, did open the way for any State to levy a surcharge on (or, conceivably, give a rebate to) their residents relative to the standard income tax due to the Commonwealth. No State took this offer up, because it was seen as 'political suicide' to add an *additional* layer of income tax – given that the Fraser Government declined to 'make room' by reducing its income tax rates.

More recently, during the negotiations over national tax reform leading up to the 1999 IGA, the option of the States re-entering the income tax field was actively canvassed, with some States favouring it. However, in the end the States collectively chose to settle for assured shares of the Commonwealth's GST rather than taking (partial) responsibility for levying income tax.

No doubt the leaders of the States at the time considered it unattractive to be responsible for adding even a modest level of State income tax to the Federal rate applying to their citizens. Implicitly, the States preferred the Commonwealth to carry sole responsibility for broad-scale tax-raising, particularly income taxation. There is little doubt, however, that this preference is generally in line with a clear preference in the community today for the major tools of income distribution – the income tax and the social security system – to operate on a national basis.

The post-World War II era of the 'welfare state'

The community has plainly come to expect much more of government over the past half century or so in terms of direct redistribution of income and the provision of core social services, notably in health and education, than in the early years of the Federation.

The Australian electorate has agreed to very few proposals to amend the Constitution of 1901 and many of those amendments have been basically technical – concerning State debts, Senate elections and vacancies and so on.

Only two sets of amendments have explicitly changed the roles of the two levels of government in social policy. The better known of these is the 1967 set of amendments allowing the Commonwealth to make laws in respect of the Aboriginal peoples and repealing the provision that for various census etc. purposes Aboriginal populations not be counted. The other, and the broader in its effects on the whole of society, was the 1946 amendment inserting sub-Section 51 (xxiiiA), giving the Commonwealth the power to make laws in a wide range of social policy areas – specifically, laws for the provision of:

- maternity allowances;
- widows' pensions;
- child endowment;
- unemployment benefits;
- pharmaceutical, sickness and hospital benefits;
- medical and dental services;
- benefits to students; and
- family allowances.

Sub-section 51 (xxiiiA) reflects a fundamental phenomenon common to many of the advanced democracies – the strong post-World War II trend for *national* governments to place the pursuit of equity and improved social outcomes for all among their most central functions. This has been the era of the 'welfare state'.

In Australia, this trend has been reflected particularly in the development of a very extensive social security system, providing benefits not only for the unemployed, the sick, the disabled, widows, single parents and so on; but in a universal public health system. Substantial Commonwealth assistance to education is in part a reflection of the same trends, although it also can be traced to the desire to 'put to bed' the long-running and divisive issue of whether governments should assist education in church-affiliated schools. Some State assistance also goes to non-government schools, although on a smaller scale and on different bases to the Commonwealth's (and varying by State).

Emergence of a national approach to core social policy

The succession of Australian Governments following World War II have to varying degrees taken forward the trend to addressing major social policy issues on a national basis, even though the States have continued to manage the delivery of health, education and most of the other relevant services.

While the Commonwealth's role expanded under Governments of both sides of the political spectrum, it was under the Whitlam Labor Government that the Federal Government's role extended fastest and furthest. The specific purpose payment (SPP) proportion of total Commonwealth grants to the States more than doubled under Whitlam, and the number of distinct SPPs roughly quadrupled.

The Whitlam Government established major SPP programs in education, housing, health, urban and regional development and transport. It was also the Whitlam Government that introduced Medibank, extending the Commonwealth's role in health directly as well as through specific purpose payments to share the funding of public hospitals with the States.

As in education, the Commonwealth now also contributes to meeting the cost of *private* provision of health services – principally through the private health insurance rebate. In both areas (health and education), a substantial part of the community wishes to have the choice of public or private provision, and government policies have responded to that community preference. Unfortunately, on this public-private dimension, there has been little consistency of approach between the two levels of government – or between successive Commonwealth Governments.

249
THE PROCEEDS ARE DISTRIBUTED ON 'HORIZONTAL FISCAL EQUALISATION (HFE) PRINCIPLES', ON THE ADVICE OF THE COMMONWEALTH GRANTS COMMISSION. SEVERAL STATES DISPUTE WHETHER THIS WAS WHAT WAS AGREED TO IN THE IGA. SEE REVIEW OF COMMONWEALTH–STATE FUNDING, *FINAL REPORT* (2002), P. 37. GIVEN THAT AS PART OF THE IGA THE STATES GAVE UP SOME TAXES AND ACCEPTED SOME ADDITIONAL EXPENDITURE RESPONSIBILITIES, SEVERAL STATES ARE NOT YET BETTER OFF THAN UNDER THE PRE-IGA ARRANGEMENTS, BUT FASTER GROWTH IN GST REVENUES THAN IN THOSE REPLACED IS PROJECTED TO MAKE ALL STATES BETTER OFF WITHIN A FEW MORE YEARS.

250
VERTICAL FISCAL IMBALANCE ESSENTIALLY MEANS MISMATCH BETWEEN THE RELATIVE REVENUE RAISING POWERS AND RELATIVE EXPENDITURE RESPONSIBILITIES OF THE LEVELS OF GOVERNMENT IN A FEDERATION.