







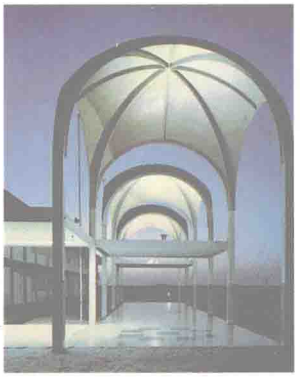
GUIDE TO HEALTH SERVICES OF THE WORLD

1994 EDITION

INTERNATIONAL HOSPITAL FEDERATION







A Guide to Health Services of the World

International Hospital Federation

1994

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Acknowledgements

The first recognition I must give is to the many scholars involved in putting the first edition of the *Guide* together. We have been but standing on their shoulders as we put together the 1994 issue.

Another general 'thank you' is also required to all of our members, academic, hospital and association colleagues for responding to the questionnaire which forms the basis for this text. This material required respondents to go to several different sources for the necessary information. We very much appreciate the work involved.

A very important input was also made by the IHF/WHO/OECD/EC Hospital Committee Working Party for Hospital Statistics. You will have seen other results of their work in the insert report in our journal *World Hospitals and Health Services* of September 1994.

I wish to thank our own secretariat administrative services director, 'Suri' Suryanarayan, for the complex task of data clarification, research amplifications and information entry involved, and our publications officer, Carl Richmond, for his work in typesetting the publication. Finally, there is always a worker bee involved in such publications: in word processing and completions of the text. In this case it was our French university management trainee, Emilie Barret.

As general overseeing editor and factotum, I am extremely grateful that all those involved were able to sort out the muddle of material to produce this global guide to healthcare systems.

Editorial for the 1994 Edition

What a task it has been! Preparing this second edition of our very successful 1990 edition of *A Guide to Health Services of the World* has been as difficult as that of editing the first issue. The problems remain of disparate service definitions, some national incompetence in collecting data and extraordinary diversity of systems.

Nevertheless, this 1994 edition is enlarged and expanded both in regard to the number of countries and the amount of data and information on each country. It is also set out in a more attractive format. We hope it becomes one of the world's standard reference texts on international health systems.

Since publishing our first edition, the demand for information on health services around the world has greatly increased. This relates to the fact that virtually all health systems around the world are being reformed or substantially reorganized. One corollary of this renewed interest is the increased demand for more standardization of definitions of healthcare activities. We have begun to address this issue in this edition by asking for clarification of data given by our international colleagues. This clarifying information has been provided by about a third of our respondents. Even so we need again to caution readers about making comparisons between nations based on the data.

As IHF intends to update this edition in 1996, we would appreciate any recommendations you can make to improve the information provided in the 1994 edition.

We see ourselves at the IHF as a link in the international network of health managers and professionals and would therefore welcome your involvement with this important project.

Errol Pickering Ph.D.
Director-General

Methodology

Conceptually the second edition of *A Guide to Health Services of the World* borrows from the first. However, new approaches have been used in the data-gathering process which have meant that a more comprehensive publication has been possible. The methodology set out here demonstrates both the strengths and weaknesses of the content.

The International Hospital Federation and the Hospital Committee of the European Community jointly set up a Working Party for Comparative International Health Statistics to study the problems associated with, and possible solutions of, collecting health statistics at the international level. The members of the Working Party were drawn from the relevant national and international organizations concerned with this issue. The Working Party developed a standard questionnaire containing a minimum set of health care and hospital data indicators to use in a pilot survey of the state of healthcare information in different countries. The results of this survey were published earlier this year and distributed as a special insert of our official journal, *World Hospitals and Health Services*.

A modified version of this questionnaire was sent to over a hundred countries to collect information for the second edition of the *Guide*. Responses to this questionnaire have provided the bulk of the information for this publication.

We were able to verify the information in the first part, 'General Economic Information', from other published sources such as *The World Development Report, 1993*. Where there were differences, we have usually accepted the information as it was provided to us, if it fell within a margin of +/-5%. In the event of large differences we have used the information given in the official secondary sources. We have also conducted basic tests of internal arithmetical logic; again, where the errors were within the +/-5% margin, the figures have been left unaltered.

Information for the second part, 'Description of the Health Service', was provided only by a few countries. These have been left largely as they are. For the twelve EC member countries, descriptions have been obtained from the recent publication of the Hospital Committee of the European Community, *Hospital Services in the EC (1993)*. For some others, we have extracted information from the relevant Annual Reports of Ministries of Health. In a few cases we have used as information sources articles published in technical journals. For Kenya, Namibia, Tanzania and Zambia the descriptions were provided by participants from these countries at our 34th Senior Managers' Course in Health Administration. In the case of a few countries we have used the information from the first edition of this *Guide*, updated for all known changes.

The third part, 'Hospital Statistics', has been reproduced as presented to us by the respondents. The terminology used by the various countries to categorize their hospitals has not always been the same as that which appears in this *Guide*. We have had to classify them as 'Short-Term', 'Long-Term' or 'Psychiatric', even where they were not defined in this manner. We have included in 'Short-Term Hospitals' all data items described as General Hospitals, Regional Hospitals, District Hospitals, Referral Hospitals, etc., except where these are specifically referred to as either 'Long-Term' or 'Psychiatric'. Similarly, nursing homes, convalescence homes, sanatoriums, etc. have been included in 'Long-Term Hospitals'. Mental Hospitals have been included in 'Psychiatric Hospitals'. We have had no external sources to verify the information, except in the case of the twelve EC countries and Austria, Finland, Norway, Sweden and Switzerland where the data were checked more rigorously as part of the Pilot Survey of the Working Party.

The fourth part, 'Contact Addresses', includes all possible sources of further information known to us. We have used the last known address in our records in each case.

Contents

ARGENTINA

1990

General Economic Information

Gross Domestic Product

GDP in national currency	—
GDP in US$	105,738m
GDP per capita per annum in US$	3,304

National Population	32m
Birth Rate (per 1000 Population)	21 (1991)
Life Expectancy at Birth (Years)	72
Death Rate (per 1000 population)	9 (1991)
Infant Mortality (per 1000 live births)	25

Health Expenditures

Total expenditure on health services in US$	4,441m
Percentage of GDP spent on health services	4.2%
Amount spent on health services per capita in US$	138

Hospital Expenditures

Percentage of GDP spent on hospital services	—
Hospital expenditures as a percentage of health service expenditures	—

Peripheral Items Included in Health Care Expenditures

Institutional domiciliary care of the physically and mentally handicapped	N/A
Institutional custodial care of the aged	N/A
Sickness benefits payments relating to loss of income	N/A
Public health programmes	N/A

Sources of Health Expenditures

Governments (all levels)	—
Personal (out-of-pocket payments)	—
Employer's company medical schemes	—
Missionary and charity organizations	—

Description of the Health Service

1. Structure and Organization

Health services are provided through both the public and private sectors. Various aid agencies also provide public health service programmes. Responsibility for government-funded health care is shared between the Federal and State administrations.

2. Financing

Funding sources for health services are mixed. Some direct government funding is applied. Social Security, Employee Insurance schemes and direct out-of-pocket payments are also revenue sources for the health sector.

3. Access and Types of Service Covered

Theoretically, universal access is possible; however, limited resources and geographic disenfranchisement mean that there are large service gaps.

4. Quality Assessment and National Standards

There is no national accreditation scheme, although lengthy planning is going on with a view to its eventual implementation. Some hospitals follow individual quality-assurance activities.

Hospital Statistics

Not provided

Contact Addresses

Ministry of Public Health and Social Welfare
Defensa 120
1345 Buenos Aires
ARGENTINA

Confederacion Argentina de Clinicas Sanitarios
y Hospitales Privados
Calle Tucuman 1668 2 Piso
Buenos Aires
ARGENTINA

AUSTRALIA

1990

General Economic Information

Gross Domestic Product

GDP in national currency	369,749m
GDP in US$	273,614m
GDP per capita per annum in US$	16,197
National Population	17.1m
Birth Rate (per 1000 Population)	14.9
Life Expectancy at Birth (Years)	73.3 (Male) 79.6 (Female)
Death Rate (per 1000 population)	7.9 (Male) 6.8 (Female)
Infant Mortality (per 1000 live births)	8.0

Health Expenditures

Total expenditure on health services in US$	21,218m
Percentage of GDP spent on health services	7.8%
Amount spent on health services per capita in US$	1,256m

Hospital Expenditures

Percentage of GDP spent on hospital services	3.2%
Hospital expenditures as a percentage of health service expenditures	40.9%

Peripheral Items Included in Health Care Expenditures

Institutional domiciliary care of the physically and mentally handicapped	Yes
Institutional custodial care of the aged	Yes
Sickness benefits payments relating to loss of income	No
Public health programmes	Partially

Sources of Health Expenditures

Governments (all levels—including public medical insurance)	69.0%
Social insurance (workers compensation)	2.5%
Public medical insurance	8.9%
Private medical insurance	10.9%
Personal (out-of-pocket payments)	17.6%

Description of the Health Service

1. Structure and Organization

In Australia, the Commonwealth, State/Territory and local governments, and the private sector and voluntary agencies have separate, but for the most part, complementary roles and responsibilities in the financing and

delivery of health services. The Australian constitution formally limits the Commonwealth's powers in relation to health and health services delivery. It is the State and Territory governments which are largely responsible for the planning, provision and administration of healthcare services for the Australian population. State/Territory governments also administer registration requirements for health professionals, including doctors and dentists, and license and regulate private hospitals and private nursing homes.

The Commonwealth government is primarily concerned with funding and the development of broad national health policies. The Commonwealth government is able to influence national health policy in a number of ways. It exerts influence through its financial arrangements with the State and Territory governments, through the provision of benefits and grants to organizations and individuals and through the regulation of health insurance. Health and health delivery research projects also receive funding under various programmes. In particular, Australia's universal health insurance programme, Medicare, is a major Commonwealth initiative which facilitates access to healthcare services. The Medicare programme provides medical insurance and free access to public hospitals for all Australian residents, and includes access to prescription medications at an affordable price under the Pharmaceutical Benefits Scheme (PBS) which is administered by the health Insurance Commission. The HIC is also responsible for the administration of the medical insurance component of the Medicare programme and undertakes measures to combat medical fraud and over-servicing.

1.1 Private Sector

In addition to government involvement in healthcare delivery at the Federal and State level, health care is delivered in Australia by individual private practitioners, voluntary agencies and both non-profit and profit-making non-government organizations. This combination of public and private health sector involvement is essential to the effective delivery of health care in Australia. Also, private health insurance is offered by private insurance funds.

1.2 Australian Institute of Health and Welfare

Following changes to its legislation, the Australian Institute of Health has become the Australian Institute of Health and Welfare. The Institute, which was established to upgrade the standard of health data and statistics in Australia, has had its role broadened to include the collation, analysis and publication of national welfare and housing statistics. The Institute is responsible directly to the Ministry for Health, Housing and Community Services.

2. Health Expenditure

As a proportion of Australia's Gross Domestic Product, health expenditure has been relatively stable over the past decade, within the range 7.6–8.1%. These health expenditure figures are approximately mid-to-low range when compared with equivalent statistics for other developed countries. The private sector, the Commonwealth, and State and Territory governments contribute to this expenditure in largely equal proportions. Preliminary figures for 1990/91 indicate that total healthcare expenditure by governments and private sector was $30,923 million, which is $2,542 million greater than in the previous year.

3. Medicare

Medicare, the national health insurance scheme, aims at universality, simplicity, equity, accessibility and cost-containment. Introduced on 1 February 1984, Medicare is funded from general revenue and, in part, a health insurance levy—initially 1% of taxable income, which from 1 December 1986 was increased to 1.25%. The Medicare levy is payable by those taxpayers earning above a threshold income and is compulsory, regardless of whether or not they have private health insurance cover. For the 1991/92 financial year, single people earning $11,747 per annum or less and married couples and sole parents with a combined income of $20,986 per annum or less will not be required to contribute a levy payment. A further $2,240 per annum is allowed for each dependent child. Since 1 July 1985 there has been no upper limit on the levy payable.

3.1 Hospital Arrangements and Funding

All Australian residents, and others covered by Medicare (detailed in 'Medical Services', section 3.2) are entitled to free accommodation and treatment in shared wards in a public hospital by doctors nominated by the hospital.

State/Territory governments are responsible for the provision of public hospital services. When Medicare was introduced on 1 February 1984 the Commonwealth provided compensation payments to the States to reflect the loss of revenue and additional costs associated with the provision of free hospital services to any Australian who chose to be a public (Medicare) patient. This funding was in addition to grants notionally identified in the general tax-sharing arrangements as the Identified Health Grants.

Under a new five-year agreement with the States commencing on 1 July 1988, these two sources of funding were terminated and new Hospital Funding Grants were introduced. The grants are increased each year to reflect general cost increases as well as age/sex-weighted population growth. Total payments for the 1991/92 financial year are estimated at $3,804 million. The State and Territory governments supplement these payments with funds from other sources of revenue, such as general tax-sharing revenue and local taxes and charges.

The arrangements also provide for incentive payments to encourage the States and Territories to improve the efficiency and effectiveness of their public hospital systems. Incentive payments in 1991/92 include: $31 million for expansion of post-acute early-discharge programmes and palliative care services to promote continued reductions in hospital lengths of stay; $12.4 million for expansion of day surgery as a substitute for overnight hospital stays and to allow for increased throughput with a view to reducing waiting times for longer-stay procedures; and $5.4 million for the development of cost-based case mix information systems. Development of such a system on a national basis will allow more informed resource management in the hospital system and assist meaningful comparisons of hospital performance.

The grants also include a specific Commonwealth contribution, $36.5 million in 1991/92, for the treatment of AIDS patients in public hospitals, indexed to the actual growth in AIDS cases treated.

The Hospital Enhancement Programme assists the States to upgrade facilities and equipment in public hospitals as well as improve selected clinical services. It is a two-year programme with the Commonwealth providing $32 million in the first year and $37 million in the last year of the programme.

3.2 Medical Services

Medical services in Australia are generally delivered either by private medical practitioners on a fee-for-service basis or by medical practitioners engaged by public hospitals or employed in community health centres. Costs incurred by patients attending private medical practitioners are reimbursed in whole or in part by means of Medicare benefits.

3.3 Benefits

The Commonwealth Health Insurance Act provides for a Medicare Benefits Schedule which lists medical services and the schedule (standard) fee applicable for each medical service. Differential fees in the States were replaced by uniform Medicare Schedule fees throughout Australia from 1 November 1986.

The Schedule covers attracting Medicare benefits rendered by qualified medical practitioners; certain medical services rendered by approved dentists; a service by an accredited dental practitioner to a dental patient in the treatment of cleft lip and cleft palate conditions; and optometrical consultations by participating optometrists. Schedule fees are generally considered by the government to represent fair and adequate remuneration.

While fees apply for Medicare benefits purposes, medical practitioners are free to charge whatever fee they wish. Since 1 August 1987, the level of medical benefits payable has depended on whether or not medical services are rendered to an in-patient in hospital. For services provided to ambulatory patients, the Medicare benefit is 85% of the schedule fee (the fee set for each service) or the schedule fee less $26.80 (indexed annually), whichever is the greater. If the patient is a private in-patient in a public or private hospital or attends a recognized day-surgery centre, the benefit is 75% of the Schedule fee.

The difference between the Medicare benefit and Schedule fee is known as 'the gap'. The Health Insurance Commission records gap payments and a patient or a registered family who, in any calendar year, incurs 'gap' costs of $246, becomes eligible for Medicare benefits at 100% of the schedule fee for the rest of that calendar year. This only applies to out-of-hospital services. The maximum total annual gap is adjusted in line with the Consumer Price Index. Medicare Benefits Schedule fees are usually adjusted on an annual basis by government decision, following consideration in the budget context. The cost of Medicare benefits in 1990/91 was $4,238 million.

3.4 Billing Arrangements

A doctor may bill for services which attract benefits by direct-billing the Health Insurance Commission or by billing the patient. When a doctor direct-bills the commission, the maximum fee is the Medicare benefit for that item of service, and it is illegal to make any additional charge in respect of that service. When the patient is billed, Commonwealth law does not restrict the level of the fee. Currently, approximately 76% of services for which a Medicare benefit has been paid are charged at or below the Schedule fee.

The patient may claim medical benefits in the following ways:

- Pay the account and then claim the benefit for that service from the Health Insurance Commission; or
- Obtain from the Health Insurance Commission a cheque for the benefit payable to the doctor, and then give it and any balance to the doctor.

Medicare benefits are not payable for compensation cases, health screening, cosmetic surgery, multiphasic screening or services for doctors' dependants, partners in practice or their dependants.

4. General Practice

General practice is central to the healthcare system and it is in recognition of this that the department and the medical profession are now working closely to ensure that high-quality general practice care continues.

For most patients, general practice is the point of entry into the healthcare system and GP consultations account for some 40% of Medicare benefits expenditure.

GPs represent about 60% of all doctors and although this means too many GPs for our population as a whole, not enough of them are practising in rural areas. The government and the profession are now co-operating on developing initiatives to redress this mal-distribution.

Other initiatives being developed will help the medical profession to enhance the quality of care available to patients. These include:

- Accreditation of general practices. This is a natural development of the vocational registration arrangements for GPs which was established in 1989 by the government in conjunction with the Royal Australian College of General Practitioners. Accreditation will provide a valuable framework within which quality of care issues can be addressed;
- Practice grants may be offered to complement fee-for-service and provide financial incentives for practices to engage in best practice care. In 1991/92 the Government committed up to $12 million for Demonstration Practice Grants likely to involve some one thousand GPs and allied health workers around the country. This programme will try out new ideas and contribute to the longer-term development of practice grants and foster new ideas for the funding and delivery of general practice;
- Options for encouraging more appropriate ordering of diagnostics and pharmaceuticals are being explored. GPs are uniquely placed in the medical system to decide on action for diagnosis, treatment and management of a patient's condition and the Government believes that these decisions could be more appropriately made. One option is the trailing of practice budgets to increase cost-effectiveness and ordering efficiency; and
- Action is also under way to look at the sorts of information needed by the general practice and how that information might be delivered.

Defining these issues and exploring solutions is the responsibility of the General Practice Consultative Committee and its working groups. Participants in the consultation process come from the government, the Australian Medical Association, the Royal Australian College of General Practitioners and consumer organizations.

5. Private Health Insurance

Health insurance funds must be registered under the National Health Act and offer insurance in accordance with the community rating principle (that is, for a given insurer, everyone pays the same contribution rate for a particular range of benefits regardless of age, sex, family size or medical condition). Single persons pay half the family rate. Contribution rates vary depending on the range and nature of benefits offered.

In public, but not private, hospitals, patients may elect to be treated as either a public or a private patient. Public patients (Medicare patients), receive free treatment from hospital-appointed doctors. Private patients have choice of doctor, and charges that can be raised are for medical treatment, accommodation and a range of surgically-implanted prostheses. Private patients in private hospitals can face a range of charges for their treatment and accommodation. There are no controls over private hospital charging policies or the level of fees a doctor can charge. Such patients may be faced with significant out-of-pocket expenses, depending on their level of health insurance cover.

5.1 Basic Private Cover

All registered health funds, as a condition of registration, offer a basic private table which provides full cover for Commonwealth-approved shared-ward charges in public hospitals. It is available for any length of stay, but reduced benefits apply in respect of nursing-home-type patients. Benefits reduce to that level after thirty-five days, unless a doctor certifies that the patient is in need of acute care. For private hospitals, the basic table provides minimum levels of benefits which vary with the patient treatment classifications and length of stay in hospital. The treatment classifications are: advanced surgical; surgical/obstetric; psychiatric; rehabilitation; other (medical); and nursing-home-type patients. Reduced benefits apply after various periods, eventually also reducing to the nursing-home-type rate, again with appropriate exemptions.

A lower day hospital benefit is paid for treatment of private patients on a day-only basis in either a public or private hospital, or approved free-standing day surgery. Since 1 September 1985, health funds have been able to offer basic cover at a lower premium for those members who wish to meet a certain amount of cost per year before benefits are payable. This is referred to as a 'front-end deductible' arrangement. Basic private health insurance only partially covers the cost of shared-ward charges in private hospitals.

5.2 Supplementary Cover

Registered health funds offer additional insurance under supplementary hospital tables. The additional tables are not regulated to the same extent as the basic table and so vary among competing funds. Generally however, the tables are designed to meet single-room charges in public hospitals and to provide extra benefits towards full private hospital accommodation fees and the more commonly incurred private hospital charges for extras.

Ancillary benefits offered by the health funds cover services such as theatre fees, labour-ward charges, dentistry, physiotherapy, home nursing, chiropody as well as the costs of some medical aids and appliances.

Registered health funds may also offer medical and hospital benefits to cover short-term visitors to Australia not covered by Medicare.

Private health insurance contributions are not tax-deductible, but individuals can receive a taxation rebate for the excess of unreimbursed healthcare expenses over $1,000 in a year.

5.3 Private Patients in Public Hospitals

A private patient in a public hospital pays a daily rate for accommodation. The rate varies from State to State, and States charge different rates for single and shared-room accommodation. As indicated above, apart from charges for a range of surgically-implanted prostheses, there are no other hospital in-patient charges.

Private medical insurance is not permitted to cover 'gap' for medical services which are rendered out of hospital or of amounts charged above the Schedule fee for any service.

5.4 Private Patients in Private Hospitals

Accommodation charges in private hospitals can vary with the patient's treatment classification. Charges are higher for a single room than for shared accommodation. Private hospitals generally also make other charges for extras such as use of operating theatres, labour-wards, intensive care facilities, drugs and dressings and prostheses. Basic table benefits do not extend to these extras charged by private hospitals.

Doctors treating patients charge for their services. Medicare benefits are payable in respect of medical costs. Private health fund benefits are payable from the basic table for insured patients to cover the 25% gap between Medicare benefits and the schedule fee. Supplementary insurance provides benefits towards additional charges which may raised by private hospitals.

5.5 Reinsurance

Reinsurance, or more correctly co-insurance, arrangements are integral to the concept of community rating. Thus, the consequence of reinsurance is that contributors to health funds with higher-than-average claims experience are subsidized by contributors to funds with lower-than-average experience.

In addition to direct contributions made by privately-insured individuals, private health funds have until recently derived some of their revenue via cost-sharing arrangements with the Commonwealth government. Basic table claim paid by the private health insurance funds for those who are 65 years of age and over are placed into the Health Benefits Reinsurance Trust Fund. Funds in the Trust are redistributed each year according to the expenditure of private health funds on the chronically-ill. If each insurer bore the risk rather than it being shared by all the health insurers, there might be an uneven burden on those health funds with particularly high-risk insurance experience.

6. Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme is a nationwide health scheme that makes prescription medicines affordable to Australians. Through this scheme, the Federal Government subsidizes the cost of around 70% of the prescription medicines bought at community pharmacies. The scheme costs the Government around $1,200 million each year to run and this is increasing as people are living longer and more expensive medicines are being developed and used.

A wide range of medicines is subsidized through the scheme. Although some medicines cost the government as much as $2,200, Australians may pay as little as $2.60 and no more than $15.70 for a pharmaceutical benefit. Pensioners and other beneficiaries who only pay $2.60 for each medicine under the scheme are compensated for this payment by a corresponding increase in their pensions.

A safety net protects consumers from paying more than necessary for prescription medicines by placing a limit on how much people have to spend on pharmaceutical benefit medicines in a calendar year. It is like a cost ceiling and varies according to people's circumstances. It is specially designed for people who are chronically ill and for families who need a lot of prescriptions.

For most families the safety net is around $360 each year. Once a person or a person's immediate family has spent around $310 on pharmaceutical benefits in a calendar year, they need only pay $2.60 for each additional medicine. When they have spent another $50 in this way, they will get all pharmaceutical medicines free for the rest of that year. For pensioners and other beneficiaries, the safety net limit is around $130. All of these figures are adjusted each year for inflation.

Australia has earned a good reputation for the quality of its healthcare professionals and the medicines that are available, since all medicines on the Pharmaceutical Benefits Scheme are subject to the same strict quality controls. The scheme benefits all Australian residents regardless of health or income, making vital medicines available and affordable.

7. Quality Assurance

Australia has an advanced hospital accreditation programme which has promoted quality assurance in hospitals. Considerable work on outcome measures has been carried out in a number of hospitals.

8. Care of the Aged

Until mid-1986 the emphasis on aged care in Australia had been on the provision of intensive nursing home care. Since that time there has been a shift in emphasis towards a more integrated care system with lower intensive care and domiciliary care aimed at keeping people independent in their own homes and so preventing inappropriate admission to long-term care. This Commonwealth initiative is being progressed through the Home and Community Care (HAAC) Programme which is cost shared between the Commonwealth and State/Territory governments.

The Commonwealth provides funding to voluntary, charitable and private organizations, as well as local government to provide hostel care for the elderly. Since February 1992, under the Community Aged Care Package Programme, the Commonwealth has funded organizations as well as local government, to provide hostel care for the elderly. Since February 1992, under the Community Aged Care Packages Programme, the Commonwealth has funded organizations to provide appropriate care in their own homes for people who would be eligible for personal care in a hostel.

Nursing home subsidies are paid by the Commonwealth to ensure that people who are assessed as needing nursing home care have access to residential support and care appropriate to their needs. Domiciliary nursing care benefits provide financial support to carers to assist frail aged and young disabled people, who would otherwise require nursing home admission to remain in the community.

Total Commonwealth expenditure on the Aged Care Programme for 1991/92 is expected to be approximately $2.5 billion.

Hospital Statistics (1990)

	Short-Term	Long-Term	Psychiatric
No. of Hospitals	994	1,437	84
No. of Beds Available	81,490	73,231	9,822
No. of Admissions per annum	3,788,000	44,400	58,900
No. of Out-patients per annum	27,492		
No. of In-patient days per annum	21,132,000	25,579,000	2,789,000
Expenditures			
Total Expenditure per annum in National Currency Units			
Capital Expenditure per annum			
Current Expenditure per annum (m)	9,484	2,086	884
Staff Costs as a % of Current Expenditure			
Staffing			
Total Staff (Full-Time Equivalents)			
Medical Practitioners	10,580	120	470
Other Hands-On Care Personnel	109,140	32,000	6,320

Contact Addresses

The Australian Hospital Association
42 Thesiger Court
Deakin ACT 2600
AUSTRALIA

The Australian Institute of Health & Welfare
GPO Box 570
Canberra ACT 2601
AUSTRALIA

AUSTRIA

1990

General Economic Information

Gross Domestic Product

GDP in national currency	1,793,630m
GDP in US$	157,751m
GDP per capita per annum in US$	20,439

National Population	7.7m
Birth Rate (per 1000 Population)	11.7
Life Expectancy at Birth (Years)	72.5 (Male) 79.0 (Female)
Death Rate (per 1000 population)	10.4 (Male) 11.1 (Female)
Infant Mortality (per 1000 live births)	7.8

Health Expenditures

Total expenditure on health services in US$	12,522m
Percentage of GDP spent on health services	7.9%
Amount spent on health services per capita in US$	1,622

Hospital Expenditures

Percentage of GDP spent on hospital services	4.2%
Hospital expenditures as a percentage of health service expenditures	50.4%

Peripheral Items Included in Health Care Expenditures

Institutional domiciliary care of the physically and mentally handicapped	Partially
Institutional custodial care of the aged	Partially
Sickness benefits payments relating to loss of income	Partially
Public health programmes	Partially

Sources of Health Expenditures

Governments (all levels)	N/A
Social insurance	N/A
Public medical insurance	N/A
Private medical insurance	N/A
'Mutual' or medical co-operative schemes	N/A
Personal (out-of-pocket payments)	N/A
Employer's company medical schemes	N/A
Missionary and charity organizations	N/A

Description of the Health Service

1. Structure and Organization

The Austrian social insurance system is a compulsory system and covers health insurance, pension insurance and accident insurance. The health insurance system covers nearly all gainfully employed and unemployed persons, persons on unpaid maternity leave, pensioners and their family members. At present, insurance protection covers about 99% of the population. The chief motives for persons taking out supplementary private health insurance are to make provision of meeting the cost of better hospital accommodation and the cost of treatment by the physician of their choice, and to reduce waiting time for examinations.

The health insurance system, which operates as an autonomous self-managing body, is supervised by the Federal Ministry of Labor and Social Affairs. The Health insurance agencies jointly with the Austrian Chamber of Physicians regulate the number of panel doctors, and through their fee-paying policy influence the services rendered by physicians.

There is a division of responsibility for health care between the Federal authorities on the one hand and the provincial authorities on the other, which is based on the Federal Constitution. Thus, Federal authorities are responsible for basic legislation with regard to hospitals and nursing homes; executive regulations and implementation are in the hands of the provincial authorities. The supervision of hospitals and nursing homes in health matters lies within the competence of the Federal authorities.

The Federal Hospital Act lays it down that every province must provide hospital facilities and nursing and medical treatment for persons requiring institutional care in its territory. In the provincial hospital plans, the provincial authorities determine the number of hospital beds. The health insurance agencies do not exercise any influence in this regard. Also, through the preparation and authorization of budgets, the provincial authorities influence the structure of services rendered by the hospitals.

The provincial and communal authorities are responsible for social services (Welfare). However, it should be pointed out that it is not possible to make a clear distinction between responsibility for health care and for social services, and that the only meaningful way to provide the two types of service—which are often differently financed—is by joint action.

The Hospitals Co-operation Fund (KRAZAF) can be regarded as a control and planning instrument both for the Federal and provincial authorities and for the social insurance agencies.

2. Financial Administration

Health expenditure amounted to AS150 billion in 1990; the result per capita health expenditure was some AS 19,000,-.

The healthcare system is financed by the compulsory health insurance, private health insurance, Federal, provincial and local authorities, the 'Hospitals Co-operation Fund' and direct payment by patients. Health insurance agencies account for 80% of public sector expenditure in health.

On medicines, there is an average of about 20% of direct payment by the patients. Under certain social insurance schemes, patients have to pay 20% of the fees for medical treatment directly. There are also certain percentages of direct payment to therapeutic substances and appliances, to dental treatment and dentures and to in-patient treatment. Self-medication is to be paid fully by the patients.

The Hospitals are financed by the health insurance agencies (including payment by the Hospitals Co-operation Fund, 55%), private insurance (6%), provinces and communes (31%) and Federal authorities (8%) (*figures for 1990*). One quarter of hospital expenditure in 1990 went towards investments, the rest towards running costs.

The Hospitals Co-operation Fund (KRAZAF) was founded in 1978. Since then, the Federal and provincial authorities have concluded a number of contracts (of limited duration) for the financing of hospitals. Executive authority for performance of these contracts lies within KRAZAF. The fund was established in order to tap new financing sources for the hospitals in a effort to make a transition to a performance-related form of hospital financing.