CREATING HEALTHY ENVIRONMENTS GLOBALLY AND LOCALLY

AIM: To explain the concept of a dual market tendency and describe how this influences the profile of health internationally and in Australia. To provide some related suggestions for improved regional health and environment planning and management.

DUAL AND SEGMENTED MARKET DEVELOPMENT

In Economy and Society, Weber defined sociology as a science concerned with the interpretive understanding of social action, and with the causal explanation of its course and consequences. The boundaries often may not be clear between being a sociologist, an economist, or approaching an issue from the perspective of another discipline. To understand the relationship between economy and society, I have always found the work of J.K. Galbraith very useful. He was a Harvard economist and former diplomat whose life spanned the 20th century and who achieved much in the world of U.S. foreign and domestic policy. The views he outlined in many books, including 'Economics and the Public Purpose', seek to explain the public policies which are necessary to pursue the public interest. In doing so he often attacked traditional economic ideas about the benefits of market supremacy and the necessity to reduce government intervention.

Galbraith argued that in the modern economy the growth of government and its institutions has meant that there are two very different market tendencies operating. He thought that what consumers have to buy and pay are strongly influenced by the interests of the managerial, professional and academic elites which run the country. He thought that the power these elites have to pursue their own interests also promotes division between a monopolistic or planned sector of the economy, and a more highly competitive economic periphery. In the centre, or planning system, the distribution of resources reflects the power of an organization, alone or with others, to pursue its own purposes. In this case, Galbraith argued, the bargaining power of the producers will be greatest and that of the consumers, taxpayers and citizens least. In the peripheral market system the importance of prices to survival means the power of the producer often is minimal or disappears. Here the consumer may hold the whip hand.

Galbraith thought that politicians, the elected representatives of the people in a democracy, need to manage two economies, not one. They need to manage a central economy planned by its large and powerful constituent organizations, which often use taxpayers' funds. They must also manage a peripheral sector of smaller producers where prices are mainly subject to the operations of supply and demand. He thought that government should align the use of power with the public interest and that this requires bringing the planning and competitive sectors of the economy into greater equilibrium by increasing the level of competition in the former, and strengthening the position of communities in the latter. Since the planning system is characterised by self-interested relationships between private sector managers, senior public servants and professionals, he thought the process of reform must inevitably begin with the legislature and its politicians, who are subject to higher levels of public scrutiny. While acknowledging its faults, Galbraith thought that the parliament (the legislature), and not the public service (the executive) or the courts (the judiciary), is the elected and therefore natural voice of the public purpose against the technocratic purpose. The technocratic purpose is to support and be supported by its brethren.

Galbraith had many colleagues and followers who can be characterised as dual or segmented labour market theorists. From this perspective, any organization, industry, nation, or the international economy, may be seen as having a central tendency towards being planned or monopolistic, and a more highly competitive periphery. Enterprises in the centre are fuelled by

technological development and the related expansion of government. They are hosts for professionals and often also for strongly organised unions, which may not gain hold in a competitive periphery because their demands may lead to labour inflexibility and loss of jobs.

Many writers have discussed primary and secondary labour markets which are to be found internationally, regionally, and even in single organizations. People from rural communities, members of subordinate cultural groups, migrants, youth and women often occupy a secondary labour market status because of their comparative lack of cultural understanding, education or work experience, according to the judgment of the dominant cultural groups. They may also occupy a secondary labour market status because of lower work attachment or reliance on alternative support from family or government. Averitt thought the continuing development of the centre would also lead to a perpetual full-employment economy. However, collective concepts of appropriate employment and living standards are also subject to international and technologically driven change. Their implementation requires effective planning and service delivery. One can discern a dual market pattern influencing the profile of health services internationally and in Australia. Will international health and related service inequalities widen further? In a global economy Australians could look upon cultural diversity as a potential strength for developing health, communication and sustainable development partnerships.

HEALTH IN INTERNATIONAL PERSPECTIVE

The dual market tendencies described by Galbraith and his followers are reflected in world health profiles, which are different for developed and developing nations. By focusing on the poorest regions, the programs of the World Health Organization (WHO) appear to be designed to reduce some of the problems which Galbraith and others identified. The WHO came into being in 1948, when twenty-six UN member states ratified its constitution. The organization defined health as 'a state of compete physical, mental and social well-being and not merely the absence of disease or infirmity'. This provides a wider perspective than the medical model of health, which places the emphasis on finding a cure for an individual's physiological symptoms, rather than on dealing with the range of environmental or personal circumstances which cause death, injury or disease.

In 1977 the WHO set 'Health for all by the Year 2000' as its overriding priority. In signing the Alma-Ata declaration in Soviet Kazakhstan, representatives of 134 nations agreed that health is a fundamental human right, and the highest possible level of health requires the action of many social and economic forces. The Ottawa Charter was produced at a WHO members' meeting in 1986. It stated that necessary supports for health include peace, shelter, food, income, a stable economic system, sustainable resources, social justice and equity. The Charter called for the development of public policy and the reorientation of health services as well as community action and education to support health goals. In 1992 the United Nations (UN) Declaration on Environment and Development put human wellbeing at the center of concern for sustainable development. In 1997 the WHO Conference called for development of health promotion through co-operation between governments and the private sector.

The ninth general program of work of the WHO, which covered the period 1996-2000, outlined ten goals and targets for world health. The first was to increase the span of healthy life for all people in such a way that the health disparities between social groups are reduced. The targets which related to this goal were that life expectancy at birth would not be less than sixty years in any country, and for all population groups the difference between the highest and lowest values for life expectancy at birth would be reduced by at least 50%. The second goal was to ensure universal access to an agreed set of essential health care services of acceptable quality, comprising at least the eight essential elements of primary health care. Targets included that at

least 85% of the world's population would have access to treatment of common diseases and to essential drugs and vaccines, biological products and blood products of good quality. The ten goals and targets of the WHO program were accompanied by four policy orientations. The aims were to integrate health and human development in public policies; to ensure equitable access to health services; to promote and protect health and to prevent and control specific health problems.

The world failed to reach the WHO goal of health for all by the year 2000. The Harvard School of Public Health in cooperation with the WHO and the World Bank provided a comprehensive overview of world health problems in 1990, presented on a nation by nation basis. Whilst health and longevity generally continue to improve as a result of development, the severity of many health inequalities continues. The average life expectancy at birth in the least developed countries ranges from 38 to 52 years, in comparison with a range of between 75 and 80 years for developed nations. The Harvard investigation of mortality, disability and risk factors indicated that a substantial proportion of international and national disease prevention planning should relate to controlling the ten principle risks of premature death, of which the most important continue to be poor nutrition, poor water supply, sanitation and hygiene, unsafe sex, tobacco use, alcohol, and occupation. These risks accounted for more than one third of the global disease burden.

In developed economies it is personal habits, such as overeating, smoking and lack of exercise, which play the most important role in explaining illness, whereas in developing nations an impoverished environment is the greatest risk to health. Respiratory infections, diarrhoeal diseases, and conditions arising during the perinatal period are the three leading health problems of underdevelopment, accounting for almost 25% of diseases internationally. The people of Sub-Saharan Africa and India bear more than two fifths of the total global burden of disease yet make up 26% of the world's population. The rates of premature death is seven times higher in Sub-Saharan Africa than in the established market economies. Such economies, including the formerly Socialist economies of Europe, have about one fifth of the world's population and about 12% of the total disease burden. China is the healthiest of the developing regions, with 15% of the world's population and 12% of total disease. China has been gradually embracing a market economy for decades. It seems likely that developing nations may learn from the policies China has implemented since its Communist revolution in 1949.

HEALTH AND SOCIO-ECONOMIC STATUS IN AUSTRALIA

Australia provides a clear example of how the development of a capitalist economy has promoted general health, but not for Aboriginal people – the original inhabitants of the country. White settlement undermined the nomadic life, means of subsistence and related culture of Australia's first people to the point of extinction in some areas. White settlement has also had terrible consequences for contemporary indigenous health, which is discussed later. In general, however, life expectancy at birth increased throughout the 20th century in Australia and is still doing so. Currently the average age of death for women is eighty-one compared with an average for men of seventy-six. Since the 1970s, improvements in life expectancy have been achieved by reductions in death rates at all ages, but particularly for people aged forty-five years or over. The life expectancy of Australians at birth is higher than for people in New Zealand, the United Kingdom and the United States, but lower than for people in Japan, Sweden and Switzerland.

Diseases of the circulatory system, which include heart disease and stroke, are the leading cause of death for Australian men and women, followed by cancers such as lung, colorectal, prostate and breast cancer. For people under forty-five years old, injury accounts for around half of all deaths. The most common causes include suicide, motor vehicle accidents, drownings and falls. Injury is the fourth most common cause of death after respiratory illness, and men are much more

likely than women to be injury victims. This reflects the traditional gender based role expectations about risk taking and risk aversion, which are still enacted in people's working lives and in their leisure. Men generally do the work which is most likely to kill.

Australia currently has the highest rate of migration in the developed world. Four in ten people are migrants or the children of migrants. One in four Australians was born overseas and people from over 200 countries live in Australia. In 1947, 81% of the overseas born population came from English speaking countries, mainly from the United Kingdom and Ireland. By 1997 only 39% of the overseas born population came from the main English speaking countries. Over half of the people who migrated to Australia in 2000 were in the work force in their home countries when they migrated. Over forty percent of the intake had professional backgrounds, 13% were tradespersons, 11% were managers or administrators and 8% were associate professionals. Only 22% were from semi-skilled or unskilled backgrounds. The health of migrants is generally better than that of the Australian born population. They have lower death and hospitalisation rates and lower prevalence of risk factors related to lifestyle, such as being overweight, having high blood pressure and high alcohol consumption. The longer they have been in Australia the more likely migrants' health patterns are to resemble those of the general population.

Socio-economic status is generally the most reliable indicator of health. Internationally and in Australia there is a comparatively clear and consistent relationship between social class and health, whether the former is measured by income, education level, occupation, or geographic region. For all Australian age groups, men and women from less advantaged backgrounds have higher death rates and report higher levels of illness than the more affluent. This is partly related to unsafe environmental and working conditions and partly attributed to personal lifestyle factors such a poorer diet, smoking, lack of sufficient exercise, or alcohol consumption. Those who are unemployed have worse health than those who have paid work. The workplace is an obvious location where the basic skills of environmental and work risk management, health promotion, and rehabilitation might most easily and usefully be taught, in order to promote improved production as well as personal, regional and national improvement in health and sustainable development practice.

About 36% of Australians live outside capital cities. Half are in major regional centres and the others are in rural and remote areas. Non-metropolitan residents have higher death rates for all major causes of death except cancers. The death rate for men and women aged 25 to 64 in non-metropolitan areas is 15% higher for men and 9% higher for women than in the general population. Lack of job opportunities in rural areas may mean unemployment and depression are major problems, especially for young males, who also appear less likely than young women to leave the area of their birth to find work in the cities. A nationally coordinated health management approach by government, employers and communities, which identifies regional health and development problems in order to reduce them, is just beginning.

Indigenous people comprise around 2.5% of the total Australia population and about one in four indigenous people live outside of urban areas, compared with one in seven other Australians. Aboriginal people die eighteen years earlier than the general population and they are much more likely to die from avoidable conditions, which are defined as those which should be wholly or substantially manageable with adequate medical care. Lack of essential services, including housing, clean water, electricity, sanitation, health care and education are major factors which combine with unemployment, poor nutrition and drug abuse to explain the poor health of many indigenous people. Improvements in Aboriginal life expectancy over the past two decades have generally resulted from reductions in infant mortality and infectious and parasitic diseases. However, Aboriginal infant mortality rates continue to be more than three times the rate for all

Australians in some areas. Aborigines are 70% more likely to be disabled or handicapped than the population as a whole. Community based and effective health and welfare management systems are vital for promoting and improving Aboriginal health, welfare and freedom.

UNEMPLOYMENT, DISABILITY AND COMMUNITY DEVELOPMENT

In 1998 in Australia there were 2.6 million workforce age individuals receiving welfare benefits. Thirty-one percent were unemployed, 21% received disability support pension, 15% were students, 14% were lone parents, 9% were partnered parents, 7% were the partners of age and disability support pensioners and a further 3% were carers or on special benefits. One in five people is now dependent to some extent on government welfare payments, compared with one in seven just over a decade ago. Around 19% of the population report having a disability. Low socio-economic status, unemployment, and Aboriginality are all linked to a higher risk of poor health, disability and crime as well. For example, in 1997 it was found that over one third of males and around half of the females in NSW jails had been assessed or treated for mental illness by a psychiatrist or psychologist at some time. Forty percent of NSW prison inmates were long term unemployed. Thirteen had an intellectual disability, although people with an intellectual disability make up only 2-3% of the general population. Sixty percent of inmates were not functionally literature or numerate. Almost 19% of all adult prisoners were identified as indigenous, and indigenous adults were over 14 times more likely to be in prison than non-indigenous adults. The victims of prisoners and their families often from high risk groups whose children are probably also in particular need of coordinated care, education and employment programs which can effectively promote individual and community health, recreation, communication and sustainable development in a wide variety of community based contexts.

AUSTRALIAN HEALTH PROMOTION AND REHABILITATION INITIATIVES

The international health agreements promoted by the WHO have been accompanied by major health policy initiatives in Australia. In 1983 the national Medicare system of taxpayer funded hospital and general practitioner service provision and drug subsidy was established. The Labor government had tried to introduce this universal, guaranteed health care service a decade earlier. This failed when Labor lost the election in 1975, and an incoming Liberal coalition government reverted to the earlier requirement for private health insurance heavily subsidised by government. Today Medicare has bipartisan support and has played a central role in the development of a national health policy framework. Under the Pharmaceutical Benefit Scheme the government also subsidises a range of drugs on the basis of community need, effective performance and price. Private health insurance, which is also subsidised by government, now provides additional services to those available to everyone under Medicare. These are quicker treatment for elective surgery, greater choice of doctor and hospital, and coverage of ancillary services such as physiotherapy or dentistry. The universal Medicare system depresses the overall cost of health care by linking all government reimbursements for the price of health care services provided in the public or private sector to a set of services listed in the Commonwealth medical benefit schedule. The government disallows insurer coverage of the total price of the health care provider's treatment, unless this conforms to government pricing requirements. The national system thereby puts a downward pressure on the price of most health care services. Few differences have been found in the quality public and private health care.

In 1986 a national health promotion planning process began in which Commonwealth and State Health Ministers established national goals, targets and strategies aimed at reducing major health problems which had been identified primarily through hospital data collection on the causes of mortality and morbidity in Australia. National health goals were established to achieve better

health outcomes in priority areas such as Aboriginal health, cardiovascular disease, cancer, injury, mental health and diabetes. Social justice goals stated that all Australians should have access to a comprehensive range of high quality health care services regardless of financial status, race, culture or language. Fostering participation of communities and individuals in decision-making at all levels of health service planning and delivery was another key goal adopted.

Pursuit of these health promotion aims at regional level is consistent with a risk management approach which state occupational health and safety (OHS) legislation have required in all Australian workplaces since the mid 1980s. State OHS acts call for an integrated business focus to be placed not only on containing costs of production, but also on the identification and control of risks to health of all those at the workplace, in order to avoid unintended consequences of business, and to continuously improve production and its health and environment outcomes. The specific requirements of this risk management approach to undertaking any kind of work will be discussed in a later lecture. OHS acts require an employer to provide a safe place of work and employees are expected to work safely. Workplace risks must be continuously identified, prioritised, controlled and monitored in consultation with workers who are given information and training. This risk management approach can logically be extended to protect risks to clients, the communities and the natural environment.

In the 1980s workplace based rehabilitation requirements were added to state workers' compensation acts, and community based aged care, disability and rehabilitation services were also expanded substantially. There are two major requirements for the future. One is for more effective coordination of the planning and delivery of health and environment related service provision so that it meet the identified needs of regional communities better. The development of appropriate and reliable data gathering systems are also necessary so that the performance of competing service providers can be more effectively assessed in terms of their comparative quality, accessibility and cost. This is essential for evidence based service delivery, the informed exercise of consumer choice, and cost-effective management of public and private funds. Duckett (2004) says that attempts should be made to measure the 'cure quality' and the 'care quality' of each service, with clients primarily being expected to make the latter assessment.

REGIONAL HEALTH AND ENVIRONMENT MANAGEMENT REQUIREMENTS

In 1990 the Council of Australian Governments (COAG) called for national standards for health and environment protection. Review of all state legislation was also commenced, to evaluate and reform its requirements and make them plain. In 1995 the Competition Policy Reform Act called for equal competition between private and public sector producers and service providers. The introduction of national standards and competition requirements with which all organizations must aim to comply should also enable their comparative performance to be identified with a view to its continuous improvement. This reflects the increasingly global recognition that the central issue of good governance is not whether the public or private sector provides services, but whether these services are effectively designed and delivered to meet national and regional goals which are consultatively defined and planned, using a reliable, data driven approach.

Australia has a high standard of living and is therefore unable to compete internationally with labour intensive production in low wage nations. For this reason, high value added services and products, which cost-effectively improve health, education, communication, environment protection and financial management are a logical focus as priorities in national planning. This approach recalls, for example, the eleven tripartite (government, employer and union) industry councils which were set up during the 1980s to cover the manufacturing industries and which conducted stock takes of industry sectors and developed strategic plans. This process

moved employers and workers' representatives from an automatic reliance on barrier protection towards strategies which included economic incentives for microeconomic reform to make organizations more competitive in the longer term. The environments in which people live and work and their influences upon personal behavior are major determinants of their welfare and health. Galbraith argued that a planned approach to spending taxpayers' funds across the whole economy but especially where many poorer people are located, is better than spending it in ways which primarily serve the interests of the existing planning system, where elite members of the technostructure and others may normally make a lot of money comparatively easily. The periodic agreements which are made between the Commonwealth and the States for funding public hospitals and other health services in specific geographical regions, appear, at least in some respects, to provide suitable models for development of other welfare and employment partnerships between government and regional communities.

During the 1990s the Commonwealth Labor government promised an employment strategy and reform to labour market assistance to help the unemployed. It also promised reform of education and training and a restructured social security system from which disincentives to work have been removed. Other major commitments were the development of a strategy to ensure assistance to all regions of Australia, and workplace agreements aimed at flexibility and increasing microeconomic reform. Under the 'job compact' the long term unemployed were promised individual case management, training and support, and a job for six to twelve months, on a productivity-based training wage. Intensive job search assistance at the end of this placement was also promised. The subsequent direction under a Liberal coalition government was to reform the Commonwealth Employment Service which was formerly the only government organization responsible for providing unemployment benefits and job search assistance. The jobless now register with Centrelink, the Commonwealth organization responsible to the Minister for Social Security, which provides an integrated range of health, family, youth, education and training related support payments. Once registered for benefits, the unemployed person is expected to attend a job placement organization. The task of providing job search assistance has been put out to competitive tender, with roughly a third of the contracts for service management being provided by community groups, a third to private sector operators, and a third to public sector providers. About three hundred agencies have signed contracts with the Commonwealth.

The government pays fees, which may be up to $10,000 per person, for making successful job placements; assisting job search through providing training; facilitating entry to retraining in traineeships or apprenticeships; or assisting the establishment of small businesses. Rates paid may depend on the difficulty of placing particular clients. The government is particularly keen to increase the employment rate of lone parents, in order to discourage the transfer of welfare dependency across generations. It also wants to see older unemployed people and those with disabilities encouraged into suitable forms of work or community service. In late 1999 the Commonwealth Liberal coalition introduced mutual obligation policy which means that the individual and community are each expected to contribute to the wellbeing of the other. Although there is strong support for this, there is debate about how mutual obligations should be conceptualized and delivered in the case of unemployed or disabled people and single parents.

Any effective approach to health improvement and related service provision cannot afford to focus only on medical and allied services provide by hospitals and related practitioners. The major focus should be on promoting a broad and holistic approach to community health and environment improvement. This should be delivered through coordinated regional community management structures which use data about broadly and consultatively defined community needs in order to identify and control health risks and environment problems. In particular, an effectively planned approach to identifying and helping those children and adults who face the

highest levels of risk is vital. The most effective structures for data driven management might be obtained through coordinated management collaborations between regional industry, local government, and other services related to health, housing, transport, recreation, education, justice or other welfare provision.

REGIONAL PLANS AND SERVICE PROVIDERS

Local government should have a wider role in establishing and ensuring the quality of community services. A nationally coordinated approach to health promotion, sustainable development and related service delivery through regionally managed contracting would generally be assisted by better coordinated regional management of health and local government affairs. Australian local councils are regulated by state government legislation and are responsible for the management, improvement and development of the resources in their areas. They also have the ability to provide goods, services and facilities, and to carry out activities appropriate to the current and future needs of local communities and the wider public. Local governments have already made agreements with Aboriginal communities in NSW about infrastructure needs and maintenance, as well as the provision of other council services. They are also involved in providing and regulating childrens' services, as well as carrying out a range of other development and welfare programs.

In 2000 the NSW Minister for Health established ten groups to implement the government's action plan for health. These groups worked closely with area health services, which are the regional health management organizations established during the 1980s. The seventeen area health services in NSW are now developing health plans which contain population profiles including size and distribution, morbidity and mortality, socio-economic status and an emphasis on the aged and their needs. A unique patient identifier and electronic health record is also being established for every individual who accesses the national health care system. This will enable evidence based health care provision to be developed more effectively for populations and individuals, whether their treatment is delivered free by taxpayer funded public hospitals or in private health facilities which are also supported by taxpayer subsidy. Priority health care programs are also being developed for people with chronic and complex conditions. A coordinated and effective data gathering approach is required across all related work and community services, in order to compare the effectiveness of all service provision outcomes.

A recent inquiry into local government in NSW required the identification of any issues of market failure which need to be addressed by legislation. It appears that a market economy is poor at addressing child welfare, community crime and problems of degradation of the natural environment. Local government may be in the best position to address such health related issues. Local governments have recently been invited by the Attorney General to establish crime prevention plans, but lack of a community coordinated approach to service funding is one reason that the efforts in this area have been largely tokenistic so far. Under national competition policy the COAG provided economic incentives for reform of certain publicly owned utilities such as water, gas and electricity. These incentives might also be used to obtain local government and related service reform, so that organizations meet identified community needs more effectively, through better integrated services. There is currently little comparative data about community need or about the outcome, quality and cost of services provided respectively by charities and the private and public sectors. As a result, councils have few effective ways of estimating the grounds on which they should provide services, withdraw them, or contract them out.

The Commonwealth and State government healthy ageing policy framework and the parallel disability policy framework makes clear that State government agencies are required to adjust the way they provide their services to better meet the needs of people with disabilities. It also

provides a structure within which local councils can make equivalent adjustments. Ideally, this should make possible a broad and integrated approach across government that responds to the identified needs of people with disabilities. Most people's disabilities are not severe. The services available to urban and other more advantaged communities – such as transport, housing, education and health care should be more generally available and could be used by people with disabilities if:

- The way services are provided is adjusted to reflect the key requirements of quality management for health and sustainable development
- Organizations whose services overlap work together in planning
- The primary focus is on the needs of individual people with disabilities and their communities

Commonwealth and State government agencies, local councils and non-government welfare organizations need to coordinate action in the following areas:

- Physical access and transport
- Promoting positive community attitudes and training staff in mainstream services
- Information about services for children and people with disabilities
- Life long learning and employment
- Promotion of environment development and tourism
- Promotion of sport, recreation, leisure and the arts

Area health plans which focus on the health and care of the aged and those with disabilities should logically be coordinated with the implementation of requirements identified in recent public inquiries related to crime prevention and the health of children, especially those who have been identified as being at risk by their teachers, health workers, police or relevant others.

The Premier of NSW recently established a strategic projects division to lead and facilitate a whole of government effort to deliver tangible and sustainable social, environmental and economic benefits to the people of NSW. Australia's universities and technical and further education colleges have considerable potential to assist regional identification of health and environment related need, and also the establishment of education, research and related community services. In 2000 the Community Relations Commission and Principles of Multiculturalism Act was introduced. It states that all individuals in NSW should have the greatest possible opportunity to contribute to, and participate in, all aspects of public life. This legislation is highly relevant for promoting, identifying and planning service delivery which meets the needs identified in regional communities more effectively. Australian indigenous and immigrant communities represent a huge repository of cultural knowledge and skills which have so far been relatively untapped by the dominant bureaucratic, professional and academic methods of organising publicly funded service delivery to meet health and environment needs.

POOLED REGIONAL FUNDING

The employment of people capable of working in a broad range of contexts to assist others to realize their personal potential through health, education, employment and related services, would also enrich the community and reduce cost. However, this can only occur in the context of an effectively coordinated regional approach to managing and funding health, local government, welfare, education and employment services, in order to meet the health and environment goals identified by regional communities. The importance of purchaser/provider splits in order to

achieve the transparency necessary for comparative evaluation and continuous service improvement is well understood in the health industry. Area health service managers have recently been required by governments to purchase care in three separate streams. Acute care funding covers needs requiring an episode of treatment in a hospital setting. General care funds are for needs best managed by people themselves, including primary health care, allied health and community care and community support services. Coordinated care funding is for complex and ongoing needs requiring a mix of services over an extended period and the assistance of a care coordinator. Clear purchaser/provider splits may need to be implemented in many other areas of service delivery where they may be relevant for effectively comparing the outcomes of a wide variety of services. The general development of effective planning and management systems which can transparently draw on broadly pooled regional funding and comparatively justify their expenditures are vital for good community management.

CONCLUSION

Australia's strategy of developing a national, consultative and evidence based approach to health improvement appears consistent with the principal recommendation of J.K. Galbraith in 'Economics and the Public Purpose'. Galbraith stated that government should seek greater alignment between the planning and competitive sectors of the economy by increasing competition in the former and providing support in the latter. Recent international agreements to promote health, sustainable development and competition have been followed by policy change and legislative review in Australia. However, there is a continuing lack of an effectively coordinated, transparent, regional approach to the consultative identification and management of health and environment problems. This hinders the development of an appropriately broad and coordinated range of services to meet identified community needs, and also inhibits comparative evaluation of the outcomes of health service provision, in order to improve it. NSW population needs are currently being profiled on a geographic basis, and related health plans are being developed with an emphasis on the needs of the aged. The health of children and the environment should be of even greater concern because the future depends upon their wellbeing. A national approach to health improvement through regionally managed contracting may be achieved most effectively through improved coordination of health, local government, and education providers with the welfare and employment related services of the Commonwealth Department of Social Security and other relevant organizations.

FURTHER READING:

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