The Australian Health Care System

An outline

September 2000

Commonwealth Department of
Health and Aged Care

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Financing and Analysis Branch
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This document describes how treatment of illness and injury is delivered and paid for in Australia, with emphasis on the funding role of the Federal Government.

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Introduction

Australia in general

Australia has a land mass roughly the same size as Western Europe or the USA (excluding Alaska). Settlement of Australia, by people now known as Aboriginal and Torres Strait Islander peoples or Indigenous Australians, occurred some tens of thousands of years ago. Settlement by people from Great Britain and subsequently other countries began in 1788 resulting in a present day population of about 18.7 million with a diversity of ethnic backgrounds. About 80 per cent of the population lives in cities. There are large regions which have only small, scattered settlements or are unpopulated. Australia is a developed country with a generally high standard of living.

System of government

In the nineteenth century, Australia was governed as a number of British colonies. Since 1901 Australia has been an independent nation having a federal system of government, with origins in the British system of government and law. The Constitution established a Commonwealth (federal) Government, giving its Parliament powers in specified fields. Each of the six States and two Territories within the Commonwealth has a parliament; in the States these parliaments have powers in all areas not specified in the constitution as Commonwealth powers. The Commonwealth, State and Territory governments operate on the Westminster system, in which the political party or coalition with the majority of elected members in the lower house of the parliament forms the government (not all State and Territory parliaments have an upper house). Ministers with executive powers are drawn from these elected members of government in either lower or upper houses. Within States there are local governments such as municipal and shire councils.

Governments, the private sector and health

Originally the only Commonwealth health power was in quarantine matters. However, in 1946 the Constitution was amended to enable the Commonwealth to provide health benefits and services, without altering the powers of the States in this regard. Consequently the two levels of government have overlapping responsibilities in this field.

The Commonwealth currently has a leadership role in policy making and particularly in national issues like public health, research and national information management.

The States and Territories are primarily responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including the regulation of health professionals.

The States and Territories deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental health, maternal and child health and environmental health programs.

The State and Territory governments directly fund a broad range of health services. The Commonwealth funds most medical services out of hospital, and most health research. The Commonwealth, States and Territories jointly fund public hospitals and community care for aged and disabled persons.

All levels of Government — plus consumers and the non-government sector — have some role in funding, administering, or providing care for older people. Residential aged care is financed and regulated by the Commonwealth Government and provided mainly by the non-government sector (by religious, charitable, and for-profit providers). The Commonwealth, States and Territories jointly fund and administer community care (such as delivered meals, home help and transport). Some State, Territory or local governments provide some community services.

There is a large and vigorous private sector in health services. The Commonwealth Government considers that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system. For this reason the Commonwealth Government provides a 30 per cent subsidy to individuals who acquire private health insurance and has introduced additional arrangements to foster lifelong participation in private health insurance.

Private health insurance can cover private and public hospital charges (public hospitals charge only patients who elect to be private patients in order to be treated by the doctors of their choice), and a portion of medical fees for inpatient services. Private insurance can also cover allied health / paramedical services (such as physiotherapists' and podiatrists' services) and some aids and appliances (such as spectacles).

Non-government religious and charitable organisations play a significant role in health services, public health and health insurance.

Health status

The Australian population has a generally good health status, with life expectancy at birth at 75.2 years for boys born in 1994-96 and 81.0 years for girls born in that period. There are some groups with poor health status, notably Aboriginal and Torres Strait Islander peoples. Otherwise the pattern of disease is similar to that of other developed countries.

Health services delivery

As indicated above, a mix of public and private sector providers deliver health services. The quality of health provided is high in both sectors.

The majority of doctors are self-employed. A small proportion consists of salaried employees of Commonwealth, State or local governments. Salaried specialist doctors in public hospitals often have rights to treat some patients in these hospitals as private patients, charging fees to those patients and usually contributing some of their fee income to the hospital. Other doctors may contract with public hospitals to provide medical services. There are many independent pathology and diagnostic imaging services operated by doctors.

For some allied health / paramedical professions, there is a significant proportion self-employed. Others are mainly employed by State and local government health organisations.

Public hospitals include hospitals established by governments and in addition hospitals originally established by religious or charitable bodies but now directly funded by government. There is a small number of hospitals built and managed by private firms providing public hospital services under arrangements with State governments. Most acute care beds and emergency outpatient clinics are in public hospitals. Large urban public hospitals provide most of the more complex types of hospital care such as intensive care, major surgery, organ transplants, renal dialysis and specialist outpatient clinics.

Private hospitals are owned by for-profit or not-for-profit organisations such as large corporate operators, religious operators, and private health insurance funds. In the past private hospitals tended to provide less complex non-emergency care, such as simple elective surgery. However, some private hospitals are increasingly providing complex, high technology services.

Separate centres for same-day surgery and other non-inpatient operating room procedures are found mostly in the private sector. Many public hospitals provide such services on the same site as inpatient care.

Specialised mental health care in the public sector is provided in separate psychiatric hospitals, general hospitals, and community based settings. Historically, mental health services have operated separately to mainstream health services, but the Commonwealth, State and Territory Governments are currently working under the National Mental Health Strategy to mainstream mental health services. Other key reforms taking place under the Strategy focus on replacing separate psychiatric hospitals with community based and general hospital services, and integrating mental health care provided in different settings.

Australia's aged care system is structured around two main forms of care delivery, residential (accommodation and various levels of nursing and/or personal care) and community care (ranging from delivered meals, home help and transport to intensive coordinated care packages for people who otherwise would need residential care). Residential services are mainly in the non-government sector, about half being operated by religious and charitable organisations.

Both public and non-government (mostly religious and charitable) sector organisations provide community care services, under the Home and Community Care Program.

Medicines or pharmaceuticals prescribed by doctors and dispensed in the community by independent private sector pharmacies are directly subsidised by the Commonwealth Pharmaceutical Benefits Scheme (PBS) which is described below. Public hospitals provide medicines to inpatients free of charge and do not attract PBS subsidies. Non-prescription medicines are available from pharmacies and in some cases other suppliers such as supermarkets. The import and supply of medicines and medical devices is regulated by the Commonwealth Therapeutic Goods Administration (TGA) in order to ensure the quality, safety and effectiveness of the products.

There are some innovative solutions to health issues arising out of Australia's unique history and needs. Notable among these are:

- the Royal Flying Doctor Service which delivers care to remote areas by aircraft;
- the Aboriginal and Torres Strait Islander peoples community controlled health services which aim to meet the special needs of Indigenous Australians; and
- Regional Health Services. Through Regional Health Services, community identified priorities for health and aged care services in rural and remote areas are met through a flexible mix of Commonwealth and state funded services.

The Australian Red Cross operates Australia's blood donation system and coordinates matching of donors and recipients for organ transplants, receiving Commonwealth, State and Territory government funding for these activities.

The national health care funding system

The system in brief

The aim of the national health care funding system is to give universal access to health care while allowing choice for individuals through a substantial private sector involvement in delivery and financing.

The major part of the national health care system is called 'Medicare'. Medicare provides high quality health care which is both affordable and accessible to all Australians, often provided free of charge at the point of care. It is financed largely from general taxation revenue, which includes a Medicare levy based on a person's taxable income. Commonwealth funding for Medicare is mainly provided as:

- subsidies for prescribed medicines (with a safety net providing free medicines for the chronically ill) and free or subsidised treatment by practitioners such as doctors, participating optometrists or dentists (specified services only);
- substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals at no cost to patients; and
- specific purpose grants to State/Territory governments and other bodies.

In addition, Commonwealth general-purpose funding grants to State and Territory governments flow partly to health services. State and Territory governments supplement Medicare funding with their own revenues, mainly for funding public hospitals.

Some categories of Australians, such as members of the armed forces and veterans, are covered by additional special arrangements, while remaining eligible for mainstream Medicare coverage. Some injuries and illnesses are covered by other forms of financing: for example, compulsory workers' compensation insurance covers work-related injuries and illnesses, and injuries from motor vehicle accidents may be covered by compulsory third person motor vehicle insurance.

Residential aged care is financed by the Commonwealth Government by means of subsidies paid to service providers, based on the level and type of care needed by the individual. Residents may pay daily care fees and accommodation payments related to the level of care, with special provisions for residents who have difficulty paying these charges. The Commonwealth decides the allocation of new residential care places by an annual regional population based planning process, inviting providers to bid to provide the new places.

Community care services for the frail aged and the disabled are jointly funded by the Commonwealth, State and Territory Governments contributing according to a formula. For community care, clients pay different fees for services depending on the type of service and the client's capacity to pay. The Commonwealth funds intensive Community Care Packages of coordinated care to enable older people to continue living at home, who might otherwise require low-level residential services.

Eligibility for Medicare

Medicare covers people residing in Australia who are Australian citizens, New Zealand citizens or holders of permanent visas. Some visitors and temporary residents, from countries with which Australia has made reciprocal health care agreements, are eligible for Medicare with some restrictions as outlined in the section on travellers and health care below.

Hospital care under Medicare

All people eligible for Medicare are entitled to a choice of:

- free accommodation, and medical, nursing and other care as public patients in State/Territory-owned hospitals, designated non-government religious and charitable hospitals, or in private hospitals which have made arrangements with governments to care for public patients; or
- treatment as private patients in public or private hospitals, with some assistance from governments.

State and Territory governments are responsible, under agreements with the Commonwealth Government, for ensuring that services adequate to meet public patient entitlements are available to all people eligible for Medicare. This component of Medicare is funded jointly by the Commonwealth Government and State and Territory governments under the Australian Health Care Agreements.

On admission to public hospitals, patients may choose to be public (Medicare) patients, or private patients. If they choose to be public patients, they receive free medical and allied health / paramedical care from doctors nominated by the hospitals, as well as free accommodation, meals and other health services while in hospital.

Medicare-eligible patients who choose to be private patients in public hospitals are charged fees by doctors, and are charged by the hospital for hospital care, usually at a rate less than the full cost of providing these services. If the patient holds private insurance, this will usually cover all or nearly all of the charges by a public hospital. Medicare pays benefits subsidising part of the cost of doctors' fees (as outlined in the section on doctors' and optometrists' services under Medicare, below), and private insurance pays an additional amount towards doctors' fees. Private insurance benefits can also contribute to payment of the costs of allied health / paramedical and other costs (for example, surgically implanted prostheses) incurred as part of the hospital stay.

Patients may choose to be treated in a private hospital. Private patients in private hospitals are charged fees by doctors and some allied health / paramedical staff, and are billed by the hospital for accommodation, nursing care and other hospital services such as use of operating theatres. If the patient holds private insurance it will contribute to these costs. If the patient is eligible for Medicare as a permanent resident of Australia, the doctors' fees generally attract Medicare benefits.

Private doctors' and optometrists' services under Medicare

Costs incurred by patients receiving private doctors' services and some optometrical services and dental surgery, whether in or out of hospital, are generally reimbursed either fully or in part by means of Medicare benefits.

Private patients are free to choose or change their doctors whether in or out of hospital, (provided in the case of in-hospital care that the doctor has the right to practise in the relevant hospital).

Medicare benefits cover services by doctors, refraction testing by optometrists, and, in some circumstances, certain specialised dental surgery services.

Medicare benefits are payable for services by nearly all doctors currently registered in an Australian state or territory. Newly registered doctors are generally required to enter further training before their services can attract Medicare benefits, unless they have already qualified as general (primary) practitioners or as formally recognised specialist doctors.

Medicare benefits are not payable for medical services rendered outside of Australia.

The Commonwealth Government's Medicare Benefits Schedule lists a wide range of consultations, procedures and tests, and the Schedule fee applicable for each of these items. Proposed listings of new medical procedures and new technologies on the Schedule are assessed by the Medical Services Advisory Committee on the basis of evidence of safety, cost-effectiveness and of real benefit to patients.

Although Schedule fees are used to calculate Medicare benefits entitlements, doctors can charge whatever fee they wish, provided the service is not 'bulk-billed'. (See the section on billing arrangements below.)

The rate of benefit for out-of-hospital medical services, such as visits to a doctor in his/her rooms, is at least 85 per cent of the Medicare Benefits Schedule fee. For the more costly services, the benefit is raised to ensure that the difference between the benefit and the Schedule fee (the 'gap') is limited. (See the companion fact sheet of selected health care statistics, showing the maximum gap amount.)

Where a patient or family receives many services in a year, there is a safety net, which reduces their out of pocket cost. When one person's or a family's 'gap' payments exceed a certain threshold amount in a calendar year, all further benefits in that year are paid at up to 100 per cent of the Schedule fee. (See the companion fact sheet showing the threshold amount.)

For out-of-hospital services, private insurers are prohibited from insuring all or part of the cost of the difference between the Medicare benefit and the fee charged by the doctor. This provision aims to avoid incentives for unnecessary increases in fees.

Some kinds of services do not attract Medicare benefits, for example cosmetic services, services for which State or Territory governments have been provided with Commonwealth funding, and services covered by workers' compensation insurance.

The rate of Medicare benefit for medical treatment provided while a private patient is in hospital is 75 per cent of the Medicare Benefits Schedule fee. The safety net does not apply to Medicare benefits for in-hospital services. Registered private health insurers offer Medicare-eligible patients insurance for the difference between 75 per cent and 100 per cent of the Schedule fee, together with additional benefits for hospital accommodation and other hospital charges.

Private specialist doctors' services under Medicare

For some kinds of medical services, Medicare requires that the service be provided by a doctor who has been formally recognised as a specialist, and that another doctor has referred the patient to the specialist. If these requirements are not met, either no benefit is payable or the benefit is lower.

For most pathology and diagnostic imaging services, Medicare benefits are paid only when another doctor has referred the patient to the doctor providing the pathology or imaging service.

These requirements are in place in order to constrain costs by removing financial incentives to obtain unnecessary specialist services. As a consequence, most access to specialist medical services is on referral from general practitioners (primary / family doctors).

Billing arrangements for private medical services under Medicare

Patients may claim Medicare benefits in the following ways:

- pay the doctor's account and then claim the benefit from Medicare; or
- obtain from Medicare a cheque for the benefit, payable to the doctor, and then give the cheque, and any balance, to the doctor.

Claims may be made either by post or over the counter at Medicare offices or agencies.

Alternatively, doctors can send accounts directly to Medicare, accepting the Medicare rebate as full payment for the service. This arrangement is known as direct billing or 'bulk billing'. Since the doctor, or any other person, may not make any additional charge relating to a bulk-billed service, there is no out of pocket cost to the patient.

Unless a service is bulk billed, Commonwealth law does not restrict the level of the fee charged. Nevertheless, around 70 per cent of services for which Medicare benefits are paid are bulk billed, and about 80 per cent are billed at or below the Schedule fee.

Medicines/pharmaceuticals

The Pharmaceutical Benefits Scheme (PBS) aims to provide all Medicare-eligible persons with access to effective and necessary prescription medications at a reasonable cost to the patients and to the nation.

The PBS provides subsidies for about 600 kinds of drugs in nearly 1500 formulations which means that patients can obtain reasonably priced medicines for most medical conditions. Additional drugs are added when assessed as meeting safety, quality, effectiveness and cost-effectiveness criteria.

Pharmaceutical benefits are paid as cash transfers direct to around 4800 approved community pharmacies who dispense PBS medications on a claims reimbursement basis. The PBS also provides other forms of assistance to improve affordable access to medicines, for example specific funding for public hospitals for certain high cost drugs, such as immunosuppressants used in transplantation.

It is estimated that around 75 per cent of all prescriptions dispensed in Australia are subsidised under the PBS. The other major source of subsidised medicines is public hospitals, where medicines are provided free to in-patients. The total cost of PBS prescription drugs dispensed from community pharmacies each year is nearly $3.9 billion. The Commonwealth pays around 83% of this cost. The remainder is funded by patient co-payments.

Under the PBS all eligible persons fall into one of two categories, which determines the amount the patient contributes and the amount of subsidy paid:

- Concessional category — people who receive certain pensions, benefits or cards administered by the Departments of Family and Children's Services (FACS) or Veterans' Affairs (DVA), or who meet certain criteria for being declared to be disadvantaged; or
- General category.

General patients pay the cost of dispensed medicines up to a maximum amount per item (for the general patient co-payment see the companion fact sheet on selected health care statistics). Where the dispensed price of a drug is above that maximum, the general patient pays that amount and the PBS pays the balance up to the listed price. If the prescription involves a more costly but equivalent brand, the subsidy may be limited to the lower cost brand (the minimum pricing policy).

Concessional patients pay a smaller amount per item than general patients do, and the PBS pays the balance up to the listed price. This is also subject to the minimum pricing policy. Pharmacists must check patients' entitlement cards before providing medicines at the concessional rates. Concessional patient prescriptions comprise 80% of the total Government Expenditure on the PBS.

A safety net arrangement applies when the total amount of co-payments paid by a patient (or immediate family) in a calendar year reaches a certain threshold. (See the companion fact sheet showing the threshold amount.) From that time until the end of the calendar year, the co-payment reduces to a smaller amount, with the benefit paid to the pharmacist increasing. In the case of concessional patients the safety net threshold is lower; and when it is reached no co-payment is required for the rest of the calendar year.

Specific federal government grants for health care services

Under Medicare, the Commonwealth government provides a range of grants to government and non-government bodies in order to achieve specific health care objectives. These include:

- the provision of services to special needs groups such as people in rural and remote areas, Aboriginal and Torres Strait Islander peoples, and people with mental illness;
- funding of medical services that involve the use of expensive equipment, for example the capital component of radiotherapy services performed on specific approved equipment; and
- improving general medical practitioner and associated services.

The Medicare levy

When Medicare began in 1984, the Medicare levy was introduced as a supplement to other taxation revenue to enable the Commonwealth Government to meet the additional costs of providing the same level of care for the whole population, over the previous system which focussed on subsidies for health care to groups with low incomes. (See companion fact sheet showing the cost of Medicare.)

Medicare levy revenue provides the equivalent of only around 27 per cent of Commonwealth funding for Medicare. Medicare is funded by a range of taxes such as income tax, taxes on sales of goods and services, and non-tax revenue which together form consolidated revenue. Parliament appropriates funds for most government programs from consolidated revenue.

The Medicare levy is paid by individuals at a basic rate of 1.5 per cent of taxable income above certain income thresholds. Taxpayers on high incomes who do not have private health insurance pay an additional 1 per cent of taxable income as part of the levy.

Private Health Insurance

Private health insurance is an important component of funding of heath care in Australia, providing about 11 per cent of total national health care funding. For insured people it provides added benefits such as choice of doctor, choice of hospital and choice of timing of procedure. Private insurance can also assist with meeting the costs of private sector services which are not covered by Medicare, such as dental, optical, physiotherapy and podiatry services.

The Commonwealth regulates insurance offered by registered health insurance organisations to ensure that the principle of community rating is maintained. Community rating means that health funds must charge everyone the same premium regardless of the health status or claims history. This ensures that private health insurance is open to a wide range of people in the community and that the aged and chronically ill are not priced out of private health insurance.

In order to support community rating there is a system of 'reinsurance' in place which redistributes the costs of claims for the elderly and those in hospital for an extended period across all private health insurance funds. This ensures that health funds with a high proportion of these higher cost members are not disadvantaged.

There are over forty private health insurance funds registered by the Commonwealth. Most of these are open to everyone, but some only offer cover to restricted groups such as employees of a particular firm.

In order to ensure that there is a balance between the public and private health sectors in Australia the Commonwealth Government has introduced a number of measures to address the affordability, stability and attractiveness of private health insurance. These measures are designed to encourage people to take out private health insurance and decrease the pressure on the public system. For example, the Commonwealth Government introduced a 30% rebate on private health insurance in January 1999.

Another initiative introduced by the Government is Lifetime Health Cover. Lifetime Health Cover is a new system of private health insurance designed to encourage people to take out hospital cover early in life and maintain their cover.

People who join a health fund before they turn 31 years of age and who stay in private health insurance will pay a lower premium throughout their lives relative to people who delay joining, regardless of their health status. People over the age of 30 will face a 2 per cent increase in premiums over the base rate for every year they delay joining.

The benefit is that in the medium to longer term the rate of premium increases will be slowed by discouraging 'hit and run' behaviour (where someone joins a health fund just before requiring treatment and then leaves soon after) and by improving the overall health of the membership of private health insurance funds so that the rate of claiming is reduced.

Consultation and administration in the health care system

In the field of health, the peak consultative body between Commonwealth, State and Territory governments is the Australian Health Ministers' Conference (AHMC). The major health funding agreements are bilateral agreements between the Commonwealth and each State and Territory, with the broad parameters being agreed multilaterally by AHMC. Strategic public health and other partnerships are negotiated in similar ways. There are subordinate bodies in which officials represent Commonwealth, State and Territory health departments.

The National Health and Medical Research Council (NHMRC) is funded by the Commonwealth government but is independent. It advises governments, other organisations and health workers on a wide range of health matters, and allocates substantial medical research funds provided by the Commonwealth. The Council's membership includes representatives of the major stakeholders in the health system, appointed from the public and private sectors. In addition to its peak council, the NHMRC has several ongoing committees and ad hoc working groups. The main ongoing committees are the National Health Advisory Committee, the Australian Health Ethics Committee, the Research Committee which oversights most Commonwealth medical research funding, and the Strategic Research Development Committee.

The Commonwealth Department of Health and Aged Care advises the Commonwealth Minister for Health and Aged Care and the Minister for Aged Care. The Health Insurance Commission and its Medicare Offices administer enrolment in Medicare, claims for Medicare benefits, pharmaceutical benefits and a range of other Commonwealth programs.

The States and Territories have varying arrangements for advising their Ministers and for administering public hospital and other health care programs.

International travellers and health care

Travelling to Australia for health care

Because Australia has a high quality health care system, with low costs compared to some other developed countries, it is an excellent destination for patients seeking treatment which they cannot access in the country where they live. People wishing to visit Australia for this purpose should, before arriving, obtain the appropriate type of visa and make arrangements for treatment and payment.

Note that reciprocal health care agreements (described in the next section) do not cover treatment if the purpose of the visit to Australia is to have treatment.

Visitors to Australia covered by reciprocal health care agreements

Eight countries have reciprocal health care agreements with Australia. These are: Great Britain, Finland, Ireland, Italy, Malta, the Netherlands, New Zealand, and Sweden. Visitors (but not visitors studying in Australia) from these countries are eligible for Medicare assistance for immediately necessary medical treatment (but not for pre-arranged treatment). Under the agreements hospital treatment is provided only if the patient elects to be a public patient.

The terms of the various agreements differ. The major differences are that the agreements with Ireland and New Zealand cover only hospital treatment and pharmaceutical benefits, and the agreements with Italy and Malta cover only the first six months from the date of arrival in Australia.

Other visitors to Australia

Other visitors are not eligible for Medicare and should arrange for comprehensive health insurance to cover unexpected health care costs during their visit to Australia. The regulated private insurance used by people eligible for Medicare is inappropriate for this purpose since it does not usually adequately cover doctors' fees for in-hospital medical services. People coming to Australia for the purpose of having treatment should ensure that they are fully informed about the costs they will need to meet.

People coming to Australia for the purpose of study are required to purchase special low cost health insurance known as Overseas Student Health Cover.

Australians travelling overseas

Medicare covers only services rendered in Australia. Australians visiting countries with which Australia has reciprocal health care agreements are generally covered by the host country's public health care system while they are in the host country. Australians planning such visits should contact Medicare to check the details of what is covered by the agreement in each country before arriving there. Health care provided while in

transit to or from these countries is not covered by the agreements and nor is the cost of repatriation in cases of serious illness or death. In visits to other countries, the full costs of health care will be generally charged to the traveller and no assistance will be available from the Australian Government. All Australians travelling overseas are advised to purchase comprehensive health insurance, regardless whether or not they are travelling to countries with which Australia has a reciprocal health care agreement.

Sources of further information

Information on programs administered by the Commonwealth Department of Health and Aged Care can be obtained by telephoning freecall 1800 020 103, by viewing the Department's World Wide Web Site at http://www.health.gov.au (especially the occasional papers publications at http://www.health.gov.au/pubs/hfsocc/occpdf.htm), or by writing to the Public Affairs, Parliamentary and Access Branch of the Department at GPO Box 9848, Canberra ACT 2606, Australia. The Department's Medicare information line can be telephoned, from within Australia, on freecall 1800 020 613.

Statistical, health expenditure and other information on Australia's health and welfare systems is collected, analysed and published by the Australian Institute of Health and Welfare. Information on the Institute's activities and publications can be obtained by visiting the Institute's World Wide Web site at http://www.aihw.gov.au/, or by writing for a list of publications to:

Publications Officer
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Tel (02) 6244 1032
Fax (02) 6244 1044,

E-mail pubs@aihw.gov.au

People in Australia can obtain information about using Medicare by telephoning the Health Insurance Commission's Medicare Information Service on 132 011, or by writing to **Medicare, GPO Box 9822** in your capital city, or viewing the Health Insurance Commission's World Wide Web site at http://www.hic.gov.au. Information on the Pharmaceutical Benefits Scheme Safety Net is available at the same web site, or by calling freecall 1800 020 613.

Businesses and government organisations overseas who may be interested in making arrangements to purchase health services in Australia have a first point of contact in the Commonwealth Department of Health and Aged Care. The address is:

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