oriented, categorically denied that a parallel move to decentralise management is aimed at offloading costs.

The plan to shift the focus of health delivery onto community outpatient clinics, extended-care facilities, and home care, particularly for elderly or chronic patients, in a bid to reduce the number of acute-care beds from 3·2 to 2·7 for every 1000 residents, is projected to eliminate 2000 hospital beds. BC will create 20 regional boards to oversee roughly 100 community health councils set up to deliver health services. The boards will determine health priorities and make bottom-line decisions about the rationalisation of beds and services. They'll be allocated global budgets to spend as they see fit, provided they ensure that "a basic level of service is maintained", says Gary Curtis, of BC health department's policy, planning, and legislation division.

Although BC's move to develop a more integrated continuum of care—from home to hospital—is being hailed as a part of a favourable trend towards more "user-friendly" health care, there's little consensus as to whether nationwide decentralisation will yield new economies. There is so much experimentation with management models that it's impossible to predict what model provinces will adopt, says health-policy consultant Dr Michael Rachlis.

Cull told reporters that regional boards must provide and adequately fund "core services". At issue is the definition of core services. Curtis says that BC will develop standards to ensure that all basic medical services continue to be available. Discretionary areas are likely to include programmes related to aboriginal and multicultural health, suicide prevention, and treatment of alcohol and drug related disorders.

Despite BC's promises to keep tight reins on the system, critics says that decentralisation lays the groundwork for future Governments to pare the list of required core services. In that context, the proposals are being widely compared with the school system, whereby provinces provide core funding to cover a basic curriculum. But across Canada, as Governments struggle to constrain their budgets, transfer payments to school boards are being slashed, forcing the boards to raise municipal property taxes. Equally problematic are capital costs, particularly those related to construction of new extended-care facilities and "one-stop shopping" health centres (as BC promises). Cull has deflected some of the criticism by announcing that the province will invest $395 million in capital projects next year. But across the nation, capital financing constitutes a thornier issue since, for the most part, municipalities are responsible for capital investment. Many observers, such as Canadian Health Coalition executive-director Pam Fitzgerald, fear that chronic and elderly patients currently "warehoused" in acute-care beds will be discharged into communities that haven't the facilities to house them, as occurred with the 1970–80s experiment with community-based psychiatric care. Curtis says such concerns are overstated, particularly in BC, which has "one of the best long-term care systems in the world", but future changes in financing arrangements cannot be precluded.

In creating a regional health system, and joining Saskatchewan, Quebec, and New Brunswick as provinces that have recently moved towards some measure of decentralisation (an Ontario commission made similar recommendations but those have yet to be acted upon), BC says that it's merely trying to improve health-care "coordination." "Instead of having two or three hospitals in a region competing with one another over who should provide the services and who should get the equipment, they will actually have to work through a regional council that will determine how best to provide services to all the people of that region. And the community will have direct control through the community health councils", Cull said.

Wayne Kondro

Australia: Medicare agreement signed

After a year of tense and acrimonious negotiations, the agreement to cover payments to public hospitals for the next five years has finally been signed. The new Medicare agreement, which will come into effect on July 1, was completed less than 10 minutes before the Federal Government's ability to sign any document expired. The deadline arose because on Feb 7 the Prime Minister, Paul Keating, announced that a federal election would be held on March 13. At 6 pm on Feb 8 the Government switched into "caretaker" mode, unable to make financial commitments or change existing policy. At 5.50 pm that day, the state of Victoria signed the agreement, while the state of New South Wales signed up at 5.55 pm. The final agreement was reached so hurriedly that one government official was booked for speeding at 150 km/h rushing documents between cities. Other states had signed the agreement progressively over the previous six months.

As could be expected, every player in the game of politics is claiming victory. Keating immediately announced that it meant that Australia's two largest states, both with conservative Governments, wanted the protection of Labor's health policy. The NSW Health Minister, Ron Phillips, claimed that the extra $78 million that the state received by delaying its signature until the last minute was a victory, as did the Victorian Health Minister, Marie Tehan, who received an extra $50 million for her state. Both state ministers reaffirmed their support for the (conservative) Liberal Party's health policy, which included a promise to implement whatever agreement the Labor Government signed before the election.

The agreement does not change policy regarding public hospital admissions or procedures. They are still available free of charge to all who require admission, although long waiting lists for some elective procedures mean that their availability is effectively rationed. The agreement relates only to the amount of money contributed by the Federal Government to the costs of running them. The extra $1600 million promised by the Federal Government to be spent over the next five years will help public hospitals substantially. But it will not reverse the trend of declining federal expenditure on health—in the past eight years the Federal Government's share of health expenditure has dropped by 4%, leaving the State Governments and the private purse to pick up the difference.

Mark Ragg

Australia: Cost-shift games and confusion

Reports that accident and emergency (A&E) departments at some large hospitals are referring the less serious cases to local general practitioners have attracted much attention in New South Wales. Such referral is not only inconvenient for patients, but could also incur unnecessary costs for those who are re-directed to a GP who charges more than the Medicare rebate. Patients do not have to pay for public hospital A&E treatments. Federal Labor health minister Brian Howe has complained about what he sees as a