# COMMONWEALTH GRANTS COMMISSION

## DISCUSSION PAPER CGC 2002/30

# NON-INPATIENT AND COMMUNITY HEALTH SERVICES

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1. This paper provides an overview of the proposed Non-inpatient and Community Health Services assessment for the 2004 Review. It presents State views outlined in the 2004 Review submissions and staff responses to them.

## BACKGROUND

### *Scope of the Category*

2. In the 1999 Review, the Community Health category covered expenses on the administration, inspection, support and operation of community health services. More specifically, the category included expenses on:

(i) non-admitted patient services in acute care institutions, including accident, emergency and outreach services provided in hospitals and outpatient, well-baby and dental clinics;

(ii) domiciliary nursing services;

(iii) home nursing services not delivered as part of a welfare oriented program;

(iv) health services provided to a particular community group, such as Indigenous people;

(v) alcohol and drug rehabilitation programs not involving admission; and

(vi) other health services provided in a community setting.

### *Specific Purpose Payments*

3. Specific Purpose Payments (SPPs) from the Commonwealth that are relevant to this category are shown in Table 1. All the SPPs are treated by inclusion. At this stage, Commission staff intend to recommend that the current treatment of these SPPS be retained for the 2004 Review.

**Table 2** DISTRIBUTION OF NON-INPATIENT AND COMMUNITY HEALTH SPPS TO STATES, 2001-02

| | | NSW | Vic | Qld | WA | SA | Tas | ACT | NT |
|---|---|---|---|---|---|---|---|---|---|
| Aged Care Assessment | $m | 13.86 | 10.29 | 7.01 | 4.12 | 3.93 | 1.34 | 0.34 | 0.82 |
| | $pc | 2.13 | 2.14 | 1.95 | 2.17 | 2.62 | 2.85 | 1.09 | 4.17 |
| Grants for Aboriginal Purposes (Direct Grants) — Community Health Services | $m | 18.18 | 11.14 | 19.92 | 25.66 | 16.55 | 2.60 | 0.00 | 21.65 |
| | $pc | 2.80 | 2.32 | 5.54 | 13.52 | 11.03 | 5.53 | 0.00 | 110.21 |
| Home and Community Care — Community Health | $m | 27.05 | 39.19 | 32.65 | 7.98 | 12.32 | 4.55 | 0.77 | 0.18 |
| | $pc | 4.16 | 8.17 | 9.08 | 4.21 | 8.21 | 9.68 | 2.46 | 0.92 |
| Youth Health Services | $m | 0.72 | 0.55 | 0.38 | 0.19 | 0.18 | 0.05 | 0.00 | 0.00 |
| | $pc | 0.11 | 0.11 | 0.11 | 0.10 | 0.12 | 0.11 | 0.00 | 0.00 |

***Structure of the Assessment***

4. The 1999 Review assessment structure is shown in Table 2.

5. The standard expenditure in 2000-01 was $217.29 per capita. In the 2002 Update, this category redistributed $188.5 million, or $9.78 per capita.

6. The factors with the greatest impact on grant shares were the socio-demographic composition and the economic environment factors. These redistributed $85.9 million and $61.4 million respectively in the 2002 Update.

**Table 2** 1999 REVIEW ASSESSMENT STRUCTURE

| Expenditure component | Component weight | Factors | Basis of calculation |
|---|---|---|---|
| | % | | |
| Scale-affected expenditure | 0.64 | Input costs | General method with weights of 80 per cent for wages, 2 per cent for accommodation and 1 per cent for electricity. |
| | | Administrative scale | General method. |
| Emergency departments | 12.97 | Dispersion | General method non-inpatient weights. |
| | | Economic environment | Based on number of general practitioners in different regions. |
| | | Input costs | General method with weights of 80 per cent for wages, 2 per cent for accommodation and 1 per cent for electricity. |
| | | Socio-demographic composition | Covers age-sex, Indigeneity, English fluency and income. |
| Outpatients | 51.91 | Dispersion | General method non-inpatient weights. |
| | | Economic environment | Based on number of general practitioners in different regions. |
| | | Input costs | General method with weights of 80 per cent for wages, 2 per cent for accommodation and 1 per cent for electricity. |
| | | Socio-demographic composition | Covers age-sex, Indigeneity, English fluency and income. |
| Community health | 34.27 | Dispersion | General method non-inpatient weights. |
| | | Economic environment | Based on number of general practitioners in different regions. |
| | | Input costs | General method with weights of 80 per cent for wages, 2 per cent for accommodation and 1 per cent for electricity. |
| | | Socio-demographic composition | Covers age-sex, Indigeneity, English fluency, income and remoteness. |
| | | Cross-border | General method. |
| Isolation | 0.21 | Isolation | General method. |

## CATEGORY SCOPE AND STRUCTURE

7. *CGC Discussion Paper 2001/12, Scope and Structure of the Standard Budget* proposed:

(i) including the expenses on community mental health in this category, they were previously allocated to the Mental Health category; and

(ii) renaming the category from Community Health Services to Non-inpatient and Community Health Services.

8. A separate assessment of community mental health expenses is not proposed. Instead, they will be merged into the community health services component because:

(i) the disabilities assessed for the two components are very similar;

(ii) community mental health services are provided increasingly from community health centres;

(iii) the 1999 Review assessment had a small impact on relativities; and

(iv) it would reduce the problem of the lack of data on the use of services that cause difficulties in the assessment of this category. Commission staff are not aware of any recent and reliable national data on utilisation of community mental health services.

### *State Views*

9. Tasmania proposed that the outpatient and emergency department services components be combined, as there was no difference in the basis of calculation for the two components.

10. Western Australia submitted that highly complex and dissected expenditure assessments failed to take into account interactions and substitutability between different types of expenditures and the overall objectives of these expenditures. It suggested that the Commission consider merging all the Health categories and use more global measures of the impact of age, sex, Indigeneity and location of residence on service delivery costs.

### *Comments*

11. While outpatient, emergency and community health services are to some extent substitutable, they are not totally so. These services differ in nature and this is reflected in the information available on patterns of use and in the location of the services.

12. However, considering the lack of reliable nation wide data on the patterns of use of these three services by different population groups, the Western Australian and Tasmanian proposals have some merit.

13. In this Discussion Paper, Commission staff assume that the three-component structure will be retained because we believe that merging them is a second best option. However, below we discuss the difficulties associated with the lack of data on patterns of use of services. In the end it may be that, given the data difficulties, the merging of the three components and the use of broad assessment measures will be necessary.

14. We seek States' views on these issues.

## CATEGORY ASSESSMENT

15. The remainder of the paper presents and discusses State views on the current assessment. Options to take the issues forward are also presented.

16. The main issues raised by States in their submissions related to the socio-demographic composition and economic environment factors.

## SOCIO-DEMOGRAPHIC COMPOSITION

### *Age-Sex Disabilities - Emergency Department and Outpatient Services Components*

17. ***Background.*** During the 1999 Review, the main issue for the age-sex factor was the data source on which the age-sex weights were based. For emergency services, the Commission's options were data from the 1994-95 National Health Survey (NHS) and data from New South Wales' Emergency Department Information System (EDIS). The Commission opted for the NHS data as data from a single State may have reflected a use pattern which was not common to all States, or which may not have been policy neutral.

18. For outpatient services, NHS data were also used to derive age-sex weights. There were no alternative data available.

19. ***State views.*** New South Wales submitted that the NHS data had a number of shortcomings:

(i) the use data were based on the proportion of people using an emergency department in the two weeks prior to the survey, but the cost of running the emergency department depended on the range of services provided to each patient and the complexity of the interventions as well as the number of people visiting the emergency department;

(ii) the two week period was not long enough to fully pick up the frequency of demand;

(iii) the survey was subject to sampling error and recall bias; and

(iv) the survey had been conducted only every 5-6 years.

20. New South Wales' EDIS provided information on demand and cost patterns by age and sex groups. The EDIS captured data on all major emergency departments in New South Wales that operated with 24-hour medical and nursing coverage.

21. The cost weights used by New South Wales came from the 1998 Flinders Medical Centre study, *Costings in the Emergency Department*. The weights indicated that cases requiring more urgent treatment cost more. This was in line with findings from a number of costing studies which have found that, aside from age, there were other patient-related cost drivers such as urgency, disposition and complexity of condition.

22. Based on the cost weights from the Flinders Medical Centre study, New South Wales calculated age-sex weights using EDIS data for 2000-01, as shown in Table 3, and compared them with the use rates currently used in the assessment.

**Table 3** EMERGENCY DEPARTMENT AGE AND SEX WEIGHTS COMPARISON

| Age group | ED weights based on National Health Survey, 1994-95 | | ED weights based on NSW Health EDIS data, 2000-01 | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| 0-4 | 2.64 | 1.02 | 2.26 | 1.81 |
| 5-14 | 1.26 | 0.88 | 0.81 | 0.60 |
| 15-24 | 1.63 | 0.96 | 0.97 | 0.85 |
| 25-44 | 1.12 | 0.84 | 0.85 | 0.70 |
| 45-54 | 0.66 | 0.44 | 0.75 | 0.60 |
| 55-64 | 0.82 | 0.29 | 0.97 | 0.77 |
| 65-74 | 0.78 | 0.77 | 1.59 | 1.21 |
| 75+ | 1.32 | 0.77 | 2.78 | 2.34 |

Source: New South Wales' main submission to 2004 Review.

23. ***Comments.*** The prime reason for using NHS data in the 1999 Review was that it came from a nation wide survey, and there were doubts that the New South Wales data were representative of all States, especially States with a large proportion of population in remote areas. These issues still remain .

24. There is no doubt that the NHS data have the shortcomings identified by New South Wales. Data from the 2000-01 NHS will soon be available, but they will still have the same shortcomings.

25. We are aware that some emergency departments in other States also have emergency department information systems. We would like to know whether data from these systems would be available for use by the Commission.

26. ***Proposals.*** Commission staff would like to base the calculation of disabilities on data from more than one State. Therefore, we would appreciate it if other States could provide data similar to that provided by New South Wales.

27. If other States cannot provide similar data, we propose to use New South Wales' EDIS data in the calculation of age-sex disabilities if a majority of States agree that EDIS cost and use patterns, shown in Table 3, are representative of their own experience. We believe EDIS data may be preferable to NHS data because EDIS data have more integrity and reliability than the NHS, and capture unit cost influences as well as demand differences.

### *Age-Sex Disabilities - Community Health Services Component*

28. ***Background.*** During the 1999 Review, there were no nationally consistent data showing utilisation of community health centres. However, national Medicare data on utilisation of services were available. The data mainly included GP use, and also some primary care and other services, such as consultations by medical practitioners other than GPs. The Commission decided that the pattern of use of these services was a good proxy for use of the range of services provided by community health centres.

29. ***State views.*** South Australia provided a small amount of data on the use of community health services in metropolitan Adelaide.

30. Tasmania claimed that the current utilisation data did not reflect the demand for community health services. It believed that the services included in the factor calculation could be seen as an alternative to community health services. Therefore a high utilisation of community health services could result in a relatively low utilisation of services such as those provided by GPs. For example, the Home and Community Care (HACC) program targets the elderly. As a result of this program it would be expected that their demands for GP services would be lowered. Hence, Tasmania contended that the current method would understate the utilisation of community health care services by those targeted by these programs.

31. Tasmania argued that national utilisation data should be used. It suggested that the alternative was to continue to use Medicare data, but add utilisation data on alternative services such as HACC.

32. ***Comments.*** Commission staff are not aware of any nationally consistent community health utilisation data. The National Centre for Classification in Health and the Community Health Management Enterprise group are currently working on the Australian Classification for Community Health (ACCH). It is designed to provide a means of reporting and comparing client data about visits to community-based health facilities, which was previously unavailable. The primary objective is the development of a national set of reporting standards to provide the basis for the proper measurement of resource utilisation and requirements across Australia.

33. In response to Tasmania, it is not clear how the multitude of health services that are substitutes for community health services impact on the use of these services.

Neither is it clear whether or not one program would have a significantly greater impact on demand patterns than others. We do not believe that the type of adjustment suggested would enhance fiscal equalisation.

34. ***Proposals.*** Commission staff intend to recommend that the 1999 Review assessment method be retained unless States can provide age-sex use and cost data on community health services.

### *Income Disability*

35. ***Background.*** During the 1999 Review, the Commission applied use weights to people with low income to reflect their greater propensity to use emergency department services. Weights for people with low income were derived from 1994-95 NHS data, including the use of the Henderson scale to adjust income levels to reflect different family structures. After adjusting for age and sex (similar to the adjustment of the Indigeneity weights), the weight allocated to people with low incomes changed to 2.11 for emergency departments, 1.47 for outpatient services and 0.99 for community health services.

36. ***State views.*** Tasmania argued that socio-economic status had a direct impact on health status and the demand for services. It said that the income disability should be expanded to include other factors associated with low socio-economic status, such as unemployment. It acknowledged that its data in respect of utilisation of services were not sufficiently complete to reasonably estimate the weighting that should be applied. Instead, it suggested that national utilisation data may provide an indication by looking at utilisation rates by local government area (LGA) and comparing those to the index of socio-economic disadvantage for each LGA.

37. Tasmania claimed that the incapacity of people with low socio-economic status to meet the gap between the Medicare rebate and the doctor's fee resulted in people not using health services until a later stage in the illness process. This often meant more expensive and longer treatment, and resulted in greater likelihood of entry into the public hospital system.

38. The ACT expressed concern that the 1994-95 NHS results were becoming outdated and would be over 10 years old by the time the 2004 Review was completed. It was also concerned that the NHS overestimated the income weights applied by the Commission as the data were not robust, given that very minor changes in the 1994-95 results would lead to very large changes in the weights.

39. The ACT stated that the income measures incorporated in the socio-demographic factors overstated the potential savings on public resources from systems serving relatively higher income populations, particularly for emergency department services. It claimed that higher incomes are often associated with higher rates of participation in the workforce and more mature aged parenthood. Because the ACT has the highest proportion of mothers aged 35 years or older in Australia, the second highest rate of low birth weight babies, and the highest rate of low birth weight babies of Indigenous mothers, it believed it had to contend with higher risks of birth complications and higher levels of medical services.

40. For the reasons discussed above, the ACT requested that the income disability be removed from the socio-demographic composition factor. If the Commission were not disposed to removing the income weights, the ACT requested that the socio-demographic composition factor only be applied to that part of emergency department expenditures for which there were private sector alternatives, or that it be discounted by 50 per cent because of the concerns with data reliability.

41. The ACT contended that emergency department services in a major referral hospital must be continuously available and capable of responding to emergencies in a way not related to the income profile of the population served.

42. It also argued that, given the extent of the non-resident use of health services in the ACT, the income weights applied to the ACT were overestimated as they took no account of the lower socio-economic status of the surrounding region.

43. ***Comments.*** Data on use of emergency, outpatient and community health services by people of different socio-economic status are limited. We would welcome the suggestion of States on possible sources for data on use of services by people of different economic status. We do not believe that area-based data, such as the Socio-economic Index for Areas (SEIFA), are the answer as they would double-count age-sex measures currently used by the Commission. The NHS has employment and education status data, but the sample is too small to obtain statistically valid results.

44. Information available on the use of emergency services indicates greater use from people with low socio-economic status.

45. We would welcome any evidence from the ACT that shows, on average, higher demand and/or cost of providing outpatient, emergency and community health services for people with higher socio-economic status.

46. *Discussion Paper CGC 2002/45, Cross-border and Special Circumstances of the ACT*, will address the cross-border issue raised by the ACT.

47. ***Proposals.*** Commission staff intend to recommend that income continue to be used as the measure of socio-economic status. At this stage, staff are aware only of the NHS as a source of data, that is consistent with the current approach to needs assessment, on the use of health services by people of different socio-economic status. We intend to use the 2001 NHS data to update the use weights.

### *Indigeneity Disability*

48. ***Background.*** In the 1999 Review, weights for Indigenous people were derived from the 1998 AIHW report *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, which used 1995-96 data. This report showed that per capita spending on Indigenous people was 2.2 times greater than spending on non-Indigenous people for both outpatient and emergency services and 3.9 times the expenditure per non-Indigenous person for community health services. Grants from the Office of Aboriginal and Torres Strait Islander Health Services (which included the Primary Health

Care Access Program grants, as discussed further on in this paper) were included in the standard budget to reflect the full expenditure differential. This increased the weight for community health expenditure to 6.7.

49. The weights were also adjusted to remove the influence of differential age-sex and income structures of the different States' Indigenous population. The adjustment resulted in Indigenous weights of 1.62 for emergency departments, 2.41 for outpatient services and 8.97 for community health services.

50. ***State views.*** Victoria argued that there was no need to assess age-sex-income weights for all populations (Indigenous and non-Indigenous), since the weights for Indigenous people were implicit in the weighting of 2.2 derived from the AIHW report.

51. Victoria also argued that applying the use rates implied for all emergency department patients to the number of Indigenous patients to determine specific age use rates for the Indigenous population was flawed and had no grounding in available evidence on the use rates for Indigenous persons. It asserted that disaggregated data should be used to assess Indigenous use of emergency department services.

52. South Australia provided data showing the funding allocation provided to three health services operating in traditional lands, a rural area and metropolitan Adelaide. It noted that the figures were only estimates, but that they indicated a trend of significantly higher per capita funding of Indigenous health services for Indigenous populations in traditional settings as compared with non-traditional rural and urban settings. As such, South Australia requested that the weights given to non-traditional relative to traditional Indigenous persons, as well as non-traditional Indigenous relative to non-traditional non-Indigenous persons, be revised.

53. ***Comments.*** As claimed by Victoria, it is true that age-sex weights for Indigenous people are implicit in the weighting of 2.16 derived from the AIHW report. However, these age-sex weights are derived using national average age and sex population profiles and States have different age-sex profiles from the national average. These have a material impact on expenditure needs that should be reflected in the assessment.

54. National average use rates are used as a proxy for both Indigenous and non-Indigenous people because of the lack of information available on the actual use rates of the two population groups. If separate comparable data are available, we will use them.

55. Where appropriate, place of residence in remote or non-remote areas will be used to differentiate between traditional and non-traditional indigenous people. The 1999 Review assessment recognised a greater need for Indigenous people in remote areas.

***Proposals.*** The kind of disaggregated data mentioned by Victoria, showing utilisation of health services for Indigenous and non-Indigenous persons, are not available. Therefore, it is proposed that the current method for assessing Indigeneity weights be retained for the 2004 Review, using information from the latest edition of the *Expenditures on Health Services for Aboriginal and Torres Strait Islander People* report, which used 1998-99 data. Commission staff propose to continue the current adjustments aimed at removing the age-sex and income influences from the Indigenous weights.

*Remoteness Disability*

56. In the 1999 Review, the Commission used its judgement to apply a weight of 2 to people living in remote areas in the community health services component. Although the Commission had no access to data which directly showed relative demand levels of remote populations, it was evident from workplace discussions and State submissions that there were higher levels of need for community health services associated with these populations. No States specifically mentioned remoteness in their submissions. We propose therefore to continue to assess an additional weight for people in remote areas.

*Low English Fluency Disability*

57. ***Background.*** In the 1999 Review, the Commission applied a cost weight of 1.5 to the proportion of the population with low fluency in English. This was to take account of the extra costs associated with the use of interpreters and longer consultation times. No use weight was applied to people with low English fluency as some of the available data suggested that people from non-English speaking backgrounds (NESBs) used health services less than others.

58. ***State views.*** No States raised the issue of low English fluency assessment in their submissions. Victoria mentioned it in relation to community health services in its workplace discussion briefing papers. It provided data about clients of one community health centre, located in North Richmond, of which about 73 per cent of the client base were from an Non-English Speaking Background (NESB). The data indicated an increase in both consultation time and number of contacts by service users for NESB clients.

59. Victoria noted that cultural and linguistic diversity increases community health service delivery costs because of:

(i) longer consultation times;

(ii) higher number of appointments per client;

(iii) greater contact with families and groups;

(iv) late presentation and presentation of multiple complaints that often require multiple referral and complex follow-ups; and

(v) additional and specific service responses to new influxes of population groups in the region.

60. Victoria also provided data, shown in Table 4, which it said illustrated that it cost approximately two times more to provide services to a client with low English fluency using a bilingual worker, and eight times more when an accredited interpreter is present.

**Table 4** NURSE SERVICES COSTING COMPARISON, VICTORIAN COMMUNITY HEALTH SERVICES

| | Total cost | Additional cost | Ratio |
|---|---|---|---|
| | $ | $ | |
| English-speaking client (30 minute consultation) | 36.50 | 0.00 | 1.0 |
| Low English fluency client requiring bilingual worker (45 minute plus follow-up due to complexity; includes one outreach visit) | 82.24 | 45.70 | 2.3 |
| Low English fluency client requiring bilingual worker and interpreter (60 minute plus follow-up due to complexity; includes one outreach visit) | 279.00 | 196.70 | 7.6 |

Source: 2004 Review Victorian workplace discussion briefing papers.

61. ***Comments and proposals.*** Victoria has presented data indicating that the current cost weight of 1.5 should be increased. Subject to States providing more data, Commission staff are inclined to suggest a weighting of at least 2.0 for the additional costs associated with providing services to people from non-English speaking background. This would take into account costs associated with such things as outreach visits and increased case complexity, in addition to the costs associated with the need for interpreters and longer consultations.

62. We ask other States to provide data similar to that provided by Victoria. We would like the costs associated with such things as multilingual workers, interpreter services and outreach visits. We also ask for information about whether additional services such as follow ups and outreach visits are provided to people from non-English speaking background as standard policy.

### *Other Socio-demographic Composition Issues*

63. ***State views.*** New South Wales argued that the assessment should incorporate a component for the health related cost of illicit drug use, and recognise the size of the illegal drug user population in New South Wales relative to other States. It provided data about deaths from opioid overdoses and national methadone statistics that showed a greater impact of drugs in New South Wales, as shown in the tables below.

**Table 5** NUMBER OF OPIOID OVERDOSE DEATHS AGED 15-44 YEARS

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|---|---|---|---|---|---|---|---|---|---|
| 1996 | 244 | 142 | 27 | 30 | 61 | 5 | 2 | 15 | 526 |
| 1997 | 292 | 168 | 26 | 36 | 70 | 1 | 1 | 6 | 600 |
| 1998 | 358 | 210 | 38 | 45 | 59 | 7 | 10 | 10 | 737 |
| 1999 | 401 | 347 | 70 | 52 | 73 | 3 | 4 | 8 | 958 |
| 2000 | 249 | 263 | 113 | 40 | 43 | 5 | 2 | 10 | 725 |
| 5 years total | 1544 | 1130 | 274 | 203 | 306 | 21 | 19 | 49 | 3546 |
| Rate per million pop per year | 108.0 | 106.2 | 34.5 | 47.2 | 95.5 | 21.2 | 25.2 | 96.5 | 83.2 |
| Relative Rate | 1.30 | 1.28 | 0.41 | 0.57 | 1.15 | 0.25 | 0.30 | 1.16 | 1.00 |

Source: National Drug and Alcohol Research Centre.

**Table 6** NATIONAL METHADONE STATISTICS ANNUAL DATA, 30 JUNE 2001

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT(a) | Aust |
|---|---|---|---|---|---|---|---|---|---|
| Number of clients | 14 945 | 7467 | 3732 | 2307 | 2522 | 459 | 641 | 25 | 32 098 |
| Rate per 1000 pop | 2.3 | 1.6 | 1.1 | 1.2 | 1.7 | 1.0 | 2.1 | 0.1 | 1.7 |
| Relative Rate | 1.38 | 0.94 | 0.63 | 0.73 | 1.00 | 0.58 | 1.23 | 0.08 | 1.00 |

(a) Methadone is not a treatment choice for drug addiction in the NT.

Source: Commonwealth Department of Health and Aged Care, Illicit Drugs Section.

64. New South Wales also suggested that the Commission should extend its assessment of services to people with HIV/AIDS to include inpatient, outpatient and community based services. It argued that there has been a shift in the setting of care in recent years. New South Wales stated that its 2001-02 budget on HIV/AIDS was estimated to be $83.5 million. Table 7 shows the distribution HIV/AIDS expenditure between types of health services.

**Table 7** SHARE OF HIV/AIDS EXPENDITURE, NEW SOUTH WALES

| | 1997-98 | 2000-01 |
|---|---|---|
| | % | % |
| Inpatient | 30 | 15 |
| Non-inpatient and community health | 40 | 50 |
| Population and preventive health | 30 | 35 |

Source: New South Wales 2004 Review main submission.

65. Tasmania provided information about the increasing health service costs associated with diabetes, and statistics which indicated that it had the highest rates for

diabetes in Australia. It said that the prevalence of diabetes increased with increasing age and appeared to affect people of low socio-economic status more than the average. Given the large proportion of the Tasmanian population which was both aged and suffering socio-economic disadvantage, Tasmania contended that a diabetes disability should be assessed to recognise the high costs of containing this expensive chronic disease.

66. ***Comments.*** New South Wales and Tasmania have asked the Commission to consider the assessment of needs arising from causes of demand for health services (drugs, heart disease and diabetes). Before assessing the relative merits of the cases made, a number of questions need to be considered.

(i) Would fiscal equalisation be enhanced by focussing on particular causes of demand for service?

(ii) Are the particular causes of demand already accounted for by other disabilities? Would this overlap with other disability assessments?

67. It is possible that fiscal equalisation may not be enhanced by focusing on some causes of demand and not others. There is little doubt that other States could point to other causes of demand that affect them more than the national average, for example, skin cancer in Queensland.

68. To achieve fiscal equalisation, Commission staff believe all causes of demand that have a material and differential impact on State budgets should be assessed.

69. It is possible that some disabilities already recognised by the Commission explain the interstate differences in expenditure caused by some indicators of demand. For example, New South Wales' higher than average expenditure on drugs could be explained by different age-sex and income structures.

70. Commission staff are inclined to believe that there is good evidence that New South Wales has a material need to spend more per capita to provide the average level of service in relation to drugs and HIV/AIDS. We also believe that these needs are not fully captured by the current assessment. However, to decide the extent to which expenditure on HIV/AIDS differs between States, we require data. We ask other States to provide similar data to that provided by New South Wales about expenditure on the treatment of HIV/AIDS across different settings of care.

71. Tasmania has not provided clear evidence that it needs to spend more per capita in relation to diabetes. In addition, as noted by Tasmania, some of the risk factors associated with diabetes are age and socio-economic status, which are already accounted for in the assessments.

72. Commission staff ask for State views on this issue.

### *Short-term Visitors*

73. ***State views.*** New South Wales asked that short-term visitors from countries with a reciprocal health agreement with Australia be included in the estimated population in

the emergency department and outpatient services components, as they are entitled to receive hospital services free of charge while they are in Australia.

74. Australia has a range of reciprocal health care agreements (RHCAs) with other countries, under which their residents can be treated in Australian public hospitals as public patients. Reciprocal agreements currently exist with New Zealand, UK, Netherlands, Italy, Sweden, Malta, Finland and Ireland.

75. New South Wales contended that the RHCAs involve cost shifting to the States, since no extra funds have been provided for the increased usage of hospitals by eligible visitors. In New South Wales, there were 1976 separations of eligible visitors in 2000-01. The estimated cost of providing acute admitted services to those patients was $5.4 million. New South Wales did not mention the cost involved in providing non-admitted patient services.

76. ***Comments.*** Commission staff are inclined to accept New South Wales' argument. An adjustment to each State population could be made based on the net number of days spent in States by overseas visitors — that is, the number of overseas visitor days subtracted from the number of days Australians spent travelling overseas.

77. ***Proposals.*** Commission staff will explore how an adjustment to Census data for overseas visitors can be made, and whether it has a material impact on relativities.

### *Refugees*

78. ***State views.*** South Australia stated that the refugee detention centres in South Australia have caused an increase in the demand for many State Government services, including health. The Departments of Human Services and Education, Training and Employment estimated that this additional demand for their services is costing in the order of $6 million annually.

79. During the South Australia workplace discussion, South Australia said that the current level of compensation received from the Commonwealth Government did not cover all costs incurred. South Australia requested that this additional cost due to Commonwealth Government policy be accounted for in the assessment.

80. ***Comments***. It is not clear to Commission staff why this is not a Commonwealth expense and why South Australia is not fully compensated for its costs. It is also not clear why South Australia alone, of the States that have detention centres, is not fully compensated.

81. ***Proposals*.** Unless Commission staff can better understand why South Australia has this disability and can better evaluate its materiality, we intend to recommend that no assessment for the costs of refugees be developed for the 2004 Review.

## ECONOMIC ENVIRONMENT FACTOR

### *Background*

82. During the 1999 Review, an economic environment factor was developed. It was applied to the emergency departments, outpatients and community health components This factor was designed to account for the greater need for State funded services in regions which had less provision of private sector alternatives.

83. The factor was based on general practitioner (GP) numbers by region using the Remote, Rural, Metropolitan Area (RRMA) classification. The Commission believed that the factor based on GPs was justified because, even though GPs are not necessarily a direct substitute for the range of services provided by non-admitted and community health service providers, they are likely to be a good proxy for the level of private provision of these services. Further, good data on GP numbers were available, whereas this was not the case for other private service providers.

84. For the emergency department services component, the disability was discounted by 50 per cent in recognition of the fact that there are many serious emergency cases which need to be treated in public hospitals because there is no private sector alternative.

85. The factor was calculated as follows.

(i) A single average number of full time equivalent GPs per capita was calculated to cover capital cities, other metropolitan centres, large rural centres and small rural centres, all of which were considered able to sustain adequate levels of GP services.

(ii) The average number of full time equivalent GPs per capita was calculated separately for each of the 'other rural', 'remote' and 'other remote' regions. (The weights for each region derived at steps (i) and (ii) were calculated by dividing the national average per capita number of GPs by the per capita average for that region.)

(iii) These weights were applied to each State according to the number of people living in each region.

(iv) The ratio of the State weighted population to unweighted population was calculated for each State and Australia.

(v) The factors were calculated by dividing the State ratios by the Australian ratio.

*State Views*

86. Victoria suggested that an adjustment be made to the factor because GP numbers were likely to overestimate the number of other service providers. It expressed concern at the lack of evidence presented by the Commission that the number of GPs in a region was an accurate proxy for the provision of other health services and asserted that it probably overestimated them.

87. Victoria also said that the number of GPs was affected by policy decisions of States. Some States offer incentives for rural or remote GPs that may not be offered by other States. Victoria recommended that a proxy that was not policy contaminated be used to calculate the number of community health service providers or the assessment of a disability should be removed.

88. Western Australia noted that the data used in the assessment showed that, compared to the national average, it had one of the lowest per capita levels of GPs in both the metropolitan area and (on average) non-metropolitan areas. It also presented data indicating that it had a low supply of private specialists, which resulted in greater demand for public services such as specialist outpatient services. It claimed that a primary reason for the overall undersupply of GPs and specialists was the geography and population distribution of Western Australia. Perth was one of the most isolated cities in the world, and the remaining population was scattered across the State in numerous small towns and communities.

89. Western Australia submitted that the economic environment factor should be modified to reflect the fact that some States had a lower private provision of services in rural/remote regions than the national average. It also submitted that the factor should be modified because private provision of services was also lower in smaller population State capitals.

90. Western Australia also considered that this factor needed to recognise that the Australian Health Care Agreements lock States into service provision standards that differed in significant respects between States. The AHCAs include the condition that States provide free access to public hospital services, defined as '...services...that are currently provided or were so provided on 1 July 1998 by hospitals that are wholly or partly funded by a State...'. This definition, which was a Commonwealth requirement, has locked Western Australia into the ongoing provision of costly public hospital outpatient clinics that other States had been able to discontinue by the time the AHCAs commenced. This has been a significant issue for Western Australia in recent budgets. The cost of the Commonwealth's requirement for the State to maintain services that have, to a large degree, been closed down in Victoria (and to varying degrees in other States) could be in the order of $100 million annually.

91. Western Australia also noted that the current calculation, based on numbers of GPs, was only indicative. It did not reflect lower numbers of specialists or lack of after hours services. A better measure of the substitution impact would be differences in MBS expenditure as this quantified the services which would otherwise be met by the States.

92. Similar to Western Australia, Tasmania argued that it had a lower proportion of medical practitioners compared to other States, which increased the demand for public services.

93. Tasmania argued that a service provided by a private GP who did not bulk bill was not a substitute for the no-cost service provided by public outpatients and emergency departments. It argued that, to better reflect the disability, the factor should be based on the number of bulk billing GPs in each region. If these data were not available from the Health Insurance Commission, Tasmania suggested that an alternative would be to discount the number of GPs in each State by the proportion of non-referred attendances to GPs that were bulk billed. While this adjustment would tend to overstate the number of GPs that bulk billed, GPs that bulk bill were likely to have a higher throughput of patients.

94. The ACT claimed that the economic environment factor entailed potential for double counting. It asserted that one of the most significant influences on the demand for, and cost of, health services in other rural areas, remote centres and other remote areas, was the significant proportion of the population in those areas comprising Indigenous Australians. The impact of this was reflected in the socio-demographic composition factor. A double counting of the same influence therefore occurred in the economic environment factor.

95. The ACT expressed concern that the economic environment factor was revised by the Commission in the annual update process for changes in GP numbers but with unchanged Census population data. This had the effect of reducing the assessment of relative need in a manner that may be reversed or reduced once updated population data were available. It was also inconsistent with the proxy nature of the original measure adopted.

96. The ACT stated that direct measurement of the influence of lack of availability of private services in remote areas would be preferable. If direct measurement proved impossible, the region adjustment in the socio-demographic composition factor for the Inpatient Services category should be used as a proxy. The factor for Inpatient Services includes the effect of higher rates of hospital utilisation of people in remote regions as a consequence of the unavailability of primary care. As such, the ACT considered that some discounting of the factor would be required.

97. The Northern Territory contended that the current measure of the disability due to economic environment was insufficient and needed adjusting, partly because the factor only took account of the lack of access to GPs and not the additional costs to government of maintaining current GP numbers in rural and remote areas, through monetary and/or in-kind support.

98. The Northern Territory also argued that the factor failed to adequately measure the disability incurred by States due to a lack of access to specialists. Western Australia and the ACT raised the same argument.

99. The Northern Territory appreciated the rationale behind the Commission's decision to use GP data as a proxy for all medical practitioners, namely the lack of a reliable data source for other service providers. It agreed that there was no simple alternative source

of data that would incorporate all disabilities associated with a lack of access to the private sector, but said that some effort should be made to try and measure these disabilities. In the absence of better data, it recommended the continued use of GP data with an adjustment to account for the additional disabilities. Queensland also submitted a similar argument.

100. Western Australia, South Australia and the Northern Territory suggested that the Commission cease using the RRMA classification for the regional adjustment and instead use the Accessibility Remoteness Index of Australia (ARIA).

***Comments***

101. Using GP services as a proxy for all community health type services possibly overestimates the private provision of community health services in non-metropolitan areas. This would result in an underestimate of relative needs for non-metropolitan areas. Considering the lack of information available on the private provision of services other than GP in non-metropolitan areas, a conservative assessment is probably justified.

102. The effects of State specific policies are removed by the use of national average GP provision by region. The use of national averages for the provision and demand of services is the Commission's normal way of approaching the assessment of States' needs.

103. It is not clear to what extent the lower proportion of private GPs in Western Australia is the result of disabilities. It is also not clear how this would impact on the provision of public services in Perth.

104. The use of MBS payments to measure the level of private services is capturing more than one effect. The level of MBS payments will be affected by the socio-demographic composition of the population and could lead to double counting as this effect is already picked up in the socio-demographic composition factor.

105. The AHCA does not prescribe a particular level of service, nor what type of non-inpatient services should be provided. In addition, it is not clear that the current agreement is any different from the previous one in regard to the provision of non-inpatient services. Commission staff need to understand where the inflexibility Western Australia is describing comes from if this issue is to be pursued further.

106. While Tasmania's argument regarding the impact of bulk-billing is plausible, Tasmania has not provided evidence that this has a material impact on the level of public sector services. At present, Commission staff are not inclined to pursue this issue further. However, we would welcome further evidence from Tasmania.

107. Commission staff cannot see how the ACT's argument concerning Indigeneity relates to the economic environment factor, when the factor only measures the lack of availability of private health services. We do not believe that this argument would warrant a change to the present economic environment assessment.

108. Commission staff believe there is some merit in the Northern Territory's argument about monetary and in-kind support for maintaining current GP numbers. If this is a common State policy, we will further investigate this issue. However, we believe this is

an issue which relates more to dispersion because that assessment includes an adjustment for locality allowances. Further discussion of this issue is in the section covering dispersion.

109. We agree with the ACT's contention that updating the number of GPs when we do not update the Census population on an annual basis may influence the assessment of relative need. It may be better not to update the assessment at all because the measure of needs (GPs) is a proxy for services available. We suspect that updating the assessment results in spurious precision in any case. In addition, it is likely that an adjustment for the cost of maintaining GP numbers in remote areas will be included in the dispersion assessment. As the dispersion factor is not updated annually, we believe updating the economic environment factor annually would be inconsistent.

110. We are inclined to agree that the number of specialists in different regions of States should be included in the economic environment assessment. At present, the most recent specialist data we have is for 1998-99, as shown in Table 8. Table 9 shows the resulting factor when the total number of specialists and GPs is used with the 1999 Review method.

**Table 8** NUMBER OF SPECIALISTS BY RRMA, 1998-99

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|---|---|---|---|---|---|---|---|---|---|
| Capital city | 4474 | 3898 | 1609 | 1334 | 1446 | 226 | 296 | 87 | 13370 |
| Other metro centre | 594 | 171 | 363 | 0 | 0 | 0 | 0 | 0 | 1128 |
| Large rural centre | 376 | 240 | 466 | 0 | 7 | 79 | 0 | 0 | 1168 |
| Small rural centre | 201 | 181 | 61 | 65 | 22 | 25 | 0 | 0 | 555 |
| Other rural | 102 | 49 | 16 | 15 | 10 | 10 | 0 | 0 | 202 |
| Remote | 1 | 0 | 13 | 26 | 0 | 0 | 0 | 27 | 67 |
| Total | 5748 | 4539 | 2528 | 1440 | 1485 | 340 | 296 | 114 | 16490 |

Source: Australian Institute of Health and Welfare, *Medical Labour Force 1998*

**Table 9** ECONOMIC ENVIRONMENT FACTORS

| | NSW | Vic | Qld | WA | SA | Tas | ACT | NT |
|---|---|---|---|---|---|---|---|---|
| Specialists and GPs (proposed factor) | 0.91795 | 0.98056 | 1.08975 | 1.06623 | 1.03075 | 1.15996 | 0.74297 | 1.74874 |
| GPs only (current factor) | 0.96992 | 0.98514 | 1.03439 | 1.03762 | 1.00800 | 1.04134 | 0.91017 | 1.37597 |

111. The Northern Territory's alternative proposal for calculating the economic environment factor involved using Medicare and PBS expenditure per person to determine the availability and use of GP services for people living in remote areas compared to those living in urban areas. This proposal implies that States' response to the lower use of GPs in

non-metropolitan areas is to provide more public services, in order to try to increase the use rate to that of metropolitan areas. In other words, States should be compensated not only for lower numbers of private services, but also for lower use of private services in non-metropolitan compared to metropolitan areas.

112. We have two concerns with this proposal.

(i) The level of demand for services may have little to do with its supply. Even with the same proportion of GPs in non-metropolitan and metropolitan areas, it is likely that demand for services will remain different in the two areas. For example, in remote areas, people would travel greater distances to reach a GP than in metropolitan areas.

(ii) It could be argued that levels of GP attendance in remote areas are reasonable and levels seen in metropolitan areas represent overservicing. If this is so, there is no need for additional public sector services.

113. For the reasons discussed above, Commission staff do not intend to recommend that this proposal be pursued further.

114. In response to comments about regional classification systems, the ARIA+ classification will replace the RRMA classification. A discussion of this, and of State's arguments raised in relation to it, can be found in *Discussion Paper CGC 2002/22, Dispersion*.

***Proposals***

115. Commission staff intend to recommend that the current approach to the factor calculation be retained, but that:

(i) the number of specialists per region be added to the number of GPs;

(ii) the ARIA+ classification be used; and

(iii) the factor not be updated between reviews.

116. We ask States for information on whether they provide any form of financial assistance to private GPs in rural and remote areas.

## SERVICE DELIVERY SCALE

### *Background*

117. No assessment of service delivery scale disability was made in the 1999 Review. The Commission believed that enough flexibility existed in the delivery of community health services to minimise the effects of service delivery scale.

### *State Views*

118. Tasmania stated that a major cost driver in delivering services to people in their own home is the time taken to travel to clients. It contended that, while these travel costs could be reduced by basing service delivery units in smaller rural communities, higher administrative and service delivery scale costs were incurred as a result. Establishing smaller facilities across the State meant the advantages of having a service area with a population which provided an optimal client base were foregone. For safety and efficiency reasons, more qualified staff needed to be employed — they must be able to operate with minimal supervision in very small or sole practice service outlets. Adding to diseconomies of scale was the need to fully equip small facilities despite the low volume of clients using the facility.

119. Tasmania asserted that its small and dispersed population attracted relatively few private health facilities that were open for extended hours or bulk billed services to Medicare. This was due to the limited opportunities to provide a centralised facility with a throughput large enough to spread fixed costs economically.

### *Comments*

120. At present, Commission staff are not convinced that service delivery scale disabilities are significant for the provision of community health services in small delivery units. We still believe that the flexibility in the way services can be organised and delivered for States minimises the service delivery scale effects.

121. No cost data were provided to support the arguments that service delivery scale disabilities exist. We would like States to provide any cost data that are available.

### *Proposals*

122. Commission staff intend to recommend that a service delivery scale factor not be assessed, unless States can provide cost data for community health or emergency department services which demonstrate the existence of service delivery scale disabilities.

# DISPERSION

### *Background*

123. The dispersion factor takes into account the additional costs associated with the provision of services to dispersed populations. The dispersion factor thus reflects the combined differences in State expenditure relating to telecommunication, freight, travel and other costs of providing services to dispersed localities.

### *State Views*

124. Both New South Wales and Victoria claimed that there were savings achievable through the use of telehealth for health administration, education and service delivery. They provided some information in support of their claims. Consequently, they requested that the Commission review the cost weights assigned to the dispersion factor.

125. Tasmania argued that the time spent travelling to home residences represented a major part of the costs of delivering community health services. It asserted that dispersion needed to be measured in terms of travel times rather than distance.

126. Tasmania also expressed concern that the current methods did not take into account the higher salary costs States incurred to ensure that services were provided in rural and remote areas. For example, Tasmania has strategies to attract GPs and Visiting Medical Officers to rural and remote areas.

127. Western Australia and the Northern Territory argued that the use of technology supplemented current service delivery but did not replace it. As such, they argued that the use of technology improved the quality and coverage of health services but did not reduce the cost.

### *Comments*

128. As in the 1999 Review, Commission staff will collect data on the costs of telecommunication, travel between regions of States, freight and locality allowances. The impact of tele-health and other technologies on State budgets should be reflected in the data to be collected.

129. Tasmania and the Northern Territory, in the context of the economic environment factor, said that they provide financial assistance to attract and retain private medical practitioners in rural and remote areas. If this is a common policy of the States, Commission staff would be inclined to support an adjustment being included in the dispersion assessment. We would appreciate receiving information from States on their programs regarding assistance provided to attract and retain medical service providers.

130. We are aware that, in some States, subsidies for retention of medical practitioners are funded by local councils. Commission staff will investigate this issue further to determine if it should be taken into account in the assessment.

131. General issues relating to dispersion are discussed in *Discussion Paper CGC 2002/22, Dispersion*.

## ADMINISTRATIVE SCALE

### *Background*

132. The administrative scale factor accounted for differences in per capita costs of providing central office functions and whole of State services. They included:

(i) the fixed costs of providing corporate services and policy and planning, or whole of State services; and

(ii) variable expenditure on corporate services and policy and planning in excess of the fixed costs but which were still affected by some diseconomies of small scale (scale-affected variable costs).

133. Fixed cost disabilities were applied to the first type of expenditure and variable cost disabilities to the second type.

### *State Views*

134. Tasmania supported the retention of this assessment, but believed that the proportion of expenditure affected was understated.

135. The ACT requested that the Commission take account of wider fixed costs than central administration in estimating the proportion of scale-affected expenditure. It claimed that, particularly in relation to community mental health services, scale-affected expenditure extended beyond expenditures on central administration and included community education and preventive work which had whole of jurisdiction benefits. Similarly, there were fixed costs relating to teaching and training responsibilities of major emergency departments and outpatient clinics.

136. The ACT also requested that a cost factor be incorporated in the assessment for States that must provide a disproportionate share of non-admitted patient services in conjunction with teaching hospitals due to their small population size or degree of urbanisation.

*Comments*

137. The concept of fixed minimum costs is presently a tightly defined one and applies only to a limited range of 'head office' rather than service delivery activities. Commission staff are reluctant to recommend that the Commission expand the notion of fixed costs beyond this.

*Proposals*

138. Commission staff intend to recommend that the administrative scale assessment be continued. The review of minimum fixed cost for health services will be conducted as part of the general review of the administrative scale assessment.

139. General issues relating to administrative scale are discussed in *Discussion Paper CGC 2002/23, Administrative Scale*.

## INPUT COSTS

140. No issues were raised specifically relating to non-inpatient services. Commission staff intend to recommend that the input costs factor be retained for the 2004 Review, assessed using the general method.

## ISOLATION

141. No issues were raised specifically relating to non-inpatient services. Commission staff intend to recommend that the isolation assessment be retained for the 2004 Review.

## CROSS-BORDER

*Background*

142. ***Emergency department and outpatient services components.*** The Commission did not assess a cross-border factor for emergency and outpatient services during the 1999 Review because of the operation of the Australian Health Care Agreement (AHCA).

143. Clause 62 of the AHCA between the Commonwealth and the ACT allows the ACT to enter into a bilateral arrangement with another State to adjust for costs of non-admitted services (emergency services, outpatient services and other non-admitted patient

services). Since 1997-98, an arrangement has been in place for annual payments from New South Wales to the ACT to include $0.66 million for net cross-border emergency department services and $1.43 million for net outpatient services, based on survey and other estimates of cross-border presentations at emergency departments and outpatient facilities.

144. ***Community health services component.*** In the 1999 Review, the Commission assessed a cross-border factor for this component to recognise that community health centres provide services to residents within easy travelling distance of the ACT.

### *State Views*

145. New South Wales contended that there appeared to be little evidence that the ACT provided community based services to New South Wales residents to the same extent as it provided acute inpatient care. It asserted that acute hospital admission data used by the Commission overstated the cross-border adjustment for the community health services component and that, until there was firm evidence of flows, the Commission should assume that a flow adjustment for community health was not warranted.

146. The ACT submitted that under the present payment arrangements for cross-border use of emergency and outpatient services, there was only a tenuous link between levels of payment between jurisdictions and the levels of service provided, as the payment had not been adjusted for indexation or growth.

147. Because of this, the ACT asked that the Commission assess a cross-border factor for the emergency department and outpatient services components, reflecting:

(i) the underlying principles of the AHCA that a State cannot discriminate in the provision of services on the basis of residential status;

(ii) the asymmetrical pattern of cross-border patient flows arising from the regional role of the ACT;

(iii) the unique significance of cross-border patient flows from New South Wales to the ACT in relation to non-admitted patient services; and

(iv) the link between cross-border flows for non-admitted patient services and tertiary referral hospital services, including major trauma and emergency department services.

148. The ACT also asserted that an assessment of cross-border demand should take account of the wider scope of demand for ACT trauma and emergency services as a consequence of improvements in transport and accessibility.

149. The ACT requested that, in addition to the current cross-border factor for the community health services component, a factor be introduced to recognise the non-resident use of the ACT's Queen Elizabeth II Family Centre (QEII), as it had approximately 50 per cent cross-border use, as shown in Table 10. The ACT said this use was not reflected in the current cross-border assessment.

**Table 10** CROSS-BORDER CLIENTS OF THE QE II FACILITY, 2000-01

| | ACT | Non-ACT | Total |
|---|---|---|---|
| No of clients | 808 | 788 | 1596 |
| Recurrent costs | $707 000 | $689 500 | $1 369 500 |

Source: ACT Department of Health and Community Care, 2002.

150. The QEII facility costs the ACT, on average, $875 per client. In 2000-01, non-resident use of this facility cost the ACT approximately $690 000.

151. The ACT also requested that the cross-border factors be weighted to reflect the different age-sex and socio-economic composition of the population used in the assessment.

### *Comments*

152. Commission staff believe that clear mechanisms exist for the reimbursement of the costs of cross-border patients, including the availability of an independent arbiter. We consider that, under the AHCA umbrella, the ACT and New South Wales are in a better position to reach a satisfactory outcome than the Commission. Therefore, it is not clear that the provisions with ACHA should be bypassed in favour of an assessment by the Commission.

153. The ACT argued that the current cross-border assessment does not correctly capture the use of the QEII facilities. This may be the case but the assessment never intended to capture the actual use of QEII facilities. Instead it aimed to capture the average use of community health services. This implies that some services may be used more or less than the average recognised in the assessment, but that in total, cross-border service use would be near the average recognised in the current assessment.

### *Proposals*

154. Commission staff intend to recommend that no cross-border factor be assessed for the emergency department and outpatient services components.

155. We intend to recommend that the cross-border factor for the community health services component be retained, unless the ACT and/or New South Wales provide data relating to services other than those provided by the QEII centre, that indicates that the current cross-border assessment for the community health services component is inadequate.

156. The ACT's arguments about the impact on costs of improved transport links increasing the regional population and the different socio-demographic characteristics of populations in the surrounding regions will be covered in *Discussion Paper CGC 2002/46, Cross-border and Special Circumstances of the ACT*.

## OTHER ISSUES

### *Primary Health Care Access Program*

157. ***Background.*** The Commonwealth, through its Office of Aboriginal and Torres Strait Islander Health, makes a number of payments to States and other bodies for primary health care for Indigenous people. The 1998-99 Commonwealth budget introduced the Primary Health Care Access Program (PHCAP) to improve the access of Indigenous people to primary health care services. The payments were made to compensate Indigenous people for their limited access to MBS funds. The amounts paid were based on the funds provided to non-indigenous people through MBS, adjusted for the greater health needs of Indigenous people and the higher costs of providing health services in remote areas. In the 1999 Review, the Commission decided to treat the PHCAP payment by inclusion because:

(i) Indigenous health is an area of State responsibility and the States incur expenditures on the provision of services;

(ii) the Commission was directly assessing the differential use and cost of services by remote Indigenous persons; and

(iii) the interstate distribution of the Commonwealth payments under PHCAP was not needs based and largely reflected the location of organisations that sought to be involved in the program.

158. In *Discussion Paper CGC 2002/11, Proposals for the Treatment of New Developments in State Finances, and Data Changes Relevant to the 2002 Update of Relativities*, the Commission confirmed the decision it made in relation to PHCAP during the 1999 Review.

159. ***State views.*** The Commission's treatment of the PHCAP payments has been an issue of contention since the 1999 Review. The Northern Territory again submitted that the Commission should reconsider its treatment of PHCAP.

160. The Northern Territory argued that PHCAP funding represented a Commonwealth payment in lieu of MBS. MBS payments are currently treated by exclusion. It also pointed out the similarity of PHCAP funding to Health Care Grants (HCGs), which are also currently treated by exclusion. Although it argued that PHCAP should be treated the same as Medicare and HCGs, it did not necessarily argue for the treatment of these payments by exclusion. The argument was raised in previous reviews that MBS payments should actually be treated by inclusion and the Northern Territory submitted that this argument had merit.

161. The Northern Territory argued that the way in which PHCAP funding is perceived by the Commonwealth indicated that the funds related to a Commonwealth responsibility. The Commonwealth, in its Budget Papers, said the funding was conditional on States providing resources to meet their existing funding obligations in this area. Therefore, the Northern Territory believed that it was not a substitute for State funding and did not meet State government needs.

162. The Northern Territory said that the introduction of PHCAP funding showed that the Commonwealth recognised greater disabilities than the Commission currently assesses. It said that PHCAP was designed to provide Commonwealth funding in place of MBS to a level of two times the MBS average per capita expenditure, and eventually up to four times. These projected funding levels indicated that people not currently receiving their fair share of funding through Medicare (that is, the remote and Indigenous populations) required much greater than the average level of Medicare funding. This was in addition to the Northern Territory maintaining its current high levels of funding for primary health care services.

163. The Northern Territory argued that the current socio-demographic composition and economic environment factors pick up some, but not all, of the disabilities implicit in the PHCAP funding levels of two and four times Medicare. It reiterated that the economic environment factor assessment method should ensure that all disabilities were measured.

164. ***Comments.*** The Commission believed that this was an issue that needed to be revisited, as there are compelling arguments on both sides. Commission staff would like comments from other States in relation to this issue.

### *Component Weights*

165. New South Wales contended that the current weight for the emergency department services component was too low and should be revised. In the 1999 Review assessment, emergency department expenditure was estimated to be 25 per cent of the expenditure on outpatients services. New South Wales noted that, in 2000-01, expenditure on emergency department services in New South Wales was $241.1 million, which was 38.6 per cent of outpatients expenditure in the same year.

166. Commission staff will review the expenditure component weights using ABS GFS data and State budget information.

## PROPOSED ASSESSMENT STRUCTURE

167. The 2004 Review proposed assessment structure is the same as that used in the 1999 Review. All of the proposed changes concern how factors are calculated.

## REQUEST FOR INFORMATION

168. ***Socio-demographic composition.*** We request information on the availability of data showing utilisation of:

(i) emergency departments;

(ii) outpatient services; and

(iii) community health services.

More specifically, data would be most useful if it showed utilisation in terms of client demographics, such as:

(i) age;

(ii) gender;

(iii) socio-economic status;

(iv) Indigeneity

(v) English fluency; and

(vi) location.

169. We request cost data on the treatment of HIV/AIDS in non-inpatient settings — that is, emergency departments, outpatient services and community health services. Data should not include costs associated with public health programs.

170. We request data about the costs associated with providing services to people from non-English speaking background, such as interpreter services, follow ups and outreach visits. Information about rates of pay would be appreciated.

171. We request information about the provision of community health services to people from non-English speaking background. For example, are additional services such as outreach services provided more to those from culturally diverse backgrounds?

172. ***Dispersion.*** In *Discussion Paper CGC 2002/22, Dispersion*, we have requested information about whether States provide assistance to medical providers in rural or remote areas, to encourage them to locate and stay there. Any relevant cost data would be appreciated.