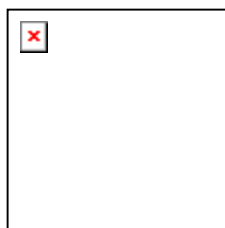




AUSTRALIAN CAPITAL TERRITORY

SUBMISSION TO THE COMMONWEALTH GRANTS COMMISSION'S STAFF DISCUSSION PAPER 2008/02-S: ASSESSING COMMUNITY AND OTHER HEALTH SERVICES FOR THE 2010 REVIEW

JUNE 2008



VIEWS ON THE COMMISSION'S ASSESSMENT PROPOSALS

INTRODUCTION

The ACT supports the latest technical changes to the proposed subtraction model and considers that the most recent iteration places the methods on a more robust footing.

The subtraction model is generally supported as it captures the main drivers of community and other health services – including the interaction and impact of expenses met by the Australian government, State government expenses and non-government sector funding. Of particular importance to the ACT is the fact that the economic environment disability captures the impact of the shortage in the supply of General Practitioners (GPs) in the ACT relative to Australia (via the use of MBS payments).

The ACT supports the view that the subtraction model has a number of advantages over the traditional factor approach, particularly when a reliable administrative dataset is unavailable to measure socio-demographic composition influences across the Australian, State and non-government sectors.

However, the model in regard to the split of expense data for private ancillary payments between NSW and the ACT is of immense concern given that the current split significantly overestimates the ACT's non-government funding (item C of the model), and has a material impact on the assessed category factor. Until these data issues are adequately resolved, the statement made in paragraph 8 of the Discussion Paper that: “...*staff consider that the subtraction model is sound and built on quality data*” cannot be supported. This matter is discussed in more detail in this submission.

It is noted that a number of common factor disabilities, and in particular, cross-border impacts are material to the ACT for community and other health services, and these impacts are still to be captured in the assessment at a later date.

In the context of simplicity and issues regarding double-counting, the ACT does not support the introduction of additional low socio-economic status (SES) and location based adjustments. A range of evidence is available to suggest that high SES groups use a range of health services at higher (or similar) rates as low SES groups.

DEVELOPMENTS IN ASSESSING NON-STATE SERVICE PROVISION

The ACT is generally supportive of the Commission's proposed changes to the method of assessing non-State sector funded expenses originally described in Discussion Paper 2007/32.

Excluding the expenses on aids and appliances has led to a more robust assessment as it has reduced unallocated expenses and their impact.

Proxy for non-government expenses

The ACT is supportive of the changes made to the private health fund ancillary benefit payments (PHF payments). In particular, the following is supported:

- the move to exclude medical services, aid and appliance expenses which addresses issues of whether PHF payments are sufficiently representative of non-government expenses; and

- the use of weighted recipient numbers which addresses issues of differences in private providers' pricing across the States.

From this perspective, the latest reiteration represents a significant improvement over the earlier proposal.

Despite this, the ACT has an outstanding concern in relation to the Commission's proposed method of separating the ACT and NSW private health insurance ancillary benefits data. At present, the data are separated according to the numbers of contributors in the two jurisdictions. As a result, 94.62 per cent of benefit recipients were assigned to NSW whilst the remaining 5.38 per cent were assigned to the ACT.

This methodology is broadly based on two assumptions:

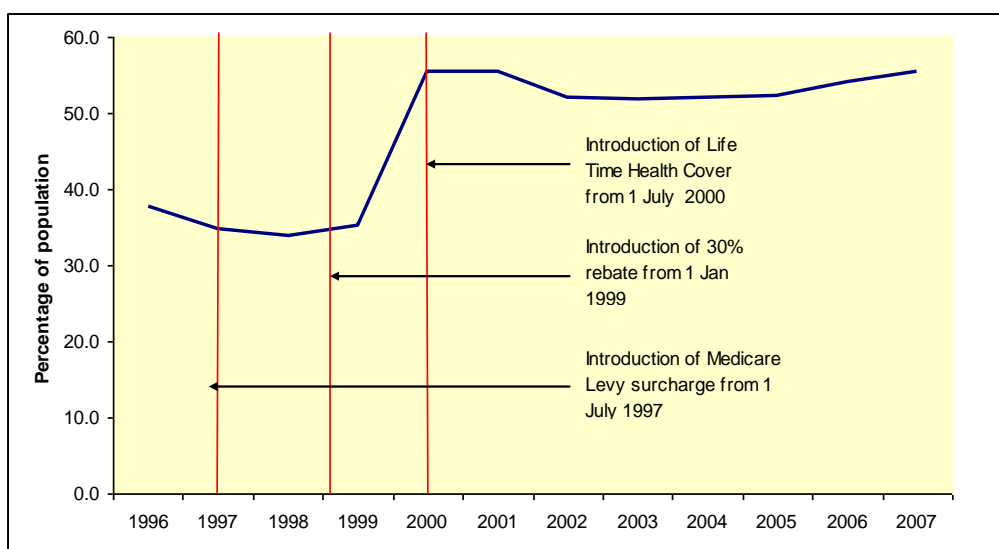
- all persons covered by private health insurance have policies that cover ancillary health services; and
- use rates of private health services across jurisdictions (NSW and ACT) are the same.

As a result, the methodology takes no account of actual use rates, which drive the level of non-government health expenses.

With regards to the first assumption, many ACT residents have only purchased basic hospital cover in order to receive taxation benefits. As demonstrated in the following graph, the introduction of the 30% rebate in January 1999 resulted in an increase in the number of ACT residents with private health insurance to over 50%, from around 35%.

Many basic hospital cover contributors in the ACT are not eligible for rebates on most ancillary health services. For example, to be eligible to receive rebates on dental costs, a level of insurance cover well in excess of basic hospital cover is required.

PRIVATE HEALTH INSURANCE COVERAGE IN THE ACT, 1996 TO 2007



Source: ACT Health.

In addition, it should be noted that even within hospital insurance, there are varying levels of cover, depending on the policy cost. Different policies also have varying levels of excess

payments for health services. This partially explains why ACT residents with private health insurance are more inclined to be treated as public patients in Canberra's public hospitals.

In past submissions and at the recent State Visit held 10-12 June 2008, the ACT has proposed several robust methods to separate the pooled data.

The most appropriate method is to separate the pooled data based on private separations in public hospitals. This method represents the most accurate approach as it accounts for actual use rates, and recognises that hospital benefit payments are paid in respect of actual activity, **not** the number of contributors, thereby addressing the shortcomings of the second assumption listed above. The AIHW *Australian Hospital Statistics 2006-07* publication shows that there were 186,437 (97.9 %) privately insured patient separations in NSW public hospitals, while the equivalent ACT figure was 4,002 (2.1 %).

Furthermore, data provided in Table 7.2 of the publication, when considered in the context of the lack of private provision in the ACT, highlights the extent to which the Commission's second assumption (use rates of private health services across jurisdictions are the same) is leading to an overstatement of ACT non-government expenses.

For example, supposing use rates were the same across jurisdictions, and given the ACT has a higher proportion of contributors and lower level of private provision, it would be fair to suggest that, *ipso facto*, the ACT is likely to be over represented by private health insurance patients in public hospitals. However, this is not the case with separations of persons using private health insurance in public hospitals, as a proportion of total separations, being significantly higher in NSW. The data shows that in NSW 12.75 per cent ¹ of total separations were for persons using private health insurance, while the equivalent ACT figure was 5.28 per cent. ² This demonstrates that the actual use rates between the ACT and NSW differ significantly, and therefore, the associated level of private expenditure would not simply mirror the number of contributors.

Accordingly, data from the AIHW that accounts for actual use rates provides a superior measure to the current proposed approach for separating the level of non-government expenditure. Therefore, the ACT supports the use of separations data on the grounds that it is the most reliable and robust measure, and best reflects the actual use of services.

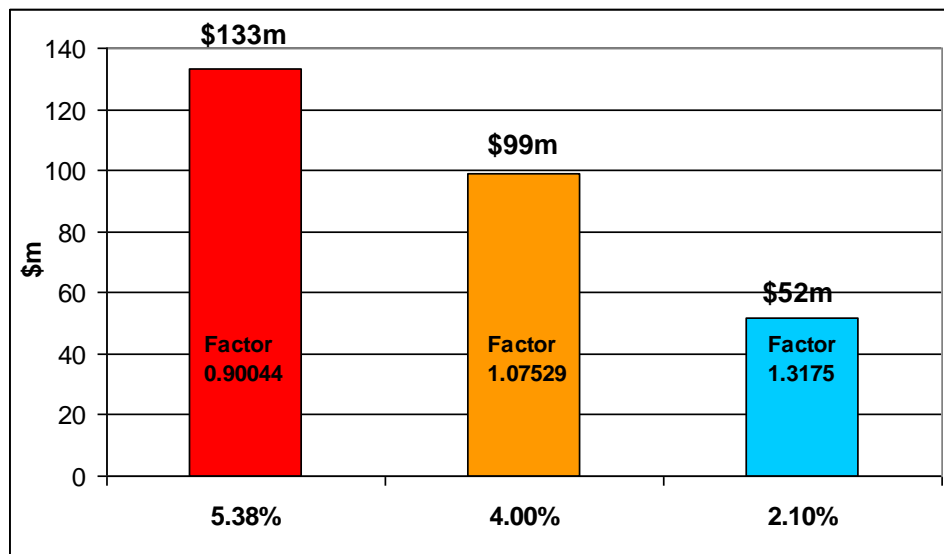
To date, the Commission has not used either of these methods, irrespective of the fact that total health expenditure data by jurisdiction and data contained in the AIHW publication both suggest that the current allocation approach is unreliable and overestimates the hospital benefit payments flowing to the ACT.

The impact of a small change in the PHF split has a **material affect** on the ACT's non-government expenditure and subsequently, the assessed government community and other health expenditure and the ACT's category factor. The ACT has modelled the impact of the differing splits suggested by health expenditure and separations, and the results are provided in the following chart.

¹ Calculated as 186,437 / 1,462,129.

² Calculated as 4,002 / 75,767.

IMPACT OF DIFFERING SPLITS OF PRIVATE ANCILLARY PAYMENTS ON THE ACT'S ASSESSED NON-GOVERNMENT FUNDING



Given the material impact, until these data issues are adequately resolved by way of the Commission making an appropriate adjustment, the ACT cannot support the statement made in paragraph 8 of the Discussion Paper that: “...staff consider that the subtraction model is sound and built on quality data”.

The ACT requests that this matter be addressed, and given its importance, further research is being undertaken regarding the proposed split of private health insurance ancillary benefits data. Any further pertinent information will be provided to the Commission in due course.

OTHER SOCIO-DEMOGRAPHIC CHARACTERISTICS

Socio-economic status

Double-counting

The Commission has noted that some States consider that the proposed assessment method could be improved by making an adjustment for the higher use rates of the population with a low SES.

The ACT is concerned that an adjustment for low SES would result in double counting, as low SES is already captured by the current assessment method by way of the age-sex and Indigeneity adjustments.

The proposed subtraction model distributes assessed total expenses between the States using each State's shares of expenses, calculated by multiplying the per person expenses for each age, sex and Indigeneity group to State populations in the relevant groups and summing these. This method of calculating total State expenditure captures the higher use and cost of those groups that are typically at the lower end of the SES scale and allocates expenditure accordingly.

Any further adjustment to the model for SES will result in double counting. For example, the dataset that has been suggested for use in capturing the impact of low SES, is the ABS National Health Survey (NHS). The survey's various measures capture the differing levels of use

associated with populations in different income quintiles and noted that “*people reporting fair or poor health increases with age*”.

This statement is evidenced by the survey data, which demonstrates the higher use of health services by the population aged 65 and above. The survey also disaggregates age by income quintiles, and showed that 40 per cent of people in the fifth (lowest) income quartile are aged 65 and above, whereas, 2 per cent of people in the first (highest) income quartile were in this age bracket.³ If an adjustment is made for low SES, the higher use and costs of those who are relatively disadvantaged (for example, the 40 per cent aged 65 and above) will be double-counted and will result in additional expenditure being allocated to these groups. This additional expenditure will be on top of the higher actual average expenditure that is already being captured by the model when expenditure is disaggregated by age, sex and Indigeneity.

Furthermore, the ACT notes that for the Inpatient assessment, the Commission acknowledged that: ‘*people aged 65 and over had the lowest mean incomes in 2003-04*’ and that ‘*In 2001, the mean (average) equivalised gross household income for Indigenous persons was 62 per cent of the corresponding income for non-Indigenous persons*’. The subtraction model in its existing form not only satisfies the goal of simplification and is consistent with other assessments, but adequately captures the higher use and costs of different SES population groups for each State.

It also appears that lower SES impacts are also captured to some degree by poorer access to services which is reflected in the subtraction model. In this context, SA Health notes that some people’s socially disadvantaged life circumstances (particularly early in life) are compounded by poorer access to health services.⁴ Thus low SES impacts are already captured by the model.

Over-estimation of low SES costs

A further adjustment to the model to capture low SES impacts would also lead to an overestimation of these impacts as evidence demonstrates that high SES groups use a range of health services at higher, or at similar rates as low SES groups.

The statement that ‘*States have provided evidence for increased use of all levels of health services by the socio-economically disadvantaged population*’, is of concern as there is evidence that this is not the case for all services.

For a range of health services, particularly preventative health services, evidence indicates that high SES groups use these services more, or no differently to low SES groups. The ABS has noted in the past that: “*In general, people from the more disadvantaged areas were less likely to have taken preventative health actions such as immunising children against contagious diseases, or having certain cancer screening tests.*”⁵

Examples of some services in which high SES groups use health services at relatively high levels are provided below in regard to:

- dental health;
- immunisation;
- cancer;
- breast cancer screening;

³ ABS 4364.0 *National health Survey 2004-05*.

⁴ See: <http://www.southernhealth.sa.gov.au/corporate/files/pages/PopulationProfile/Introduction.pdf>

⁵ ABS, Catalogue 4102.0 - Australian Social Trends, 1999.

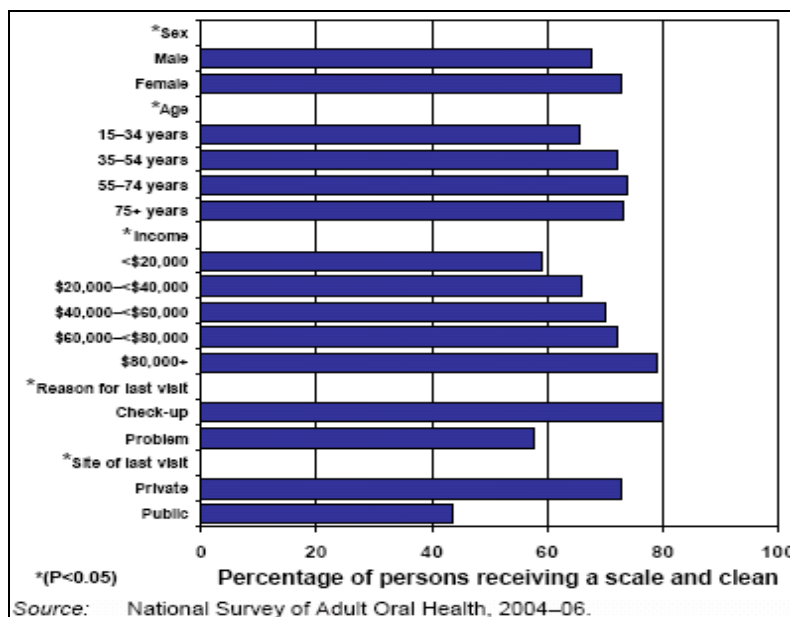
- pap smears;
- drug and alcohol use; and
- emergency departments.

Dental Health

Research by the Australian Institute of Health and Welfare (AIHW), in conjunction with Adelaide University and Australian Research Centre for Population Oral Health, using the *National Survey of Adult Oral Health, 2004–06* notes that lower income was associated with less emphasis on prevention and higher levels of tooth loss. In regard to the greater use of some services by those on higher incomes:

- a higher percentage of persons in high income groups reported receiving scale and clean services than lower income groups – see following chart;
- a lower percentage of persons reported receiving dental radiographs in low income groups compared to higher income groups; and
- a higher percentage of persons reported receiving crown/bridge services (provided to replace tooth crowns or teeth that have been lost for reasons such as dental decay and cuspal fractures) in higher compared to lower income groups.⁶

PERCENTAGE OF PERSONS RECEIVING A SCALE AND CLEAN



Immunisation

There is also evidence that immunisation use is lower for low SES groups. For example, SA Southern Health research indicates that the relative social disadvantage of some groups and communities is associated with higher risk to health from lower immunisation rates.⁷

The Australian Childhood Immunisation Register (ACIR) shows that, for example, the proportion of children that are fully immunised varies, in part according to SES. The ACT and

⁶ AIHW Research Report No. 32 Dental service patterns by patient and visit characteristics.

⁷ See: <http://www.southernhealth.sa.gov.au/corporate/files/pages/PopulationProfile/Introduction.pdf>

Victoria have the highest coverage, while SA and Tasmania have below average rates of vaccination.

**PERCENTAGE OF CHILDREN 60-<63 MONTHS OF AGE
ASSESSED AS FULLY IMMUNISED ***

State	Number of children	% Fully immunised
ACT	1,061	90.6
NSW	22,048	88.3
VIC	16,088	90.3
QLD	13,095	88.4
SA	4,352	85.7
WA	6,552	83.9
TAS	1,483	86.4
NT	872	88.3
AUS	65,551	88.2

* Age calculated 31 December 2007. Date of processing as at 31 March 2008. % fully immunised = no. children vaccinated/no. children in register x 100.

Source: Australian Childhood Immunisation Register (ACIR) statistics
<http://www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp>

Cancer

In terms of cancer more generally, the ABS notes in its data collections that cancer prevalence rates (and therefore, *ipso facto*, use of services) were similar for those living in areas with the greatest disadvantage (those in the lowest quintile of the index of socioeconomic disadvantage) and those living in areas with the least disadvantage (those in the highest quintile of the index of socioeconomic disadvantage).⁸

Breast-cancer screening

In terms of breast-screening, evidence indicates that participation / use of breast screening for low SES women are no higher than for high SES women.

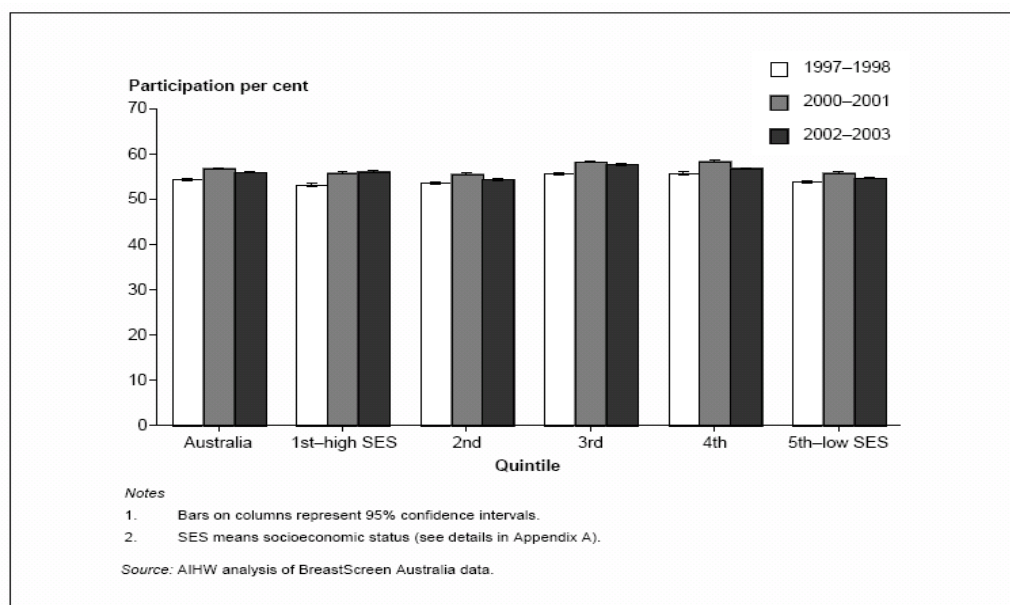
According to the AIHW, breast cancer mortality rates were highest among women with the highest socioeconomic status.⁹ As this is the case, this generally leads to higher usage levels. While the general policy is to invite women in the target age group to be screened biennially, most States have a policy of re-inviting a proportion of women annually for screening, for example, women with a strong family history of breast cancer or women having previously been diagnosed with breast cancer.¹⁰

⁸ Australian Bureau of Statistics, *Cancer in Australia: A Snapshot, 2004-05*, Catalogue 4822.0.55.001.

⁹ 2002–2003 - *The Australian Institute of Health and Welfare and the Australian Government Department of Health and Ageing for the BreastScreen Australia Program*, May 2006, Canberra.

¹⁰ Ibid, page 54.

**PARTICIPATION OF WOMEN AGED 50–69 YEARS IN BREASTSCREEN AUSTRALIA
BY SOCIOECONOMIC STATUS, 1997–98, 2000–01 & 2002–03**



**PARTICIPATION IN BREASTSCREEN AUSTRALIA BY AGE AND SOCIOECONOMIC
STATUS, 2002–2003**

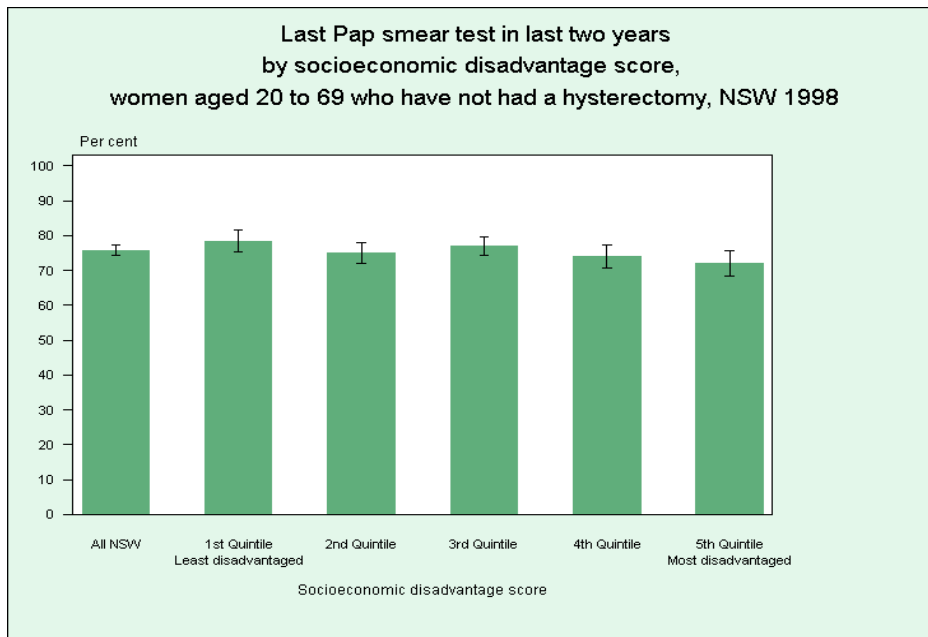
Age group		1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile	Australia
40–44	Number	20,182	19,234	22,926	21,947	19,604	103,893
	Rate	12.8	12.2	14.9	14.8	13.3	13.6
45–49	Number	36,047	32,195	38,225	37,150	33,579	177,196
	Rate	24.0	22.3	27.7	27.5	25.4	25.3
50–54	Number	76,533	69,107	69,777	67,207	62,151	344,775
	Rate	53.3	51.7	55.0	53.4	50.1	52.7
55–59	Number	68,777	60,943	65,469	64,322	59,256	318,767
	Rate	57.9	55.1	60.3	58.4	56.4	57.6
60–64	Number	49,035	46,283	51,379	53,366	49,814	249,877
	Rate	58.7	56.9	59.5	59.6	58.9	58.7
65–69	Number	38,068	37,271	42,342	45,597	41,733	205,010
	Rate	56.5	55.7	57.3	57.9	56.7	56.9
70–74	Number	26,535	25,741	29,593	30,116	27,195	139,181
	Rate	42.2	41.9	43.2	42.0	40.6	42.0
75–79	Number	12,898	9,672	12,289	13,093	11,189	59,140
	Rate	21.4	17.4	19.9	21.2	19.5	19.9
80–84	Number	3,926	2,573	3,535	3,742	3,074	16,851
	Rate	8.3	6.2	7.8	8.7	7.7	7.8
85+	Number	834	482	765	852	682	3,616
	Rate	1.8	1.3	1.9	2.4	2.1	1.9
All ages	Number	332,835	303,501	336,300	337,393	308,277	1,618,306
	Crude rate	35.5	34.1	37.3	37.5	35.6	36.0
	ASR (A)	36.6	35.0	38.2	37.8	36.0	36.7
Ages 50–69	Number	232,412	213,604	228,967	230,493	212,953	1,118,429
	Crude rate	56.2	54.4	57.9	57.0	55.0	56.1
	ASR (A)	56.2	54.5	57.8	56.9	54.8	56.1

Notes: Period covers 1 January 2002 to 31 December 2003. Rates are the number of women screened as a percentage of the eligible female population and age-standardised to the Australian population at 30 June 2001. The first quintile corresponds to the highest level of socioeconomic status and the fifth to the lowest.

Source: AIHW analysis of BreastScreen Australia data. See <http://www.aihw.gov.au/publications/index.cfm/title/10273>

Pap smear testing

Evidence also suggests that higher SES women use pap smear testing at higher levels than low SES women, as shown in the following chart.



Source: NSW Health Surveys 1997 and 1998 and ABS SEIFA index (HOIST). Epidemiology and Surveillance Branch, NSW Health Department.

Drug and alcohol users

The ACT also notes that drug users also place additional burdens on the public health system, whether or not they come from low or high SES groups.

The AIHW report *2004 National Drug Strategy Household Survey: State and Territory Supplement* found that drug use in the ACT was the second highest in Australia. In particular, the ACT has the second highest use rate of meth/amphetamines, which adds to costs given its use leads to an increased likelihood of psychotic episodes.

Table S6: Recent^(a) illicit drug use summary: proportion of the population aged 14 years and over, Australian states and territories, 2004

Substance/behaviour	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
	(per cent)								
Marijuana/cannabis	10.7	9.8	12.1	13.7	11.7	10.9	14.0	20.9	11.3
Pain-killers/analgesics ^(b)	2.8	3.3	3.4	2.7	2.9	3.9	2.7	5.2	3.1
Tranquillisers/sleeping pills ^(b)	1.1	1.0	1.0	1.3	0.7	0.7	0.7	1.3	1.0
Steroids ^(b)	*< 0.1	*0.1	—	*< 0.1	*< 0.1	—	—	*0.4	< 0.1
Barbiturates ^(b)	*< 0.1	0.2	0.2	0.3	*0.3	—	*0.3	*0.4	0.2
Inhalants	0.4	0.4	0.5	0.5	0.4	*0.4	0.9	*0.2	0.4
Heroin	0.1	0.3	*0.1	*0.2	*0.2	*< 0.1	*< 0.1	*< 0.1	0.2
Methadone ^(c)	*< 0.1	*0.1	*< 0.1	*< 0.1	*< 0.1	*0.2	*0.4	*< 0.1	0.1
Other opiates/opioids ^(b)	0.2	0.2	0.2	0.3	*0.1	*0.6	*0.2	0.8	0.2
Meth/amphetamine (speed) ^(b)	3.1	2.8	3.0	4.5	4.1	1.8	4.3	3.9	3.2
Cocaine	1.2	1.2	0.7	1.2	0.7	*0.2	1.6	1.0	1.0
Hallucinogens	0.6	0.7	0.9	0.6	0.7	*0.6	1.0	*0.6	0.7
Ecstasy ^(d)	3.5	3.1	3.4	4.1	2.8	1.6	6.0	3.7	3.4
Ketamine	0.3	0.3	0.3	*< 0.1	*0.1	—	*0.2	*0.6	0.3
GHB	0.1	0.2	0.2	*< 0.1	*0.1	—	*0.1	*0.3	0.1
Injected drugs	0.3	0.4	0.4	0.9	0.6	*0.5	*0.3	*0.6	0.4
<i>Any illicit</i>	<i>14.6</i>	<i>14.3</i>	<i>15.9</i>	<i>17.3</i>	<i>15.4</i>	<i>15.4</i>	<i>17.6</i>	<i>26.0</i>	<i>15.3</i>

(a) Used in the past 12 months.

(b) For non-medical purposes.

(c) Non-maintenance.

(d) In previous surveys this included 'designer drugs'.

Source: AIHW, 2004 National Drug Strategy Household Survey: State and Territory Supplement.

According to the AIHW, a higher proportion of people who were more socioeconomically advantaged were recent users of illicit drugs (16.6%) compared with the other socioeconomic groups.

CHARACTERISTICS BY ILLICIT DRUG USE STATUS, PERSONS AGED 14 AND OLDER, AUSTRALIA, 2004

	Never used	Ex-users	Recent Users
	%	%	%
1 st quintile (most disadvantaged)	63.5%	21.4%	15.2%
2 nd quintile	63.1%	22.2%	14.7%
3 rd quintile	62.3%	22.2%	15.5%
4 th quintile	62.2%	23.7%	14.2%
5 th quintile (most advantaged)	59.3%	24.1%	16.6%

Source: Drug Statistics Series, Number 16 2004 National Drug Strategy, Household Survey Detailed findings, October 2005, Australian Institute of Health and Welfare Canberra, AIHW cat. no. PHE 66.

The National Drug Strategy Household Survey 2004 also highlighted that the risky and high-risk patterns of alcohol consumption in the long term did not seem to vary greatly by SES, though persons of higher SES appeared more likely to consume alcohol at risky and high-risk levels in the short term compared with those of lower SES. Persons of higher SES also seemed more likely to have recently used marijuana/cannabis or amphetamine-type substances.¹¹

¹¹ See: <http://www.aihw.gov.au/publications/phe/sdua04/sdua04-c02.pdf>, page67.

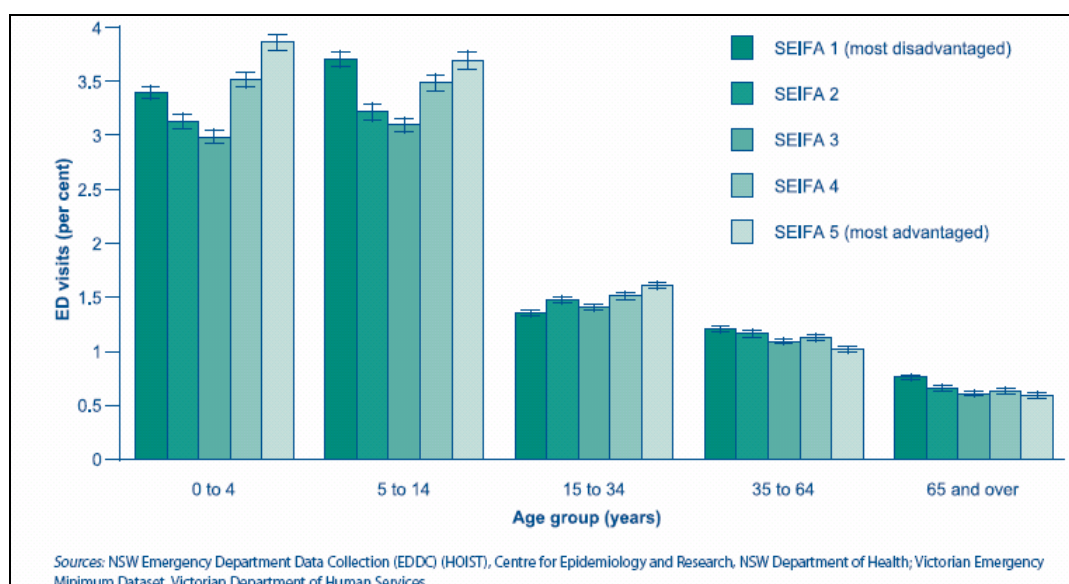
Emergency Departments

In terms of emergency departments (EDs), applying low income SES adjustments to the ED and outpatient services component of the assessment is of particular concern as ED services must be continuously available and capable of responding to emergencies for the population served as a whole, and not specific SDC groups, or those with specific health needs.

The range of ED services are provided to the whole population irrespective of income, Indigeneity, age, gender, or CALD background.

The following provides a good example of this - asthma visits to EDs, by socio-economic status based on data from NSW and Victoria. The first graph shows that higher SES patients aged 0-34 tended to use EDs more than for those aged 35 and over for asthma related conditions. The age groups 0 to 14 use services at higher rates than those 15 and over.

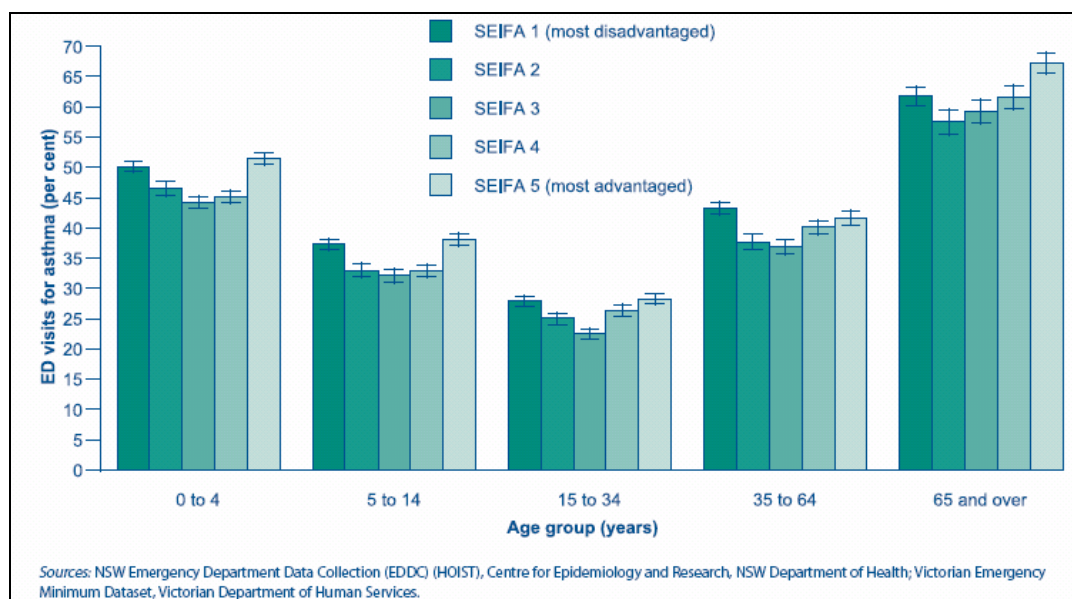
PROPORTION OF ALL EMERGENCY DEPARTMENT VISITS THAT ARE FOR ASTHMA, BY AGE GROUP AND SOCIO-ECONOMIC STATUS, NSW AND VICTORIA, JULY 1999 TO JUNE 2004



Source: AIHW, Asthma in Australia, 2005.

The second graph shows that the higher SES patients suffering from asthma related conditions also tended to be hospitalised more than lower SES patients, particularly for those aged 65 years and over.

PROPORTION OF ALL EMERGENCY DEPARTMENT VISITS FOR ASTHMA THAT RESULTED IN ADMISSION TO HOSPITAL, BY AGE GROUP AND SOCIO-ECONOMIC STATUS, NSW AND VICTORIA, JULY 1999 TO JUNE 2004



Source: AIHW, Asthma in Australia, 2005.

This evidence indicates that the statement that ‘... increased use of all levels of health services by the socio-economically disadvantaged population’, is not correct. It suggests that applying a separate SES adjustment would, in many cases, overstate the impact of low SES users as high SES persons may use a range of services at higher or at similar levels.

It also reinforces the view that there are significant concerns with using a general dataset, such as the NHS, as a basis of adjusting for low SES impacts, given evidence available showing that high SES leads to higher use of some services. The Commission’s view that adjusting for low SES can also lead to a mismatch between service utilisation and expense is also pertinent.

Location

The ACT supports the Commission’s view that a remoteness adjustment should not be included in assessing health needs unless more evidence and reliable data emerge, and because it will lead to double-counting. Reliable data would need to be available to accurately isolate the influences of poor health outcomes from age-sex and Indigeneity.

Additionally, a remoteness adjustment is not required as there is insufficient evidence that poor health outcomes result in higher health expenses.

The Commission has stated that people who live in regional and remote areas generally have poorer health outcomes than people who live in other regions and may use services more. This is not necessarily the case for all services. It is noted that a number of indicators of poor health status / outcomes are higher in urban areas compared with more remote locations.

For example, for the periods 1993–1997 and 1998–2002 the age-standardised breast cancer incidence rate, which may be a good proxy for poor health outcomes for women (as around 20% of all deaths of women occur as a result of breast cancer), shows that the age-standardised breast

cancer incidence rate was significantly lower in outer regional, remote and very remote areas than for the major cities.

This is despite the fact that participation in breast screening is highest in rural to remote areas. Participation rates in ‘Major cities’ and ‘Very remote’ areas were lower than those in other regions.

INCIDENCE OF BREAST CANCER IN WOMEN AGED 50-69 YEARS, 1993–1997 AND 1998–2002 BY REGION -AUSTRALIA MAJOR CITIES INNER REGIONAL OUTER REGIONAL REMOTE VERY REMOTE

	Australia	Major cities	Inner regional	Outer regional	Remote	Very remote
1998–2002 rate	296.5 [#]	302.1 [#]	295.5 [#]	273.0 [#]	253.5*	216.4*
95% CI	292.9–300.0	297.7–306.5	288.1–303.1	262.8–283.6	226.6–282.8	177.6–259.1
1993–1997 rate	273.0	278.8	270.4	251.5*	230.8*	204.4*
95% CI	269.3–276.6	274.2–283.3	262.6–278.3	241.0–262.4	203.5–260.7	163.7–249.7

* Significantly different from the Australian rate.

[#] Significantly different from the 1993–1997 rate.

Note: Rates are the number of breast cancers detected per 100,000 women and age-standardised to the Australian population at 30 June 2001.

Source: AIHW analysis of BreastScreen Australia data, page - See: <http://www.aihw.gov.au/publications/index.cfm/title/10273>

In terms of cancer, data indicates that cancer incidence, and thus use of services, are higher for urbanised populations.

The Tasmania Cancer Registry data, for example, shows that for all cancers, the age standardised incidence rates were highest for males and females living in inner regional areas of Tasmania and lowest for males and females living in remote and very remote areas.

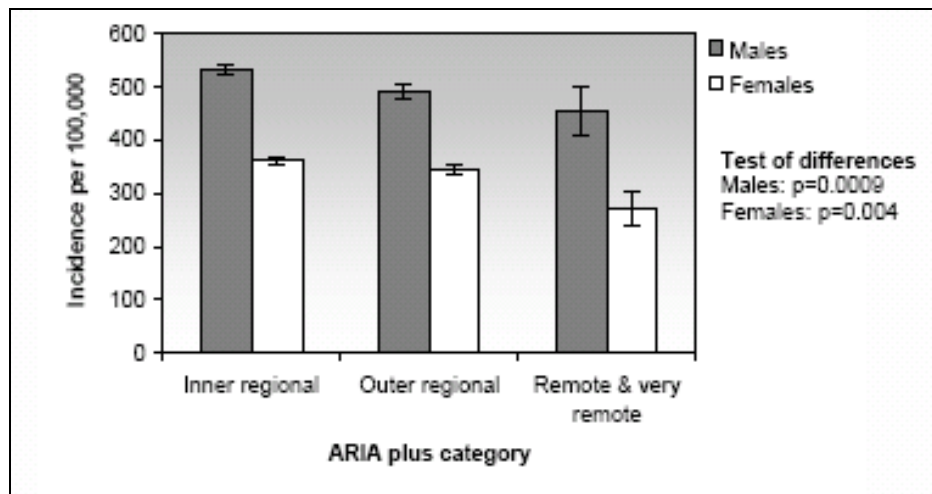
Incidence rates for males were 529.9 per 100,000 in inner regional areas, 491.3 per 100,000 in outer regional areas and 454.2 per 100,000 in remote and very remote areas. For females, incidence rates were 360.0 per 100,000 in inner regional areas, 343.1 per 100,000 in outer regional areas and 270.6 in remote and very remote areas.¹²

A test of differences of the incidence rates across ASGC Remoteness Areas was statistically significant for males and females for all cancers, with incidence rates for all cancers highest in inner regional areas, lower in outer regional areas and lowest in remote and very remote areas.¹³

¹² Tasmania Cancer Registry - See: http://www.menzies.utas.edu.au/pdf/20yr_P2.pdf

¹³ Ibid.

**AGE STANDARDISED INCIDENCE RATES FOR ALL CANCERS
BY ASGC REMOTENESS AREAS CATEGORIES FOR TASMANIA, MALES AND
FEMALES, 1993 –1999**



Source: Tasmania Cancer Registry.