Australian Government

Commonwealth Grants Commission

ASSESSING COMMUNITY AND OTHER HEALTH SERVICES FOR THE 2010 REVIEW

STAFF DISCUSSION PAPER
CGC 2008/02-S

SUPPLEMENT TO STAFF DISCUSSION PAPERS
CGC 2007/21-S AND 2007/32-S

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INTRODUCTION

1 This paper provides additional information to States on progress staff are making on the development of the Community and other health services assessment. Submissions from States on issues included in this paper are optional. However in the absence of further submissions, staff plan to recommend to the Commission the assessment set out in discussion paper 2007/32-S, updated by the technical changes included in this paper.

2 The paper includes additional details on why staff consider the subtraction model to be conceptually valid, some technical developments on the proposed treatment of non-State expenses and issues around incorporating additional socio-demographic characteristics other than age, sex and Indigeneity.

CONCEPTUAL VALIDITY OF THE SUBTRACTION MODEL

3 In responding to discussion papers 2007/21-S Community and other health services and 2007/32-S Assessing Community and other health services supplement, a number of States expressed reservations about the subtraction model. This paper provides an additional explanation to States as to why staff consider that the subtraction model is a valid approach.

Simplification

4 In the 2004 Review, there were two other health categories in addition to Admitted patient services (Inpatients). Together, these two categories contain a dozen separate components. The staff view is that the assessment approach, using the subtraction model being proposed for the 2010 Review, is methodologically no less robust than the 2004 Review approach, is conceptually sound and is simpler. The approach being proposed is consistent with the top down approach to the development of assessments and the assessment guidelines.

What did we propose?

5 Commission staff proposed assessing State community and other health services expenses using a subtraction model implemented in five steps:

(i) national total Community and other health expenses are the sum of:

- Australian government expenses on community and other health services;
- non-government expenses on community and other health services; and
- State government expenses on Community and other health services;

(ii) assessed total expenses for each State are calculated by distributing total expenses calculated in (i) between States using State shares of expenses calculated by multiplying the per person expenses for each age, sex and Indigeneity group (AIHW expenditure data) to State populations in the relevant groups and summing these;

(iii) total Australian Government funded expenses on Community and other health services are distributed across the States using State shares of adjusted MBS payments;

(iv) non-government funded expenses on Community and other health services are distributed across the States using States shares of private health insurance ancillary health benefit payments; and

(v) for each State, Australian Government (iii) and non-government funded expenses (iv) are subtracted from assessed total expenses (ii), to arrive at the assessed expenses.

Reasons for proposing the subtraction model

6 The Community and other health services category includes all public health services except for those relating to admitted patients (and patient transport expenses). Staff were unable to find sufficiently comprehensive and reliable administrative datasets to allow direct measurement of a range of possibly material disabilities such as age, gender, Indigeneity, location, socio-economic status (SES) and Culture and Linguistic Diversity (CALD).

7 The available reliable and relevant national data, health expenditure data published by the Australian Institute of Health and Welfare (AIHW)[1], allow us to assess the overall community and other health services expenses required in each State (from all funding sources) to meet needs arising for population characteristics, such as age and sex, at national average levels. Additional AIHW health expenditure publications enable us to incorporate an adjustment for Indigeneity[2]. As the overall expenses are met by the Australian Government, State government and non-government sectors, the expenses not funded by State governments must be subtracted from the total to derive the expenses met by the States.

8 Although data availability contributed to the decision to adopt this approach, staff consider that the subtraction model is sound and built on quality data. It adequately assesses two major drivers of State health expenses, the average need for health services arising from the age, sex and Indigeneity characteristics of State populations and the economic environment in which States' services are provided. Whilst the model could be presented using a traditional factor approach, the subtraction method seems conceptually easier to understand and more transparent.

State views

9 Three States consider the subtraction model conceptually valid and support it, at least in principle. They consider that it removes complexity. They suggest further work to demonstrate its robustness. This work is being undertaken and the results so far are described in the technical section following this section.

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1 AIHW, *Health system expenditure on disease and injury in Australia, 2000-01*, second edition. The 2004-05 edition of this publication is due for release shortly.

2 AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001-02*. The 2004-05 edition of this publication has recently been published.

10 The other States do not support the use of the subtraction model because they believe it assumes that services provided by the Australian Government, State Governments and non-government providers are substitutable. They would prefer an approach which more directly measures State needs.

11 Other specific criticisms include that:

- the provision of Community and other health services is 'complementary to the medical practitioners' sector, but with a different set of cost drivers;
- unmet demand undermines the assumption of substitutability – the provision of a service by a private provider does not reduce outstanding demand for public services;
- if the method is adopted for health, consistency would require that all assessments recognise the extent to which private services remove the need for public services; and
- the approach assumes substitutability of services and a mature health system whereby all health needs are currently being met by either the Australian government, State government or the non-government sector.

Staff response

12 Staff do not consider that the model assumes all private services to be substitutable for State services or that all health needs are currently being met.

13 The subtraction model recognises that there is a total amount spent on health services across States in a given year. The spending reported by the Australian Institute of Health and Welfare is classified to the Australian Government, State governments and non-government sectors. To obtain what is spent by States, the amounts spent by other sectors are subtracted from the total. The model says nothing about the extent of substitutability or needs not met by such expenses. The expenses capture what has happened - what services have been funded and by which sectors. Unmet needs still exist, but are not funded. If some of these are met in the next period, say for remote Indigenous people, then that will be reflected in increased expenses for the next period and different assessed expenses, reflecting the change in average policy on the provision of services to remote Indigenous people.

14 If different cost drivers apply to expenses in the three sectors, the average total expense per capita for each age, sex and Indigenous group which is used to weight State populations in the relevant groups relate to, and capture, drivers for all three sectors.

15 The model implies that the community and other health services provided by non-State sectors supplement services provided by State governments. Some States said that private providers do not locate in uneconomic environments and State governments take 'fall-back' responsibility in these areas. It is also the case that not all people can afford private services, and again, the States provide the fall-back. These are widely accepted cases and the model recognises them.

16 Whilst the three sectors may offer different services with various levels of accessibility, the need for services is largely driven by the same set of population factors, as captured by the average total expense per capita by age, sex and Indigeneity. A given set of health needs, for

example, through choice may be met through acupuncture, chiropractic or natural therapies, all not provided in the public system. Alternatively, through affordability, access issues or choice, the needs may be met by a visit to a GP or through State provided services. Where services are not provided by the non-State sectors, for example Emergency Departments, under the proposed approach the expenses associated with these services will not be deducted from the total simply because it is not funded by the non-State sectors.

17 In summary, the model is used to calculate assessed State community and other health services expenses. Total assessed expenses for the sum of Australian government, State government and non-government sector expenses are calculated, recognising that age, sex and Indigeneity of State populations have an impact on all expenses.

18 Actual non-State expenses could then be subtracted from the total expenses for each State to derive the State own expense requirement, if no policy or pricing influences could be assumed. Because this cannot be assumed, we do not use actual expenses. We make adjustments to them to make them policy and pricing neutral. Proxying actual non-State funding means that actual disabilities are automatically captured obviating further disability adjustment.

19 This indirect approach should give no different results than if State government expenses were able to be assessed directly recognising the disabilities relating to age, gender and Indigeneity, along with others such as location, SES and CALD that have economic environment influences.

20 In relation to the suggestion that there may be implications for all other expense assessments, staff believe that we are being consistent. We equalise so that all States have the capacity to deliver the services they need to deliver. In relation to education services, we recognise that the level of private services has an impact on what States need to spend. A State with a large private sector is recognised as needing to spend less than a State with a large public sector. We give States the capacity to provide school services on the basis of its actual mix of State and private services.

21 This is conceptually no different from our intention in the proposed Community and other health services assessment, albeit with a different implementation approach. In addition, in the 2004 Review, we recognised that services provided by the private sector reduced the need for State provided services. The extent to which this changed a State's expenses was proxied by the deficit in GP supply in each State (the difference between actual supply and assessed GP supply required by States, given their population characteristics). A bigger deficit meant that the States needed to provide more services.

DEVELOPMENTS IN ASSESSING NON-STATE SERVICE PROVISION

22 Following further consideration of Australian Government and non-government health expenses reported by the AIHW and the Private Health Insurance Administration Council (PHIAC), staff propose to make the following changes to the method of assessing non-State sectors funded expenses described in discussion paper 2007/32-S:

- excluding patient transport expenses from the assessment, as these will be assessed within the Admitted patient category;
- reallocating the expenses on medical services by individuals and private health insurance funds from the non-government sector to the Australian Government sector because the Medicare Benefits Schedule (MBS) payments are considered to be a better proxy than private health ancillary services for these expenses;
- excluding the expenses on aids and appliances from the assessment as staff consider that this largely relates to glasses, which is not primarily a State government's responsibility; and
- using weighted private health ancillary recipient numbers as the proxy to assess non-government sector expenses to avoid issues around ancillary benefit schedules not being uniform across the private health funds and hence States.

23 Excluding the expenses on the patient transport and aids and appliances reduces to a large degree the unallocated expenses assumed to have the same disability drivers as per the allocated expenses.

Proxy for non-government expenses

24 There is a fair degree of consensus on using MBS payments as the proxy for assessing Australian government expenses. However the proxy proposed by staff for assessing State shares of non-government expenses is more contentious. Staff proposed that private health fund ancillary benefit payments be used as the proxy for assessing these expenses, so that a State's share of non-government expenses will be assessed as the same proportion of its share of private health fund ancillary benefit payments.

25 Some States questioned whether private health insurance benefit payments were sufficiently representative of non-government expenses when private health insurance ancillary benefit payments represent only a fraction of total non-government expenses.

26 The importance of the latter issue diminishes after excluding expenses related to *medical services, aid and appliance* and *patient transport* from non-government sector expenses. These expenses reduce from $12 047m to $6 651m in 2004-05, increasing private health fund ancillary benefit payments' proportion of total non-government expenses.

27 However, staff consider that more important than the relative size of private health ancillary benefit payments is whether they are distributed in a similar fashion to total non-government expenses. The distribution of private health ancillary benefit payments among Community and other health services (*dental services, other health practitioners, community health,* and *public health*) is very similar to that for total non-government expenses. The distribution patterns as shown in Table 1 suggest private ancillary benefit payments sufficiently represent the total non-government expenses at the national level.

Table 1 The comparison of community and other health services expenses by service types between private health insurance and non-government, 2004-05

	Dental services	health practitioner	Community health	Public health	Total
Ancillary benefit payments ($m)	4454	2026	116	55	6651
share of services (%)	67.0	30.5	1.7	0.8	100.0
Non-government expense ($m)	1070	487	55	9	1621
share of services (%)	66.0	30.1	3.4	0.5	100.0

28 Staff consider that there is a case that ancillary benefit payment schedules are inconsistent across private health insurance funds and hence States. For example, the average benefit paid for each dental service between 2004 and 2005 was $49 in South Australia but only $43 in Victoria. Therefore, although ancillary benefits are unaffected by differences due to private providers' pricing, they are influenced by private health insurance companies' benefit payment policies. That in turn could lead to a material distortion to the assessed States' share of total non-government expenses.

29 To make non-government assessment policy and price neutral, staff now propose to use weighted recipient numbers as the proxy. Details of the calculation will be explained in the next section.

Demonstration of the updated approach

30 The following section reports on how the amendments will be implemented to derive new assessment results. Read in conjunction with the Discussion papers 2007/21-S and 2007/32-S, the information provided below should give States a full view of the assessment.

Step 1 — National Community and other health expenses

31 The derivation of the expenses met by the Australian Government and non-government sectors for 2004-05 is shown in Table 2. The figures are different from those in discussion paper 2007/32-S mainly due to the reallocation of expenses on 'medical services' and excluding those on 'aid and appliance' and 'ambulance'. In addition, the AIHW has recently revised the health expenditure data for 2004-05 resulting in some changes as well.

Table 2 Community and other health services expenses by sources by areas, 2004-05

Source	Comm. health	Dental	Medical services	Other health practitioner	Public health	Total
	$m	$m	$m	$m	$m	$m
A. Aus Govt	408	423	11589	641	866	13927
B. Aus Govt SPPs	37	-	-	-	395	432
C. Aus Govt Private health insurance rebate	-	322	261	159	-	742
D. Individual	116	3403	1622	1508	55	6704
E. Private health insurance funds	0	729	591	359	-	1679
F. Total of Medical services by C, D and E			2474			
				Aus Govt	*A-B-C+F*	15227
				Non-Govt	*C+D+E-F*	6651
				State	*from GFS*	12079.5
					Total	**33958**

Source: (1) AIHW health expenditure database.
(2) State GFS.

Step 2 — Assessing total expenses for each State

32 **Calculating per person expenses by age and sex**. There have been no changes to per person expenses by age and sex as shown in Table 2 in discussion paper 2007/32-S.

33 **Indigenous adjustment**. Table 3 shows that, after removing patient transport, representing 3.20 per cent of total expenses, total Community and other health services expenses on Indigenous people in 2001-02 were $843.7m. The Indigenous adjustment was recalculated using these data and the method set out in DP 2007/32 S.

34 **Calculate assessed total expenses for each State.** Applying the same method set out in DP2007/32S, the State shares of total expenses were calculated by multiplying the per person expenses for each age, sex and Indigeneity group (AIHW expenditure data with Indigenous adjustment) to State populations in the relevant groups, summing these and dividing the sum by total Australian weighted population.

35 Table 4 also shows the assessed total expenses for each State which were derived by applying the total community and other health expenses of $33958m (from Table 2 above) to the calculated shares.

Table 3 Community and other health services expenses, for Indigenous Australians and non Indigenous Australians, 2001-02

Health service type	Indigenous	Non-Indigenous	Indigenous share
	$m	$m	%
Non-admitted patients	142.4	3,116.5	4.4
Medical services	99.6	11,112.5	0.9
Community health services (including state dental)	439.9	2,810.5	13.5
Dental services (excluding state dental)	21.8	3,734.2	0.6
Other professional services	16.9	2,252.4	0.7
Public health activities	72.5	1,029.9	6.6
Other health services (nec)	50.6	1,458.9	3.4
Total community and other health services	**843.7**	**25,514.9**	**3.20**

Source: AIHW, *Expenditures on Health for Aboriginal and Torres Strait Islander Peoples, 2001-02*, Table 2.1.

Table 4 Assessed total community and other health expenses for each State 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
Share of total comm. & other health (%)	34.02	24.82	18.51	9.46	8.20	2.55	1.48	0.96	100
Assessed expenses ($m)	11553.0	8428.7	6284.7	3211.4	2785.0	866.3	503.5	325.0	33957.5

Source: Commission analysis.

Step 3 — Assessing Australian Government funding

36 Total Australian Government funded expenses on Community and other health services was distributed across the States using State shares of adjusted MBS payments. State shares are as per Table 5 in discussion paper 2007/32-S.

37 Applying State shares to the total Australian Government funded expenses on Community and other health, $15227m from Table 2, we calculated the assessed Australian Government funding for each State as shown in Table 5.

Table 5 Assessed Australian Government expenses on community and other health for each State 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Assessed expenses ($m)	5604.0	3785.7	2803.8	1287.7	1147.7	324.7	195.6	77.7	15227.0

Source: Commission analysis.

Step 4 — Assessing non-government funding

38 Total non-government funded expenses on Community and other health were distributed across the States using State shares of weighted recipient numbers of private health insurance ancillary benefits reported by Private Health Insurance Administration Council (PHIAC).

39 The ACT's data are separated from the New South Wales' data according to the numbers of contributors in the two jurisdictions. As at 31 December 2004, there were 2 972 000 contributors in NSW and 169 000 contributors in the ACT[3]. Consequently, 94.62 per cent of benefit recipients were assigned to New South Wales whilst the remaining 5.38 per cent were assigned to the ACT.

40 **Calculating weights of each ancillary service.** Using the number of recipients as the proxy avoids the issue around health insurance funds paying different benefits for the same services. However simple addition of recipient numbers does not reflect the cost which varies considerably between ancillary services. Therefore we propose to use weighted recipient numbers.

41 Weights for each type of service are calculated by comparing the Australia average benefit per service with the selected benchmark, the Australia average benefit per Acupuncture/Acupressure service. Table 6 shows the types of services included along with the respective average benefits and weights.

42 **Calculating State shares of non-government expenses.** Weights in Table 6 are applied to the recipient numbers of the respective services in States and the sum of weighted recipient numbers is used to calculate State's share of the total non-government funded expenses. Table 7 provides a comparison of the amount of weighted private health insurance ancillary recipient numbers across States and Territories for 2004-05. The shares for each State calculated from weighted recipient numbers vary from the shares calculated using actual ancillary benefits. These differences reflect the different benefit payment schedules of private health funds operating within the States.

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3 PHIAC Annual Coverage Survey http://www.phiac.gov.au/statistics/survey/excel/survey.xls.

Table 6 Weights of ancillary services, 2004-05

Type of ancillary services	Benefit paid per service($)	Weight
Acupuncture / Acupressure	19.19	1.00
Chiropractic	21.75	1.13
Community, Home, District Nursing	12.67	0.66
Dental	46.43	2.42
Dietetics	26.65	1.39
Domestic Assistance	22.43	1.17
Ex gratia Payments	114.68	5.98
Fitness & Lifestyle Courses/Equipment	59.76	3.11
Hearing Aids and Audiology	483.16	25.17
Hypnotherapy	44.36	2.31
Maternity Services	25.23	1.31
Natural Therapies	20.78	1.08
Occupational Therapy	28.22	1.47
Orthoptics (Eye Therapy)	51.54	2.69
Osteopathic Services	26.66	1.39
Physiotherapy	25.49	1.33
Podiatry (Chiropody)	31.13	1.62
Psych/Group Therapy	45.22	2.36
School	120.95	6.30
Sickness and Accident	374.28	19.50
Speech Therapy	32.42	1.69
Theatre Fees	112.94	5.88
Other Services	55.31	2.88

Table 7 Weighted private health insurance claim for ancillaries services by States ('000), 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Private health insurance claims - weighted[(a)]	29795.1	16520.5	16344.0	9617.5	8464.1	1759.1	1692.6	371.7	84564.6
State share	35.23	19.54	19.33	11.37	10.01	2.08	2.00	0.44	100
State share calculated using actual benefits[(b)]	35.93	18.13	18.83	12.24	10.28	2.10	2.04	0.45	100

(a) Recipients in NSW and the ACT are spitted according to their coverage.
(b) State share calculated using actual benefits are taken from DP 2007/32S
Source: PHIAC, Statistical Trends - Membership and Benefits Statistics.
http://www.phiac.gov.au/statistics/trends/index.htm

43 Applying State shares to the total non-government funded expenses on Community and other health, $6651m from Table 2, we derive the assessed non-government funding for each State as shown in Table 8.

Table 8 Assessed non-government expenses on community and other health for each State 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
Assessed expenses ($m)	2343.4	1299.3	1285.5	756.4	665.7	138.4	133.1	29.2	6651.0

Source: Commission analysis.

Step 5 — Assessing State government expenses

44 The assessed State government expense can be calculated by subtracting assessed Australian Government funding and non-government funding from assessed total expenses on community and other health services in each State as shown in Table 9. Table 9 also presents the assessed expenses in per capita terms, from which the category factors have been derived.

Table 9 Assessed Community and other health services expenses and category factors, 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
A. Total health expenses ($m)	11553.0	8428.7	6284.7	3211.4	2785.0	866.3	503.5	325.0	33957.5
B. Australian Government funding ($m)	5604.0	3785.7	2803.8	1287.7	1147.7	324.7	195.6	77.7	15227.0
C. Non-government funding ($m)	2343.4	1299.3	1285.5	756.4	665.7	138.4	133.1	29.2	6651.0
Assessed State government expenses A-B-C ($m)	3605.5	3343.7	2195.4	1167.3	971.5	403.3	174.7	218.0	12079.5
Mean resident pop'n (m)	6.745	4.995	3.932	1.995	1.537	0.484	0.325	0.201	20.214
Assessed State government expenses ($pc)	534.54	669.46	558.38	585.24	631.95	833.00	538.09	1082.00	597.59
Category factor	0.89450	1.12027	0.93439	0.97933	1.05749	1.39394	0.90044	1.81061	1.00000

Source: (1) Mean resident population, ABS, special data request.
(2) Commission analysis.

45 The assessment results in Table 9 are still preliminary and will change when 2006 Census data are applied, along with more recent AIHW data including 2004-05 Health system expenditure on disease and Expenditures on health for Aboriginal and Torres Strait Islander peoples.

OTHER SOCIO-DEMONGRAPHIC CHARACTERISTICS

46 Some States consider the assessment could be improved by the inclusion of adjustments for other socio-demographic characteristics such as location, socio-economic status (SES) and cultural and linguistic diversity (CALD). Each of these characteristics will be discussed below.

Location

47 Staff consider that location has an impact on State community health expenses for three reasons.

- Patients have limited access to alternative health services provided by non-State sectors due to isolation and financial disadvantage, thus they rely more on public health services.
- Dispersion, isolation and diseconomies of small scale incur higher costs of State government health services.
- People who live in regional and remote areas generally have poorer health outcomes than people who live other regions and may use services more.

48 The first disadvantage, relating to differential access to State health services, is captured through the adjustment for non-State service provision. Influences due to the second impact will be captured by the general location factor.

49 In relation to the third impact, there is insufficient evidence that poor health outcomes result in higher health expenses. In addition, to avoid double counting, we would require reliable cross-classified data which are able to isolate the influence of poor health outcomes from the other two impacts and to isolate the effects already capture through the age-sex and Indigeneity adjustments.

50 Therefore a remoteness adjustment can not be included in assessing State's health need unless more evidence and reliable data emerge.

Socio-economic status

51 Staff believe that there are two categories of drivers of State government health expenses: health indicators and social indicators.

52 Health indicators are those factors related to the population characteristics, such as age and Indigeneity, which determine a person's health status and cost of treatment. An older person requires more health services than a younger healthier person needs. It usually costs more to treat an Indigenous person than a non-Indigenous person for a similar medical condition. These indicators are captured when total State community and other health services needs are assessed.

53 Social indicators are those factors that influence a patient's choice of whether to use public health services or to use alternatives and whether to interact with health system at an earlier or later stage. These indicators are recognised when non-State community and other health services expenses for each State is deducted from their assessed totals.

54 Health indicators and social indicators are often interrelated; for example Indigeneity is a health indicator as well as a social indicator. Another example is socio-economic status.

55 States have provided evidence for increased use of all levels of health services by the socio-economically disadvantaged population, leading to higher health needs for States with higher proportions of lower socio-economic populations. However, whilst a conceptual case for social determinants of health needs to be included appears to have been made, it is not clear which SDC measure would identify the SES disadvantaged population best. In addition, States have not provided data or approaches on how to include such a factor within the assessment.

56 Staff would prefer more reliable and comparable data from which to calculate an appropriate adjustment but are looking further at this issue. A possible solution is to derive an adjustment weight, similar to the Indigenous adjustment weight, based upon use of health services by the lower socio-economic population using ABS National Health Survey (NHS) data. An indicator for low socio-economic status could be based upon income or SEIFA. However, using this approach there could be a mismatch between service utilisation and expense, along with issues around merging survey and expenditure datasets.

CALD

57 Victoria has provided quantitative data indicating that CALD groups have higher use, and higher cost per service for admitted patient services. Information from Centrelink indicates that non-English speaking customers' consultations are 30 per cent longer.

58 These data do not show that CALD groups are higher or more costly users of non-admitted patient services. If they are higher users, it is unlikely to be because of their poor health status.

59 AIHW stated in *Australia's health 2006* that 'Research has found that most migrants enjoy health that is at least as good, if not better, than that of the Australian-born population. Immigrant populations often have lower death and hospitalisation rates, as well as lower rates of disability and lifestyle-related risk factors (AIHW: Singh & de Looper 2002). This 'healthy migrant effect' is believed to result from two main factors: a self-selection process which includes persons who are willing and economically able to migrate and excludes those who are sick or disabled; and a government selection process which involves certain eligibility criteria based on health, education, language and job skills (Hyman 2001).'[4]

60 These comments suggest that the higher use of public services by CALD groups reflects their choice of whether to use public health services or to use alternatives rather than their health needs. The influence of their decisions to use State government health services is recognised when non-State community and other health services expenses for each State are deducted from their assessed totals.

61 It might be the case that providing services to patients with low English proficiency, extra communication costs may incur. However, we are unaware of any including, Centrelink's

[4] AIHW, *Australia's health 2006*, p235-236.

estimate, which provide a reliable source for suggesting an appropriate cost weight. Unlike Centrelink consultations, medical consultations have costs other than labour costs, for example material costs, which do not increase with a longer consultation times.

62 In the 2004 Review, Victoria presented data on costs associated with translators and increased consultation times, indicating that the cost for a low English proficiency client utilising community health services through an interpreter was around three times that for a client fluent in English. However, it is not clear to what extent low English proficiency clients make use of interpreters. In addition, as we are proposing expenses based approach, more helpful data upon which a CALD weight could be derived would indicate the proportion of community and other health services expenses on an identifiable CALD group. With these data, an adjustment similar to that for Indigeneity could be derived. In the absence of such data, staff propose not to consider a CALD adjustment.