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From: Teresa Stewart [<mailto:Teresa.Stewart@dtf.vic.gov.au>]
Sent: Friday, 6 June 2008 3:14 PM
To: Linda Pure; Anthony Nichols; Lace Wang
Cc: Alain Baillie; Sarah Huggins; Joe Monforte
Subject: Vic comment on CGC 2008/02-S Supplement to CGC 2007/21-S AND 2007/32-S Community and Other Health

Good afternoon Tony,

Apologies for the delay in getting our comments on the supplementary staff paper on the Community and Other health assessment to you. Overall Victoria continues to support the subtraction model in principle, but have some concerns and questions about some of the technical developments.

Placement of patient transport expenses

As previously indicated, Victoria supports the inclusion of patient transport expenses in the admitted patient expense category.

Relocation of medical expenses from non government sector to Australian Government sector

We would appreciate further information to support the CGC's assumption that medical expenses incurred by individuals and private health insurance funds are more accurately distributed using the MBS, rather than the private health insurance proxy.

The use of different proxies for Australian Government funding and individual and private health insurance financing correctly assumes that there are different factors (of affordability, access and choice) affecting the extent to which these two sectors will supplement State community health services.

Given this, it is not clear why expenditure which actually occurs in the non-government sector should be assumed to be driven by the factors which shape Australian government provision.

Using weighted private health insurance recipient numbers

Victoria is concerned that the proposed change to the non-government expenditure proxy has not been tested for robustness or significance. Key concerns include:

1. Materiality: It is not clear from the paper whether the change to the proxy for non government expenditure has a material impact on the assessment. The use of a weighted private health insurance number proxy adds considerable complexity to the assessment. Unless this makes a significant difference this should be excluded in the interests of simplicity and transparency.

2. Location: We are concerned that the proposed adjustment could in effect be a quasi location adjustment - since difference in benefits may well reflect differences in service costs in different States. If an additional

location adjustment were then to be applied to the assessment the impact could be double counted.

3. Complexity: Differences between State's share of payment value and share of weighted payment numbers suggests that there are differences in the complexity of procedures undertaken across States. This has not been fully explored or the implications for what should be netted off total expenditure worked through.

We do not have definitive positions on these issues, but they are examples of important hypotheses which have not yet been tested. Further work is required to demonstrated that the Commission's technical proposals are robust.

Cultural and linguistic diversity

Data collected for the purposes of informing a cultural and linguistic diversity (CALD) adjustment to the admitted patient category clearly demonstrates that, as for indigenous people, it costs more to treat a CALD person than a non CALD person with a similar condition. Unlike indigeneity, these indicators are not captured in the current assessment model. It was not feasible for Victoria to undertake an intensive data collection exercise specific to both admitted and non admitted services. However, it follows from this evidence that CALD populations would also have greater needs of other health services. This evidence is specific to Victorian's population with profound language difficulties, equivalent to the Low English Fluency population. By contrast, comments in the paper (para 59) relate to the health and likely service costs of the broader migrant population. This is not relevant.

Following Victoria's work place visits Victoria intends to collect further data about the additional costs of providing community health services to CALD groups, to inform a possible cost weight. Pending this data Victoria seeks a placeholder in the Community Health assessment model to accommodate a CALD cost weight.

With respect to humanitarian refugees, Victoria recommends the Commission consult the Department of Immigration and Citizenship (DIAC) . Victoria will also try to collect further population data where available - DIAC data may only be for the State of entry, which will not capture significant secondary migration to Victoria.

We are happy to discuss further.

Kind regards

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