



COMMONWEALTH GRANTS COMMISSION

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POPULATION AND PREVENTIVE HEALTH

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1. This paper provides an overview of the proposed Population and Preventive Health assessment for the 2004 Review. It presents issues raised by States in the 2004 Review submissions, and staff responses to them.

BACKGROUND

Scope of the Category

2. The 1999 Review category comprised expenses on public health services, consisting of population health programs and preventive health programs. Population health service programs were defined as those that aim to protect, promote and/or restore the collective health of whole or specific populations. Preventive health programs were defined as those aimed at preventing disease. More specifically, the category included expenses on:

- (i) health promotion campaigns;
- (ii) occupational health and safety programs;
- (iii) food standards regulation;
- (iv) environmental health, nutrition services and epidemiology;
- (v) communicable disease surveillance;
- (vi) immunisation programs, breast cancer screening and screening for childhood diseases;
- (vii) pharmaceuticals provided outside hospitals, aids and appliances used for health purposes and supplied in an ambulatory setting, glasses, hearing aids, wheel chairs etc;
- (viii) research into medical and health sciences undertaken outside acute care hospitals; and
- (ix) medical instrumentation undertaken in institutions other than acute care institutions.

3. The category also included outlays on administration, support, operation etc of health affairs and services that could not be assigned to other health categories.

Specific Purpose Payments

4. Specific Purpose Payments (SPPs) from the Commonwealth relating to this category, and their treatment, are shown in Table 1. At this stage, Commission staff intend to recommend that the current treatment of these SPPs be retained for the 2004 Review.

Table 1 DISTRIBUTION OF PUBLIC HEALTH SPPS TO STATES, 2001-02

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT
National Public Health and Essential Vaccines (treated by inclusion)	\$m	88.01	57.49	44.53	24.69	19.17	8.27	5.41	4.56
	\$pc	13.54	11.98	12.38	13.01	12.78	17.59	17.31	23.21

Structure of the Assessment

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

6. The standard expenditure was \$54.90 per capita in 2000-01. In the 2002 Update, this category redistributed \$21.9 million in grant shares, which was \$1.14 per capita.

7. The factors with the greatest impact on grant shares were the socio-demographic composition factors, which redistributed \$19.6 million in the 2002 Update assessment.

Table 2 1999 REVIEW ASSESSMENT STRUCTURE

Component	Component weight	Factors	Basis of calculation
Scale-affected expenditure	24.01	Input costs	General method with weights of 80% for wages, 2% for accommodation and 1% for electricity.
		Administrative scale	General method.
Population health	44.75	Input costs	General method with weights of 80% for wages, 2% for accommodation and 1% for electricity.
		Cross-border	General method.
Preventive health	22.03	Input costs	General method with weights of 80% for wages, 2% for accommodation and 1% for electricity.
		Dispersion	General method.
		Socio-demographic composition	Covers age-sex and low English fluency. Based on target populations for each program (childhood immunisation, breast cancer screening and cervical screening) and a weight of 1.5 for people with low English fluency.
HIV/AIDS	9.00	Cross-border	General method.
		Input costs	General method with weights of 80% for wages, 2% for accommodation and 1% for electricity.
Isolation	0.21	Socio-demographic composition	Based on prevalence of HIV.
		Isolation	General method.

How States Are Providing Services

8. The National Public Health Partnership (NPHP)¹ defines public health as the organised response by society aimed at protecting and promoting health, and preventing

¹ The NPHP is established through a Memorandum of Understanding endorsed by Commonwealth and State Health Ministers. The Partnership operates through the National Public Health Partnership Group, reporting to the Australian Health Ministers' Advisory Council. It sets out the roles and responsibilities of the Commonwealth and the States in public health.

illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups.

9. The Australian Institute of Health and Welfare's (AIHW) *National Public Health Expenditure Report*² (NPHER) said that public health is characterised by planning and interventions aimed at better health in populations rather than at the health of the individual. Such efforts usually address factors that determine health and the causes of illness rather than its consequences, with the aim of protecting or promoting health, or preventing illness.

10. The major change in public health services are the result of changes in funding arrangements, particularly between the Commonwealth and the States. Much of the funding is now part of the Public Health Outcome Funding Agreements (PHOFAs).

11. Under the PHOFAs, the funding arrangements for the earlier, separate SPPs for eight public health program areas have been broadbanded (or pooled) into a single Agreement and SPP (the National Public Health SPP) for each State and Territory. These programs were:

- (i) National Drug Strategy;
- (ii) National HIV/AIDS Strategy;
- (iii) National Immunisation Program;
- (iv) BreastScreen Australia;
- (v) National Cervical Screening Program;
- (vi) National Women's Health Program;
- (vii) National Education Program on Female Genital Mutilation; and
- (viii) Alternative Birthing Program.

12. A key feature of the PHOFAs is the removal of nationally agreed input and process controls so that States have the flexibility to use pooled Commonwealth/State funds according to local needs and priorities to achieve the agreed targets and outcomes. The PHOFAs are outcomes based agreements, focusing on the achievement of agreed outcomes, and do not tie the States to specific activities or matching of funding. The States are, however, required to adhere to certain principles and to continue commitment to national strategies.

² Australian Institute of Health and Welfare, National Public Health Expenditure Report 1998-99, 2001.

MAJOR ISSUES FOR THE 2004 REVIEW

13. States expressed dissatisfaction with the 1999 Review assessment method. They said that the division between preventive health and population health was artificial, and should not be kept.

14. In the 1999 Review, socio-demographic composition factors were applied to preventive health but not population health expenditure. A majority of States said that socio-demographic composition factors should also be applied to population health expenditure.

15. The paper proposes:

- (i) the division of public health expenditure into different components from those in the 1999 Review method; and
- (ii) the development of a new method for assessing socio-demographic composition disabilities, based on a general measure of health status.

CATEGORY SCOPE AND STRUCTURE

16. *CGC Discussion Paper 2001/12, Scope and Structure of the Standard Budget*, proposed retaining the 1999 Review Public Health category definition, but:

- (i) ceasing the separate assessment of HIV/AIDS expenditure; and
- (ii) renaming the category Population and Preventive Health.

17. The discussion paper proposed that the HIV/AIDS expenditure should cease to be separately identified as an expenditure component within the Population and Preventive Health category. The Commonwealth SPP associated with treatment of HIV/AIDS, which formed the HIV/AIDS component, has been broadbanded with other SPPs into the National Public Health SPP (which is assessed within the current Public Health category), and the expenditure on HIV/AIDS cannot be separately identified.

State Views

18. New South Wales stated that the AIHW's NPHER identified expenditure on 'HIV/HEP C & Sexually Transmitted Infections (STI) program' and 'Needle and Syringe programs'. These items cover a range of expenditures on HIV/AIDS, Hepatitis C, sexual health and injecting drug use. Given that these figures are readily available on a nationally consistent basis and the population demand varies significantly across States, New South Wales requested that the Commission assess separate needs for 'HIV/HEP C & STI' and 'Needle and Syringe'.

19. Western Australia considered that the distinction between population health and preventive health was artificial and did not reflect current practice within the public health field. Western Australia recognised differences between programs where the primary focus was populations or groups and those where the primary focus was individuals. For example, a school nutrition program could involve group workshops with canteen staff to increase healthy food choices, and a school immunisation program would involve injections for each pupil. However, it said that programs could involve both group and individual components. For example, immunisations are given on an individual basis, but encouraging parents to bring their children to be immunised would be done on a group basis utilising print and television advertising.

20. South Australia also said that the distinction between the population and preventive health components was not clear. For example, screening programs could quite sensibly be included under population health and it was not clear where health promotion campaigns were included.

21. South Australia noted that this issue was important because socio-demographic composition disabilities were assessed in the preventive health expenditure component but not in the population health expenditure component. It said that if health promotion campaigns were included in population health, it would be appropriate for socio-demographic composition characteristics to be recognised as a disability, as health risk factors are not equally distributed across the population. Major risk factors are quite markedly concentrated amongst socio-economically disadvantaged people (for example, smoking) and older people (for example, hypertension, being overweight, obesity and physical inactivity). South Australia noted that there was much quantitative data supporting these points, including AIHW data. Many health promotion campaigns seek to target high risk groups rather than the population as a whole.

Comments

22. For the 1999 Review, public health expenditure was divided into preventive health and population health on the basis that the first one covered expenditure targeted at individuals and the second covered expenditure targeted at the whole population and sub-populations. Preventive health expenditure was further divided into immunisation, breast cancer screening and cervical cancer screening expenditure for which separate needs assessments were made.

23. The National Public Health Expenditure Project, with the aim of providing information on the costs of public health activities, categorised public health activities into eight major public health expenditure categories for its 1998-99 report. Table 3 shows the eight categories and total State expenditure on each of them.

Table 3 PUBLIC HEALTH ACTIVITY CATEGORIES AND TOTAL STATE EXPENDITURE, 1998-99

	Total State expenditure	Percentage of total expenditure
	\$m	%
Communicable disease control	121.0	19.7
Selected health promotion	147.1	24.0
Immunisation	105.9	17.3
Environmental health	40.0	6.5
Food standards and hygiene	13.4	2.2
Breast cancer screening	85.7	14.0
Cervical cancer screening	21.3	3.5
Other core public health services	78.7	12.8
Total	613.1	100

Source: Australian Institute of Health and Welfare, National Public Health Expenditure Report 1998-99, 2001

24. State submissions and information from the NPHER indicate that the three main expenditure items under the current preventive health expenditure component — immunisation, breast cancer screening and cervical cancer screening — contain elements of individual based expenditure and whole of population expenditure. Similarly, programs within the population health component contain expenditure targeted at individuals, such as screening for disease risk factors and individual counselling as part of health promotion programs.

25. Commission staff are inclined to agree with Western Australia and South Australia that the current split between preventive health and population health expenditure is too difficult to make in practice. It may be preferable to merge the two components. This raises a number of questions.

- (i) Should separate assessments of immunisation, breast cancer screening and cervical screening be retained?
- (ii) Should a separate assessment be made of each of the public health activities shown in Table 3 (including the three mentioned in (i)) ?

26. In the 1999 Review, separate assessments were made for expenditure on immunisation, breast cancer screening and cervical cancer screening because they were considered the main expenditure items within the preventive health component. No distinction was made within the population health expenditure. Table 3 shows that the main public health expenditure items are communicable disease control, selected health promotion activities, immunisation and breast cancer screening. At this stage, Commission staff are inclined to propose separate assessments for:

- (i) communicable disease control (which would include the adjustments requested by New South Wales);

- (ii) breast cancer screening; and
- (iii) other public health expenditure.

27. Commission staff do not think that a separate assessment for immunisation is required because, as discussed below, changes to the immunisation program have resulted in immunisation targeting the majority of the population. Therefore, we do not believe that a relevant population assessment is needed, which means that the proposed assessment for immunisation would be identical to the assessment for other public health expenditure.

28. We are also not inclined to propose a separate assessment of selected health promotion activities because they cover a wide variety of activities that affect a large number of population groups. It would be difficult to assess specific socio-demographic composition needs. We are not inclined to retain a separate assessment of cervical cancer screening because of the small amount involved (about \$1 per capita).

Proposals

29. At this stage, Commission staff intend to recommend that:

- (i) the population health and preventive health components be merged; and
- (ii) three new expenditure components be created:
 - breast cancer screening;
 - communicable disease control (which includes expenditure on HIV/AIDS, STI and needle and syringe programs); and
 - other public health activities.

30. The assessment would also contain components for scale-affected expenditure and isolation.

31. Table 4 shows the proposed assessment structure for the 2004 Review. The proposed disability assessments for each component are discussed below.

32. As an alternative to the three services components discussed above, public health expenses could be assessed in a single component. Three of the four factors applied to each of the three components are the same: input costs, dispersion and cross-border. The proposed socio-demographic composition factors, discussed below, vary mainly because of relevant population issues.

33. It would be possible to show the three socio-demographic composition assessments as one. The advantage of this would be a simplified presentation, although the category factor would be the same. It may be possible to simplify the presentation even further by having one general socio-demographic composition factor for all public health expenses, that is by not differentiating between public health programs.

34. While the remainder of the paper is based on the proposed five component structure shown in Table 4, Commission staff think that a three component structure, with only one service delivery component, has considerable merit and should be considered further.

Table 4 PROPOSED ASSESSMENT STRUCTURE FOR THE 2004 REVIEW

1999 Review Structure		Proposed Assessment Structure for 2004 Review	
Expenditure component	Factors	Expenditure component	Factors
Scale-affected expenditure	Input costs Administrative scale	Scale-affected expenditure	Input costs Administrative scale
Population health	Input costs Cross-border	Breast cancer screening	Input costs Cross-border Socio-demographic composition Dispersion
		Communicable disease control	Input costs Cross-border Socio-demographic composition Dispersion
Preventive health	Input costs Cross-border Socio-demographic composition Dispersion	Other public health	Input costs Cross-border Socio-demographic composition Dispersion
HIV/AIDS	Input costs Socio-demographic composition		
Isolation	Isolation	Isolation	Isolation

ISSUES

35. States' submissions were structured around the 1999 Review assessment. As we are now proposing to radically change this assessment for the 2004 Review, many State arguments do not fit neatly. Most State arguments are therefore discussed under their respective disability headings and out of context of the proposed assessment structure.

Socio-demographic Composition

36. ***Background.*** In the 1999 Review, no socio-demographic composition factors were assessed for the population health component. The then Commission considered that the majority of population health services were aimed at the whole population. The cost of providing policy formulation, promotional and education services was not considered to be affected by the socio-demographic composition of a State.

37. For the preventive health component, a socio-demographic composition factor was assessed to take account of the relevant (or target) population for the programs (childhood immunisation, breast cancer screening and cervical screening) and the effects on costs of low English fluency.

38. ***State views.*** A number of States submitted that an assessment of socio-demographic composition disabilities should be made in the population health component.

39. Victoria considered that the needs assessed in the preventive health component were not balanced enough. A more balanced assessment would also recognise the costs associated with treating other community groups such as people from Non English Speaking Backgrounds (NESBs), wider disease prevention needs and the greater preventive health needs of large urban areas.

40. Victoria also claimed that the concentration of high public health risk populations in urban areas, where transmission of diseases was easier and control more difficult, meant that there was greater need for expenditure on preventive health measures in urban areas. Hence, an urbanisation factor should be assessed.

41. Western Australia noted that certain population health programs were affected by disabilities other than input costs and cross-border influences. For example, the number of workshops for school canteen staff targeted at increasing healthy food choices increased with larger numbers of schools — an aspect dependent on population size and dispersion.

42. Western Australia stated that this led to one of two conclusions, either:

- (i) substantial portions of population health programs should be reclassified as preventive health (where socio-demographic composition and dispersion factors applied); or
- (ii) socio-demographic and dispersion factors should be applied to the population health component.

43. Tasmania said that, to assess the relative needs of each State, it was necessary to consider the relative needs of each target group, weighted by the relative commitment to each of the preventive illness programs nationally. It said that it would be necessary to aggregate State expenditures on each program to assess the relative commitment by States. This expenditure information could then be applied to the target group in each State to assess the weighted needs of each State.

44. The ACT believed that the scope of the socio-demographic composition factor was not wide enough, as all States participated in a wider range of programs with a significant population and preventive health focus. This included the National Health Priority Areas of cardio-vascular health, cancer control, injury prevention and control, mental health, diabetes and asthma.

45. The ACT requested that the socio-demographic composition factor be discontinued. It claimed this would be consistent with the nature of related programs which provided benefits to the whole population of the States, and would also overcome anomalies of low needs being assessed for such expenditures, notwithstanding high rates of incidence of the associated disease.

46. The Northern Territory requested that the Commission expand the socio-demographic factor to reflect the diversity in preventive health programs and the clear link between expenditure and health status. This general effect needed to be taken into account, and the simplest way to do so would be to use differences in mortality rates as a proxy for need for expenditure on preventive health programs.

47. *People from non-English speaking background.* New South Wales said the Commission should recognise that providing culturally acceptable and effective population health services required extra resources, and make an adjustment for the NESB population. It asserted that, while the cost of meeting the population health needs of the NESB population was not as great as the costs associated with preventive health (due to less reliance on direct patient translation services), there were additional costs in providing culturally appropriate services in population health. For example, the New South Wales Multicultural Health Communication Service ran health promotion campaigns targeting specific ethnic groups and produced health promotional material in languages other than English.

48. Victoria noted that newly arrived NESB migrants typically had a much higher incidence of carrying and transmitting diseases that represent significant public health risk. Governments needed to take preventive measures to overcome or limit this risk. The public health measures taken to screen for such diseases were costly due to the variety of disease, as well as the inherent costs involved with treating large numbers of migrants from differing cultural backgrounds. States with high proportions of the population representing a potentially greater public health risk faced a consequently higher demand for preventive services.

49. The Northern Territory also raised issues about the need to screen for diseases, such as tuberculosis. Tuberculosis rates in the Northern Territory were eight times the national average. It claimed that it faced higher costs as a result of the need to screen and treat Commonwealth offenders, such as illegal immigrants, for tuberculosis. The incidence of such cases had increased substantially in the last few years. In the three years, 1999 to 2001, 283 Indonesian nationals incarcerated in the Darwin Correctional Centre for people smuggling were assessed by the TB unit. In 2001, there were about 500 illegal foreign fishermen detained on Darwin Harbour.

50. The Northern Territory suggested that the Commission apply a cost weight of 1.5 to people from NESBs in order to capture the additional costs of adapting population

health programs to reflect the cultural and language diversity of the Northern Territory population.

51. *Socio-economic status.* Tasmania argued that a disability should be assessed for low socio-economic status. It claimed that additional effort was needed to assist low socio-economic households to change and improve their health care activities. It said that a recent survey by Tasmania's health authority revealed that low income households were less likely to access health care services, purchase prescriptions, eat healthy food or maintain a healthy household. These issues demonstrated a need for greater service delivery to low-income households if they were to improve their health status. Hence, a weighting should be applied to people of low socio-economic status to reflect the additional cost of ensuring that this group of people were able to benefit from population health programs. It claimed that a weight was applied to people with low English fluency, and that weights should be applied to other groups as well.

52. South Australia argued that if health promotion campaigns were included in the population health component, it would be appropriate for socio-demographic composition to be included in the calculation, as health risk factors were not equally distributed across the population. Major risk factors were markedly concentrated amongst socio-economically disadvantaged and older people, and many health promotion campaigns sought to target high risk groups rather than the population as a whole.

53. *Remoteness.* Western Australia asserted that increased demand for population health services in rural and remote regions was indicated by the decreased prevalence of health-enhancing behaviours amongst these populations. It provided data from its 1995 population health survey which indicated that the percentage of adults engaged in health-enhancing behaviours such as not smoking, exercising, using sunscreen and eating fruit and vegetables, decreased with increasing remoteness. Western Australia claimed that this resulted in a higher level of need for population health services in rural and remote regions, with a requirement for programs designed specifically to target people in those areas. For example, the Kimberly Public Health Unit was developing a 'Kimberley-specific fat in food' resource in order to address the specific issues in their areas.

54. Western Australia submitted that the greater need for population health services in remote regions should be reflected by the assessment of a socio-demographic composition factor, with a weight for remote populations.

55. *Indigeneity.* Western Australia submitted that there were increased costs associated with delivering public health services to the Indigenous population. For example, it ran specific Aboriginal Public Health programs and employed Aboriginal Environmental Health Workers. Western Australia also contended that there was compelling evidence that the need for public health services was greatest in Indigenous communities, such as the fact its hospital morbidity dataset (1994-2000) showed increased hospitalisation rates for Indigenous people in a number of environment related categories.

56. The Northern Territory also argued that an assessment based on Indigeneity should be introduced. According to the National Public Health Expenditure Report, the Northern Territory spent over eight times as much as other jurisdictions on health promotion. This difference was primarily the result of additional need for expenditure,

particularly on Indigenous people because of their poor health status. Many health promotion campaigns were targeted at the Indigenous population, which must be provided in a culturally appropriate manner. Material used in national campaigns elsewhere could not always be used in the Northern Territory, and must be translated into a form that would be easily understood by its population.

57. The Northern Territory contended that, as the need for expenditure was ultimately related to health status, the Commission should use a broad indicator of health status as a measure of need for public health expenditure. Differences in mortality rates would be the simplest approach.

58. *Urbanisation.* Victoria noted that diseases such as Hepatitis B, Tuberculosis and parasitic diseases have been found to affect the migrant population. It also claimed that the risks of and costs associated with highly contagious diseases were significantly greater in urban areas in terms of identifying problems and managing solutions. As Sydney and Melbourne are the major ports of entry for migrant populations, these urban areas were at greatest public health risks and had additional demand for preventive expenditure on potential public health risks. Victoria therefore argued that an urbanisation factor should be included to account for the significantly greater public health risks in urban areas.

59. *Chronic Diseases.* The Northern Territory provided data showing that its population had a much greater rate of chronic diseases such as kidney disease, diabetes, heart diseases and respiratory infections. The high incidence of chronic diseases was primarily related to the high rates of death from chronic disease amongst the Indigenous population. Many of the risk factors associated with chronic diseases related to environmental and lifestyle factors such as housing, environmental health, nutrition, low birth weight, smoking and alcohol consumption. There were a number of health promotion and population health programs that covered these issues — preventive and education programs together constituted over 29 per cent of the Northern Territory's public health budget. This focus was necessitated by the much higher rates of chronic disease. The Northern Territory thus asserted that a disability for chronic diseases should be assessed, based on death rates for key chronic diseases.

60. *Communicable Diseases.* The Northern Territory suggested that the Commission retain the HIV/AIDS component and expand it to include needs for expenditure on all communicable diseases. It provided data which showed its population suffered from high rates of infection from communicable diseases such as tuberculosis, sexually transmitted disease (other than HIV/AIDS), vector-borne diseases and gastroenteritis. It claimed this high rate resulted in a greater need for expenditure — the NPHR's figures indicated that the Northern Territory spent 23.5 per cent of its public health budget on communicable diseases, which was higher than the Australian average of 22.6 per cent (when New South Wales expenditure on HIV/AIDS was excluded the Australian average was approximately 16 per cent). A substantial proportion of the Northern Territory's expenditure was related to tuberculosis.

61. The Northern Territory said it had a much greater diversity of disease, which also impacted on costs. There were additional costs associated with providing services to Indigenous people — for example, the 'tracking' of patients was more costly as a result of the high mobility of the Indigenous population. It was claimed that a case of tuberculosis in

an Indigenous community may have 100 contacts to follow up, compared with 5-15 in other jurisdictions.

62. The Northern Territory requested that the Commission include a communicable diseases component, with weights for rates of infection from HIV/AIDS, sexually transmitted diseases, intestinal infectious diseases, tuberculosis, zoonotic and other bacterial diseases, influenza and pneumonia and lower respiratory tract infection.

63. The Northern Territory stated that, if a communicable diseases component was assessed, dispersion, input costs and economic environment factors should also be assessed in that component.

64. ***Comments and Proposal.*** States have argued convincingly that a wide range of socio-demographic characteristics and morbidity influence what they spend on public health services. Commission staff think there is a conceptual basis for the existence of low socio-economic status and Indigeneity disabilities, mainly based on the evidence available for other health services and the fact that ‘at risk’ groups are more confined to people of low socio-economic status and Indigenous people. However, there is little direct evidence that additional use and/or costs are incurred for public health activities. One available piece of evidence for higher than average spending on Indigenous people comes from the AIHW’s 2001 report on Expenditure on Health Services for Aboriginal and Torres Strait Islanders. It indicated higher per capita public health expenditure on Indigenous people. It is not clear how remoteness leads to a need for additional expense.

65. We would like more information on how recently arrived migrants impact on the cost of providing public health services, besides those effects already accounted for in the low English fluency assessment. It is not clear how their location in urban areas additionally influences the need for public health programs.

66. Public health expenditure covers a wide range of activities. Commission staff think it would not be practical to attempt to measure separate demand and/or cost influences in relation to the various groups identified by the States for each of the main public health activities. The necessary data are not available to derive reliable weights, and probably not even to estimate them.

67. In addition, many public health activities are targeting ‘at risk’ groups, such as smokers, and overweight and obese people, who are found in all groups in society.

68. Commission staff propose that these two disabilities be assessed through a general health status measure such as mortality rates. The reasons for this are:

- (i) public health activities cover a myriad of services for which different demand and cost patterns exist;
- (ii) no appropriate use or cost data exist for these services; and
- (iii) many ‘at risk’ groups targeted by public health activities are not exclusively of low socio-economic status, Indigenous or from NESBs, and may be better captured through a broad health status measure.

69. We will try to develop a measure based on regions of States that will also capture the effects of remoteness and urbanisation.

70. We believe that disabilities related to chronic and communicable diseases would be picked up by the proposed assessment.

71. The AIHW's 2001 report on Expenditure on Health Services for Aboriginal and Torres Strait Islanders said that the health status of Indigenous people is three times worse than non-Indigenous, but spending on public health expenditure is about 1.5 times more for Indigenous people. This indicates that some discounting of the health status factor may be appropriate.

72. The assessment would be applied to all service delivery components of the category, except communicable disease control for which we are proposing a different assessment.

73. Commission staff will investigate possible measures of health status. There are a number of measures available, including mortality, morbidity, disability and handicap, perceived health and risk factor indicators. We would welcome suggestions from States for measures of health status which could be used in the assessment.

Dispersion

74. ***Background.*** In the 1999 Review, a dispersion factor was assessed for the preventive health component, but none for the population health component.

75. The Commission noted that the introduction of a dispersion factor for the population health component had some appeal, as there appeared to be ways in which the influences that the common dispersion factor took into account would affect the costs of population health services. However it concluded that those influences were likely to be too small to justify the application of the dispersion factor.

76. ***State views.*** Western Australia submitted that there were dispersion cost and demand impacts on population health services. It claimed that it was often difficult to deliver health promotion campaigns to remote areas. Few campaigns were solely electronic. They tended to take a multifaceted approach combining visual (for example, television), oral (for example, seminars) and aural (for example, radio) to deliver the message. At a minimum, this required the mailing of information packages and follow-up telephone calls to local health care providers across the State. At a maximum, it involved moving personnel, equipment and information around the State. Hence, there was additional expenditure on health promotion campaigns in Western Australia as a result of its dispersed population compared with other States.

77. Western Australia provided data showing public health expenditure for three public health units in 2001-02. Public health expenditure in the Pilbara was \$49 per capita, compared with \$2.81 in the North Metropolitan region. Western Australia claimed the increased expenditure was a result of the greater need for public health services in remote

regions, coupled with increased costs associated with delivering services to a small, scattered population.

78. Western Australia also said that an example of a greater cost borne in rural regions was the management of drinking water quality. In order to meet drinking water testing standards, testing on samples must occur within 24 hours. In geographically smaller States, this standard was relatively easy to achieve. For Western Australia, transporting water samples to Perth from the State's North West and central regions within 24 hours was logistically difficult and in some cases required a plane to be chartered (where a commercial flight was unavailable).

79. **Comments.** Commission staff are inclined to support a dispersion assessment for the three service delivery components discussed above.

Scale-affected Expenditure

80. **Background.** An administrative scale factor was assessed in the 1999 Review. The scale-affected expenditure for the category was assessed as \$17 million, of which \$2 million was considered as fixed cost and \$15 million as variable cost.

81. The scale-affected expenditure component was 24 per cent of expenditure in this category. This was because many of the services covered by the category were provided for a State as a whole and costs associated with them were not directly related to the size of the population served.

82. **State views.** In the area of public health, the Northern Territory claimed it suffered large administrative scale disabilities as a result of the need to fund research and develop tools relevant to its circumstances. It stated that it spent \$10.45 per capita on research, compared with a national average of \$4.94. The Northern Territory Government was a member of the board of both major research centres in the Northern Territory and provided both with core funding and funding for specific projects.

83. In addition, unlike other jurisdictions, the Northern Territory claimed it is often unable to use national datasets as a result of sampling or other problems. Instead, it must conduct its own research and construct its own datasets. An example of this was the need to develop and maintain a Northern Territory Childhood Immunisation Database to provide community recall lists of clients due for immunisations. Other jurisdictions use the Australian Childhood Immunisation Register (ACIR) for this function. The Northern Territory could not because the ACIR was unable to produce lists of children due and overdue for vaccination based on the community of residence — such lists are crucial for the provision of immunisation services in remote communities. The ACIR produced reports of children due for vaccination by GPs billing Medicare. However this is not useful for remote communities without a Medicare billing GP.

84. The Northern Territory also said that the need to involve community members when designing population and preventive health programs came at some administrative cost. It said that the success of such programs depended on community acceptance of the program and the key messages it imparted. It provided as an example the

Strong Women Strong Babies Strong Culture program, which employed members of Indigenous communities, supported by Department of Health and Community Services staff. The time of the DHCS staff was not costed into program delivery. It claimed the administrative and developmental costs of this program were scale-affected variable costs.

85. The Northern Territory stated that, if the Commission decided to remove scale-affected variable costs, it would need to introduce a separate factor to take account of the additional expenditure incurred in funding original research. It would also need to include a disability factor that accounted for the expenditure incurred as a result of a high mortality rate and unique disease profile.

86. *Comments.* The size of the scale-affected expenditure for public health will be reviewed in conjunction with the review of the general administrative scale assessment.

Input Costs

87. In the 1999 Review, an input costs factor was assessed for the preventive health, population health and scale-affected expenditure components. No States commented on input costs in their submissions. Commission staff will propose an assessment of input costs in the scale-affected expenditure component and the three new service delivery components using the 2004 Review method.

Cross-border

88. *Background.* During the 1999 Review, the ACT suggested that the costs of some public health services, such as communicable disease surveillance, nutrition services, pharmaceuticals provided outside hospitals and aids and appliances used for health purposes, were responsive to population size. The Commission decided that a cross-border factor was justified for expenditure on population health. The impact of the cross-border factor for the preventive health component on the ACT's grant share in the 1999 Review was very small.

89. The Commission decided that cross-border factors were justified for expenditure on immunisation services provided to cross-border school students, kindergarten students and pre-schoolers. A cross-border factor was applied to the childhood immunisation part of the preventive health component.

90. *State views.* New South Wales argued that there was no firm evidence of cross-border flows for population health services and that the factor was therefore not warranted.

91. New South Wales provided data on child immunisation from the Australian Childhood Immunisation Register which indicated that only 15.4 per cent of children from the Queanbeyan, Yass, Yarrowlumla and Gunning local government areas were immunised by ACT Government providers in 2000-01, instead of the 50 per cent proportion currently assumed in the assessment. On that basis, New South Wales concluded that the adjustment was overstated and should be reduced.

92. The ACT claimed that the allowance provided by this factor did not meet a reasonable test of materiality. The outcome was anomalous given that the present general method made no allowance for costs associated with the differences in socio-economic composition of the ACT and regional population.

93. The ACT considered that a cross-border factor based on the proportion of total hospital separations would represent a reasonable proxy of the costs arising from the cross-border use of the ACT health system which were not recognised by other assessments. The ACT asked that the Territory's proposed modified general method (which is predominantly based on hospital separations) be applied to the Population Health component as it more accurately reflected the population and preventive health costs faced by the ACT than the application of broad judgment.

94. ***Comments and Proposal.*** Socio-economic factors should not influence the costs of immunisation, as it appears that it costs the same amount to immunise any child, regardless of their socio-economic status.

95. New South Wales did not indicate whether the data represented only children aged 4-6, or children aged zero to 6. No cross-border assessment is made for children aged zero to 4. If New South Wales' data include children aged zero to 4, the average cross-border use would be lower than that estimated by the Commission. Commission staff will review this assessment.

96. While at this stage Commission staff are inclined to recommend that a cross-border factor be applied to relevant public health expenses, we would like more evidence from New South Wales and the ACT. If evidence is not presented, we would favour a conservative assessment of needs.

Economic Environment

97. ***Background.*** An economic environment factor was considered briefly during the 1999 Review but little input was received from States. No assessment was made.

98. ***State views.*** Tasmania argued that an economic environment adjustment was needed to reflect the higher price small States must pay for services as a result of the lack of competition between service providers. It said that, as most States contract out these services, the price was generally determined by the market and not government policy. For example, it recently sought expressions of interest to deliver a screening program. Only one expression was received from the existing service provider. Tasmania said that, as a result of its small market for this service, there was little interest from firms operating in larger markets to enter the Tasmanian market. The lack of competition gave the current service provider a strong negotiating position, potentially resulting in a higher cost to the State, as it was essential that the service was provided. An average unit price for each State would provide a measure of the relative difference in the cost each State incurs in delivering these services.

99. The Northern Territory claimed that most of its preventive health services, such as immunisation, were provided through State Government providers. This was

different from other jurisdictions where it was common for services such as immunisation to be provided by GPs. This is shown in Table 5.

100. The Northern Territory requested that an economic environment factor be introduced to account for the greater reliance on public providers. It said the disability was essentially the same as that encountered in the provision of community health services, and the Commission should therefore use the same factor as that used in the Non-Inpatient and Community Health Services category.

Table 5 PERCENTAGE OF VACCINATIONS SUPPLIED TO THE AUSTRALIAN CHILDHOOD IMMUNISATION REGISTER, 30 JUNE 2002

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Unknown	Aust
Unknown	-	-	-	-	-	-	-	-	0.03	0.00
Division of GP	0.00	0.00	-	0.00	0.01	-	-	-	-	0.00
Council	6.79	48.28	7.77	8.14	17.51	14.28	-	-	-	18.41
State Health Dept	0.00	-	0.01	5.08	0.05	0.13	40.19	0.04	-	1.19
Flying Doctor Service	0.02	-	0.35	0.00	0.15	-	-	-	-	0.09
Medicare GP	82.19	49.13	26.98	61.72	66.31	85.06	38.10	3.03	-	58.23
General Practice	0.59	1.50	56.20	1.19	3.22	-	-	-	-	11.62
Community Nurse	-	0.00	-	-	-	-	-	-	-	0.00
Public Hospital	2.91	0.23	3.10	5.36	4.77	0.15	1.10	1.83	62.81	2.52
Private Hospital	0.19	0.00	0.03	0.00	-	-	0.01	0.95	-	0.08
Aboriginal Health Service	0.49	0.09	0.50	0.47	0.33	-	0.19	6.47	-	0.45
Community Health Centre	6.80	0.75	4.53	18.04	7.55	0.38	20.42	87.49	37.16	7.29
Aboriginal Health Worker	0.02	-	0.54	0.00	0.09	-	-	0.18	-	0.12
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Source: Australian Childhood Immunisation Register Statistics, Australian Health Insurance Commission.

101. **Comments.** Commission staff believe there is some merit to Tasmania's claim but, if this issue is to be pursued further, we require clear evidence. We would like States to provide data on the unit cost of providing public health services.

102. The Northern Territory's data show that for most States immunisation is provided through GPs, at no cost to the States. It said that the data were representative of other public health services.

103. The economic environment factor in the Community Health assessment already accounts for the greater need for public services in non-metropolitan areas. Some of the services covered would be classified as public health, such as immunisation.

104. What is not covered by the economic environment factor in the Community Health assessment would be the cost of vaccines.

105. It is not clear whether similar differences in private/public services provision would be found for other services. We ask the Northern Territory to provide information for other public health activities. Commission staff will investigate this issue further.

PROPOSED ASSESSMENT

Immunisation and Breast Cancer Screening

106. **Background.** In the 1999 Review, needs for these two expenditure items were assessed through disability factors for:

- (i) input costs;
- (ii) dispersion;
- (iii) socio-demographic composition; and
- (iv) cross-border.

107. The two socio-demographic composition factors included assessments of relevant population and low English fluency. The relevant populations used were:

- (i) breast cancer screening — women aged 40-70; and
- (ii) childhood immunisation — children aged 0-6 and women aged 15-49.

108. **State views.** The section contains only State views specific to these two assessments. States have made many comments regarding the assessment of preventive health in general which we consider are addressed by the proposed assessment structure.

109. Tasmania requested that a socio-economic adjustment be included in the socio-demographic composition factor. This was required to reflect the additional effort needed to encourage people with low socio-economic status to change behaviour and to take advantage of illness prevention programs.

110. The ACT stated that, for breast cancer screening expenditure, the need for early detection measures was evident for women younger than 40 years. It asserted that the present assessment, while reflecting diverse State practices, did not fully reflect the range of early detection and population health measures that States needed to undertake.

111. The ACT claimed that the socio-demographic composition factor was inadequate as it assessed the ACT as having the lowest relative needs of all States for expenditure on breast cancer screening, despite the fact that the incidence rates of breast

cancer for women aged 50-69 years in 1998 were highest in the ACT. This arose primarily from:

- (i) the lower proportion of ACT women in the 40 to 70 year age group who were not fluent in English;
- (ii) the higher weighting given for low English fluency; and
- (iii) the lower proportion of the ACT's total population represented by women aged 40-70 years, compared to the national average.

112. The Northern Territory stated that the assessment for preventive health programs did not reflect the cost impact of disabilities associated with health status and disease profile. It believed the socio-demographic factor was too narrow and needed to include demand weights for high needs groups such as the Indigenous population. It claimed that there was a greater demand for preventive services in the Territory, relative to other jurisdictions, as health outcomes were relatively poorer.

113. *Comments relating to immunisation expenditure.* Since the 1999 Review, immunisation programs have expanded to include greater emphasis on pneumococcal and influenza vaccination. The National Public Health Expenditure Report has immunisation expenditure classified into:

- (i) childhood immunisation;
- (ii) pneumococcal and influenza immunisation; and
- (iii) other.

114. Table 6 shows immunisation expenditure by States as reported in the National Public Health Expenditure Report.

Table 6 EXPENDITURE ON IMMUNISATION

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Childhood	\$m	19.12	11.54	2.45	3.36	6.39	1.02	0.94	1.45	46.28
Pneumococcal & influenza	\$m	-	11.69	3.83	2.60	1.89	1.05	1.68	0.34	22.27
Other immunisation	\$m	18.80 ^(a)	3.00	8.05	2.78	0.18	0.00	0.00	5.36	38.97
Total	\$m	37.92	26.23	14.33	8.74	8.46	2.07	2.61	7.16	107.53
	\$pc	5.96	5.60	4.12	4.74	5.68	4.39	8.46	37.42	5.71

(a) Pneumococcal and influenza immunisation expenditure was not reported separately by New South Wales, therefore it makes up the majority of expenditure on Other immunisation.

Source: *National Public Health Expenditure Report 1998-99*, Australian Institute of Health & Welfare, 2001.

115. According to the Australian Vaccination Schedule, the target populations for the range of immunisation recommended by the National Health and Research Medical Council are:

- (i) children aged 0-4 years;
- (ii) Aboriginal children in Central Australia aged 2-14 years;
- (iii) adolescents aged 10-13 years;
- (iv) adolescents aged 15-19 years;
- (v) women of child-bearing age, 15 to 49 years;
- (vi) adults aged 50 years and over;
- (vii) Aboriginal and Torres Strait Islander people aged 50 years and over;
and
- (viii) adults aged 65 years and over.

116. In relation to Indigenous people, it seems likely that there would be a greater cost of delivery in remote areas. The higher costs could be captured by the proposed health status factor.

117. ***Proposal for immunisation.*** As most of the population is targeted by at least one immunisation program, and in the interest of simplicity, Commission staff are inclined to recommend that no relevant population assessment be made for expenses on immunisation.

118. Commission staff intend to recommend that the current low English fluency adjustment be retained. We are also inclined to include a health status factor as described above, and an assessment of input costs, dispersion and cross-border factors.

119. This proposed assessment is the same as that proposed for the other public health expenditure assessment and, therefore, Commission staff propose to merge immunisation expenditure with expenditure on other public health expenditure.

120. ***Comments relating to breast cancer screening expenditure.*** The ACT claimed that the breast cancer assessment was inadequate. The assessment is for expenses on screening women aged between 40 to 70 for breast cancer every two, not for breast cancer treatment.

121. Information provided by States for the 1999 Review showed that the average State policy was to provide free breast cancer screening to women aged 40 to 69. The current BreastScreen Australia policy statement says that women are selected for screening on the basis of age alone. Women aged 40 years and above are eligible. All promotional materials and recruitment strategies are targeted at women aged 50-69 years.

122. Table 7 shows breast cancer screening expenditure by States as reported in the National Public Health Expenditure Report.

Table 7 EXPENDITURE ON BREAST CANCER SCREENING

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
		\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Breast screening	\$m	31.93	18.87	15.40	7.67	6.26	2.99	1.46	1.10	85.68
	\$ per woman 40-70	32.71	26.16	30.14	28.78	25.89	39.47	31.50	53.72	29.97

Source: *National Public Health Expenditure Report 1998-99*, Australian Institute of Health & Welfare, 2001.

123. **Proposal.** Commission staff intend to recommend that the 1999 Review assessment be retained for the 2004 Review. We also intend to recommend that the current low English fluency adjustment be retained. The component would include a health status factor to account for low socio-economic status, Indigenous and other relevant 'at risk' groups.

124. We also intend, as discussed above, to include an assessment of input costs, dispersion and cross-border factors.

Communicable Disease Control

125. The proposed component would include expenses on:

- (i) HIV/AIDS, hepatitis C and sexually transmitted infection (STI) programs;
- (ii) needle and syringe programs; and
- (iii) other communicable disease control, such as tuberculosis, Ross river virus, Japanese encephalitis.

126. Table 8 shows communicable disease control expenditure by States as reported in the NPHR.

Table 8 EXPENDITURE ON COMMUNICABLE DISEASE CONTROL

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
HIV/AIDS, hepatitis C & sexually transmitted infection programs	\$m	25.25	9.81	9.55	5.38	3.22	0.68	1.15	2.25	57.29
Needle & syringe programs	\$m	11.17	2.99	1.62	0.98	0.74	0.26	0.35	0.02	18.12
Other communicable disease control	\$m	9.83	9.39	7.98	5.43	6.25	0.14	0.23	6.29	45.54
	\$m	46.25	22.19	19.16	11.79	10.21	1.08	1.73	8.55	120.95
Total	\$pc	7.26	4.74	5.51	6.39	6.85	2.29	5.61	44.68	6.42

Source: *National Public Health Expenditure Report 1998-99*, Australian Institute of Health & Welfare, 2001.

127. **State views.** New South Wales said that the correlation between numbers of methadone clients and numbers of opioid overdose deaths with the number of heroin users was self-explanatory. The correlation between number of diagnoses of hepatitis C infection and the number of heroin users was less obvious as hepatitis C could be transmitted in many ways. However, studies of hepatitis C risk factors in Australia³ indicated that around 80 per cent of people diagnosed with hepatitis C were exposed through injecting drug use.

128. New South Wales said that these indicators gave a good indication of the relative size of the drug using population across different States, but a much less certain indication of the absolute size of the drug using population in each State. As such, they could justifiably be used to compute factors designed to determine the relative positions of the States.

129. New South Wales provided data indicating that the relatively high level of drug use imposed significant costs on its health system. In the area of preventive health, this was largely reflected in expenditure on needle and syringe programs, aimed at preventing the spread of HIV and other diseases contracted from unhygienic needle use.

130. **Comments.** The target group for needle and syringe programs is injecting drug users. Given the nature of this subject, there are no definitive data showing the proportion of the Australian population who inject drugs. The ABS publication *Illicit Drug Use, Sources of Australian Data*, does not mention any data source which could provide statistics about the relative number of injecting drug users in each State.

131. New South Wales suggested using a combination of data from different sources to give an indication of the size of the drug using population, as shown in Table 9.

³ *National Hepatitis C Strategy 1999-2000 to 2003-04*, 2000, p.4.

Table 9 DRUG USING POPULATION BY STATES

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of:									
Methadone clients	14,945	7,467	3,732	2,307	2,522	459	641	25 ^(a)	32 098
Hepatitis C diagnoses	8,286	5,475	2,985	1,288	992	294	285	255	19 860
Opioid overdose deaths	1,544	1,130	274	203	306	21	19	49	3 546
Population ('000)	6564	4 831	3632	1923	1507	469	316	199	19 445
Per cent of total Australian:									
Methadone clients	46.6	23.3	11.6	7.2	7.9	1.4	2.0	0.1 ^(a)	100.0
Hepatitis C diagnoses	41.7	27.6	15.0	6.5	5.0	1.5	1.4	1.3	100.0
Opioid overdose deaths	43.5	31.9	7.7	5.7	8.6	0.6	0.5	1.4	100.0
Population	33.8	24.8	18.7	9.9	7.8	2.4	1.6	1.0	100.0
Possible adjustment factors – based upon:									
Methadone clients	1.38	0.94	0.62	0.73	1.01	0.59	1.23	0.08 ^(a)	1.00
Hepatitis C diagnoses	1.24	1.11	0.80	0.66	0.64	0.61	0.88	1.25	1.00
Opioid overdose deaths	1.29	1.29	0.41	0.58	1.10	0.25	0.31	1.4	1.00

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

Source: Methadone statistics: Commonwealth Department of Health and Aged Care, Illicit Drugs Section. Figures as at 30 June 2001.

Hepatitis C diagnoses: National Centre for HIV Epidemiology and Clinical Research. Annual average of the years 1996 to 2000.

Opioid overdose deaths: National Drug and Alcohol Centre. Numbers are the total over the period 1996 to 2000. Population figures as at 30 December 2001.

132. **Proposal.** Commission staff intend to recommend that an assessment of needs be made based on the number of people with HIV/AIDS and hepatitis C similar to the 1999 Review assessment for HIV/AIDS related expenditure. An assessment based on the drug using population should be made for expenditure on needle and syringe programs.

133. Commission staff intend to recommend that the current low English fluency adjustment be retained. The component would also include a health status factor to account for low socio-economic status, Indigenous and other relevant 'at risk' groups. We also intend, as discussed above, to include an assessment of input costs, dispersion and cross-border factors.

Other Public Health Expenditure

134. Other public health expenses cover:

- (i) selected health promotion activities (including activities such as nutrition, exercise and physical activity, school health and suicide prevention);
- (ii) environmental health (including activities such as rodent control, chemical regulation, water quality control and radiation safety control);
- (iii) food standards and hygiene (including activities such as development and surveillance of food standards, and education such as food safety awareness campaigns);
- (iv) cervical cancer screening; and
- (v) other core public health services (including activities such as alcohol regulation, tobacco control, human remains regulation, and air and noise pollution control).

135. Environmental health, food standards and hygiene and other core public health services do not, overall, appear to target specific population groups or be affected by the socio-demographic composition of the population.

136. On the other hand, expenses on selected health promotion activities and cervical cancer screening would be affected by the size of the relevant target population and its socio-demographic composition.

137. **Proposal.** Commission staff are inclined to recommend that no relevant population assessment be made for this component because:

- (i) selected health promotion activities cover a wide range of activities — it would be too difficult to identify the relevant population for each activity and, in any case, the result would likely be close to an equal per capita assessment; and
- (ii) expenditure on cervical cancer screening is not sufficiently material (about \$1 per capita) to warrant a separate assessment.

138. We propose to include a low English fluency cost weight and the proposed health status assessment. We also intend, as discussed above, to include an assessment of input costs, dispersion and cross-border factors.

PROPOSED ASSESSMENT STRUCTURE

139. The 2004 Review proposed assessment structure, shown in Table 10, differs markedly from the 1999 Review structure. The main differences are that:

- (i) the population health and preventive health components have been merged; and
- (ii) three new expenditure components have been created:
 - breast cancer screening;
 - communicable disease control; and
 - other public health activities.

Component Weights

140. New South Wales submitted that the Commission incorrectly assessed the amount of preventive health and population health expenditure. It requested a review of the share of expenditure for each component to reflect information from the NPHER.

141. Commission staff will determine component weights using the NPHER, ABS GFS data and State budget information.

Table 10 PROPOSED ASSESSMENT STRUCTURE FOR THE 2004 REVIEW

Component	Factors	Basis of calculation
Scale-affected expenditure	Input costs	General method.
	Administrative scale	General method.
Breast cancer screening	Input costs	General method.
	Cross-border	General method.
	Socio-demographic composition	Based on the target population, a weight for low English fluency and a general health status measure.
Communicable disease control	Dispersion	General method.
	Input costs	General method.
	Cross-border	General method.
	Socio-demographic composition	Based on target populations, a weight for low English fluency and a general health status measure.
Other public health	Dispersion	General method.
	Input costs	General method.
	Cross-border	General method.
	Socio-demographic composition	General health status measure and a weight for low English fluency.
Isolation	Isolation	General method.

REQUEST FOR INFORMATION

142. We request information on how recently arrived migrants increase the cost of providing public health services, over and above the costs related to low English fluency.

143. We request, from New South Wales and the ACT, estimates of cross-border patient flows for public health activities.

144. We request from all States data on the unit cost of providing public health services.

145. We request information about the impact of private sector services on the need to provide services relating to public health.