Response to Dept. of Health & Ageing's Discussion Paper
January 2002

Review of funding formula for divisions of general practice

The aim of the Divisions' Program and the Department of Health & Ageing's expectations of divisions are central to the way the funding formula should be developed as different Program aims and Division functions may require different components of funding.

For example, if the delivery of health services is to be a function of divisions, they would require appropriate infrastructure funding based on service delivery, rather than the existing funding that supports the Program's aim: "to improve the health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level."

Victorian divisions have consistently raised with GPDV the need for some objective measure of the minimum and maximum sizes for divisions to be effective. This would provide divisions with some guidance as to what is and is not achievable; allow policy on amalgamation to be based on evidence; and provide more clarity about how the funding formula components should fit together (e.g. whether or not a flagfall is desirable, and if so, what its amount should be based on).

One division has suggested that if the aim of the Divisions Program were population health, then the formula could be population-based. If the aims are broader (as they currently are) funding could be based on broader criteria, including patient health outcomes, integration and quality. Other divisions have raised concerns that they do not receive funding for their resource-intensive work on state-funded initiatives. Although this is all about the integration of general practice with the rest of the health system and therefore central to the aim of the Divisions Program, at the moment the funding criteria does not recognise this type of work.

a) The flagfall & amalgamation

One of the Review's principles is to ensure a clear rationale for each funding component and the rationale for the flagfall is that there is "a critical mass of resources required to manage a division, irrespective of … size" (p.3, Discussion Paper). But there is a lack of objective evidence about what this critical mass of resources is and the flagfall amount seems to be set at a level which is in fact lower than the amount required to run a division (hence the current need for "top-up" grants for small divisions). In once sense, this means that other population-based components of funding simply go towards subsidising the flagfall shortfall. Logic suggests that if the Department wishes to encourage amalgamation, it would abandon a flagfall, as it is a measure that effectively maintains the *status quo.*

Adopting, or adjusting, the flagfall amount for the historical reason that it has always been part of the divisions' funding formula, might provide a quicker solution, but further detailed analysis is required if the funding formula for divisions is to be improved.

Rather than seeking input on what the principles should be for dealing with divisions who wish to amalgamate, what is sought by divisions – and GPDV – is a clear indication of the minimum and maximum size for a viable division and how this varies in a metropolitan or

rural area. Commissioning research to establish this objectively – if the work begun by QDGP does not answer the question fully enough – would then provide an evidence base for the formulation of policy on amalgamation.

b) Calculation of population levels

Feedback from divisions suggests general support of Estimated Resident Population (ERP) on the basis that it will provide more up-to-date information.

c) RRMA to ARIA

The discussion paper argues that ARIA values vary along a "continuous spectrum" without artificial boundaries that create rigid "cut off" points, as RRMA does. However, ARIA does have scores between 1 and 12, and these translate into 5 categories of: highly accessible; accessible; moderately accessible; remote; and very remote. Depending on how funding is tied to ARIA – whether to scores or categories – the problems reported under RRMA may be replicated.

Other reservations about ARIA include:

- The index is geographical and not intended to reflect need.
- Taking account of road distance alone may be quite simplistic. Time travelled, terrain and public transport (both local and intrastate) are all factors that also affect accessibility.
- Rural areas of Victoria do not have access to some of the grants etc. that recognise remoteness; yet divisions in rural Victoria still have to overcome problems of rural recruitment etc. and eligibility to funding through RRMA categories is one way of achieving this. If Victorian divisions were ineligible, this would seriously compromise their ability to address the rural issues they face.
- Some service centres in Victoria no longer have the range of state-funded health services that were once available (e.g. theatre, obstetrics in some rural areas), necessitating further travel by residents.

Given that 91.6% of Victoria is classified as Highly Accessible under ARIA (7.3 Accessible; 1.2% Moderately Accessible and 0% remote or very remote), Victorian rural divisions are likely to have significantly changed funding levels if this measure is introduced. This would be counter to the Review Group's stated need to avoid and/or manage large increases or decreases in individual Divisions' total OBF allocations.

The possibility of using GP:population ratios as a measure of workforce – and/or an alternative to ARIA – should be fully examined by the Review. (See below *Disadvantage and GP workforce measures.)* Some metropolitan divisions have argued that if it is the cost of running a rural division that is supposed to be offset by the rural loading, then some of the other differences in infrastructure cost (e.g. higher rents in urban areas) should also be taken into account. There may be a range of different rural/remote costs that the loading is aiming to offset (e.g. infrastructure costs especially for additional travel; rural workforce shortages and recruitment/locum costs; low GP: population ratios) but each of these might give rise to a different formula to recognise it. Clarity about what the loading is designed to offset should help determine how the loading should be calculated and make the formula more transparent.

d) SEIFA

There seems to be general agreement among Victorian divisions about retaining SEIFA. But there is more debate about whether or not the SEIFA loading alone is an adequate measure of disadvantage. Divisions have raised issues such as the need for additional resources to meet the health needs of specific groups, including people with drug and alcohol dependency, homeless people, people living in refuges and supported residencies; and to adequately meet the needs of non-English speaking communities.

If the Department wishes to encourage divisions to consider the health inequalities that are evident in Australia when planning and delivering their work programs, then the funding policy should consider those inequalities and the likely impact of funding changes on equity in health outcomes and in access to services.

Disadvantage and GP workforce measures

As SWPE is calculated on the basis of patient attendance, it has the potential to underestimate populations. This is particularly the case for disadvantaged groups who tend to underutilise primary care. It also affects rural communities where *in general* individuals access health services less than people in metropolitan areas. If the Divisions Program is intended, ultimately, to improve health outcomes through general practice, the funding formula should take account of such factors which can inadvertently reinforce the disadvantage of certain groups (barriers to accessing GPs ⇨ low SWPE ⇨ lower divisions funding ⇨ reduced capacity of general practice ⇨ further inequity in access).

The possibility of using GP: population ratios as a measure of workforce should be fully examined by the Review, to see if it has the potential to bring about a more equitable distribution of funds.

e) ATSI loading

It is widely accepted that census figures for the Aboriginal population are completely inadequate. The funding Review does not refer to this problem at all. A recent VACCHO report states:

> "The 1996 Australian Bureau of Statistics Census reported that there are 22,587 Aboriginal people living in Victoria (ACCHS believe that these figures are understated by up to 60%) and it should be acknowledged that the [current] survey points out that Aboriginal people use both mainstream and ACCHS." (VACCHO, 2001, *Current Workforce & Future Needs Analysis: Results of community consultations* p.9)

While the ABS figures are acknowledged to underestimate the Aboriginal population, there may be other ways of allocating funding to divisions, which would need to be examined in consultation with Aboriginal health organisations. For example, it might be possible to consider AMS' needs for the general practice workforce. In Victoria, VACCHO found (in 2001) that there are 29 (9 EFT) GPs in the 21 Aboriginal Community Controlled Health Services (ACCHSs). 50% of ACCHSs did not have a doctor working at their organisations and 90% required additional doctors. While GPDV is not advocating a particular formula for allocating funds to divisions, we believe this issue could be more thoroughly examined by the Review committee and NACCHO could be invited to have some input. NACCHO have previously stated publicly that they have concerns about funding allocated to divisions for

Aboriginal health, and divisions' accountability for it. In Victoria, VACCHO is also concerned about how the money is actually used by divisions.

Feedback from some divisions suggest that divisions of general practice are also sensitive to these issues. One division suggested that those divisions receiving substantial funding on the basis of ATSI population within their boundaries should be obliged to specifically report on the activities undertaken with that funding. Another division points out that it might be more likely for divisions to undertake activities in Aboriginal health if this loading were not subsumed into the core grant.

The current funding Review could provide an opportunity to examine the best method for allocating funds to divisions to encourage their work in Aboriginal health. This must be done in consultation with Aboriginal health organisations.

f) Linking funding to outputs

We agree that the Department should not further link funding to outputs at this time, on the basis (as argued by Central Bayside Division) that this approach risks: divisions setting low targets they can be sure to meet; discouraging innovation; and penalising poor performance when more assistance to build capacity is what may be required. At the same time, accountability is, of course, important, and poorly performing divisions should not be allowed to jeopardise the viability of the divisions in general, nor to limit the potential of the Divisions Program to effect great change in general practice.

General Practice Divisions – Victoria Ltd
ABN 80 081 371 968 ACN 081 371 968
1st Floor, 458 Swanston Street
Carlton Victoria 3053
Tel: (03) 9341 5200 Fax: (03) 9348 1375
Email: gpdv@gpdv.com.au Website: www.gpdv.com.au