RESPONSES BY STAKEHOLDERS TO THE DIVISIONS STANDING COMMITTEE OF GPPAC DECEMBER 2001 DISCUSSION PAPER ON THE REVIEW OF THE OUTCOMES BASED FUNDING FORMULA

Introduction

Background

The General Practice Branch of the Department of Health and Ageing is undertaking a review of the formula which has been used to calculate each of the 123 Division of General Practice's share of the total allocation for Outcomes Based Funding (OBF) (currently about $60 million, annually). In April 2001, the then Minister for Health and Aged Care, Dr Michael Wooldridge MP, approved the terms of reference for this review and agreed that the General Practice Advisory Partnership Council's Divisions Standing Committee should assist the Department with the review.

This paper has been written for the Divisions Standing Committee's 27 February 2002 meeting, to assist with the development of recommendations to the Minister for Health and Ageing about the outcomes of the review. It summarises the responses by stakeholders to the discussion paper (see Attachment A) distributed in early December 2001. The discussion paper provided information about the discussions undertaken by the Committee during 2001 about principles for a revised formula, the adequacy of various components of the existing formula, and the discussion paper sought comments from stakeholders on these issues.

Summary of respondents

New South Wales	9 Divisions NSW State Based Organisation (Alliance of NSW Divisions)
Victoria	16 Divisions Vic State Based Organisation (General Practice Divisions Victoria) Rural Workforce Agency Victoria Rural Doctors Association of Victoria
Queensland	5 Divisions Qld State Based Organisation (Qld Divisions of General Practice)
South Australia	3 Divisions SA State Based Organisation (SA Divisions Incorporated) SA State Office of the Commonwealth Department of Health and Ageing
Western Australia	5 Divisions
Tasmania	3 Divisions Tas State Based Organisation (Tasmanian Divisions of General Practice)
Northern Territory	2 Divisions
Australian Capital Territory	1 Division
Other	Office of Aboriginal and Torres Strait Islander Health (Commonwealth Department of Health and Ageing)

Total = 53 respondents

General comments

The 53 responses to the discussion paper varied in comprehensiveness from short emails to six page letters and many of the responses addressed one or two areas only (generally these were areas of particular importance to the respondent). Many comments did not address the question posed in the discussion paper but talked generally about the issue under discussion. At times, some respondents appeared to make comments which were based on misconceptions, which we will attempt to clarify in the course of this paper. For example, one respondent appeared to be unaware that the Divisions Standing Committee included four Division representatives which had been nominated by the Australian Divisions of General Practice (see Attachment B), and believed that the Committee was a Department-only committee.

A number of respondents reported that they found it difficult to comment on the discussion paper without knowing the weightings for elements or the financial outcomes of each option for their Division. These comments did not acknowledge the attempt of the discussion paper to consider options in principle and to seek ideas from stakeholders which the Divisions Standing Committee had not yet considered.

As one respondent stated, "it will be difficult to reach a position [on a revised formula] that satisfies all parties" and that, consequently, their response would "promote self-interest". With most respondents answerable to their membership, it is not surprising that most responses reflected their individual interests. The resulting diversity of (and often conflicting) views on a number of issues means that any outcome of the review of the funding formula is unlikely to be universally popular.

It is important to note that the 53 respondents are not necessarily representative of the Divisions movement as a whole, and consequently their responses should not be viewed as 'votes' on an issue. For example, the distribution of responses across states is unequal, with 35% of the Divisions (and the total) respondents being Victorian. The information about the types of responses is included below only as an indication of the responses received, and should not be interpreted as a definitive statement of the proportion of the broader Divisions' movement opinion.

Summary and discussion of responses

a) The $50,000 flagfall

Question to consider: Are there further issues about the flagfall that the Divisions Standing Committee needs to consider?

Responses:
Of the 53 respondents:

- 20 (38%) provided no comment;
- 19 (36%) suggested an increase in the level of the flagfall.
- 10 (19%) supported retaining the flagfall at the current level;
- 2 (4%) suggested eliminating the flagfall;
- 1 (2%) viewed the current level as arbitrary; and
- 1 (2%) suggested a flexible flagfall with increases based upon need.

Discussion:
Whilst a substantial proportion of respondents suggested an increase in the current flagfall, it is important to note that qualitative evaluation of many of these respondents' comments suggests a misunderstanding of the purpose of the flagfall. It may not have been adequately explained in the discussion paper. The flagfall is not intended to reflect the minimum costs for a Division to 'open its doors', nor is it intended to represent the total infrastructure funding for the Division. The flagfall is included in the funding formula as a constant amount which compresses the range of funding and ensures that the final distribution of funding results in a meaningful amount of funding for each Division.

Some respondents suggested weighting the flagfall for rurality. This suggestion is countered by assertions from some urban Divisions that they encounter increased infrastructure costs (for example higher rental costs) which offset the increased costs which rural Divisions incur (for example with travel). Another suggestion was to weight the flagfall to reflect the numbers of general practitioners within the Division. This suggestion has a number of complexities which are discussed in the "other elements for consideration" section on page 11.

One respondent suggested providing a flexible flagfall level that allowed scope for discretion to assist Divisions with unexpected costs incurred during the period of the Agreement. Discretionary pools of funding are fraught with potential problems. Issues around equity and complexity of administration (for Divisions and the Department) are immense. In addition, discretionary pools of funding would require the setting aside of a predetermined amount of funding from the $60m pool, thus reducing the funding available to all Divisions for their core funding allocation.

Question for consideration: What should be the principles, with a formula-based approach, for dealing fairly with Divisions which wish to amalgamate?

Responses:
Of the 53 respondents:

- 20 (38%) provided no comment;
- 20 (38%) provided (a wide variety of) specific suggestions;
- 7 (13%) provided general comments (as did some other respondents); and
- 6 (11%) stated that they supported the suggestion in the discussion paper (Divisions should receive their combined flagfall amounts in the first year following amalgamation, half the combined flagfall amount in the second year, and a single flagfall amount in the third year).

Discussion:
Some respondents appeared to be under the misapprehension that discussion of amalgamation reflected a statement of policy by the Department, rather than reflecting the terms of reference of the review; to "recommend principles for determining funding allocations for Divisions which wish to amalgamate or dis-aggregate". Consequently, some comments were made based on this perception. For example, some respondents expressed support for the notion of amalgamation of smaller Divisions in order to promote efficiency, while other respondents provided arguments against externally imposed amalgamation, particularly in rural areas due to the large geographic areas which may result. A couple of respondents sought clarification about the 'ideal' size of a Division, including a suggestion that research should be commissioned into this issue. A couple of respondents expressed concern over a

perception that the impetus for amalgamation was financial savings for the Commonwealth. One respondent asked for clarification about where savings would go. As a general principle, the Department does not see amalgamations as a financial savings strategy for the Commonwealth. As mentioned in the discussion paper, the Department does not want to create any disincentives for Divisions which wish to amalgamate, but the interests of all other Divisions that do not change must also be considered.

Respondents appeared to have a general consensus that provision of only one flagfall for amalgamated Divisions was a disincentive for amalgamation. Many respondents argued that amalgamation was likely to be a costly process initially (including costs such as lease surrender, legal fees, staff redundancy payments) and that this should be acknowledged in funding arrangements. Many of the suggested approaches for dealing with flagfall levels reflect this and propose a higher level of funding initially, with decreases over time.

Four respondents advocated a 'case by case' approach in order to reflect the individual circumstances of Divisions. For example, one respondent argued that the amalgamation of rural Divisions (possibly covering large geographic areas) would probably pose different issues to the amalgamation of two adjacent urban Divisions. This respondent suggested that case studies from across Australia, should be used to devise a national policy in the future. The request for case by case consideration is at odds with the request by two respondents that the process be consistent, simple and transparent, in order to allow Divisions to consider the cost-benefits of amalgamation.

Suggested options for dealing with the flagfall included:

- Provision of only one flagfall from the date of amalgamation;
- Provision of 2 flagfalls for a period of three years only;
- Provision of 2 flagfalls in the first year, 1.5 in the second and 1 in the third (as suggested in the discussion paper);
- Provision of 2 flagfalls in the first year, 1.5 in the second and 1.25 in the third;
- Provision of 3 flagfall amounts in the first year, 2 flagfall amounts in the second year, 1.5 flagfall amounts in the third year and a single amount in the fourth year;
- Provision of 2.5 flagfalls in the first year and single flagfalls in the following years;
- Provision of the two flagfalls on an ongoing basis; or
- Provision of the total funding amounts for the two Divisions for a period of time (for rural Divisions).

The above suggestions were sometimes also accompanied by a suggestion for the provision of an incentive payment (possibly independent of the Outcomes Based Funding pool) in the first year to further promote amalgamation. One respondent suggested that these incentive payments would decrease over time, thus promoting early consideration of amalgamation. Another, related, suggestion from two respondents was the consideration of incentives for Divisions which 'integrate key functions' – enter in to some sort of virtual amalgamation.

b) The calculation of population levels

Question for consideration: Are there any other issues relating to Estimated Residential Population (ERP) data that the Divisions Standing Committee has not considered?

Responses:
Of the 53 respondents:

- 26 (49%) supported the Divisions Standing Committee motion to use ERP data;
- 18 (34%) provided no comment;
- 5 (10%) did not respond to the question; and
- 4 (8%) misunderstood the question.

Discussion:
The Divisions Standing Committee agreed that a move to 1999 or more recent ERP data would be appropriate as it more accurately reflects recent population levels. The current formula is based on 1996 Census population data. The majority of respondents agreed this data is out of date and that the most recent population figures available should be used.

From many of the responses received it became apparent that there was a general misunderstanding on how the ERP data would be used within the formula. Many respondents believed/suggested that ERP data could be applied annually over the funding agreement period rather than as a single application at the beginning of the funding agreement period. The problem with applying ERP data annually is that OBF funds for Divisions could change from one year to the next across the funding agreement period. Divisions have previously indicated that they prefer to know their funding allocations for the funding agreement period in advance in order to assist with strategic and business planning.

Some respondents expressed concerns regarding seasonal increases in population in certain areas due to tourism and seasonal work (for example fruit picking) which Census and ERP population data may not reflect. These seasonal variations are addressed when calculating the infrastructure component in the existing formula (where population or SWPE –whichever is the greater is used). This is done because population can be considered an indicator of doctor workload (ie the larger the population of an area -either postcode or division - the greater the potential workload for the doctors in that area). SWPE can also be used in the same way. Thus areas with high seasonal variations, and subsequently larger SWPE values than population numbers, are not disadvantaged.

Questions were raised by individual respondents about methods for recognising areas of high population growth or areas including refugee centres. The calculation of ERP is extremely complex and a detailed explanation is outside the scope of this paper. However, in its very simplest form, ERP is rebased every 5 years according to the official census figures with births, deaths, migration (overseas and interstate) and a variety of other factors contributing to the figures for years in the intercensal period. As a result, areas of high population growth are captured, but it should be noted that the ERP figures remain as estimates until the next census figures are available and rebasing is performed. Additionally, any formula which is applied for a period of three years may not reflect population changes during that time.

A number of respondents commented on the under-representation of Aboriginal and Torres Strait Islander peoples in population data. This had been previously acknowledged by the Divisions Standing Committee but had not been mentioned in the discussion paper. One respondent suggested using Aboriginal Medical Services (AMS) data to develop more accurate population figures, however the capacity of AMSs to provide such information and the uneven distribution of AMSs throughout Australia may make this suggestion difficult to implement.

c) A move from Rural, Remote and Metropolitan Areas (RRMA) to Accessibility/Remoteness Index of Australia (ARIA) classifications

Question for consideration: Are there any issues that the Divisions Standing Committee has not considered in its assessment of a move from RRMA to ARIA?

Responses:
Of the 53 respondents:

- 20 (38%) support (either strongly or in principle) a move to ARIA;
- 18 (34%) provided comments, often raising concerns with both RRMA and ARIA;
- 10 (19%) – usually urban Divisions - provided no comment; and
- 5 (9%) were strongly opposed to a move from RRMA to ARIA.

Discussion:
The high level of response to this aspect of the discussion paper indicates its perceived importance to respondents. Many of the organisations that commented on only one or two issues in total, responded to this aspect of the discussion paper. Most of the urban Divisions which responded to the discussion paper either provided no response, or commented on the costs which they perceive urban Divisions encounter (such as higher rental costs) which rural Divisions do not, and for which there is no 'urban' loading.

Many respondents commented that without data on how a move to ARIA would affect their Division's allocation, they felt unable to firmly support or oppose the move and some simply argued that if ARIA resulted in a reduced allocation, they were opposed. Many acknowledged the problems with RRMA (including the poor recognition of regional centres) and the dated nature of the data upon which it is based. However, many also listed perceived limitations of ARIA (such as not reflecting road terrain, weather conditions, lack of availability of public transport, and the costs incurred in accessible but rural areas such as STD phone calls). Many of these respondents provided neither a definitive stance nor an alternative solution. One suggestion was to substitute or complement (unclear which) the use of RRMA or ARIA with a measure of the general practitioner to population ratio. This is fraught with difficulty – see the "other elements for consideration" section on page 11 for discussion.

Other suggestions included further discussion around use of the Robin Hood Index, the Jesuit Social Services Index and the Section of State information as alternative measures. Little is known about the first two indexes and their national applicability or robustness, and the difficulty with the Section of State classification is that it includes the rigid cut-offs associated with RRMA.

In general, respondents did not appear to completely understand how ARIA is calculated (for example, one respondent requested an 'island loading' be applied – but this is already included in ARIA). This lack of understanding of ARIA by stakeholders may need more consideration by the Divisions Standing Committee.

Question for consideration: Are there any issues the Divisions Standing Committee should consider in its assessment of the use of an "index of dispersion" in the formula?

Responses:
Of the 53 respondents:

- 36 (68%) provided no comment;
- 13 (25%) supported the inclusion of this element;
- 2 (4%) respondents stated that they would like to know more before providing a comment;
- 1 (2%) respondent viewed this as important only to remote Divisions; and
- 1 (2%) respondent suggested the index be applied to the dispersion of general practitioners, as well as the population, of a Division.

Discussion:
The high proportion of no comment on this element is difficult to interpret, but suggests no significant opposition to the inclusion of this index. There was a suggestion for inclusion of an element relating to the dispersion of general practitioners. It is suggested that the dispersion of the population is a better reflection of the characteristics of a Division.

d) Socio-Economic Index for Areas (SEIFA) Index

Question for consideration: Are there any other issues relating to the use of SEIFA in the formula that the Divisions Standing Committee has not considered?

Responses:
Of the 53 respondents:

- 17 (32%) supported the continued use of SEIFA;
- 14 (26%) provided no comment;
- 9 (17%) suggested alternative factors for the Divisions Standing Committee to consider;
- 8 (15%) had concerns over the SWPE component used with SEIFA in the formula;
- 4 (8%) did not respond;
- 1 (2%) supported the use of SWPE.

Discussion:
The use of SEIFA was generally accepted by many respondents as the most effective measure of socio-economic disadvantage. However there was general confusion over the use of SEIFA in the formula and how factors of socio-economic disadvantage are calculated within the formula. In the current formula SEIFA is used in the 'services' part of the formula and is applied to SWPE.

A concern many respondents expressed was that Aboriginal and Torres Strait Islander people are often not picked up in SWPE values due to their low level of access to primary health care services funded under the Medicare Benefits Schedule. Respondents pointed out that if SEIFA is applied to the SWPE values for a Division (as in the 'services' part of the formula) Divisions with high Aboriginal and Torres Strait Islander populations appear to be disadvantaged. However, the SEIFA index takes Aboriginal and Torres Strait Islander populations into account in calculating Divisions' SEIFA values. Additionally, the Aboriginal and Torres Strait Islander loading may help to address such issues.

Other concerns relating to the SWPE measure is the perception that rural areas are disadvantaged by having local general practitioners provide hospital based services using Medicare Benefits Schedule item numbers not included in calculating SWPE. Divisions experiencing the above argued that SWPE disadvantages them as scores may not accurately reflect their general practitioner workload, however, it is not clear whether the general practitioners are undertaking primary care or secondary/tertiary care. The focus of the work of Divisions of General Practice is supporting general practice/primary care. General practitioner to population ratios were suggested as an alternative to the SWPE measure but this is problematic – see the related discussion in the "other elements for consideration" section on page 11.

Please note that recent investigations suggest that SEIFA data based on 2001 Census data will not be available from the Australian Bureau of Statistics until around September 2003 and hence SEIFA 1996 census data may need to continue to be used.

e) The $2.55 Aboriginal and Torres Strait Islander loading

Question for consideration: Are there any issues warranting further consideration by the Divisions Standing Committee in its assessment of the appropriateness of the Aboriginal and Torres Strait Islander loading?

Responses:
Of the 53 respondents:

- 23 (43%) provided no comment;
- 20 (38%) supported the notion of the Aboriginal and Torres Strait loading;
- 1 (2%) misunderstood the purpose of the loading; and
- the remaining respondents commented on other issues such as:
    - a need for accountability of Divisions for the proportion of Outcomes Based Funding acquired from the loading, compared to the amount spent on Aboriginal and Torres Strait Islander health programs (4[6%]);
    - the under-representation of Aboriginal and Torres Strait Islander peoples in Census population data (2 [4%]); and
    - the perceived problems of providing a loading only to those Divisions with large Aboriginal and Torres Strait Islander populations (3 [6%]).

Discussion:
There was some confusion over the purpose of the Aboriginal and Torres Strait Islander loading with many respondents suggesting the need for clarification and accountability mechanisms for funds. One respondent commented that the loading itself makes up for the areas of the formula, such as population and SWPE measures, where Aboriginal and Torres Strait Islanders appear to be disadvantaged. Many respondents who supported the loading suggested it be increased to not only address the above concern but to assist the higher health needs of the indigenous population. It has not been articulated, previously, whether the Aboriginal and Torres Strait Islander loading aims to address concerns about the potential under representation of Aboriginal and Torres Strait Islander people in Census data and SWPE calculations, or to reflect their health disadvantage, or both.

Accountability of Divisions in using their Aboriginal and Torres Strait Islander loading for programs targeted at Indigenous health were common suggestions. Respondents commented on their desire for Divisions to have more direction and clarification.

A suggestion had been made at a Divisions Standing Committee meeting that consideration be given to providing the loading only to those Divisions with a high population of Indigenous people. This suggestion was met with concern by stakeholders and there was acknowledgment that this approach would create a rigid "cut-off" point. Many commented that the lack of funding for Divisions with smaller Aboriginal and Torres Strait Islander communities may prove to be a disincentive for those Divisions to run Aboriginal health programs or to include Aboriginal health components in their broader programs (eg on diabetes). One respondent suggested that Divisions with Aboriginal Community Controlled Health Services (ACCHS) located within their boundaries should receive an extra loading to assist them in building partnerships. Conversely, another respondent argued that Divisions without such services should receive extra funding to support work required to fill the gap for services.

The under-representation of Aboriginal and Torres Strait Islander people in population data was again commented on. One respondent suggested using local AMS data to gain a clearer picture of local populations. However, as discussed previously, this may not present a feasible option.

f) $30,000 "top-up" given to six small Divisions

No questions for consideration were given regarding the $30,000 top-up for 6 small Divisions within the discussion paper. However many respondents commented on the Divisions Standing Committee's consensus that the formula should be designed so that no Division would require supplementary payments.

Responses:
Of the 53 respondents:

- 29 (55%) provided no comment;
- 14 (26%) supported the withdrawal of the $30,000 top-up payment;
- 5 (10%) did not respond;
- 4 (8%) did not support the withdrawal of the $30,000 top-up; and
- 1 (2%) suggested a higher 'flagfall' amount be considered for these 6 Divisions.

Discussion:
Small Divisions expressed their reliance on the $30,000 top-up payment, but the majority of respondents that commented on the issue supported withdrawal of the $30,000 top-up payment given to 6 small Divisions. Of those who supported the withdrawal, several questioned the viability of the 6 small Divisions arguing that amalgamation would be appropriate. However, the Division Standing Committee's suggestion (that the formula should be revised in an equitable way so that these 6 small Divisions do not require the 'top-up') was echoed throughout the majority of comments.

Suggestions made by respondents to address the needs of smaller Divisions included 'crisis funding' for these Divisions when needed, Commonwealth management of smaller Divisions or increased flagfall amounts for the Divisions concerned. 'Crisis funding' would require the Department to quarantine an amount from the overall OBF pool, and the management of smaller Divisions by the Commonwealth is unlikely to be feasible. An increased flagfall for some Divisions would essentially be the same as the existing 'top-up', but just renamed.

One respondent commented that the 'one-size fits all' approach to the formula may be 'discriminating' against the smaller divisions, however, other respondents supported the notion of equal treatment of all Divisions.

g) The appropriateness of more directly linking funding to outputs or results achieved

Question for consideration: If the Department continues to examine the appropriateness of moving to a funding arrangement that is more outputs related, are there any further considerations?

Responses:
Of the 53 respondents:

- 18 (34%) actively supported the notion in principle;
- 13 (24%) provided no comment;
- 12 (23%) respondents appeared to be undecided; and
- 10 (19%) actively opposed such a move.

Many respondents provided suggestions or comments.

Discussion:
The high level of comment from respondents to this question suggests considerable interest related to such a proposal. 8 respondents stated that current arrangements (strategic and business planning and six monthly reporting against these plans) were sufficient for ensuring accountability of Divisions for outputs. One of these respondents commented that a move to new arrangements 3-4 years after the move to the current Outcomes Base Funding arrangements would be destabilising to Divisions.

However, 18 respondents supported the notion in principle. Many suggested that further discussion and consultation would be required before implementation some time in the future. In general, respondents' comments repeated the issues raised on page 8 of the discussion paper about the complexity of implementing such a proposal. 4 respondents expressed concern about the potential for a move to linking funding to outputs resulting in an increase in the administrative burden on Divisions. 7 respondents expressed concern about the potential impact on Divisions of providing 20% of funding as a retrospective payment.

Other comments received

The following list provides a summary of other comments made in the responses to the discussion paper.

General comments related to the review

- Comments relating to the outcomes of funding reductions: A number of respondents expressed concern at the potential impact of a reduction in Outcomes Based Funding for Divisions. These included a statement that loss of funding may result in a loss of experienced staff who have established rapport with general practitioners, and some respondents noted that even small reductions in funding for small Divisions could have a significant impact. No Divisions commented on the potential impact which a substantial increase in funding may have.
- Comments relating to phasing of changes to current allocations: Page 1 of the discussion paper noted that if Divisions' allocations were to increase or decrease substantially

following a review, options such as phasing in these changes may need to be explored. One respondent requested that this be carefully managed and another respondent requested consultation with Divisions on the options.

- Implications of the outcome of this review for funding allocations under other Programs: Two respondents sought clarification of the implications of the Outcomes Based Funding formula review for the More Allied Health Services and Workforce Support for Rural General Practitioners Programs.
- One request that the review of the formula should be considered within a broad context of the role of Divisions and clarifying 'what the Department is buying'.
- One request for an increase in the total pool of funding.
- One request for a guarantee that no Divisions' Outcomes Based Funding will be reduced as a result of the review of the formula.
- One request that the current level of funding in each state should not significantly change. This suggestion does not take in to account the possibility that current state totals may be inequitable.
- Comments relating to the deadline for comments: Despite the extension of the deadline for comments on the discussion paper, one respondent commented that there was still not sufficient time to comment on the paper. It should be noted that of the 53 responses received, 50 were received by 21 January 2002. Another respondent requested that Divisions be informed of their 2002-03 funding allocations as soon as possible in order to assist them with writing their strategic plans by 31 March 2002. This was a reason for the need to receive comments from stakeholders as soon as possible.

Other elements for consideration

- 3 respondents requested further consideration of a weighting for the non-English speaking background (NESB) population within a Division, however, this is addressed in the SEIFA calculations.
- One respondent suggested the development of a special funding pool for populations with significantly low SEIFA or high mortality.
- A number of respondents viewed the general practice profile, not the population profile of a Division as the main driver of service demands. Respondents suggested the inclusion in the formula of a measure relating to variables such as general practice sizes, the ethnic background of general practitioners, the numbers of general practitioners (general practitioner to population ratio measure) and levels of general practitioner engagement.
    - A general practitioner to population ratio measure was sometimes suggested as a complementary or substitute measure for RRMA/ARIA. This is problematic as people living in rural and remote Divisions are disadvantaged by their lack of proximity to services, not just the numbers of general practitioners in the Division as a whole.
    - The notion of including an element in the formula which is related to the number, level of participation in the Division or characteristics of general practitioners is problematic. There are difficulties associated with:
        - determining which circumstance the formula should support. Should the element result in more funding for Divisions with large numbers of general practitioners (and hence a greater workload to support those general practitioners) or Divisions with few general practitioners (and hence a greater workload for with recruitment and supporting busy general practitioners)? Stakeholders have argued both cases.
        - determining which general practitioners data should be used. Suggestions include a 'head count' of GPs in the Division, a measure of workload for the GPs, a measure of the full time equivalency of GPs or the number of active GPs in a

Division (self reporting by Divisions would be required for this option and the reliability of the measure would be of concern).

It should be noted that the existing Outcomes Based Funding formula reflects the characteristics of the population within each Division, and this is consistent with the aim of the Divisions of General Practice Program.

- One respondent suggested that incentives for consumer representation should be considered.
- Two respondents requested recognition for Divisions which work across the primary care workforce (eg including allied health professionals) and which work to link primary care with the secondary and tertiary levels.

Other comments unrelated to the review of the formula

Some respondents took the opportunity to comment on issues of concern to them which were unrelated to the funding formula review process. These included:

- One request for less planning and reporting requirements;
- A request for the extension of rural initiatives (eg the More Allied Health Services and Workforce Support for Rural General Practitioners Programs) to urban fringe areas;
- A request for reconsideration of the definition of 'committed' funding (an issue related to the conclusion of Divisions' funding agreements); and
- A suggestion that a revision of the "Implementation Guide for Outcomes Based Funding" was necessary.

Attachment B: REVIEW OF THE OUTCOMES BASED FUNDING FORMULA FOR DIVISIONS OF GENERAL PRACTICE – A DISCUSSION PAPER FOR GENERAL CIRCULATION (sent to stakeholders in December 2001)

1. Introduction

The General Practice Branch of the Department of Health and Ageing is undertaking a review of the formula which has been used to calculate a Division of General Practice's share of the total allocation for Outcomes Based Funding (OBF) for all Divisions each year (currently about $60 million)(a history of the funding arrangements for Divisions of General Practice is at Attachment A). In April 2001 the then Minister for Health and Aged Care, Dr Michael Wooldridge MP, approved the terms of reference for this review (see Attachment B) and agreed that the General Practice Advisory Partnership Council's Divisions Standing Committee (DSC) should assist the Department with the review.

All Divisions were advised by letter from Andrew Tongue in June 2001 about the intended process for this review. The letter also noted that the aim of the review is to establish how the formula can be revised to best balance the needs of all Divisions of General Practice and reflect changes within Divisions since the current formula was developed in 1997.

As indicated in the June letter**, the review of the formula will not result in a cut in the overall funding for Divisions**. **Instead, the review aims to ensure that the OBF allocation is fairly distributed between Divisions**. The Department appreciates that funded organisations, such as Divisions, would find it difficult to manage large variations, positive or negative, in their OBF allocations. In addition, in an environment where the total allocation for OBF does not increase, there may be winners and losers. Options to manage this (eg phasing) may need to be explored.

Since July 2001 the DSC and General Practice Branch have had a number of discussions about principles for a revised formula and the adequacy of various components of the existing formula. In particular, a workshop was held in August 2001. DSC members have agreed to the development of this discussion paper as the basis for consultation with Divisions, State Based Organisations (SBOs), the Australian Divisions General Practice (ADGP) and other interested stakeholders.

This paper:

- describes the current formula;
- reflects those discussions with the DSC about various components of the formula, and notes those issues on which the DSC has reached a view and those issues requiring further consideration; and
- discusses next steps in the review of the formula.

2. The current formula

The current formula was designed to reflect the population and general practice profile of a Division. This approach recognises that the profile of a Division reflects health outcomes needing to be achieved for the people within that Division. The huge diversity of the profile of Divisions is shown in the following:

- The total population in Divisions ranges from approximately 19,000 to more than 515,000.
- The number of practising general practitioners in Divisions ranges from around 10 to more than 800.

More specifically, the current formula is based on the size and characteristics of the population covered by the Division (including adjustments for factors associated with poorer health status such as socio-economic status and the number of Aboriginal and Torres Strait Islander people). The formula also incorporates a component that recognises the relative workload of General Practitioners in the area covered by the Division and the additional infrastructure costs associated with the delivery of Divisions' services in rural areas. The range of funding at present received by the 123 Divisions of General Practice is approximately $160,000 to $1,400,000 per annum. A diagrammatic illustration of the formula is found in Table 1. A more detailed description of the current formula is found in Attachment C.

Table 1: Current structure of the formula

Infrastructure				
Flagfall ($50,000)	+	$1.30/head or $1.30/SWPE	+	Rural loading for populations in RRMA 4-7
Services				
SWPE/SEIFA^2 x $1.35	+	$2.55/head for Aboriginal and Torres Strait Islanders	+	Rural loading for SWPE in RRMA 4-7
Other				
Divisions with pop < 30,000 receive an additional $30,000				

Note: SWPE – Standardised Whole Patient Equivalent.
RRMA – Rural, Remote, and Metropolitan Areas categories.
SEIFA – Socio-Economic Indexes for Areas

3. Issues considered by the DSC

The following section reflects on those discussions with the DSC about various aspects of the current formula and notes those issues where the DSC has reached a view and those issues requiring further consideration. Each section finishes with possible questions that capture the types of issues that have been, or are being, considered by the DSC. Responses to these questions will assist the DSC in its consideration of these issues. Further comments on any other issues raised in the paper are also welcome.

b) The $50,000 flagfall

The flagfall/base amount was included in the formula to acknowledge that there is a critical mass of resources required to manage a Division, irrespective of size (geographic or population based) of the Division.

The DSC discussed the appropriateness of the flagfall and noted that in reality the minimum amount Divisions receive is more than $50,000 given it also includes the minimum amount for all other elements of the formula. In general, within a fixed budget environment, increasing the flagfall will reduce the amount available for the population component of the formula and this will impact most on Divisions with large populations.

Overall there was agreement that a flagfall was necessary, although there were varying opinions amongst the DSC about the appropriate level. On balance, retention of the flagfall at the current level was agreed.

Question to consider: Are there further issues about the flagfall that the DSC needs to consider?

The impact of a flagfall on potential amalgamations between Divisions was discussed. There is a perceived disincentive for Divisions to amalgamate if after amalgamation they receive one flagfall amount. A suggestion was made that amalgamating Divisions should receive their combined flagfall amounts in the first year following amalgamation, half the combined flagfall amount in the second year, and a single flagfall amount in the third year.

Other options include taking a case by case approach, looking at the actual short term costs of amalgamation to the amalgamating Divisions as well as any savings from efficiencies generated by the amalgamation.

While the Department does not want to create any disincentives for Divisions which wish to amalgamate, the interests of all other Divisions that do not change must be considered. It would be undesirable to treat amalgamating Divisions outside the formula, when some of the existing Divisions may have a profile that is very similar to the newly amalgamated Division.

The DSC did not agree a position on the impact of a flagfall on potential amalgamations and is interested in views and ideas.

Question for consideration: What should be the principles, with a formula-based approach, for dealing fairly with Divisions which wish to amalgamate?

c) The calculation of population levels

The formula currently uses 1996 census data to determine population levels for Divisions.

The use of census data has been queried given that this data is collected every five years. Census data does not reflect recent population changes, for example in areas of high growth.

The Department has explored the option of using Estimated Resident Population (ERP) data in the formula since this data is calculated annually. Upon examination it was found that

there was a relationship between ERP 1999 data and 1996 census data and that there would not be a significant difference between using one or the other.

The DSC agreed that a move to 1999 or more recent ERP data would be appropriate as it more accurately reflects recent population levels.

Question for consideration: Are there any other issues relating to ERP data that the DSC has not considered?

d) A move from RRMA to ARIA

Divisions receive a rural loading based on the number of people living in "Rural, Remote, Metropolitan Areas" (RRMA) categories 4-7 within the Division's catchment area. This element of the formula recognises that a more remote Division has greater infrastructure costs (eg transport and communication). RRMA is based on 1991 Statistical Local Areas (SLAs).

ARIA stands for Accessibility/Remoteness Index of Australia. This index was developed by the National Key Centre for Social Applications of Geographical Information Systems at the University of Adelaide. ARIA is a geographic approach to measuring remoteness and uses Geographic Information System technology to provide a measure of remoteness from service centres for all places and points in Australia. ARIA defines five categories of remoteness (ranging from highly accessible to very remote) based on road distance to service centres. ARIA can also be calculated as a continuous variable on a scale from 0 to 12.

Further information about ARIA is available in the publication "Measuring Remoteness: Accessibility/Remoteness Index of Australia – Occasional Papers: New Series Number 14, October 2001". This paper can be found on the Department's web site at the following address http://www.health.gov.au/ari/aria/htm.

The DSC agrees with the principle that rurality and remoteness need to continue to be acknowledged in the formula.

It is Departmental policy to move to ARIA as an alternative measure of rurality and remoteness. ARIA has a number of advantages over RRMA. In particular:

- ARIA recognises that places can be both rural and accessible. In its incorporation of population density into the remoteness classification, RRMA wrongly allocates a higher score to SLAs that may be quite accessible in terms of their distance from large urban centres but contain relatively low population densities.

- ARIA uses detailed point towns and road network distances rather than the SLA centroids and straight line distances as used in RRMA.

- ARIA is relatively stable over time since it does not include population density (which can change significantly over time). The only reason why ARIA values should change is as a result of a nearby population centre growing or shrinking significantly or due to changes to the structure of the road network. ARIA values will thus not be influenced by changes in administrative boundaries.

DSC members have agreed that using a continuous variable ARIA would be beneficial since it would remove the stepping effects associated with the RRMA classification.

While under RRMA areas are classified as one of the 7 available categories, under ARIA, values for different areas vary along a continuous spectrum. Under a continuous variable ARIA there are no artificial boundaries which create rigid "cut off" points.

The stepped nature of RRMA is problematic as there is a rigid "cut off" point for receipt of rural loadings or movement between different loadings. As a result, minor differences in population can mean there are significant differences in funding received. For example, a Division's area could include a town with a population of 25,001. The town would therefore have a RRMA classification of 3 (large rural area), and the Division would not receive any rural loading for this population. However, if the population had been 2 people less the town would be classified as RRMA 4 and the Division would have received an additional rural loading for the people located in this area.

However, a continuous variable ARIA will not be using stepped categories and therefore minor changes in an ARIA score will only result in minor changes in rural loadings. This is a more equitable approach.

Another advantage of using a continuous variable ARIA is that it would allow loadings to apply from the most desirable point in the accessibility spectrum. For example, to reflect emerging pressures in outer metropolitan areas, some loading could be applied to these areas as well as greater loadings to other points on the accessibility spectrum (ie rural and remote areas).

The Committee noted that there would be winners and losers from a move to ARIA, as there would of course be from any changes to other elements of the formula. However, as indicated previously in this paper, irrespective of the impact of any changes to individual components of the formula, the Department appreciates that funded organisations, such as Divisions, would find it difficult to manage large variations, positive or negative, **in their total OBF allocations**. The Department acknowledges the need to avoid and/or manage large increases or decreases in individual Divisions' total OBF allocations.

Question for consideration: Are there any issues that the DSC has not considered in its assessment of a move from RRMA to ARIA?

Divisions that receive funding under the More Allied Health Services Program will be familiar with the concept of an "index of dispersion". This index relates to the dispersion of the population in a Division, and acknowledges the extra costs faced by rural Divisions with widely dispersed or "scattered" populations.

Consideration is also being given to incorporating this element into a revised OBF formula in recognition of the fact that the costs of servicing a Division vary according to how general practitioners and the general population are distributed within a Division.

Question for consideration: Are there any issues the DSC and Department should consider in its assessment of the use of an "index of dispersion" in the formula?

d) SEIFA index

The socio-economic status of a Division's population is taken into account by adjusting (dividing) the Division's average SWPE value by the Socio-Economic Indexes for Areas (SEIFA) squared, and then multiplying this figure by $1.35. This recognises that patients in lower socio-economic groups represent a higher workload to the General Practitioner.

Squaring the SEIFA index makes the formula more sensitive to socio-economic status. It also increases the spread of the SEIFA index, thus allowing a more obvious reflection of differences in socio-economic status between Divisions.

The particular SEIFA index used in the current formula is the Index of Relative Socio-Economic Disadvantage. This index is derived from attributes such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations, ethnicity and the number of Aboriginal and Torres Strait Islander people.

- SEIFA vs SMR

The SEIFA index takes into account the socio-economic status of a Division's population and was used as a proxy for morbidity in the formula. The Department and DSC have been considering whether there is a better indicator of morbidity that could be incorporated into the formula.

While it was acknowledged that morbidity data would be the Committee's first preference for inclusion in the formula, national morbidity (or burden of disease) data is not currently available. The DSC agreed that the Department should continue to monitor whether such data becomes available in the future for consideration in any subsequent revision of the formula.

The use of Standardised Mortality Ratios (SMR) was explored by the Department, and findings presented to the DSC. Members noted that Divisions with a high SEIFA value tend to have a low SMR value, while Divisions with a low SEIFA, particularly those with high indigenous populations, tend to have a high SMR.

The DSC agreed that given that appropriate and national morbidity or burden of disease data is not available, the key issue is whether SEIFA or mortality is a better proxy for morbidity. It was noted that mortality and morbidity rates are not closely related (eg if a population has a high mortality rate then they will most likely have a low morbidity rate given that older people are generally sicker).

Given that SEIFA may more accurately reflect the health status of a community than mortality (ie due to SEIFA's consideration of a wide range of factors), in the short term the Committee agreed that the use of SEIFA may be better.

- Other indicators of disadvantage

The use of other indicators of disadvantage, such as Non-English Speaking Background (NESB), in the formula were considered by the DSC. As noted previously SEIFA is a recognised indicator of overall socio-economic status that takes into account a number of factors including ethnicity.

The DSC agreed that it was not necessary to start incorporating other indicators of disadvantage, such as NESB, in the formula, especially given the complexities associated with determining the most appropriate indicators.

Question for consideration: Are there any other issues relating to the use of SEIFA in the formula that the DSC has not considered?

e) The $2.55 Aboriginal and Torres Strait Islander loading

Divisions receive $2.55 per head of Aboriginal and Torres Strait Islander populations as part of the "services" component of the funding.

The adequacy of the Aboriginal and Torres Strait Islander loading has been discussed by the DSC in terms of whether it sufficiently recognises the greater health needs of indigenous people. There is also a concern that the value of the Aboriginal and Torres Strait Islander loading is offset by the low access that Aboriginal and Torres Strait Islander people have to Medicare funded services on which SWPE calculations, used elsewhere in the formula, are based.

It should also be noted that the SEIFA index used elsewhere in the current formula is derived from a number of attributes, including the number of Aboriginal and Torres Strait Islander people.

The specific amounts currently received by Divisions annually due to the Aboriginal and Torres Strait Islander loading range from approximately $500 to $80,000, and around three quarters of Divisions receive less than $10,000.

A suggestion was made that Aboriginal and Torres Strait Islander loadings only be given to those Divisions with a high population of indigenous people, thus resulting in these Divisions receiving more funding from the loading. This approach would create a rigid "cut off" point for the receipt of this loading, similar to the current problems with RRMA. Thus minor differences in the population of Aboriginal and Torres Strait Islander people in a Division could result in either a Division being eligible or not eligible for the loading.

No decision has yet been made by the DSC about the appropriateness of the current Aboriginal and Torres Strait Islander loading.

Question for consideration: Are there any issues warranting further consideration by the DSC in its assessment of the appropriateness of the Aboriginal and Torres Strait Islander loading?

f) The $30,000 "top-up" given to six small Divisions

In order to ensure a minimum funding level for Divisions with populations of 30,000 or less, an additional $30,000 per annum is currently paid to six Divisions with populations of this size after the formula has been applied.

The need for a "cut off" point for the receipt of the "top-up" allocation is inequitable since minor differences in population levels can effect the eligibility of a Division for this "top-up" allocation (see earlier and similar discussion in relation to RRMA).

The DSC agreed that the formula should be designed so that no Division would require supplementary payments. All Divisions should be treated the same and under the same formula.

g) The appropriateness of more directly linking funding to outputs or results achieved

As noted previously, the current formula is designed to reflect the population and general practitioner profile of a Division, recognising that the profile in turn reflects the health outcomes needing to be achieved. The formula is sometimes referred to as the OBF formula because it was developed as part of the overall Outcomes Based Funding approach introduced in 1997.

The DSC has discussed the possibility of more directly linking individual Divisions' funding to the outputs or results achieved (or not achieved) by the individual Divisions. As part of this discussion, a suggestion was made, but there was no DSC agreement, that a portion of each Division's funding (eg 20%) should be paid retrospectively subject to an assessment of each Division's satisfactory performance on certain common targets (eg maybe accreditation uptake, or national health priorities). This would be in addition to the existing planning and reporting accountability requirements in OBF funding agreements.

The practical difficulties of such an approach were raised including:

- The tension between rewarding good performance, whether caused by good luck or good management, and penalising poor performance, whether caused by bad luck or bad management.
- The difficult balance to be struck between creating incentives for better performance while rewarding strong performers/penalising poor performers.
- Defining the appropriate set of targets which all Divisions could be expected to achieve (eg should there be a focus on targets relating to the national health priorities or issues such as accreditation uptake?).
- The tension between national targets and Divisions' responsiveness to local needs.
- Monitoring/measuring the performance of all Divisions in relation to the targets.
- The fact that this approach would create additional and significant workload requirements for Divisions and the Department.

The DSC agreed that the concept of linking funding to outputs or results achieved could be explored in more detail over the next three years but not be introduced at this point in time.

Question for consideration: If the Department continues to examine the appropriateness of moving to a funding arrangement that is more outputs related, are there any further considerations?

5. Next steps

In this paper we have taken you through the discussions the DSC has had to date regarding the current formula. Issues which the DSC has reached a view have been highlighted, along with those issues which require further consideration.

The DSC and Department are interested in obtaining your comments on the issues canvassed in this paper, plus any other comments. It would be appreciated if comments could be forwarded to the Department by 4 January 2002**.**

Comments can be forwarded preferably by email to Ms Katherine Pontifex or Ms Michelle Ooi at either of the following email addresses:

Katherine.pontifex@health.gov.au
Michelle.ooi@health.gov.au

Alternatively comments could be sent by mail to:

Ms Katherine Pontifex/Ms Michelle Ooi
General Practice Branch
Department of Health and Ageing
MDP 71
GPO Box 9848
CANBERRA ACT 2601

Alternatively comments can be faxed to Ms Pontifex at the Department on (02) 6289 8621 (Please ring Ms Pontifex on 6289 7183 before faxing).

Comments will then be consolidated and presented for review by the DSC at its meeting on 31 January 2002. The aim is to be able to get a final set of options, with a DSC recommendation, to the Minister for Health and Ageing in February 2002 for her approval.

Attachment A: History of the funding arrangements for the Divisions of General Practice

From 1992 to 1997 Divisions of General Practice (under the Divisions and Project Grants Program – DPGP) were funded by the Department according to two elements. Divisions received basic infrastructure grants to support their core activities and this was calculated according to a formula. Divisions then applied for funding for projects. Applications for project funding were assessed against DPGP guidelines and selection criteria by State Advisory Panels (SAPs).

In 1995, the then Secretary of the Department announced that the Department would explore the possibility of a move to block grant payments to Divisions, instead of project based funding. This was in response to Divisions' dissatisfaction with the project submission approach, given its significant role in determining, to a large extent, Divisions' capacity to undertake activities. Moreover, the rapid growth of the program meant that the project submission approach and the administrative arrangements required to support this were unsustainable in the longer term, particularly given the finite amount of program funding.

The Divisions Strategy Group (DSG) (which was replaced by Divisions Development Advisory Committee [DDAC] in 1998, which in turn was eventually replaced by the Divisions Standing Committee of GPPAC in 2000) provided advice to the Department relating to the move to block grant funding for Divisions, including the formula to be used to determine Divisions' annual OBF allocations. During 1996 and 1997, Divisions were consulted by the DSG through a workshop and a discussion paper.

In October 1997 all Divisions were sent an offer outlining their notional entitlements using the new funding formula (this was the current formula as outlined in this paper). All Divisions had moved to new funding agreements based on the new funding formula by July 1999.

A review of the funding formula was conducted in November/December 1998. A survey was distributed to all 123 Divisions, the 8 SBOs and the Australian Division of General Practice (ADGP) and the results were discussed at the inaugural meeting of DDAC in December 1998. Of the 64 responses received, 25 felt there was no need to change the formula and 39 made specific suggestions for changes. DDAC recommended and the then Minister agreed that the current formula should remain unchanged at that time, but should be reviewed over the next three years.

Attachment B: Terms of Reference for Divisions of General Practice Outcomes Based Funding Formula Review

The Department provides $60 million each year to 123 Divisions of General Practice under the Outcomes Based Funding agreements. Each Division's share of the total funding is determined according to a funding formula. 102 Divisions of General Practice will complete their Outcomes Based Funding agreements with the Department of Health and Aged Care on 30 June 2002. (The remaining 21 Divisions complete their current agreements on 30 June 2003). Any new funding arrangements which would apply from 1 July 2002 will need to be approved by the Minister of Health and Aged Care.

The broad terms of reference for the review of the existing Outcomes Based Funding formula are to:

1. Consider the processes and issues canvassed in the development of the existing funding formula, the results of the 1998 survey of stakeholders about the formula, and relevant research relating to the formula (such as the Queensland Divisions of General Practice's "Capacity Building Project").

2. Investigate options for a revised funding formula.

3. Consult with stakeholders about proposed options for a revised funding formula.

4. In analysing the available options, the review will be guided by the following principles:
    - The revised funding formula should reflect the aim of the Divisions of General Practice Program: " *to improve the health outcomes for patients by encouraging General Practitioners to work together and link with other health professionals to upgrade the quality of health service delivery at the local level*";
    - Arrangements for Outcomes Based Funding post 30 June 2002 will continue to be consistent with the Implementation Guide for Outcomes Based Funding, May 1999;
    - Arrangements for Outcomes Based Funding post 30 June 2002 will continue to be consistent with the core, developing and potential roles for Divisions of General Practice as outlined in Appendix J of the Implementation Guide for Outcomes Based Funding, May 1999;
    - The revised funding formula should be transparent and there should be a clear rationale for each element of the formula; and
    - The revised funding formula should result in equity of distribution of funds between Divisions whilst also ensuring that all Divisions receive sufficient funding to provide a minimum level of infrastructure.

5. Recommend a revised funding formula to the Department of Health and Aged Care by December 2001.

6. Further, in light of the structure of the recommended revised funding formula, the review will also recommend:
    - principles for determining funding allocations for Divisions which wish to amalgamate or dis-aggregate; and
    - options for the funding formulas for the More Allied Health Services and Workforce Support for Rural General Practitioners programs, given the links between the current Outcomes Based Funding formula and these funding formulas.

Attachment C: Divisions of General Practice Outcomes Based Funding Formula

The formula includes components for infrastructure and services. Six small Divisions also receive an additional $30,000 per annum.

Infrastructure:

This is made up of a $50,000 **flagfall** or base amount that acknowledges that there is a critical mass of resources required to manage a Division irrespective of the size of the Division.

In addition to the flagfall, Divisions receive an amount for **infrastructure per head of population** to take account of the diversity in the profile of Divisions. For example, according to the 1996 census data, populations served by Divisions vary in size from 19,672 to 518,533 with a median of 130,416 and the General Practitioner membership varies from 10 to more than 800 with a median of 120 per Division *(Source: Distinct Divisions: Report on the 1999/2000 Annual Survey of Divisions of General Practice in Australia).*

Divisions receive either **$1.30 per head of their population** or the **Standardised Whole Patient Equivalent (SWPE) value for the Division**, depending upon which of these total figures is larger. Using either an allocation of population per head or the SWPE ensures that those Divisions with a large daily or seasonal influx of populations (resulting in increased General Practitioner workloads), or those regions of rapid growth, are not disadvantaged by simpler measures of just resident population.

The SWPE is a measure of patient load covered by a Division's General Practitioners, and is calculated by summing together the annual amount (as a fraction) of care that the General Practitioner gives to each of his/her patients (the "fractions of care" for each patient are calculated using Medicare and Department of Veterans Affairs schedule fee data). Each patient's "fraction of care" is weighted according to the sex and age of the patient, thus taking into account the work impact for the General Practitioner of seeing each patient (eg older patients represent a larger work impact).

This allocation per head of population for infrastructure recognises that a Division with a larger population or busier General Practitioners has higher associated infrastructure costs.

Divisions also receive a **rural loading** based on the number of people living in "Rural, Remote, and Metropolitan Areas" or "RRMA" categories 4-7. This element of the formula recognises that a more remote Division has larger infrastructure costs such as higher transport and communication costs.

The RRMA categories were developed in 1994 by the then Department of Primary Industries and Energy and the then Department of Human Services and Health. They are classed as follows:

1 – capital city of state/territory
2 – other metropolitan centres (100 000 plus)
3 – large rural centre (25 000-99 999)
4 – small rural centres (urban centres 10 000-24 999)
5 – other rural areas (remaining sites in rural locations with populations less than 10 000)
6 – remote centres (centres of 5000 plus in remote locations)

7 – other remote areas (remaining sites in remote locations)
(Source: Rural, Remote and Metropolitan Areas Classification, November 1994).

The rural loadings used in the current formula were developed as part of the transition phase between the project grant period and the outcomes based funding period, and are as follows:

- RRMA 4 $0.12
- RRMA 5 $1.36
- RRMA 6 $1.68
- RRMA 7 $2.47

Services:

The "services" component of the formula recognises Divisions' provision of support to General Practitioners. Rather than being based on the number of General Practitioners (there are major difficulties in counting General Practitioners in an environment where they have varying work patterns and mobility) this component is based on General Practitioner workload (SWPE).

The socioeconomic status of a Division's population is taken into account by adjusting (dividing) the Division's average SWPE value by the Socio-Economic Indexes for Areas (SEIFA) squared, and then multiplying this figure by $1.35. This recognises that patients in lower socio-economic groups represent a higher workload to the General Practitioner.

The SEIFA index used in the current formula is the Index of Relative Socio-Economic Disadvantage. This index is derived from attributes such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations, ethnicity and aboriginality.

Squaring the SEIFA index makes the formula more sensitive to socio-economic status. It also increases the spread of the SEIFA index, thus allowing a more obvious reflection of differences in socio-economic status between Divisions.

The **rurality and General Practitioner workload** of a Division is also taken into account. An average SWPE value is determined for each of the RRMA 4-7 categories and then multiplied by the appropriate rural loading. This calculation recognises that the cost of providing support to doctors is more expensive in remote areas.

Divisions also receive $2.55 per person for all the **Aboriginal and Torres Strait Islanders** in their Division in recognition of the greater health needs of indigenous people, and the need to liaise effectively with Aboriginal community service providers and provide appropriate services to these populations.

Minimum funding level

In order to ensure a minimum funding level for Divisions with populations of 30,000 or less, an additional $30,000 per annum is paid to six Divisions with populations of this size after the formula has been applied.

Attachment B: DIVISIONS STANDING COMMITTEE OF THE GENERAL PRACTICE PARTNERSHIP ADVISORY COUNCIL (GPPAC) - MEMBERSHIP STRUCTURE

- Three representatives from GPPAC
- Four Divisions representatives nominated by the Australian Divisions of General Practice (ADGP)
- A representative from National Aboriginal Community Controlled Health (NACCHO)
- Two consumer representatives
- A representative from the Department
- Two general practice academics

Plus an observer from the ADGP