Review of Financial Aspects of the Ambulance Service of NSW

Report to the Minister for Health on Revenue and Charging Structures

November 2005

INDEPENDENT PRICING AND REGULATORY TRIBUNAL
of New South Wales

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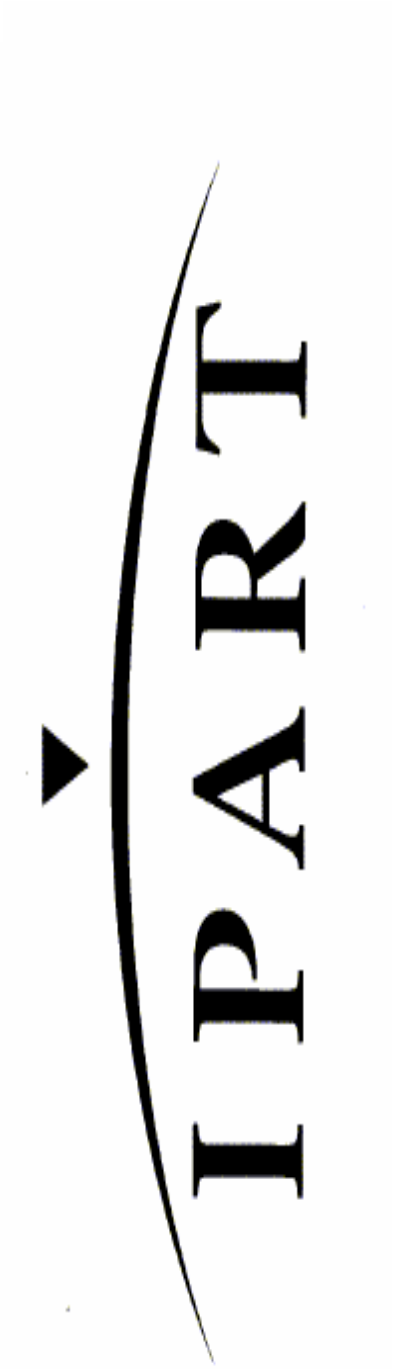

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The Tribunal members for this review are:

Dr Michael Keating, Chairman
Mr James Cox, Full Time Member
Ms Cristina Cifuentes, Part Time Member

Inquiries regarding this review should be directed to:

Dennis Mahoney ☎ (02) 9290 8494
Gerard O'Dea ☎ (02) 9290 8439
Bee Thompson ☎ (02) 9290 8496

Independent Pricing and Regulatory Tribunal of New South Wales
Level 2, 44 Market Street, Sydney NSW 2000
☎ 02 9290 8400 Fax 02 9290 2061
www.ipart.nsw.gov.au
All correspondence to: PO Box Q290, QVB Post Office NSW 1230

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1 INTRODUCTION AND OVERVIEW

Over the last five years, *demand* for the services provided by the Ambulance Service of New South Wales (the Ambulance Service or the Service) has grown steadily. For example, the number of patients the Service treats or transports has increased by an average of 2.6 per cent per year since 1995/96. Given the forces driving this growth, it is reasonable to expect that demand will continue to grow by at least the current trend rates for the foreseeable future.

On the *supply* side, the Service has maintained or improved its capacity in recent years, in part by lifting the number of vehicles that respond to incidents by an average of 4.8 per cent per year since 1995/96.

As a consequence of these demand and supply trends, the overall cost of funding the Service is expected to grow strongly in the immediate future.

In this context, the Premier asked[1] the Independent Pricing and Regulatory Tribunal of New South Wales (the Tribunal) to investigate and report on the Ambulance Service's current revenue and charging structures, and develop a cost index to quantify changes in the cost of providing its medical and transport services. The aim of this review was to recommend how the sustainability of the Service's funding can be improved. (See Attachment 1 for the full terms of reference.)

The Tribunal has completed its review of revenue and charging structures, following the process outlined in Box 1.1. This report explains its findings and recommendations. The second part of the review, which focuses on developing a cost index, is due to be completed in December.

Box 1.1 The Tribunal's review process

The Tribunal undertook this review in accordance with section 9(1)b of the *Independent Pricing and Regulatory Tribunal Act 1992* and its terms of reference.

As part of this process, the Tribunal:

- published an issues paper on 1 March 2005
- advertised the review on 4 March 2005 and invited the Ambulance Service of NSW to provide a submission detailing its responses to the issues raised in the issues paper and any other matters relevant to the review
- invited other interested parties to respond to the Service's submission and received nine written responses, of which seven were not marked confidential and so were published on the Tribunal's website. (A list of these respondents is provided in Attachment 2.)
- held a workshop with invited stakeholders on 4 August 2005 to discuss the key issues of the review. (A list of participants is provided in Attachment 2.)

The Tribunal then considered all comments and contributions made by stakeholders, and each matter in its terms of reference. (Attachment 1 lists where within this document each matter is discussed.)

The Tribunal would like to thank all the stakeholders who took part in this review, and contributed their ideas on improving the funding of the Ambulance Service and other aspects considered as part of this review.

[1] Under section 9(1)b of the *Independent Pricing and Regulatory Tribunal Act, 1992.*

1.1 Overview of findings

The Tribunal found that the costs of running the Ambulance Service are either in line with, or well below, those for similar services in other Australian jurisdictions. This suggests that the Service is cost-efficient (at least relative to other jurisdictions).

However, its current fee structure and scales do not reflect the costs of providing its various services. On average, fees recover less than 60 per cent of the cost of services rendered. For some short emergency trips, they recover less than a third of the estimated cost. But for a few services, such as some non-emergency trips, the fees appear to over-recover costs.

The Tribunal considers this situation to be detrimental to the financial sustainability of the Service, and contributes to the inefficient use of its resources by hospitals and to inequity between different users and community sectors. Therefore, it considers that the current fee structure and scales need to be adjusted. It has recommended specific changes and new fee scales for each type of service. Where the recommended changes to fees are large, it considers they should be phased in, so that users have time to adjust.

The Tribunal also found that the Ambulance Service provides many services for which users do not pay, either directly or indirectly. This means that, even if fees were fully cost-reflective, a substantial revenue shortfall would remain, a shortfall filled by Government funding. As the demand for ambulance services is expected to grow, the size of this shortfall will also grow.

Therefore, the Tribunal believes the Service should take steps to create a more effective charging regime, including introducing fees for 'treat-not-transport' and standby services, reducing the rate of bad debt, and developing a formal hardship policy to control the number of cases where fees are waived.

The Tribunal also recommends to the Government that it consider several issues that influence the effectiveness of the Ambulance Service's charging regime, including reviewing the *Health Insurance Levy Act 1982*. Alternatively, it may wish to explore replacing the HIL with a more broad-based ambulance levy – either by pursuing changes to the Medicare Levy Funding model, or by introducing a Community Ambulance Charge in NSW.

1.2 Overview of recommendations

Based on these findings, the Tribunal made 21 recommendations in relation to the Service's current revenue and charging arrangements that aim to improve the sustainability of the Service's funding. These recommendations are:

1. That the "first 16km free" provision should be removed from the structure of fees for all services that involve distance-based charging.
2. That, for Inter-hospital emergency cases, the fee scales below should be implemented in 2006/07, subject to appropriate cost indexation that will be recommended in the next phase of the review (see page 17), due mid-December.

Recommended Inter-hospital emergency fee scales – 2006/07

	Call-out fee($)	Variable rate ($ per km)
Road	298	2.98
Fixed wing	2,365	1.10
Helicopter	3,385	74 (per 6mins>30)

3. That the fully cost-reflective Inter-hospital fee scales for emergency services shown below should be phased in, subject to appropriate cost indexation, over three years.

Fully cost-reflective Inter-hospital emergency fee scales

	Call-out fee($)	Variable rate ($ per km)
Road	426	4.26
Fixed wing	2,628	1.22
Helicopter	4,513	98 (per 6mins>30)

4. That, for Inter-hospital non-emergency services, the fully cost-reflective fees shown below should be implemented in 2006/07, subject to appropriate cost indexation.

Recommended Inter-hospital non-emergency fee scale 2006/07

Call-out fee($)	Variable rate ($ per km)
195	1.20

5. That Inter-hospital Fixed Wing cases should continue to be billed a single call-out fee (the Fixed Wing fee), and that road travel is charged at the recommended emergency Road variable rate while air travel is charged at the recommended Fixed Wing variable rate.

6. That the maximum charge of $3,991 for Inter-hospital Road and Fixed Wing cases should be maintained, subject to appropriate cost indexation.

7. That, for Primary emergency services, the fee scale shown below should be implemented in 2006/07, subject to appropriate cost indexation.

Recommended Primary fee scales, 2006/07

	Call-out fee($)	Variable rate ($ per km)
Emergency		
- Road, Fixed Wing and Helicopter	205	1.85
Non-emergency	195	1.20

8. That, for Primary emergency services, the fees should be increased by 10 per cent per year in real terms in 2007/08 and 2008/09.

9. That, for Primary non-emergency services, the fully cost-reflective fees shown above should be implemented in 2006/07, subject to appropriate cost indexation and that these fees be maintained in real terms in 2007/08 and 2008/09.

10. That the existing maximum charge of $4,066 for Primary cases should be maintained, subject to appropriate cost indexation.

11. That the Ambulance Service should charge a fee for treat-not-transport cases and that it should be based on the Road emergency fee scale

12. That:

    a) the Ambulance Service should introduce a standby fee, levied on the owners of premises or vehicles involved in dangerous incidents or events where an ambulance is required to be present; for example at chemical spills or other industrial accidents

    b) the standby fee should be set as for the emergency fee scale up to the first hour and then $35 for every 15 minutes thereafter.

13. That the Ambulance Service should clarify its hardship policy for the purpose of determining specific cases where ambulance charges can be waived.

14. That the Ambulance Service should charge the Department of Veterans' Affairs the appropriate scheduled fee for all services it provides to DVA card holders, irrespective of whether the patients concerned hold other concession cards that exempt them from fees.

15. That the Department of Health, in consultation with private health insurance funds, should undertake a public education campaign to raise awareness of ambulance charges and the available insurance options, including ambulance-only cover, to help protect them from the financial impact of these charges.

16. That

    a) the Service should discontinue its practice of paying invoices raised by other jurisdictions for ambulance services provided to NSW residents in those jurisdictions, as responsibility for payment rests with the individuals concerned

    b) the Service should continue to charge non-NSW residents (including international visitors) the same fees that apply to residents, in accordance with the proposed fee scales.

17. That the Government should review the *Health Insurance Levy Act, 1982* to address, where possible, the concerns of the relevant participants in the industry.

18. That the Government should review the basis for its exemptions policy or seek to recoup from the Commonwealth the cost of exemptions given to Health Care card holders.

19. That the funding of the Ambulance Service should be revisited in three years to assess its progress towards sustainability.

20. That the Government should explore the introduction of an ambulance-service component to the Medicare Levy for the purpose of providing future funding for the Ambulance Service of NSW.

21. That the Government should give consideration to the introduction of a Community Ambulance Charge should it not be possible to reach agreement on a national system of funding via the Medicare Levy.

1.3 Structure of report

This first report explains the Tribunal's recommendations on revenue and charging structures, including why it reached its decisions and what those decisions mean for the Service, ambulance patients and hospitals and Government funding. It is structured as follows:

- Chapter 2 provides an overview of the Ambulance Service, including its services and costs, and its efficiency and effectiveness
- Chapter 3 explains why the Service's current fee structure and scales need to be made more cost-reflective, and discusses the Tribunal's recommended changes and fee scales
- Chapter 4 discusses how the charging regime could be made more effective, by applying the new fee scales to a broader range of services, taking steps to reduce the rate of bad debts and other measures
- Chapter 5 focuses on several broader issues that the Government may need to consider if it wishes to further improve the sustainability of the Service's funding arrangements
- Chapter 6 explores the possibility of a broader-based community ambulance charge

The Tribunal members who undertook this review were Dr Michael Keating AC (Chairman), Mr James Cox (Chief Executive Officer and Full-time Member), and Ms Cristina Cifuentes (Part-time Member).

2 OVERVIEW OF THE AMBULANCE SERVICE OF NSW

The Ambulance Service comprises five divisions – four road ambulance divisions and one aero-medical division. At the end of June 2004, it employed 3,301 full-time equivalent (FTE) staff and 115 volunteer staff, most of who were qualified ambulance officers. It operated 852 fully-equipped road ambulances and 396 other vehicles. Its aero-medical division planned and co-ordinated five fixed-wing aircraft (on contract with the Royal Flying Doctor Service) and nine helicopters (on contract with six non-government charitable organisations).

This chapter provides an overview of the services of the Ambulance Service, the factors driving growth in the demand for these services, the costs of providing them, the current arrangements for charging for them, and the efficiency and effectiveness of the Service.

2.1 Types and volume of services

The Ambulance Service provides four types of transport service:

- emergency road transport
- non-emergency road transport
- emergency fixed wing transport
- emergency rotary wing (that is, helicopter) transport.

It also provides several other services, including:

- treat-not-transport services (called TNT services - where road officers treat patients on the spot, but do not transport them anywhere)
- standby services (where ambulances are called to an accident/incident by police or fire brigade for safety reasons; neither transport nor treatment may be required).

The Service measures its volume of services in several ways, including the number of *incidents* to which it responds, the number of individual ambulance *responses* it makes (that is, the number of vehicles that respond to incidents), and the number of *patients* (also called 'cases') it treats or transports. The number of patients treated or transported in 2003/04 is shown in Table 2.1.

Table 2.1 Number of patients, 2003/04

Inter-hospital Transports		Total	Percentage
Primary Transports		**72.8**	**9.7%**
of which:	*Direct charge*	*122.2*	*16.2%*
	Medical Fund	*59.9*	*8.0%*
	Pension	*374.7*	*49.7%*
	DVA	*7.8*	*1.0%*
	Third Party	*15.0*	*2.0%*
	Total Primary Transports	**579.6**	**76.9%**
Treat-Not-Transport		**100.9**	**13.4%**
Total		**753.3**	**100.0%**

Source: Ambulance Service of NSW, private communication.

In 2003/04, the Service provided transport services to around 653,000 patients and hospitals, mostly as emergency and non-emergency road cases (around 643,000). Around 90 per cent of total patients were either transported to a hospital or treated on the spot (called Primary cases). The remaining 10 per cent was transferred between hospitals (called Inter-hospital cases). The Service also provided treat-not-transport services to around 100,000 patients.

2.2 Factors driving the growth of the Service

The various measures of the demand for, and supply of, ambulance services indicate that the Service has expanded more or less steadily over the last five years. The number of incidents it attends has grown by an average of 1.8 per cent per year since 1995/96. The number of patients treated or transported has grown by an annual average of 2.6 per cent over the same period and the number of responses has grown by an annual average of 4.8 per cent.

The increase in the number of incidents partly reflects state-wide population growth, which has increased by an average of 1.1 per cent per year since 1995/96. The rising ratio of responses to incidents reflects the introduction of Rapid Response vehicles in central Sydney. These vehicles arrive quickly at incidents, assess needs and stabilise patients before an ambulance arrives. It would not be unusual for a general-purpose ambulance, rapid response vehicle and a back-up paramedic and/or rescue unit to be assigned to a major incident. Supervisors' vehicles might also respond in such cases.

However, a wide range of other factors has contributed to the overall growth in demand, and is expected to drive future demand. In its submission to the Tribunal, the Ambulance Service indicated that it considers the main drivers of future demand to be:

- the ageing of the population (people aged 60+ are the largest users of its services)[2]
- social factors (such as the increased number of people living alone)
- lack of access to alternative services and changes in medical practice that have reduced after-hours General Practitioner services
- rising community expectations
- trends towards greater levels of hospital specialisation, which mean patients are not necessarily taken to the nearest hospital after an incident and may need to be transferred between hospitals for specialised treatment.

The Service also noted that trends in the growth in demand differ between metropolitan and rural areas. For example, in metropolitan Sydney, the total number of responses is growing faster than in rural areas. In addition, demand for non-emergency transport services is growing faster in metropolitan Sydney, while demand for emergency transport services is growing faster in rural areas.

Further, the Service noted that several changes are contributing to an increase in the costs of meeting demand. These include changes in the types of services desired, such as the increasing demand for retrievals (where the Service provides a team of officers to prepare and then transport very ill patients who can no longer be treated adequately at their current

[2] The ABS projects that the NSW population will rise 16 per cent between 2002 and 2022 but that within that population the number aged 65 and over will increase from 875,000 to 1.5 million or by 70 per cent. Source: ABS projections, Series II Household and Family Projections Australia 2001 to 2026, ABS Cat No.3236.0, Table 6.11.

hospital and must be carefully moved to a more suitable one), and the rising level of clinical capability required of the Service (it is increasingly required to "take care to the patient" rather than "take the patient to care").

The future mix of ambulance demand is difficult to forecast. However, given the forces driving demand and current government social and health policy arrangements, the Tribunal considers it reasonable to expect that the various *overall* measures of demand will continue to grow at least at current trend rates. It also considers it reasonable to expect that the cost of funding the Ambulance Service will continue to grow.

2.3 Costs

In 2003/04, the Ambulance Service's expenses totalled $366.8m (Table 2.2). The largest item, employee-related expenses, was $256.5m (or 69.9 per cent of total cost). Salaries and wages accounted for $198.4m, of which $40.9m or 21 per cent was overtime payments. Other significant costs were medical goods and services, bad and doubtful debts, vehicle leases and maintenance, and depreciation.

Table 2.2 Costs of the Ambulance Service of NSW, 2003/04

Operating Expenses	$m	$m	$m
Employee Related	**256.5**		
of which: Salaries and Wages		198.4	
Long Service Leave		6.5	
Annual Leave		20.9	
Workers' Compensation Insurance		11.9	
Superannuation		18.7	
Goods and Services	**78.8**		
including: Aeromedical		24.3	
General Expenses		36.9	
including: Bad and Doubtful Debts			6.3
Motor Vehicle Operating Leases			13.2
Maintenance	**16.0**		
Depreciation (vehicles, buildings, plant & equipment)	**14.8**		
TOTAL EXPENSES (including $0.6m grants, borrowings)	**366.8**		

Source: Ambulance Service of NSW, *Annual Report* 2003/04. The last two columns show the major costs only for Goods and Services and General Expenses and are not exhaustive. Numbers may also not add due to rounding.

The bulk of the total funding for the Service came from the Government via budget allocations to NSW Health (Table 2.3).[3] A relatively small proportion ($72.5m or 19.8 per cent) came from fees levied directly on its users which are included in the item 'Sales of goods and services' in Table 2.3.

[3] Of the $269.9m shown in Table 2.3 as Government contributions, $98m was, in effect, provided by the Health Insurance Levy mentioned in section 2.2.2 below.

Table 2.3 Funding of the Ambulance Service of NSW, 2003/04 $m

Sales of goods and services	72.5
Investment income	1.1
Grants and contributions	2.2
Other revenue	3.5
Total Revenues	**79.3**
NSW Health recurrent allocations	236.9
NSW Health capital allocations	14.2
Acceptance by the Crown Entity of employee superannuation benefits	18.7
Total Government Contributions	**269.9**
Miscellaneous #	17.6
TOTAL FUNDING	**366.8**

Gain on asset disposal, net increase in Asset Valuation Reserve, reduction in owner's equity.
Source: Ambulance Service of NSW, *Annual Report* 2003/04, pp 30-39. Numbers may not add due to rounding.

The Tribunal commissioned PricewaterhouseCoopers (PwC) to model the funding outcomes *if* the current cost trends and revenue and charging arrangements were to remain in place. Based on reasonable assumptions about growth in costs and demand,[4] PwC found that by 2008/09, the annual cost of funding the Service will have increased by around $100m, of which around $80m would have to be funded by Government.

2.4 Current charging arrangements

Under the current arrangements, not all patients are charged for the services they receive from the Ambulance Service – either directly or indirectly. One reason for this is that under State Government policy and statutory determination, NSW residents are exempt from charges if they hold a Pensioner Concession card, Health Care Concession card or a Commonwealth Seniors Health card or other Health Care card.[5] Another reason is that for some services, including treat-not-transport services, no fee has been established.

In 2003/04, around 374,700 Ambulance Service patients were exempt from charges because they held some kind of concession or Health Care card. This represents almost half of the total number of patients in that year. Another 100,900 patients, or 13.4 per cent of total patients, were not charged because they received treat-not-transport services.

Of those patients who are charged, some paid directly while others paid indirectly. Indirect payments included those paid via bulk agreements between the Ambulance Service and the Department of Veterans' Affairs (DVA) and the Motor Accident Authority. They also include members of health insurance funds on behalf of their members.

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4 After detailed consultation with the Ambulance Service, PwC assumed that:
- existing fee levels and bulk agreements would be repriced in step with inflation
- demand for ambulance services (ie, the number of "cases") would rise by 4 per cent pa.
- the Health Insurance Levy (HIL) rate would rise in step with the legislative formula and HIL volumes would rise in step with the projected growth in the NSW population of 0.8 per cent per annum
- employee-related costs would rise to reflect increases in average weekly earnings and extra staff
- non-employee-related costs would rise to reflect inflation and case-related growth.

5 A range of other residents are also exempt, including ministers of religion, corrective services inmates, those under arrest, victims of sexual and domestic violence, SIDS patients, ambulance service employers and their immediate families, children at risk, and Life Members.

By law, each registered health fund in NSW is required to pay a Health Insurance Levy (HIL) for members of the fund who purchase basic hospital cover (unless the member has been exempted by Government policy from paying ambulance fees). The HIL is paid into Consolidated Revenue and thus, indirectly, helps fund the Ambulance Service.

The current charging arrangements and the Tribunal's recommendations to make these arrangements more cost-reflective are discussed further in Chapters 3 and 4.

2.5 Efficiency

The efficiency of the Ambulance Service refers to its ability to meet its operational and clinical goals using the minimum resources required, thereby minimising the costs incurred. The Tribunal assessed this efficiency using the available data.

Most of this data came from inter-jurisdictional comparisons compiled and published by the Productivity Commission. A consultant's report that the Tribunal commissioned on aspects of ambulance jurisdictions in New Zealand, British Columbia and London also touched on efficiency and measures.[6]

In general, the Tribunal found that the Service is as cost-efficient, or more cost-efficient, than other ambulance jurisdictions in Australia.[7] It based this view on four measures that provide indications of the Service's cost-efficiency – costs per patient, cost per ambulance response, costs per full-time equivalent (FTE) staff, and fleet utilisation levels.

2.5.1 Costs per patient

The Ambulance Service's average cost per patient either treated or transported in 2003/04 was around $487.[8] When adjusted by the Productivity Commission to be comparable with other jurisdictions, this cost is $512 (Table 2.4).[9] This is lower than the national average and lower than in Victoria, Queensland, Tasmania and the ACT.

6 The overseas services of a size (in terms of staff) comparable to the Ambulance Service of NSW were the British Columbia Ambulance Service (BCAS) and the London Ambulance Service (LAS). The LAS is the largest "free" ambulance service in the world (in that no user pays directly to the LAS) with 3,822 staff making 1.5m responses (176 responses per 1,000 people) from 70 ambulance stations. The BCAS employed 3,200 staff and made 468,000 responses (112 per 1,000). The Ambulance Service of NSW employed 3,301 staff and made three quarters of a million responses (139 per 1,000) from 242 'response locations' in 2003/04. Source: PricewaterhouseCoopers *Ambulance Service of NSW Funding Model: A Comparison with Other National and International Ambulance Services,* May 2005, pp 26-27; available on the Tribunal's website at Other Projects/Current Projects. Hereafter referred to as PricewaterhouseCoopers Report to IPART.

7 The Tribunal recognises that cost comparisons can be misleading because jurisdictions may have very different mixes of road and air services and equipment needs. The mix matters because costs vary greatly between road and air services. In the case of NSW, the total cost of road ambulance services per road ambulance was $296,235 in 2003/04. For the five fixed wing aircraft and nine helicopters the total cost per aircraft was $2.4m and $1.4m respectively.

8 The total cost of the Service, $366.8m, divided by 753,400.

9 The Productivity Commission imputes a user cost of capital for buildings and plant and equipment that inflates the Ambulance Service reported costs to $375.832m.

Table 2.4 Costs per patient, 2003/04 $

	2001/02	2002/03	2003/04	Ratio of FY04 on FY02
NSW	491.4	477.6	512.0	1.04
Victoria	599.4	590.7	602.6	1.01
Queensland	551.4	499.5	533.4	0.97
WA	445.5	445.4	454.4	1.02
SA	435.3	461.7	509.3	1.17
Tasmania	475.5	491.4	666.1	1.40
ACT	488.8	570.9	523.4	1.07
NT	439.8	434.2	450.0	1.02
Australia	**521.6**	**506.9**	**536.2**	**1.03**

Source: Productivity Commission, Report on Government Services, 2004 and 2005. The 2002 report does not provide patient numbers for earlier years.

2.5.2 Costs per ambulance response

The Service's 2003/04 costs per response were just over $400 (Table 2.5).[10] This is lower than in most states and territories, and in some cases, significantly lower.

Table 2.5 Costs per response, 2003/04 $

	1999/00	2000/01	2001/02	2002/03	2003/04	Ratio of FY04 on FY00
NSW	413.5	397.1	386.7	392.9	405.0	0.98
Victoria	432.8	432.2	458.3	448.7	459.8	1.06
Queensland	421.7	471.8	472.3	428.8	428.0	1.01
WA	494.6	481.1	436.3	451.9	463.9	0.94
SA	452.6	415.7	435.3	461.7	462.3	1.02
Tasmania	435.5	484.6	416.1	404.7	417.9	0.96
ACT	535.8	470.2	488.8	528.6	523.4	0.98
NT	493.4	417.4	374.6	384.1	398.0	0.81
Australia	**430.5**	**416.6**	**432.1**	**425.2**	**432.9**	1.01

Source: Productivity Commission, *Report on Government Services 200,5* Tables 8A.19-20 and past issues.

2.5.3 Costs per FTE staff

The Ambulance Service's costs per full-time equivalent (FTE) staff were around $111,117 in 2003/04.[11] After adjustment by the Productivity Commission, costs per FTE staff were $113,854 (Table 2.6). This cost is below the national average, substantially lower than in Victoria, substantially higher than in Queensland and SA, and marginally higher than in WA and the ACT.

Table 2.6 Costs per full-time equivalent salaried staff, 2003/04

2003/04	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Total costs ($m)	375.8	310.3	277.3	66.8	90.2	21.3	14.1	10.3	1,166.3
Salaried staff (FTE)	3,301	2,246	2,662	596	849	187	128	117	10,008
Costs per FTE ($)	**113,854**	**138,175**	**104,188**	**112,079**	**106,188**	**113,984**	**110,398**	**88,453**	**116,534**

Source: Productivity Commission, *Review of Government Services 2005*, Tables 8A.21 and 8A.26.

10 Based on data in the Ambulance Service *Annual Report 2003/04*, cost per response is marginally lower at $395 (which is total costs at $366.8m divided by 928,000 responses).

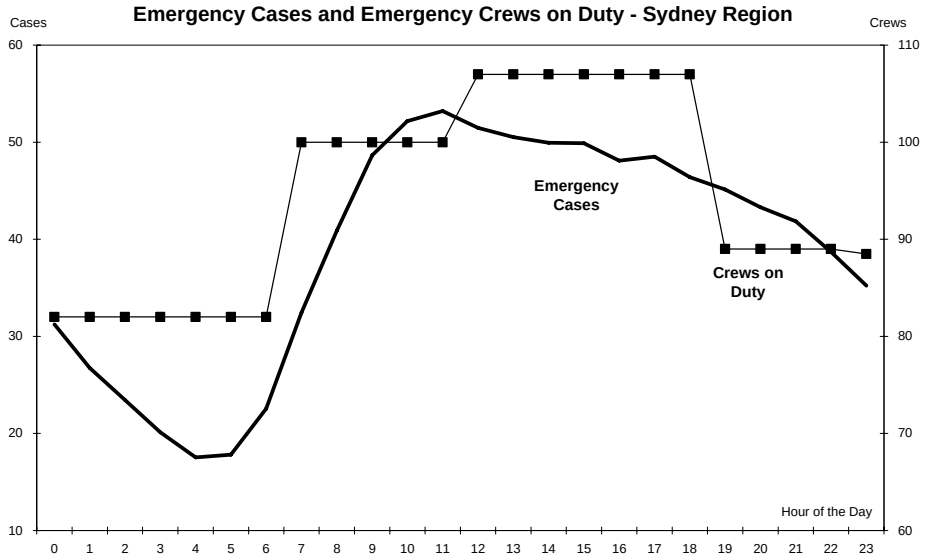
11 Total costs divided by 3,301 (that is, excluding volunteer staff).

2.5.4 Fleet utilisation levels

In general, if fleet utilisation levels are high (so a high percentage of the ambulances and crews on duty are always 'out of station' on cases), there is a close match between capital resources and demand (so few resources are being 'wasted' relative to demand).

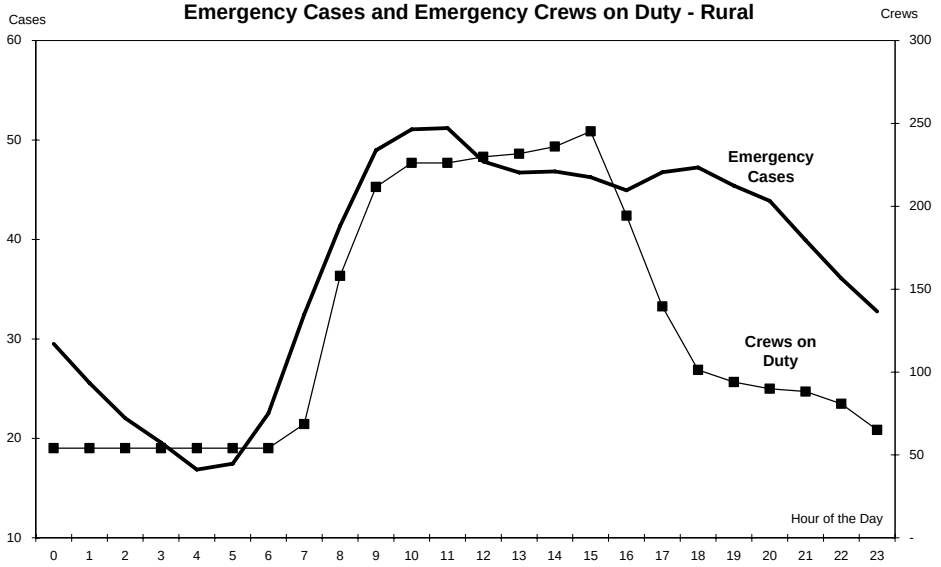
The Tribunal's analysis of the Ambulance Service's fleet utilisation suggests there is a close match between resources and demand. For example, Figures 2.1 and 2.2 indicate a reasonable correlation between the number of emergency cases over a 24-hour period and the number of crews on duty. This correlation is particularly clear in the busiest hours, between 7am and 6pm. Further, the Service seems to manage with fewer crews on duty relative to the number of emergency cases in the evening hours, both in the metropolitan and rural areas.

Figure 2.1 Matching 24 hours of ambulance supply to demand in the Sydney Region



Source: Ambulance Service of NSW, private communication; for both Figures 2.1 and 2.2.

Figure 2.2 Matching 24 hours of ambulance supply to demand in rural areas



2.6 Effectiveness of the Service

The effectiveness of the Ambulance Service refers to its ability to deliver the results or outcomes expected of it. The Tribunal assessed the Service's effectiveness using the available data. It looked at several indicators of effectiveness, including the Service's Key Performance Indicators (KPIs) and response times, and how satisfied its users are with the services they receive. Based on these indicators, the Service appears to be reasonably effective.

2.6.1 Key Performance Indicators

The Service has several KPIs that it uses to measure its operational performance and clinical capability. Its performance against these KPIs, as reported in its Annual Report, suggests that it is broadly effective in meeting its operational goals.

2.6.2 Response times

Over recent years, the Ambulance Service's response times have remained fairly steady. For 50 per cent of emergency calls, it achieved a response time of around 10 minutes or less, while for 90 per cent of emergency calls the response time was around 20 minutes or less (Table 2.7).

Table 2.7 Response times for emergency calls in NSW (minutes)

	1999/00	2000/01	2001/02	2002/03	2003/04
50% of responses	9.0	10.3	9.7	9.7	9.9
90% of responses	18.0	20.7	19.2	19.2	19.5

Source: Productivity Commission, *Report on Government Services 2005,* Table 8A.24.

The Service's response times are slightly slower than those in most other jurisdictions (Table 2.8). However, this may not indicate less effectiveness, as a range of external factors can affect response times. These include the speed at which vehicles can safely travel, which depends on such factors as the condition of the road and the degree of traffic congestion.

Table 2.8 Interstate response times for emergency calls (in minutes)

2003/04	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
50% of responses	9.9	9.0	8.0	9.0	9.2	10.3	7.5	9.0
90% of responses	19.5	16.0	17.0	15.2	15.8	21.3	12.3	14.0

Source: Productivity Commission, *Report on Government Services 2005,* Table 8A.24.

2.6.3 Customer satisfaction

The Convention of Ambulance Authorities (CAA) regularly surveys the users of ambulance services in each state and territory to assess their level of satisfaction with the services they received.

The 2004 CAA survey of 1,300 NSW users found that most were very satisfied or satisfied with many aspects of the service they received, including the call response time, their dealings with communication staff, the ambulance response time, and the care and treatment they received from the ambulance officers (Table 2.9).

Table 2.9 Selected findings of the CAA 2004 National Patient Satisfaction Survey

Key area	Dissatisfied or very dissatisfied (%)	Neither satisfied nor dissatisfied (%)	Very satisfied or satisfied 2004 (%)	Very satisfied or satisfied 2003 (%)
Call response time satisfaction rating	1	1	98	61
Satisfaction with communications staff	1	1	98	97
Ambulance response time	2	2	96	56
Ambulance officer care rating	1	1	98	98
Treatment satisfaction	1	1	98	99
Ambulance officer satisfaction rating	1	2	97	94
Trip/ride satisfaction	3	4	93	94
Overall satisfaction	1	1	98	97

Source: Ambulance Service of NSW, 2003/04 Annual Report, p 55.

The Tribunal notes that in recent years, the Ambulance Service has made several changes aimed at maintaining or enhancing its effectiveness.

These changes include establishing a Professional Standards and Conduct Unit and a Clinical Services Unit, and undertaking a major multi-year upgrade of officer clinical skills. It has also expanded its Patient Transport Service and Rapid Responders in response to a better analysis of demand characteristics, changed roster patterns to better match resources to demand and moved to fleet leasing, which it believes has improved reliability, reduced

fuel, maintenance and repair costs and lowered the average age of ambulances from 5.5 years to less than 3 years.

2.7 Standards of quality, reliability and safety

The term 'service quality' can refer to a wide range of desirable outcomes for consumers, including the quality of the service itself and various indicators of reliability. However, the highest possible quality is not necessarily the most efficient, since better service involves costs, and trade-offs must be made between service quality and cost and price.

As the previous section discussed, the Ambulance Service is efficient relative to ambulance services in other Australian jurisdictions, and several measures suggest that it is also effective in delivering the outcomes expected of it. This seems to suggest that the Service's standards of quality and reliability are appropriate.

In addition, the Service has worked progressively over recent years to strengthen its position in relation to patient and staff safety. With regard to patients, this has included:

- introducing an Incident Information Management System (IIMS) that allows for the reporting and investigation of incidents involving patients or other matters
- creating a Patient Safety Officer position at State headquarters to oversee all elements of patient safety while in ambulance care
- introducing enhanced safety features into the operational fleet, including improved access to the patient compartment
- redesigning the interior of operational ambulances to provide greater patient safety during transport by the introduction of more secure equipment stowage areas, seat belts on attendants seats, patient stretcher harness', child safety seats and improved restraints in neonatal transport capsules.

3 MAKE FEE SCALES MORE COST-REFLECTIVE

As part of its analysis of the costs, revenue and charging structures, the Tribunal assessed whether the Ambulance Service's current fee scales and fee structure reflect the costs involved in providing services. It found that the fee scales, which apply only to Inter-hospital transfers and non-exempt Primary transport services, are not cost-reflective. In some cases, the relevant fee under-recovers the cost of the service, and in others it over-recovers this cost. However, on average, the current fees recover less that 60 per cent of the cost of services. It also found that the current fee structure compromises the cost reflectivity of the fee scales.

The Tribunal believes the current fee scales and structure should be adjusted to increase the cost-reflectivity of fees. This chapter explains its reasons for this belief. It also explains the Tribunal's assessment of the current fee structure and fee scales, and sets out its recommended fee scales. Finally, it analyses the likely impact of the recommended fee scales on ambulance bills, the Ambulance Service's revenues, Area Health Service costs and Government funding.

As a result of the Tribunal's review, the Ambulance Service undertook a major cost allocation and review exercise. This built upon existing work undertaken by the Ambulance Service and allowed costs per case for emergency and non-emergency services to be derived using the 2003/04 cost data. The data were relied upon by the Tribunal to derive the fully cost-reflective fee scales presented in this chapter.

The Tribunal was satisfied that the 2003/04 cost data was reasonable for the purposes of this review. However, it believes that the Ambulance Service should continue to allocate its costs on the basis undertaken as part of this review so that it remains fully cognisant of the current costs per case that underlie each service it provides. This will allow the Service to better align charges with the costs of provision of each service, in line with the principles developed as part of this review. In addition, any changes to the Ambulance Service's costs and/or cost allocations in the future may then be reflected into future estimates of full cost-reflectivity.

In this chapter, the fully cost-reflective and the recommended fee scales are shown in 2005/06 dollars in order to make them comparable to the current fee scales.

The 2005/06 fully cost-reflective scales are derived by indexing the 2003/04 cost information to 2005/06 using assumed inflation rates of 2.5 per cent for 2004/05 and 2005/06. These inflation rates reflect the movement in the Consumer Price Index (CPI), rather than movement in the costs of the Ambulance Service. The Tribunal has been asked to develop a cost index for the Service in the second phase of this review (see Attachment 1). If this index were to differ from the CPI for 2004/05 and 2005/06, the fully cost-reflective fee scales and the Tribunal's recommended fee scales would be adjusted prior to implementation.

3.1 The case for more cost-reflective fee scales

The Tribunal believes that the fee scales should be adjusted so they better reflect costs, for three important reasons:

- to provide incentives for hospitals to use ambulance services more efficiently
- to make ambulance charges more equitable
- to improve the future financial sustainability of the Ambulance Service.

3.1.1 Provide incentives for hospitals to use ambulance services more efficiently

The Tribunal believes that making the Inter-hospital fee scale more cost-reflective will provide incentives for hospitals to use ambulance services more efficiently. As hospitals make decisions about ambulance services on the basis of the costs of these services, the lack of cost reflectivity in the fee scales influences the types of services they use.

For example, under the current fee scales, hospitals have no financial incentive to use the non-emergency Road service as it costs the same as the (higher quality) emergency service and more than non-ambulance alternatives. Similarly, hospitals have no financial incentive to schedule non-emergency Inter-hospital transfers during working hours, which would be more cost effective for the Ambulance Service. More cost-reflective fee scales will provide better signals to hospitals, to encourage them to use the Services' resources more efficiently.

3.1.2 Make Primary charges more equitable

The Tribunal also believes the Primary fee scale should be more cost-reflective because this will make charges more equitable. The current fees incorporate several inequities between different groups of patients.

The first of these inequities is between patients who are charged directly for the services they receive, and those who have private health insurance and so pay indirectly through the Health Insurance Levy (HIL) that their health funds pay on their behalf. The revenue that is collected from privately insured patients via the HIL at least covers the estimated costs associated with providing services to this section of the community.[12],[13] At the same time, patients who are charged directly for ambulance services pay only about one third of the cost of providing the service. This means that under the current fee scales, directly chargeable patients are being subsidised for these services from general revenue, while privately insured households do not receive this subsidy.[14]

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12 A payment of around $100 per household per year would cover the cost of all Primary emergency services (see Chapter 6). The HIL is currently around $54 per year for a single payer and $107 per year for a household. This suggests that HIL payments at least cover the costs of service, and probably more than the actual costs if usage patterns are taken into account. According to the Australian Health Insurance Association, health insurance fund contributors represent 44 per cent of the NSW population but only 8 per cent of ambulance cases.

13 This has occurred in part because the HIL was not initially introduced as a form of user pays, but rather as a de-facto community ambulance charge given the large proportion of households privately insured when it was introduced. Arguably, under the current funding model, the HIL could recover only the cost of providing ambulance services to privately insured patients.

14 One way to resolve the inequities in the current charging structure would be through some form of community levy. This possibility is discussed in some detail in Chapter 6.

The second inequity is between patients who are transported longer distances and those who are transported short distances. This is because the current fee structure does not adequately apportion variable costs to the variable charge component of the fee scale. For example, the higher level of cost recovery for longer distances means that on average, patients in rural areas probably pay a higher proportion of costs than those in metropolitan areas. Some patients may even be charged more than the cost of service – for example, those travelling long distances with the non-emergency Road service.

The third inequity is between patients who receive non-emergency services and those who receive emergency services. Under the current fee scale, the fees for emergency services in NSW are much less cost-reflective than those for non-emergency services. In addition, the fees for emergency services are low compared to those levied in other states and territories. For example, in 2003/04 an emergency 30km road journey in NSW cost $224, compared to $949 in metropolitan Victoria, $499 in Western Australia and $317 in the ACT. In contrast, NSW fees for non-emergency service are similar to those in other jurisdictions.[15]

The Tribunal believes that there is good reason to set the Primary emergency fee scale below full cost-reflectivity. Everyone in the community derives a benefit from having the Ambulance Service standing ready to provide emergency services when they are needed, and it would be unfair to ask only those who happen to use the service to cover the full cost of the stand-by function. However, the Tribunal considers that the extent of the current subsidy is unsustainable.

Further, the Tribunal is not convinced that higher charges will discourage inappropriate use of Ambulance services by patients who are directly charged. Higher charges may, however, encourage more people to take out insurance, and therefore the Tribunal believes that the recommended fee increases, combined with a public education campaign about ambulance charges and available insurance options (see recommendation 15), is appropriate.

3.1.3 Improve the future financial sustainability of the Ambulance Service

The final reason why the Tribunal believes the current fee scales need to be adjusted to make them more cost-reflective is that this will improve the financial sustainability of the Ambulance Service. Greater cost reflectivity will strengthen the link between expenditure and income, and result in a higher proportion of revenue being derived from charges.[16] In turn, this is likely to improve the financial sustainability of the Ambulance Service.

3.2 Tribunal's analysis of current fee structure

In analysing the current fee structure, the Tribunal considered whether to retain the current provisions whereby, for all cases except Inter-hospital Helicopter cases, there is no charge for the first 16km and, for Inter-hospital Helicopter cases, there is no charge for the first 30 minutes of transport. The Tribunal believes that the 'first 16km free' provision should be removed, because it compromises the cost reflectivity of fee scales that aim to recover the variable costs of these services from variable charges. However, it does not believe the provision for Inter-hospital Helicopter cases should be removed at this stage, due to lack of

15 IPART, *Review of Financial Aspects of the Ambulance Service of NSW - An issues paper, March 2005.* Discussion Paper DP81, p 13.

16 This, of course, assumes that the problem of unpaid bills is effectively resolved. The issue of bad debts is discussed in Section 4.

sufficient information.[17] The fully cost-reflective and the recommended fee scales discussed in the sections below reflect these beliefs.

The Tribunal also noted that the cost reflectivity of fees could potentially be improved by making other changes to the current fee structure. However, due to information constraints, it was not able to explore these options as part of this review. The first option relates to introducing time-based charges instead of, or in addition to, distance-based ones. In its report to the Tribunal, PwC noted:

> An appraisal of whether distance or time is a more reflective measure of how variable costs change depends on the extent to which labour costs vary for longer or most complex incidents. If labour costs generally do not rise, then the additional costs are contained mainly to vehicle utilisation and running costs, which makes distance travelled a reasonable proxy for quantifying variable costs.
>
> However, if longer responses often result in overtime payments or other labour allowances, then an excess waiting time charge could be appropriate. This would improve incentives to ensure a timely handover and acceptance of patients at health facilities to enable Service officers to move on to servicing their next allocated job. As overtime is a significant cost for the Service, there may be merit in considering a combination of a distance charge plus an excess waiting time charge so as to improve the cost reflectivity of charges.[18]

The second option relates to introducing separate fee scales for metropolitan and rural services. In metropolitan areas, the Ambulance Service provides 24-hour stations, and its transportation services mostly involve short trips. However, in rural areas, ambulance stations are open for only part of each 24 hours, and staff are on stand-by out of hours. In addition, many of the transportation services involve long trips. Because of the different costs these arrangements involve, there may be advantages in developing separate fee scales for metropolitan and rural areas, to better reflect actual costs in each area. The Tribunal believes further research needs to be undertaken to determine whether this approach is worth pursuing.

Recommendation 1

That the 'first 16km free' provision within the structure of fees for all services except Inter-hospital Helicopter cases be removed.

3.3 Tribunal's analysis of current fee scales

In order to recommend fee scales that move the current fees towards cost-reflective levels, the Tribunal first established a set of fully cost-reflective fee scales for Inter-hospital and Primary cases. It then compared the current fee scales to the fully cost-reflective fee scales to determine what portion of costs the current fees recover. Finally, it developed recommended fee scales for Inter-hospital cases and Primary cases that will move fees towards greater cost-reflectivity.

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17 As discussed in Attachment 3, the variable cost for Helicopter cases could not be accurately estimated because inter-hospital cases are measures in minutes and Primary case are measure in kilometres.

18 PricewaterhouseCoopers *Ambulance Service of NSW Funding Model: A Comparison with Other National and International Ambulance Services,* May 2005, p 39; available on the Tribunal's website at Other Projects/Current Projects. Hereafter referred to as PricewaterhouseCoopers Report to IPART.

3.3.1 Fully cost-reflective fee scales

To derive a set of fully cost-reflective fee scales, the Tribunal relied on information supplied by the Ambulance Service on its total 2003/04 costs, and on the allocation of these costs to the different services and between fixed and variable costs. This information indicated that in 2003/04, the Service spent $366.5m[19] to treat or transport more than 750,000 patients. The Tribunal then:

- Expressed this expenditure in 2005/06 prices by assuming an inflation rate of 2.5 per cent for both 2004/05 and 2005/06.[20]
- Allocated the total expenditure to the services reflected in the fee scales – that is, Inter-hospital emergency Road, Fixed Wing and Helicopter services, Primary emergency services and non-emergency Road services.
- Calculated how much of the expenditure allocated to each service was fixed, and how much was variable, based on the Ambulance Service's estimate that 78 per cent of its costs are fixed, and 22 per cent are variable.
- Calculated the fully cost-reflective call-out charge for each service by dividing the total fixed costs allocated to it by the appropriate number of cases.
- Calculated the fully cost-reflective variable charge for each service by dividing the total variable costs allocated to it by the appropriate distances travelled (km) or, for Inter-hospital Helicopter cases, time.

The resulting fully cost-reflective fee scales are shown in Table 3.1. A more detail explanation of how the Tribunal derived these fee scales is in Attachment 3.

Table 3.1 Fully cost-reflective fee scales, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Interhospital				
Call-out ($/case)	426	195	2,628	4,513
Variable rate ($/km[1] or 6 minute interval[2])	4.26	1.20	1.22	98
Variable road rate for Fixed Wing cases			*4.26*	
Average chargeable km (min) per case	111	73	667	78
Average charge per case	897	283	3,496	5,786
Primary				
Call-out ($/case)	489	195	489	489
Variable rate ($/km)[1]	4.37	1.20	4.37	4.37
Average chargeable km per case	19	32	784	62
Average charge per case	573	234	3,914	758

1. The variable rate is levied per km travelled (including the first 16km) in all cases except Inter-hospital Helicopter cases.

2. Inter-hospital Helicopter cases are billed per 6-minute interval elapsed after the first 30 minutes. The 78 minutes of chargeable minutes shown in the table is the average flying time less 30 minutes

19 This amount excludes $0.3 million of expenditure from the Special Purpose and Trust Fund that is included in total expenditure of $366.8 million shown in Table 2.2.

20 The inflation rate of 2.5 per cent for 2004/05 is the annual average or year-on-year rate to June 2005 for the Sydney CPI. The rate for 2005/06 is projected.

These fully cost-reflective fee scales include a single set of fees for Primary emergency services (that is, with no differentiation between road and air services). The Ambulance Service argues, and the Tribunal agrees, that a single fee scale for Primary emergency cases is appropriate, since it is the Ambulance Service that decides what mode of transport to use and not the patient

In addition, the fee scales include two variable rates for Inter-hospital Fixed Wing transport – that is, the rate for air transport ($1.22/km) and the rate for the emergency Road transport ($4.26/km). This is because most Fixed Wing cases involve road transport at either end of the flight, and current practice is to bill these cases as a single call-out charge and a variable charge for the total distance travelled by both road and air. In the absence of further information, the Tribunal was reluctant to recommend changes to this billing practice, and has calculated the fee scale for Inter-hospital cases on the assumption that the practice will continue to apply. [21]

3.3.2 The cost-reflectivity of the current fee scales

The current fee scales, applicable from 1 July 2005, are shown in Table 3.2. To estimate the overall cost reflectivity of the current fee scales, the Tribunal compared the average charges per case under the current fee scales with the average costs per case (according to the fully cost-reflective fee scales). It found that under the current fee scales, the charges levied on chargeable Inter-hospital cases recover 73 per cent of the costs of the service, while those levied on chargeable Primary cases recover only 36 per cent of the costs (Table 3.3). The charges levied on all chargeable cases recover 59 per cent of costs.

Table 3.2 The current fee scales, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Interhospital				
Call-out ($/case)	166	166	166	1,830
Variable rate ($/km over 16)[1,2]	4.25	4.25	4.25	123
Maximum charge ($/case)	3,991	3,991	3,991	na
Primary				
Call-out ($/case)	169	169	169	169
Variable rate ($/km over 16)	4.34	4.34	4.34	4.34
Maximum charge ($/case)	4,066	4,066	4,066	4,066

1. The Road and Fixed Wing variable rate is applied to km travelled in excess of 16km.
2. The Inter-hospital Helicopter variable rate is levied per 6 minute interval after the first 30 minutes.

[21] The 'fully cost-reflective' call-out charge for Fixed Wing cases somewhat understates the cost as it does not include the fixed costs of any emergency road transport that may occur on either end of the flight. Since the magnitude of these costs is unknown and the Tribunal was reluctant to make its' own estimates, no adjustment was made to reflect these costs. The impact of such an adjustment on the call-out charge for emergency Road cases would be small, given the relative number of cases involved.

Table 3.3 Average charge per case under current fee scales compared with average costs per case, 2005/06 $

	Road		Fixed Wing	Helicopter	Total
	Emergency	Non Emerg	Emergency	Emergency	
Interhospital					
Cost per case	897	283	3,496	5,786	
Charge per case	569	409	2,935	3,423	
Charge as % costs	**63%**	**144%**	**84%**	**59%**	**73%**
Primary					
Cost per case (pooled emergency)	573	234	3,914	758	
Charge per case	183	238	3,498	367	
Charge as % costs	**32%**	**102%**	**89%**	**48%**	**36%**
Total					**59%**

1. The costs of emergency Road, Fixed Wing and Helicopter services have been combined.

Under the current Inter-hospital fee scale, non-emergency Road services over-recover costs, while emergency Road, Fixed Wing and Helicopter services under-recover costs.[22] Primary emergency cases significantly under-recover costs, while Primary non-emergency cases slightly over-recover costs.

Average levels of cost recovery are not good indicators of cost recovery on individual bills. For both Inter-hospital and Primary cases, the extent of under or over recovery depends on the distance travelled. Charges for shorter distances currently under-recover more than those for longer distances, due to the 'first 16km free rule' and to the low call-out fee and high variable charge on the current fee scale. For example, the bill for a 5km Primary emergency trip will recover 33 per cent of the (pooled emergency) cost, whereas the bill for a 100km trip will cover 58 per cent of the cost (Table 3.4). Bills will over-recover the costs for non-emergency trips that are longer than about 30km and for Inter-hospital Fixed Wing trips of between 860km and 915km. However, the level of cost recovery on very long trips is constrained by the application of maximum charges, which applies to trips of more than 915km on both the Inter-hospital and Primary fee scales.

Table 3.4 Level of cost recovery for different trip lengths under current fee scales

Distance travelled	5 km	30 km	100 km	450 km	860 km	1500 km
Interhospital						
Road emergency	37%	41%	61%	86%	92%	59%
Road non-emergency	82%	97%	166%	273%	305%	199%
Fixed Wing		8%	19%	63%	100%	87%
Primary						
Emergency (pooled cost	33%	37%	58%	84%	90%	58%
Non-emergency	84%	99%	169%	278%	311%	203%

Note: Maximum charges apply of $3991 for Interhospital cases (except Helicopter) and $4066 for primary cases

22 As previously indicated, Fixed Wing service costs are somewhat understated as they do not include the fixed costs of any emergency Road transport that may occur on either end of the flight (see footnote 21).

In summary, the current fee scales are not cost-reflective because:

- Fees for Inter-hospital services currently recover less than three quarters of the cost, while fees for Primary cases recover about a third of the cost.[23]
- On average, fees for non-emergency Road services over-recover costs, while fees for all other services under-recover costs.
- The balance between the call-out charge and the variable rate is not reflective of costs and, as a result, patients who are transported longer distances (often rural) are charged a higher proportion of the cost of the service than those transported shorter distances (often metropolitan), until the maximum charge is reached.
- The 'first 16km free' provision exacerbates the inequitable charges for longer trips compared to shorter trips.
- The bills for some long trips exceed the cost of the service provided.

3.3.3 Tribunal's recommended fee scale for Inter-hospital cases

The Tribunal's recommended fee scale for Inter-hospital cases is shown in Table 3.5. This fee scale reflects its belief that it is appropriate for the Ambulance Service to levy fully cost-reflective charges for these services, to provide better signals to hospitals about the costs of different transport modes, thereby encouraging more efficient use of resources.

As with the Primary fee scales, the fees are shown in 2005/06 dollars and they will depend on the outcome of the Tribunal's investigation of an appropriate cost index (see remarks that immediately precede section 3.3.1).

For non-emergency cases, fully cost-reflective fees should be introduced immediately. For emergency cases, fully cost-reflective fees should be phased in over three years, in line with the Ambulance Service's view that hospitals will need time to adjust to the new charges.

Under the recommended fee scale, the average bills for all emergency Inter-hospital cases will increase compared to bills on the current fee scale, while those for non-emergency cases will fall.

In addition, the call-out rate for all types of Inter-hospital services will increase while the variable rate will fall. Because a high proportion of the costs of providing Inter-hospital services are fixed (78 per cent), the fixed component of the charge (the call-out rate) also needs to be relatively high. As a consequence of this structural change, bills for short trips will increase substantially, while those for long trips may fall. (The impact of the recommended fee scale on bills is discussed in more detail in section 3.4 below.)

[23] The proportion of costs actually recovered from Primary cases is far lower due to the high levels of unpaid bills. This issue is dealt with in Chapter 4 of this report.

Table 3.5 The recommended fee scale for Inter-hospital cases, 2005/06 $

	Road		Fixed Wing	Helicopter	TOTAL
	Emergency	Non Emerg	Emergency	Emergency	
Recommended fee scale for Year 1					
Call-out	298	195	2,365	3,385	
Variable rate	2.98	1.20	1.10	74	
Variable road rate for fixed wing cases			*2.98*		
Cost recovery	**70%**	**100%**	**90%**	**75%**	**77%**
Recommended fee scale for Year 2					
Call-out	362	195	2,497	3,836	
Variable rate	3.62	1.20	1.16	84	
Variable road rate for fixed wing cases			*3.62*		
Cost recovery	**85%**	**100%**	**95%**	**85%**	**88%**
Recommended fee scale for Year 3					
Call-out	426	195	2,628	4,513	
Variable rate	4.26	1.20	1.22	98	
Variable road rate for fixed wing cases			*4.26*		
Cost recovery	**100%**	**100%**	**100%**	**100%**	**100%**

Note: The maximum charge of $3,991 for Road and Fixed Wing services continues to apply.

Further, as Section 3.3.1 discussed, in most Fixed Wing cases, a Road service is required at one or both ends of the flight. Current practice is to bill Fixed Wing cases a single call-out fee and a variable charge for the total distance travelled by both road and air. The Tribunal believes that charges for these cases should continue to include a single call-out charge only (the Fixed Wing fee), and that the road travel component be charged at the recommended emergency Road variable rate, and the air travel component be charged at the recommended Fixed Wing variable rate.

Finally, the Tribunal believes that the current maximum charge for Inter-hospital cases of $3,991 for Road and Fixed Wing services should be maintained, subject to appropriate cost indexation.

The Tribunal estimates that under the recommended fee scale, the proportion of costs recovered for Inter-hospital services will increase from 73 per cent on the current scale to 77 per cent in year 1, 88 per cent in year 2, and 100 per cent in year 3.

Recommendation 2

For Inter-hospital emergency cases, that the fee scale for year 1 shown in Table 3.5 should be implemented in 2006/07, subject to appropriate cost indexation.

Recommendation 3

That beyond 2006/07, the fully cost-reflective Inter-hospital fee scale for emergency services should be phased in over three years as shown in Table 3.5, subject to appropriate cost indexation.

Recommendation 4

For Inter-hospital non-emergency services, that the fully cost-reflective fees shown in Table 3.5 should be implemented in 2006/07, subject to appropriate cost indexation.

Recommendation 5

That Inter-hospital Fixed Wing cases should continue to be billed a single call-out fee (the Fixed Wing fee), and that road travel be charged at the recommended emergency Road variable rate and air travel be charged at the recommended Fixed Wing variable rate.

Recommendation 6

That the maximum charge of $3,991 for Inter-hospital Road and Fixed Wing cases should be maintained, subject to appropriate cost indexation.

3.3.4 Tribunal's recommended fee scale for Primary cases

The Tribunal's recommended fee scales for Primary cases are in Table 3.6 in 2005/06 dollars.[24] These fee scales aim to achieve greater equity between patients who require shorter, and those who require longer, trips. They also aim to improve equity between directly chargeable patients and the rest of the community, including those who pay the HIL.

Table 3.6 The recommended fee scales for Primary cases, 2005/06 $

	Road		Fixed Wing	Helicopter	TOTAL
	Emergency	Non Emerg	Emergency	Emergency	
Recommended fee scale for Year 1					
Call-out	205	195	205	205	
Variable rate	1.85	1.20	1.85	1.85	
Cost recovery (pooled costs)	**42%**	**100%**	**42%**	**42%**	**44%**
Recommended fee scale for Year 2					
Call-out	226	195	226	226	
Variable rate	2.04	1.20	2.04	2.04	
Cost recovery (pooled costs)	**46%**	**100%**	**46%**	**46%**	**48%**
Recommended fee scale for Year 3					
Call-out	248	195	248	248	
Variable rate	2.24	1.20	2.24	2.24	
Cost recovery (pooled costs)	**51%**	**100%**	**51%**	**51%**	**52%**

Note: The maximum charge of $4,066 continues to apply.

The recommended fees for non-emergency services are the fully cost-reflective fees, as recommended for Inter-hospital transports. These fees will reduce average bills for this service compared to bills on the current fee scale.

The Tribunal was mindful of the impact that higher charges might have on those who have to pay ambulance bills. It believes the increases should be phased in over a number of years to allow the community to adjust to the higher charges. Fees should initially remain affordable to those who are liable for payment but do not (yet) have ambulance insurance. In addition, it believes that the maximum charge of $4,066 for Primary cases should be maintained, subject to appropriate cost indexation.

The Tribunal estimates that under the recommended fee scale, the proportion of costs potentially recovered for Primary cases will increase from 36 per cent on the current fee scale to 52 per cent by the end of the third year. The proportion of costs actually recovered will depend on the rate of bad debts, which is discussed in section 4.5.

[24] The actual fees will depend on the outcome of the Tribunal's investigation into a cost index (see Section 3.3.1).

Recommendation 7

For Primary emergency services, that the emergency fee scale for year 1 shown in Table 3.6 should be implemented in 2006/07, subject to appropriate cost indexation. A single set of fees will apply to all Primary emergency cases, regardless of transport mode.

Recommendation 8

For Primary emergency services, that the fees be increased by 10 per cent per year in real terms in 2007/08 and 2008/09.

Recommendation 9

For Primary non-emergency services, that the fully cost-reflective fees shown in Table 3.6 should be implemented in 2006/07, subject to appropriate cost indexation, and that these fees be maintained in real terms in 2007/08 and 2008/09.

Recommendation 10

That the maximum charge of $4,066 for Primary cases should be maintained, subject to appropriate cost indexation.

3.4 Likely impacts of recommended fee scales

The Tribunal estimated the impact of its recommended fee scales on bills, Ambulance Service revenues and hospitals' costs. Each of these matters is discussed below, followed by a brief discussion on the likely social impacts of the recommended fee scales.

3.4.1 Impact on bills

The Tribunal's analysis indicates that the recommended fee scales will have different impacts on bills, depending on the type of service used and the average distance travelled. This is illustrated in Tables 3.7, 3.8 and 3.9 below, which compare the bills for short, medium and long trips under the current fee scales with those under the recommended scales in year 1 and year 3. Note that the recommended fee scales are shown as 2005/06 prices. Actual fees (and hence bills) are likely to be slightly higher when the new fee scale is implemented, due to the effects of cost indexation.

Table 3.7 shows that, for short trips, all bills under the recommended fee scales are higher than under the current fee scale, due to the higher, more cost-reflective fixed charges and the removal of the 'first 16km free' provision. However, the bill for a 250km Primary Fixed Wing case is lower under the recommended fee scale because, although 250km is a relatively short flight, it is a long trip when measured on the (single) Primary emergency scale. In addition, bills for Inter-hospital emergency cases are significantly higher than for Primary emergency cases under the recommended fee scales. This is due to the fact that fully cost-reflective fees have been introduced on the Inter-hospital scale, but not on the Primary scale. Bills for non-emergency cases are similar for Inter-hospital and Primary cases, because fully cost-reflective fees for this service have been introduced on both scales.

Table 3.7 Bills for short distances, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Trip length	5 km	5 km	250 km	15 minutes
Interhospital				
2005/06 fee scale	166	166	1,161	1,830
Year 1	313	201	2,641	3,385
Year 3	447	201	2,934	4,513
% increase compared to bills on the current fee scale				
Year 1	89%	21%	127%	85%
Year 3	169%	21%	153%	147%
Primary				
2005/06 fee scale	169	169	1,184	as for
Year 1	214	201	668	emergency
Year 3	259	201	808	road and
% increase compared to bills on the current fee scale				fixed wing
Year 1	27%	19%	-44%	(per km)
Year 3	53%	19%	-32%	

Table 3.8 shows that the recommended fee scale will generally have a smaller impact on bills for medium distance trips than it will for those for short trips (in percentage terms). For example, the bill for a 50km Primary emergency Road trip will fall in year 1, but will increase by 14 per cent by year 3, due to the recommended real increase in emergency fees of 10 per cent per year in years 2 and 3. The bill for a 600km Inter-hospital Fixed Wing trip will increase by 14 per cent in year 1, and by 27 per cent in year 3, compared to bills on the current fee scale. The bill for a 50km non-emergency Road trip will decrease by almost 20 per cent for both Inter-hospital and Primary cases.

Table 3.8 Bills for medium distances, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Trip length	50 km	50 km	600 km	75 minutes
Interhospital				
2005/06 fee scale	311	311	2,650	2,752
Year 1	447	256	3,026	3,937
Year 3	639	256	3,363	5,250
% increase compared to bills on the current fee scale				
Year 1	44%	-18%	14%	43%
Year 3	106%	-18%	27%	91%
Primary				
2005/06 fee scale	317	317	2,701	as for
Year 1	298	256	1,316	emergency
Year 3	360	256	1,593	road and
% increase compared to bills on the current fee scale				fixed wing
Year 1	-6%	-19%	-51%	(per km)
Year 3	14%	-19%	-41%	

Table 3.9 shows that, for long trips, bills for all Primary cases will be lower under the recommended fee scale. For Inter-hospital emergency cases, bills for long road trips will decrease slightly in year 1, but by year 3 they will be higher than on the current scale as more cost-reflective charges are phased in. Note that the bills for 1,500km Inter-hospital Fixed Wing trips are constrained by the maximum charges on the current fee scale and the recommended scale.

Table 3.9 Bills for long distances, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Trip length	200 km	200 km	1500 km	120 minutes
Interhospital				
2005/06 fee scale	949	949	3,991	3,675
Year 1	894	436	3,991	4,490
Year 3	1,278	436	3,991	5,986
% increase compared to bills on the current fee scale				
Year 1	-6%	-54%	0%	22%
Year 3	35%	-54%	0%	63%
Primary				
2005/06 fee scale	967	967	4,066	as for
Year 1	575	436	2,983	emergency
Year 3	696	436	3,610	road and
% increase compared to bills on the current fee scale				fixed wing
Year 1	-40%	-55%	-27%	(per km)
Year 3	-28%	-55%	-11%	

Note: Maximum charges apply of $3991 for interhospital (except helicopter) and $4066 for primary cases

Figures 3.1 and 3.2, below, further illustrate the impact of the distance travelled on bills. For example, Figure 3.1 compares how bills for inter-hospital road trips change as the distance travelled increases under the current and recommended fee scales. It shows that bills for emergency Road services will be higher for trips up to 150km, but lower for longer trips. It also shows how (real) bills will change when the fully cost-reflective fee scales are phased in (by year 3). Bills for all distances will be higher on the fully cost-reflective fee scale, until the maximum charge applies on both fee scales, at around 1,000km. Bills for non-emergency services will be higher for trips up to 32km but lower for longer trips.

Figure 3.2 compares how (real) bills for Primary cases change as the distance travelled increases under the current and recommended fee scales. For emergency trips, in year 1 bills for trips of 16km will increase by 39 per cent, while those for trips longer than 40km will fall. By year 3, bills for trips of more than 70km will fall. For non-emergency services, bills for trips of less than 30km will be slightly higher, but those for longer trips will be lower.

Figure 3.1 Bills for Inter-hospital Road transport on the current fee scale and the recommended fee scale, 2005/06 $

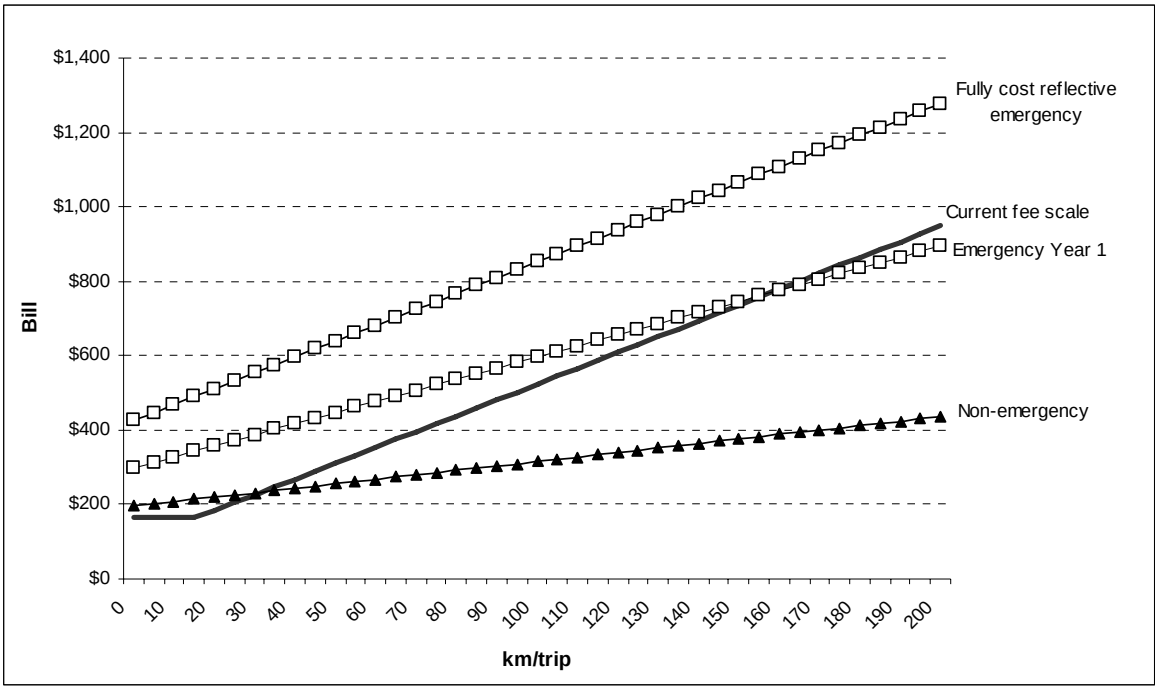
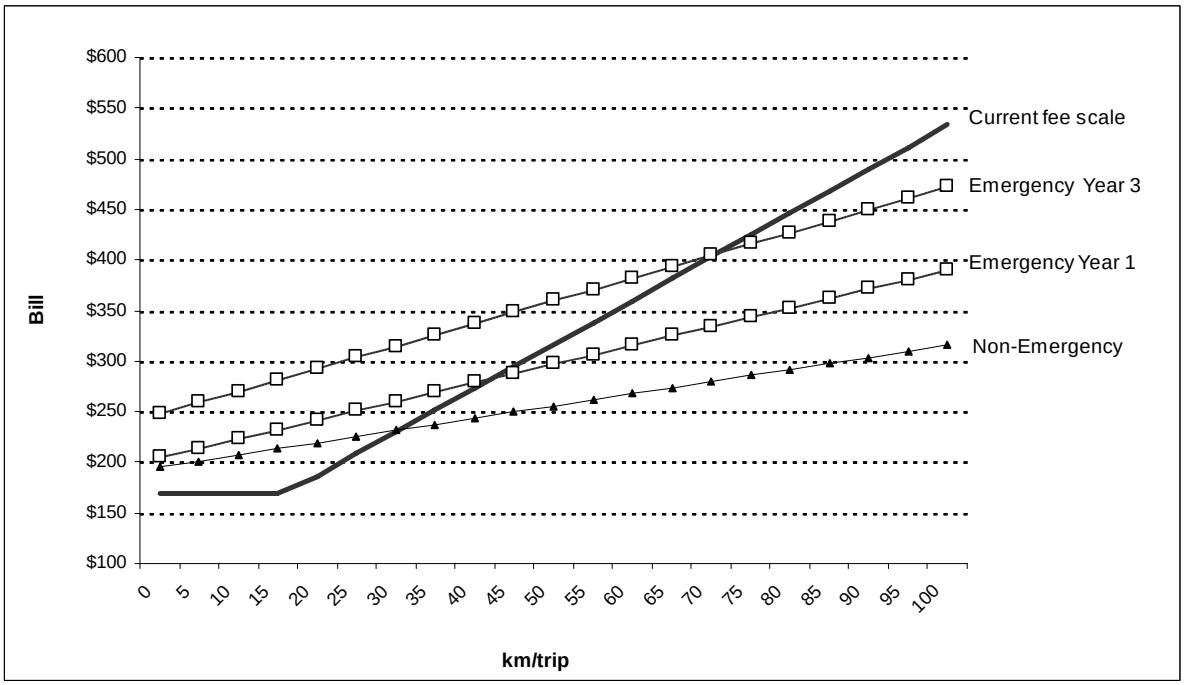


Figure 3.2 Bills for Primary cases on the current fee scale and the recommended fee scale, 2005/06 $



3.4.2 Impact on the Ambulance Service's revenue

The Tribunal's analysis indicates that, using 2003/04 case statistics, the recommended fee scales will result in a net increase in the Ambulance Service's billed revenue of $6.3m by the end of the first year, and a net increase of around $24.7m by the end of the third year (Table 3.10). The increase in actual revenue received will depend on the rate of bad debts, which is discussed in Section 4.5.

Table 3.10 Gross revenue impacts of recommended fee scales, assuming 2003/04 usage patterns, 2005/06 $ million

	Road		Fixed Wing	Helicopter	Total	TOTAL
	Emergency	Non Emerg	Emergency	Emergency	emergency	
Interhospital						
Year 1	2.3	(1.8)	0.9	1.7	4.9	3.2
Year 2	7.7	(1.8)	1.8	2.7	12.2	10.4
Year 3	13.0	(1.8)	2.6	4.3	19.9	18.1
Primary						
Year 1	3.7	(0.0)	(0.5)	(0.0)	3.1	3.1
Year 2	5.3	(0.0)	(0.5)	(0.0)	4.8	4.7
Year 3	7.0	(0.0)	(0.4)	0.0	6.6	6.5
Total						
Year 1	6.1	(1.8)	0.4	1.6	8.0	6.3
Year 2	12.9	(1.8)	1.3	2.7	16.9	15.1
Year 3	20.0	(1.8)	2.2	4.3	26.5	24.7

3.4.3 Impacts on hospitals' costs

The Tribunal estimated the aggregate effects of the changes in fee scales on hospitals, again using 2003/04 case statistics. It found that in the first year after the recommended fee scales are implemented, hospitals as a group would pay around $4.9m more for emergency services and $1.8m less for non-emergency services. By the third year, they would pay $19.9m more for emergency services (plus indexation).

3.4.4 Social impacts of fee changes

Given that the Ambulance Service's current fees are low relative to those charged in other jurisdictions, especially for emergency responses, and that they cover a small proportion of total costs of operating the Service, it is highly likely that it has been adding materially to the well-being of many NSW citizens at no, or comparatively low, direct cost to themselves.

On the other hand, as discussed at the beginning of this chapter, some citizens may be making a disproportionately large contribution to funding the Service relative to the use they make of it. It may be that the burden of contributing towards the costs of the Ambulance Service is falling inequitably on a small proportion of the population.

Changes that widen the base from which contributions are collected, or address the high level of non-payment of invoices in some way, might have positive social impacts in terms of improved equity. Both are discussed in the next chapter.

It was not possible for the Tribunal to assess the likely social impact of any sizeable increase in fees, or changes in the fee structure, without data on users of ambulance services classified by income or some other measure of financial standing. Instead, it estimated how total charges would be affected relative to present charges for patients who travel different distances in section 3.4.1.

3.5 Protection of consumers

The need specifically to protect consumers from the abuse of monopoly power (as mentioned in the terms of reference) might arise if there were a significant change in the approach to funding, such as a major change in the current balance between Government funding and the user pays approach. The recommended fee scales are unlikely to alter this balance in a significant way.

In its submission, the Ambulance Service expressed more concern that consumers be protected from deterioration in standards that might result if greater competition from private ambulance service providers were introduced. (There are currently no private commercial ambulance services in NSW.)

However, the Service noted that competition for non-emergency ambulance services could be considered, depending on the circumstances. Some of those circumstances would include a better alignment of the Service's own fee scales with the cost of non-emergency service provision as the Tribunal has recommended.

At this stage, given that a major purpose of the review was to move *towards* more cost-reflective fee scales for the Ambulance Service from a position of 'under-pricing', the Tribunal sees no compelling case for specific recommendations that might relate to the protection of consumers from any abuse of monopoly power.

Nevertheless, the Tribunal did consider the protection of consumers when setting the ultimate size of the annual increases in Primary patient fees (which it limited to 10 per cent real rises in 2007/08 and 2008/09) and in deciding to stop well short of fully cost-reflective fee scales for Primary patients. Given the monopoly position of the Service in providing emergency ambulance services to the community, it is hoped that a future review of the Service's funding sustainability will also include a close examination of the costs of the Service to determine their efficiency, before Primary patient fees are moved any closer to full cost-reflectivity.

4 CREATE A MORE EFFECTIVE CHARGING REGIME

Under the current charging regime, the Ambulance Service provides a range of valuable services for which it is not paid – either directly, by fees levied on the patients concerned, or indirectly via the Health Insurance Levy, Department of Veteran's Affairs or third party agreements with the Motor Accidents Authority (Table 4.1).

There are several reasons for this. In some cases - including treat-not-transport as shown in the table - there is no fee set for the service. In others, the fee is waived on hardship grounds or the patient concerned is eligible for exemption from fees under the various exemption arrangements. In yet other cases not shown in Table 4.1, the patient concerned does not or cannot pay the fee, and the Service incurs a bad debt.

Table 4.1 Number of patients invoiced and not invoiced, by patient category, 2003/04

			Number of patients (000s)			
			Non-charged	Invoiced	Total	% of total
Inter-hospital Transports			13.0	59.8	**72.8**	**9.7%**
Primary Transports						
of which:	*Direct charge*		*45.1*	*77.1*	*122.2*	*16.2%*
	Medical Fund		*59.9*		*59.9*	*8.0%*
	Pension		*374.7*		*374.7*	*49.7%*
	DVA			*7.8*	*7.8*	*1.0%*
	Third Party			*15.0*	*15.0*	*2.0%*
	Total Transports	Primary	479.7	100.0	**579.6**	**76.9%**
Treat-Not-Transport			100.9		**100.9**	**13.4%**
Total			**593.5**	**159.8**	**753.3**	**100.0%**

Source: Ambulance Service of NSW, private communication.
Note: Numbers may not add due to rounding.

The Tribunal considered a wide range of issues related to the current coverage and effectiveness of the Service's charging regime. In general, it found this regime should be extended and made more effective by:

- Introducing a fee for 'treat-not-transport' services.
- Introducing a fee for standby services.
- Developing a formal hardship policy to control the number of cases where fees are waived.
- Charging for all services provided to Department of Veterans' Affairs card holders, regardless of whether they hold an alternative eligible concession card.
- Taking steps to reduce the rate of bad debts.
- Charging all patients according to the proposed fee scale, regardless of whether or not they are NSW residents and refusing to pay for services provided to NSW residents in other jurisdictions.

Each measure, and the Tribunal's analysis of the likely system-wide effects are discussed below.

4.1 Introduce a fee for 'treat-not-transport' services

Of the three-quarters of a million patients that the Service deals with each year, around 100,000 receive on-the-spot treatments without the need for transportation to a hospital. The number of these 'treat-not-transport' or TNT cases has risen by almost 50 per cent in the last few years and now accounts for just over a sixth of all Primary cases (Table 4.1). However, because no fee has been set for TNT services, none of these patients is charged.

Some 83 per cent of 580,000 'Primary transport' cases in 2003/04 were exempt from ambulance fees under the current exemption arrangements.[25] Another 4 per cent were already covered under the bulk agreement with the MAA and under the DVA. If we assume that the same proportion of TNT cases would be exempt from TNT fees, there remains some 13,400 patients per year who, in principle, should be charged for the services they receive.

In some other Australian jurisdictions, the ambulance service already levies a fee for TNT services on eligible patients.[26] (Some also levy a co-payment fee on otherwise exempt patients, a matter considered below.) The Tribunal considered whether a TNT fee should be introduced in NSW, taking into account the practical difficulties that the collection of a new fee might entail.

The Tribunal concluded that there is no substantial reason for a TNT charge not to be levied on eligible patients. It considers that this fee should be based on the emergency fee scale for Primary road transports.

A related matter for TNT services is the introduction of a 'co-payment' for otherwise exempt patients that could recover some of the costs involved in providing TNT services, and curtail 'trivial' use of the Service. In this way, it could be likened to the co-payment required to obtain prescribed medicines from pharmacies. However, the Tribunal considers that the benefits of such a fee would be outweighed by difficulties associated with its collection.

For example, the primary focus of Ambulance Service staff involved in providing TNT services is the health and welfare of their patients, not collecting, receipting, securing and accounting for small sums of money. Requiring them to play this additional role at the time of the TNT event could reduce their ability to perform their primary role effectively. As the Service and the Health Sector Union noted in their submissions, it could also lead to increased hostility towards ambulance officers. In addition, trying to collect co-payment fees after the event is unlikely to be economical, given the small sums of money involved,

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25 The number of non-charged Primary patients in Table 4.1 is 479,700 of a total 579,600 or 82.8 per cent. The 45,100 non-charged Direct Charge patients in Table 4.1 are about 24,000 persons of unknown name or address and the remainder have had their fees waived either at the Premier's direction, the Service's discretion or on the basis of other government policy.

26 Other jurisdictions in Australia, British Columbia and New Zealand charged fees for TNTs: Victoria $221; South Australia $466; Queensland the greater of $84 or $11.55 per km up to a maximum $800; WA Metro $499 for an emergency call (priority 1& 2) and $302 for a non-emergency call (priority 3); Tasmania $442.97+$4.32 per km above 15kms; BCAS $C50 when an ambulance responds to a call and treatment and/or transportation are refused; and St John's Ambulance NZ a flat part charge rate of $NZ67.50 in Auckland. For jurisdictions with a distance based TNT charge, the patient is charged for the distance to the site and back to the station. Source: PricewaterhouseCoopers Report to IPART, p 42.

cost of invoicing and related processing, and the community's propensity to leave ambulance debts unpaid.

Further, there is no evidence to suggest that the number of TNT cases that are trivial is a concern. The Service was not able to quantify this number, partly because the definition of 'trivial' is subjective. In general, it believes that the number is not large. It also argues that the risks associated with a patient not calling for an ambulance when the case is serious are far greater than the risks of responding to cases that turn out to have been trivial.

Therefore, on balance, the Tribunal believes a co-payment for TNT cases should not be introduced at this time. However, if the number of these cases continues to escalate as a proportion of '000' calls, this issue may need to be revisited at a later date.

Recommendation 11

That the Ambulance Service levy a fee for treat-not-transport cases, and that this fee should be based on the recommended Primary Road emergency fee scale.

4.2 Introduce a fee for standby services

For safety reasons, the police or the fire brigade sometimes call on the Ambulance Service to stand by, ready to respond if required, when they are dealing with dangerous incidents or industrial accidents (such as chemical spills). However, because there is currently no set fee for standby services, the Ambulance Service does not charge for these services.

The Tribunal recognises the valuable precautionary nature of these services, and considers it appropriate that a full commercial fee should be levied on the party or parties primarily responsible for the accident or incident, even if those parties did not request the services themselves.

One way to set the standby fee would be on the same basis as the existing sporting charges fee is set - taking into account the number, time and type of ambulance required and the number, time and grade of ambulance officers in attendance. Another, which the Service has suggested, is to set the standby fee as an emergency call-out fee plus the kilometre fee for the first hour and then $35 for every 15 minutes after that.[27] The Tribunal considers that the second approach should be used, given the Ambulance Service's preference for this approach.

Recommendation 12

(a) That the Ambulance Service levy a standby fee on the owners of premises or vehicles involved in dangerous incidents or events where an ambulance is required to be present (for example at chemical spills or other industrial accidents); and

(b) That this standby fee should be set as for the recommended Primary emergency scale up to the first hour and then $35 for every 15 minutes thereafter.

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[27] The Service has informed the Tribunal that the average case time for standby services is one hour. The '$35 per 15 minutes' represents the services of two ambulance officers, the same as the Service's proposed charge for providing paramedic support to hospital Emergency Departments.

4.3 Clarify the hardship policy

The Ambulance Service appears to exercise considerable discretion over the charging of patients. The Tribunal believes that the Service's hardship policy should be clarified, and perhaps its administration formalised, to set out the bases on which fees can be waived.

The Tribunal therefore suggests that a specific accountability should be introduced into the Service's internal processes. In particular, the Service should:

- ensure all authorities with a right to waiver are aware of the hardship policy and are able to determine eligibility to waive under it
- prioritise the types of cases or individuals who are to be granted an exemption.

Recommendation 13

That the Ambulance Service should clarify its a hardship policy for the purpose of determining specific cases where ambulance charges can be waived.

4.4 Charge for all services provided to DVA card holders

In NSW, the Department of Veterans' Affairs (DVA) pays the ambulance fees levied on veterans who hold a DVA Card, under an agreement between the DVA and the Ambulance Service. In addition, pensioners and other Health Care Card holders are exempt from ambulance fees. When the Ambulance Services provides services to a DVA Card holder who also holds a Health Care Card, its current practice is not to charge the DVA for these services.

However, in other states where similar arrangements are in place, the ambulance services' practice is different. For example, in Victoria and Queensland, the DVA is charged for all ambulance services provided to DVA Card holders, regardless of whether they also hold a Health Care Card. As the Tribunal can see no reason for the different practice in NSW, it believes the Ambulance Service should charge the DVA the appropriate fee for all services it provides to DVA Card holders.

In its submission, the Ambulance Service noted that the DVA does not pay for repatriation journeys (for all DVA card holders in Australia), which often involve long distances and high charges. It therefore charges DVA Card holders who are not Health Care Card holders directly for these journeys. Many DVA Card holders appear to be unaware of this, and many are unable to, or refuse to, pay when they are charged so the Service incurs a bad debt. The issue of bad debts is discussed below.

Recommendation 14

That the Ambulance Service charge the Department of Veterans' Affairs (DVA) the appropriate scheduled fee for all services it provides to DVA card holders, irrespective of whether the patients concerned hold other concession cards that exempt them from fees.[28]

[28] The Tribunal understands that the Service was already discussing this matter with the DVA. It therefore does not view this recommendation as a new source of revenue as a result of the review.

4.5 Taking steps to reduce the rate of bad debts

The Ambulance Service is aware that its rate of bad debts is relatively high, and has been working to reduce this rate. In 2000, 54 per cent of all invoices were classed as bad debts; by 2004 this rate was down to 47 per cent. However, this is still about 5 percentage points higher than the bad debt rate for the next highest jurisdiction.

In its submission, the Service suggested that its high level of bad debts can be attributed to three factors:

> …many people are not aware that ambulance services are not covered by Medicare or that the Ambulance Service charges fees; charges are levied on those without private insurance, who, on average, have a lower income than those with private insurance; and the average cost of recovering a debt currently exceeds the average fee charged.[29]

In relation to the first factor, the low level of public awareness about ambulance charges, the Tribunal believes this may be the case in some other jurisdictions and not others (such as Victoria). The factor might be heightened in NSW, however, because only 16 per cent of patients who receive Primary transport services are currently charged directly, and no patients are charged for TNT services. Therefore, the Tribunal believes that the Department of Health should undertake a public awareness campaign in consultation with private health insurance companies. The campaign should aim to make people more aware of ambulance charges and the insurance options that are available to help protect them from the impact of these charges (such as, ambulance-only insurance). Publicising the fact that ambulance fees can be as high as $4,066[30] will help people make an informed choice about whether to take out this kind of insurance.

In relation to the second factor, patients without private health insurance tend to have lower average incomes than those who do, the Tribunal did not receive any evidence to support this assertion. However, it notes that it is widely believed to be correct. Based on this belief, some stakeholders expressed concern about any move to more aggressive debt collection. For example, the Council of Social service in NSW (NCOSS) argued:

> Taking into account the fact that a significant proportion of 'bad debtors' can be assumed to include low income working households, and further comprises families and individuals who have experienced – or are experiencing – some form of health crisis, the use of more aggressive techniques for debt recovery by the State Debt Recovery Office (SDRO) or any other agency is inappropriate. NCOSS has previously provided public comment on the NSW Fine enforcement system, and the unfortunate role this has played in a range of socially adverse consequences for low income families and individuals in NSW, in part a result of the processes utilised by the SDRO in the pursuit of outstanding fines.[31]

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29 Ambulance Service submission, section 3.5.6.

30 This is the maximum fee that can currently be levied for ambulance services to individuals. The Tribunal has recommended no increase in this maximum fee (other than by appropriate indexation).

31 NCOSS submission, section 4 e). NCOSS was responding to suggestions by the Tribunal's consultant that a range of more aggressive collection methods be explored. See PricewaterhouseCoopers Report to IPART, May 2005, p 16.

In relation to the third factor, that most debts aren't high enough to warrant the cost of debt collection fees, the Tribunal notes that many ambulance bills may be quite high (see Tables 3.7 to 3.9) in the light of its recommended fee scales, especially for emergency services. If its recommendations are implemented, debt collection should be more viable.

The Tribunal also considered several approaches that could be used to lower the bad debt ratio, either by improving debt recovery or improving billing practices.[32] In particular, it considered introducing sanctions for non-payment of Ambulance Service invoices, such as cancellation of driver's licence or motor vehicle registration. It also considered introducing a late payment fee, to provide an additional incentive for patients to pay on time, and for the Service to pursue unpaid bills. On balance, it believes that such sanctions should not be recommended at this stage.

The Tribunal notes that even if its recommended steps to reduce the rate of bad debts are implemented, a proportion of Ambulance Service invoices are still likely to be unpaid. For example, around 24,000 patients (4 per cent of Primary transport cases) in 2003/04 were not properly identified, or their addresses were not obtained. (These patients include homeless people, those who are mentally ill or drug-affected, and those not carrying identification.) In these cases, it is not possible to invoice them effectively.

Recommendation 15

That the Department of Health, in consultation with private health insurance funds, undertake a public education campaign to raise people's awareness of ambulance charges, and the available insurance options, including ambulance-only cover, to help protect them from the financial impact of these charges.[33]

4.6 Charge all patients according to the proposed fee scale

In its submission, the Ambulance Service pointed out that it is financially disadvantaged by the current cross-border arrangements, in two ways. First, it currently pays the charges levied on NSW residents when they are visiting other states, if these residents are entitled to free ambulance services in NSW.[34]

Second, there are wide differences between the ambulance charges levied on NSW residents in other States and the charges levied on non-NSW residents by the Ambulance Service. The Service argued that:

> … the disparity in interstate charges places a considerable financial burden on the Ambulance Service. This burden would be reduced should NSW charges be realigned to reflect actual costs. These charges should also be applicable even if individual user charges were abolished for NSW residents.
>
> Alternatively, interstate residents using ambulance services in NSW could be charged at the rate applicable in their home State. As other States operate various levy, insurance or funding schemes that are linked to their local fees structure, this would ensure that NSW

32 The Service has an internal system for monitoring part-payments on a case-by-case basis.

33 To the extent that patients buy insurance cover, revenue to the Ambulance Service from direct charges would fall and revenue from the HIL would rise. In the light of the Tribunal's Recommendation 16a, the education campaign might also usefully highlight the services not currently covered by insurers.

34 Ambulance Service submission, section 3.5.4.

> charges to interstate residents would remain consistent with the funding systems applicable in the relevant jurisdictions.[35]

In relation to the first point, the Tribunal can see no reason why the Ambulance Service should pay the charges levied on NSW residents by an ambulance service in another jurisdiction. The Tribunal therefore believes the Service should discontinue this practice.

In relation to the second point, the Tribunal has recommended fee scales that are more cost-reflective, which if implemented, will reduce the disparity between NSW and interstate ambulance charges. However, it does not believe that the Service should charge interstate patients at the rates applicable in their own jurisdictions, as that would not be cost-reflective and would make some NSW charges captive to interstate practice. To ensure equitable treatment and achieve administrative simplicity, it considers that the Service should charge all patients according to the recommended fee scale, regardless of their state or country of residence.

Recommendation 16

(a) That the Service discontinue its practice of paying invoices raised by other jurisdictions for ambulance services provided to NSW residents in those jurisdictions, as responsibility for payment rests with the individuals concerned.

(b) That the Service charge non-NSW residents (including international visitors) the same fees that apply to residents, in accordance with the recommended fee scales.

The Service currently charges non-NSW residents the same fees as NSW residents so that no additional revenue will result from this recommendation (other than from the recommended higher fees which were accounted for in Chapter 3).

4.7 Likely system-wide effects of changes to charging regime and fee scales

The Tribunal and the Ambulance Service estimate that the recommended changes to the Service's charging regime and fee scales could generate an initial $21m in revenue for the Ambulance Service, rising to $40m once the phasing in of the higher fee scales has been completed (Table 4.2).

35 Ambulance Service submission, section 3.6.5.

Table 4.2 Estimated revenue impacts of the recommendations on the charging regime and fee scales (increases in revenue before appropriate indexation)

Recommendations	Year 1 2006/07 $m	Year 2 2007/08 $m	Year 3 2008/09 $m	Who pays ?
Charge T&NT at the emergency road fee scale	1.71	1.88	2.06	Primary - Direct
Charge a Standby fee at the emergency road fees scale for the first hour plus $35 per 15 minutes thereafter	0.02	0.02	0.02	Direct charge to private industry
Charge *all* DVA patients	12.59	13.39	14.22	DVA
Improve debt collection procedures	0.10	0.34	0.49	Primary - Direct
Stop paying charges levied on NSW residents by other jurisdictions	2.04	2.04	2.04	
Charge *all* patients on the same relevant fee scale:				
Interhospital	3.15	10.35	18.05	Hospitals
Primary	1.67	2.55	3.48	Primary - Direct
	21.28	**30.57**	**40.36**	

Source: Ambulance Service, private communication.

However, the estimates in Table 4.2 are not very reliable. One reason for this is that users of ambulance services are likely to change their usage patterns in response to the recommended changes to the charging regime and the fee scales. For example, it is likely that there will be some switching in demand at the margin away from services that will attract a charge for the first time (such as TNT services) or have higher fees, and towards services that are now cheaper (such as non-emergency transports). More people might also take out insurance cover. However, because the extent of these changes cannot be known, the Tribunal has based its estimates on the usage patterns as they existed in 2003/04.

Other key assumptions used in estimating the revenue impacts shown in Table 4.2 are as follows:

- The estimated additional revenue from the TNT fee is based on the recommended fee for 13,400 patients, less bad debts (which the Service expects to be around 47 per cent). No provision is made in the calculation for the extra costs of processing and debt collection.
- The estimated additional revenue from the Standby fee is based on the recommended fee for around 50 standby cases per year and after adjustment for bad debts at 47 per cent.
- The estimated additional revenue from charging all DVA patients (around 59,000 in 2003/04) an average bill of around $270 for emergency and non-emergency services by year 3 would be just under $16m, which is just over $14m more than is currently paid.
- The net revenue gain from improved debt collection procedures is difficult to estimate. The estimate in the Table is based on estimates made by the Ambulance Service which assume that its bad debt ratio is progressively reduced (by two percentage points by year 3).
- The estimated additional revenue from no longer paying ambulance charges levied on NSW residents in other jurisdictions is based on the current costs of this practice to the Ambulance Service.

In addition, as the Ambulance Service currently charges non-NSW residents the same fees as NSW residents, no extra revenue will result from this recommendation. Finally, estimates of the effect of the recommended fee scales and their phasing in are shown in Table 4.2. These differ from the estimates in Chapter 3 for Primary cases because these deduct estimated bad debt charges.

4.7.1 Revenue for the Ambulance Service

The total additional revenue from creating a more effective charging regime and making fee scales more cost-reflective is likely to be around $40 million by the end of the third year after implementation of the recommended changes.

4.7.2 Costs to Area Health Services and to patients

On unchanged usage patterns, in the first year after the recommended fee scales are implemented, **hospitals** as a group would pay around $3.2 m more for emergency and non-emergency services. By the third year, if the fee scales were altered as recommended, the cost of ambulance services would have risen by around $18.1m.

For Primary **patients**, the aggregate cost in the first year would increase by a net $1.7m for emergency and non-emergency transport services. By the third year, the cost would be $3.5m higher. Widening the charging regime would cost Primary patients an extra $1.8m in year 1, rising to $2.6m by year 3.

4.7.3 Adequacy of current insurance premiums and of the HIL in light of higher fees

The net rise in Ambulance Service fees, especially for emergency services, suggests that the ambulance insurance premiums implied in the provision of basic hospital cover might be too low. The same might also be true for the HIL rate, considered as a proxy for a broad-based ambulance charge. The Tribunal considers that these matters are best dealt with by the health funds themselves and as part of any review of the *Health Insurance Levy Act 1982* that the Government may wish to undertake.

4.7.4 Response from patients, Area Health Services and health funds

It is not possible to predict with any certainty the likely response of patients, hospitals and the health funds to changes in the fee scales and changes in the HIL rate that might be made in response to the fee scale changes.

That said, it is highly likely that there will be some switching in demand at the margin towards services which are now relatively cheaper than before and a switching away from those services which now carry fees for the first time or which have higher fees than before.

It is because the relative changes in fee scales are so significant, among other things, that the Tribunal has recommended that the largest changes to the Service's revenue and charging structures be phased in and that the structures be revisited in three year's time.

4.7.5 Renegotiations of bulk agreements

Changes to fees for emergency services and the subsequent changes in usage patterns and cost efficiencies they may cause, may make it necessary for the Service to renegotiate its bulk agreements to ensure that these remain cost-reflective.

4.7.6 Relationship with ambulance service providers in other jurisdictions

The Tribunal appreciated the financial disadvantages faced by the Service in dealing with cross-border transports, in part because of the fees being charged to NSW residents by other jurisdictions are higher than the fees charged by the Ambulance Service of NSW for transporting non-NSW citizens.

It decided not to recommend a different fee scale for non-NSW residents, however, on equity grounds (as discussed in section 4.6). This, in effect, is asking the Service to continue to manage its relationship with other ambulance service providers under existing circumstances (but without a sense of obligation to pay the bills of NSW residents transported by other jurisdictions – see the recommendation in section 4.6).

4.8 Effects on Government funding

Given that the Government currently funds $270m of the $367m of costs of running the Ambulance Service (2003/04 figures), any revenue obtained from other sources will ease the future burden of the Ambulance Service on NSW taxpayers.

The recommendations in this review, insofar as they apply to moving towards cost-reflective fee scales and extending the coverage of those scales, would still only apply to a comparatively small proportion of NSW citizens. Further, the Tribunal has recommended that the higher fee scales should be phased in over three years, thus restraining the rise in revenue that the Service might expect from higher fees. The lower fee scales for non-emergency services, which the Tribunal recommends should be introduced in full from 1 July 2006, will reduce the Service's revenue.

The Tribunal estimates that the effect of its recommended fee scales and its recommendations for widening the coverage of fees will increase Ambulance Service revenue by a net $21.3m in 2006/07, rising to $40.4m in 2008/09. These estimates make no allowance for indexation of the fees or for changes in usage that are likely to result from the altered fee levels and structure. Further, most of the extra revenue to the Service that comes from Inter-hospital cases will likely come from public hospitals which themselves require Government funding via the budget allocation to NSW Health. Therefore, the extra $18.1m from the hospitals estimated in year 3 in Table 4.2 is not a reduction on the call on Government funding.

Other recommendations are likely to affect revenue, although estimates of the size of their effects are also uncertain because the Tribunal has not been able to make reasonable assumptions of how much potential users of the services will respond to altered price signals. The measures, to the extent that they increase the Service's revenue, will curtail the call on Government funding.

4.9 Impact on borrowing and capital requirements

The Ambulance Service has limited capacity to borrow under the *Public Authorities (Financial Arrangements) Act 1987*. Its capital requirements are effectively fully met by Government grants. Given that non-NSW Government sources generate under a quarter of the Ambulance Service's funding, the size of its current and future capital requirements are unlikely to be significantly affected by changes to pricing polices. However, these requirements may be reduced if the *coverage* of user charges were extended in a major way, to encompass some or all of those sections of the community that are currently exempt from paying for ambulance services.

The net book value of its non-current assets at 30 June 2004 was $168m. That is much less than even one year's direct NSW Government grants (which were $251m in 2003/04).

5 REVIEW OTHER ISSUES RELATED TO THE CHARGING REGIME

During its review, the Tribunal identified several important issues that it believes warrant further consideration but which are beyond the scope of this review. Specifically, the Tribunal recommends that Government consider:

- Reviewing the *Health Insurance Levy Act 1982* to ensure its provisions are relevant in the current circumstances.
- Reviewing fee exemptions policy, or seeking to recoup from the Commonwealth Government some of the costs of exemptions related to Commonwealth cardholders.

In addition, the Tribunal recommends that the Government revisit the funding of the Ambulance Service in three years, to assess its progress towards sustainability.

Each of these issues is discussed below.

5.1 Review the Health Insurance Levy Act 1982

In its submission, the Ambulance Service observed that the *Health Insurance Levy Act 1982* (the Act) has not been reviewed since its inception.[36] According to the Service, some clauses in the Act provide ambiguous guidance to those required to enact them. For example, the Act is apparently not explicit enough on whether the levy is intended to cover:

- ambulance transports by *private* providers in other States
- services by non-government providers with funding from other government sources such as the Royal Flying Doctor Service
- non-emergency services
- discretionary repatriation of patients to NSW from other States.

The Tribunal has no view on the extent to which the Act may, or may not, reflect current circumstances but it acknowledges the concerns expressed by the Service and the private health insurance funds. The Tribunal believes that the Government should review the Act, to address relevant concerns.

Recommendation 17

That the Government review the Health Insurance Levy Act 1982 to address, where possible, the concerns of the relevant participants in the industry.

[36] The Australian Health Insurance Association asserted that reviews of the *Health Insurance Levy Act 1982* and the *Ambulance Service Act 1990* are required if the NSW Government is to comply with National Competition Policy (AHIA submission, section 4). The AHIA also asserted that both Acts and/or the practical implementation of them have created difficult or costly procedures for the health funds.

5.2 Review exemptions policy or recoup some of the cost of exemptions

Of the 580,000 Primary transport patients the Service dealt with in 2003/04, 65 per cent were not charged because they held one of the range of concession cards that make them eligible for fee exemption (see Table 4.1).[37] The Tribunal estimates that the cost to Government of these exemptions was around $74m (assuming that they would have been charged at the (then) current fee scales and travelled the same distances, on average, as charged patients.)

The Ambulance Service has no control over the number of people who receive concession cards that exempt them from ambulance fees. In 1996, the Audit Office noted that:

> …since the present policy was introduced … demographic trends have shown significant increases in the quantity of people eligible for the age pension. At the same time, there have been significant improvements in the Commonwealth's payments to many persons who remain eligible in NSW for 'free' ambulance services. Therefore, it is not at all clear that circumstances existing in 1981 lead to the same outcome in equity terms in 1996.[38]

The Tribunal supports this assessment. It also believes that the high percentage of ambulance cases to which exemptions currently apply is a major contributor to the community perception that ambulance services are 'free'.

Depending on the degree of concern about the potential for the costs of funding the Ambulance Service to increase as the State's population ages, the Government may wish to review the basis for its exemptions policy. Such a review is inherently likely to involve social and political judgements. Alternatively, some recoupment from the Commonwealth Government might be sought for the cost of exemptions provided to Commonwealth Health Care Card holders.

Recommendation 18

That the Government review the basis for its exemptions policy, or seek to recoup from the Commonwealth the cost of exemptions provided to its Health Care card holders.

5.3 Undertake a future review of revenue and charging structures

Given the wide range of recommendations and the inevitable changes to usage patterns they might cause, the Tribunal considers that it would be appropriate to revisit the Service's revenue and charging structures in three years' time, to monitor its progress towards funding sustainability.

Recommendation 19

That the funding of the Ambulance Service be revisited in three years to assess progress towards sustainability.

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37 Exempt are those who hold a Pensioner Concession card, Health Care Concession card, DVA card or a Commonwealth Seniors Health card or other Health Care card.

38 *NSW Ambulance Service Charging and Revenue Collection*, Performance Audit Report August 1996, p 22.

6 EXPLORE ALTERNATIVE SOURCES OF REVENUE

Most of the recommendations in this review focus on the user-pays elements of Ambulance Service funding. However, as Chapter 3 discussed, the Ambulance Service benefits everyone in the community by standing ready to provide emergency services 'on demand'. This suggests that a broad-based community levy may be an appropriate means of funding the Service.

In NSW, both user-pays and broad-based levy approaches have been used. For example, the Health Insurance Levy (HIL) was introduced in 1982 as a means of providing a broad funding base for the Ambulance Service. At the time of its introduction, almost 70 per cent of NSW residents had private health insurance. However, since then, private health insurance coverage has dropped as low as 30.8 per cent and is presently 44 per cent of the NSW population.

Therefore, if the HIL is viewed as a community ambulance charge, it is currently rather narrowly based. However, if it is viewed as a user-pays charge, it over-collects revenue in the sense that the total cost of providing ambulance services to privately insured patients is far smaller than the total revenue collected via the HIL (see section 3.1.2).

As part of this review, the Tribunal considered the possible role that some form of broader based levy could play in providing ongoing funding for the Ambulance Service. In particular, it identified two possible options that it believes the Government should explore:

- changing the Medicare Levy funding model to provide ongoing funding for ambulance services in each state and territory
- introducing a Community Ambulance Charge in NSW.

The Tribunal's preliminary considerations on each of these options are discussed below. Note that if either option were to be introduced, it would replace the existing HIL, and would mean that Primary emergency ambulance services would be provided free of charge to all NSW residents (except where they are provided under bulk arrangements).

6.1 Changing the Medicare Levy funding model

The Tribunal considers that the most appropriate way to introduce a broad-based ambulance levy would be to introduce an additional ambulance-service component to the existing Medicare Levy. This levy is charged to all Australians in proportion to their incomes, and is administered centrally by the Federal Government. It is currently used to fund general medical services provided in hospitals and by General Practitioners.

Increasing the Medicare Levy so that it also funds ambulance services in NSW (and other states and territories) would spread the burden of funding the Ambulance Service across the NSW community on a more equitable basis. The Medicare Levy is a proportional tax, which means that all taxpayers pay the same percentage of their taxable incomes. This means that those on lower taxable incomes pay a lower amount in dollar terms than those on higher incomes, and those with incomes below the tax-free threshold don't pay anything. If it were used to fund ambulance services, people who don't pay tax would receive free ambulance services, while those on low taxable incomes who do not currently qualify for a fee

exemption in NSW would pay significantly less in aggregate than those on higher taxable incomes.

Ideally, the Medicare Levy would be increased to fund the Primary emergency response of the ambulance services across Australia. This means that from a NSW perspective, the levy increase would need to collect around $245m (in 2003/04 dollars).

The main difficulty associated with introducing an ambulance-services-related addition to the Medicare Levy is that it would require agreement between the Commonwealth and the States and Territories. This would require an agreed funding model that takes into account the different costs of providing ambulance services in each state and territory.

Recommendation 20

That the Government explore the introduction of an ambulance-service component to the Medicare Levy for the purpose of providing future funding for the Ambulance Service of NSW.

6.2 Introducing a Community Ambulance Charge

If it is not feasible to fund ambulance services through an addition to the Medicare Levy, then the Government may wish to consider introducing a NSW-only Community Ambulance Charge (CAC). The Tribunal undertook some preliminary analysis of this option, including considering how a CAC might be implemented, how much revenue it would need to collect, who should contribute to it, and the potential problems associated with its introduction. Its considerations are outlined below.

6.2.1 How might a CAC be implemented?

A CAC currently exists in Queensland, where it is collected as part of electricity bills. The Tribunal considered several alternative methods for implementing a CAC in NSW, including collecting it as part of other widely levied bills (such as local council rates). It concluded that the most effective and efficient method for NSW would be to include a CAC in the network component of residential electricity bills, and to charge it quarterly but calculate it daily.

The Tribunal believes a CAC would best be included in the network component of residential electricity bills because:

- Electricity billing systems already exist, and the incremental cost of incorporating a CAC into these systems would be minimal compared to the Ambulance Service establishing its own billing system.
- Electricity accounts are virtually universal and are paid by residents (not landlords), which would ensure that the CAC has a broad base. In addition, there are only a small number of distribution network service providers (DNSPs), which would minimise co-ordination costs. Electricity accounts also provide a cost-effective way of encouraging payment, because failure to pay them can result in disconnection.

However, if a CAC were billed as part of existing electricity accounts, it would be important for it to be separately identified on the bill. This would help ensure that people recognise that the CAC is not an increase in electricity prices, and that electricity retailers do not

receive an increase in enquires and complaints from customers about the size of their accounts.

The Tribunal also believes a CAC should be billable every quarter but calculated daily, in much the same fashion as the electricity network service availability charge. This will prevent people who move house within a quarter being double-billed or not billed at all.

Ideally, any payments made by customers on their electricity accounts would first be attributed to the CAC. This would ensure that disconnection or restriction of the electricity supply as a result of not paying the full amount owing would always be due to non-payment of the electricity component of the bill and not non-payment of the CAC.

6.2.2 How much revenue would a CAC need to collect?

Given that the concept of a CAC reflects a view that there is value associated with having an emergency response service available to all NSW residents, the Tribunal believes it would be appropriate for a CAC to collect sufficient revenue to fund the Primary emergency response costs. In 2003/04, these costs were $271.1m[39].

According to the Tribunal's calculations, if a CAC were levied on residential electricity customers, it would need to be set at around $100 a year (in 2003/04 dollars). (This calculation and the assumptions the Tribunal used are explained in Attachment 4.) However, given the Government's existing policy on concessions, it might also be appropriate to charge pensioners and other Health Care card holders at a discounted rate. The Tribunal calculates that a discount of 67 per cent would cost approximately $45.4 million, which presumably would be funded as a CSO payment.

The Tribunal suggests that if a CAC were to be introduced, the revenue collected through it should be hypothecated to the Ambulance Service. Economists generally believe that hypothecation of revenue for a specific purpose reduces the flexibility of government to spend the marginal dollar on the project or purpose with the highest social value. However, there is also a view that the community is more likely to accept an extra tax if it knows and accepts the specific purpose of this tax.[40] The Tribunal believes that the latter is likely to be the case with a CAC, especially given the high regard in the community for the services provided by the Ambulance Service.

In addition, the revenue raised through a CAC would not cover the full costs of the Ambulance Service. Based on the Ambulance Service's current annual expenditure and the total revenue likely to be generated through the Tribunal's recommended fee scales, the Tribunal calculates that even with a CAC, the Government would still need to provide the Service approximately $90 million per annum from consolidated revenue. Therefore, there is little risk that the Government would forego a project or purpose with a higher social value because it hypothecated the revenue raised by a CAC to the Ambulance Service.

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39 $271.1m is made up of $245m that is funded by a CAC plus funding that is obtained by way of bulk agreements with MMA, DVA and WorkCover.

40 Gittins, R., *Its time to smarten up,* Sydney Morning Herald, 17 March 2003.

In addition, the Tribunal considers that as well as separately identifying the CAC component on electricity bills, a detailed explanation of the CAC should be added, including an assurance that the CAC is fully directed to the Ambulance Service. These features should maximise community acceptance of the charge. Even so, some in the community may be critical about the introduction of such a levy.

6.2.3 Who should contribute to a CAC?

To simplify the collection of a CAC, the Tribunal believes that it should be levied on residential households only. Although businesses also benefit from the availability of an emergency ambulance service, they would better contribute through a bulk agreement with WorkCover, effectively passing the cost onto workers' compensation insurance. In recommending not to levy the CAC on businesses the Tribunal is aware that further work will be necessary to ensure that residential customers are not able to access business (general supply) tariffs as a means of avoiding paying the CAC.

In addition to business exemptions, the Tribunal considers there should be exemptions for households who own or rent more than one property in NSW for which they have an electricity account, and for households whose primary residence is outside NSW. The Tribunal also considers that it is appropriate for households that include a pensioner or other Health Care cardholder to contribute to a CAC, but at a discounted rate.

Exemptions for multiple electricity account holders

Some households own or rent two (or more) residential properties in NSW for which they hold electricity accounts. (For example, the second property may be a holiday home or a farm.) As the need for a household to access ambulance services is not linked to the number of properties it owns, the Tribunal considers that these households should pay only one CAC.

To facilitate this, customers should be given a unique CAC identification number. This could be their electricity account number, their national metering identifier (NMI) number, or a specifically generated number. Customers who have electricity accounts for two or more properties would supply this CAC identification number to obtain an exemption on the second and subsequent properties.[41]

Exemptions for interstate residents

In a few cases, households whose primary residence is outside NSW might own or rent a second property in NSW (for example, a holiday house). The Tribunal considers it inappropriate to charge these households a NSW CAC, as they may already be covered for ambulance services by virtue of paying a CAC in Queensland or having medical or ambulance cover in other states.

To facilitate this exemption, these households could be required to provide proof of insurance in the form of a CAC receipt or Health Fund membership in order to obtain an exemption on their NSW property. Alternatively, the Government could provide a blanket exemption on proof of interstate residency and apply direct charges to these people should they require ambulances services within NSW.

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41 ABS and AHI data suggest that the average length of ownership of residential properties is 5 years. It would therefore be unnecessary to renew the application for exemption on less than an annual basis.

Discount for pensioners and Health Care card holders

Pensioners and other Health Care card holders account for approximately 65 per cent of Primary ambulance transports yet only make up 25 per cent of residential households. The Tribunal considers that it is reasonable for this group to make some contribution to funding the Ambulance Service. However, concerns about its capacity to pay the full CAC may justify a rebate or discount on the full CAC – for example, so they pay only one third (33 per cent) of this charge.

The Tribunal considers that if a discount were available, individuals should be required to apply for this discount. For customers with a long period of eligibility for Health Care cards such as aged pensioners, they could be granted the discount for a period of five years without needing to reapply. However, customers with short-term eligibility only (such as those on unemployment benefits or student allowances), could be required to apply on an annual basis.

6.2.4 Potential problems associated with the introduction of a CAC

One of the major weaknesses of a CAC is that, like all set price charges or levies, it is regressive in nature – that is, lower income households pay a higher percentage of their income than higher income households. This is one of the main reasons why the Tribunal prefers the Medicare Levy option. The Tribunal has also identified some other potential problems with introducing a CAC, including that it may increase the rate of electricity disconnections due to non-payment of bills, and that it may increase the administration costs and default risk for electricity businesses. Each of these problems is discussed below.

Increase rate of electricity disconnections

In submissions and during the consultation process for this review,[42] several stakeholders raised concerns that implementing a CAC as part of residential electricity bills could increase the rate of disconnections due to non-payment of these bills.[43] Based on the average size of annual residential electricity bills, the Tribunal calculates that a CAC of $100 per year would increase the total average bill by around 10 per cent.[44] Such an increase could cause payment difficulties for low-income families.

One approach to partly address this concern would be to increase the availability of Energy Account Payment Assistance (EAPA) vouchers. The NSW Government currently provides around $8m a year in the form of EAPA vouchers. These $30 vouchers are given to customers who are having difficulty paying their electricity bill. Charitable organisations such as St Vincent de Paul, Salvation Army and Anglicare assess eligibility for and distribute the vouchers, but usually do not provide the full amount of the bill in EAPA vouchers. In the absence of more detailed analysis, it may be appropriate to increase the supply of EAPA vouchers by a further 10 per cent to enable assistance to be given to low income[45] families with dependant children who are not eligible for a Health Care card/Pensioner Concession.

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42 For example, see the NCOSS submission p 5 and the EWON submission p 1 (on the Tribunal's website).

43 The average number of electricity disconnections in NSW is 21,394 pa. This amounts to 0.8 per cent of the total number of customers. Of this number 60 per cent (Urbis Keys Young 2005) are reconnected within 24 hours.

44 The Tribunal's household survey indicated an average residential electricity bill of around $1,059 pa.

45 To receive a Health Care Card a family with two children cannot earn more that $670 pwk. This is less than 50 per cent of the average income for this cohort. This income is well below the average for a family with young children. The ABS survey for 2003/04 indicates that the average household income for a family with young children is $1486 pw rising to $1738 pw where the oldest child is between 15-24 years of age.

A further option, which would further mitigate the impact of disconnections due to the introduction of a CAC, would be to install load limiting meters in vulnerable households. These electronic meters[46] allow for electricity supply to be restricted to a programmable level while an account is outstanding, rather than completely disconnecting the customer. (For example, this level might be sufficient to allow for lights and the use of a microwave oven only.) A similar approach has been taken in the water industry where, rather than completely disconnecting customers who do not pay their bills, water supply is restricted by mechanical means.

Increased administration costs and default risk for electricity businesses

If a CAC were added to the network component of residential electricity bills, there would be an increase in the administration costs to retailers.[47] There could also be an increase in the number of complaints and enquires retailers receive from customers who, if not sufficiently informed, may see the CAC as an increase in electricity charges.

In addition, by increasing the overall size of electricity bills, the addition of a CAC might also increase the risk of customers defaulting on their bills. Retailers would be required to pay the network component of all bills to distributors (including the CAC portion) regardless of whether or not they receive payment from the customer. This increase in risk would increase retailers' costs and would need to be considered in implementing a CAC.

Recommendation 21

That the Government consider the introduction of a Community Ambulance Charge should it not be possible to reach agreement on a national system of funding via the Medicare Levy.

The Tribunal notes that if a broad-based levy is not introduced in NSW and the Ambulance Service increasingly relies on user-pays funding, it will be important to raise community awareness of ambulance charges and the insurance options available to help protect against the impact of these charges, such as ambulance-only insurance. (See section 4.5.)

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46 Ampy-Email manufacture these meters. The price is approximately $170 per unit. It should be noted however that there would also be install costs involved which may range up to $100. However, on the positive side these meters are interval meters and would not be replaced if the resident moved house.

47 As these costs are currently around $5 per invoice, this cost would be less than this amount.

ATTACHMENT 1 TERMS OF REFERENCE

I, Robert J Carr, Premier of New South Wales, pursuant to Section 9(1)(b) of the *Independent Pricing and Regulatory Tribunal Act 1992*, request that the Tribunal investigate and report on the following matters related to the Ambulance Service of NSW:

1. A detailed analysis of revenue and charging structures of the Ambulance Service, taking into account the system-wide effects of implementing different fee structures.

2. A cost index to quantify changes in the cost of providing medical and transport operations undertaken by the Ambulance Service and to sustain services into the future.

A final report on revenue and charging structures is to be provided to the Premier and Minister for Health by mid-September 2005 [subsequently extended to end-October 2005].

A final report on the cost index is to be provided to the Premier and the Minister for Health by end November 2005 [subsequently extended to mid-December 2005].

In conducting the investigation into revenue and charging structures, the Tribunal should consider:

i. the views of major stakeholders in the NSW health system, in particular the views of Area Health Services and their hospitals;

ii. the cost of providing the medical and transport operations concerned;

iii. staffing and equipment requirements to sustain the ambulance service into the future;

iv. the efficiency and effectiveness of the ambulance service in terms of emergency transport, non-emergency transport and rescue functions, particularly in the context of other similar services in Australian jurisdictions;

v. ambulance charging arrangements in other States and Territories;

vi. the protection of consumers from abuses of monopoly power in terms of prices, pricing policies and standards of service;

vii. the impact of pricing policies on borrowing and capital requirements and, in particular, the impact of any need to renew or increase relevant assets;

viii. the social impact of the recommendations;

ix. standards of quality, reliability and safety of the services concerned (whether those standards are specified by legislation, agreement or otherwise); and

x. the effect of any recommendation on the level of Government funding.

Observations from the review that can improve the effectiveness and efficiency of the ambulance service should be reported as part of the review.

Table A1.1 indicates where the terms of reference have been considered throughout the report.

Table A1.1 Consideration of the terms of reference by the Tribunal

Term of Reference	Where discussed
(i) views of major stakeholders	Various; also posted on Tribunal website
(ii) cost of providing the medical and transport operations	Chapter 3
(iii) staffing and equipment requirements to sustain the Service into the future	Chapter 2
(iv) the efficiency and effectiveness of the ambulance service in the context of other jurisdictions	Chapter 2
(v) ambulance charging arrangements in other States and Territories	Chapter 4; also PwC report posted on Tribunal website
(vi) the protection of consumers from abuses of monopoly power	Chapter 3
(vii) impact on borrowing, capital and asset renewal and expansion	Chapter 4
(viii) the social impact of the recommendations	Chapter 3 and 4
(ix) standards of quality, reliability and safety	Chapter 2
(x) the effect of the recommendations on Government funding	Chapters 3 and 4

ATTACHMENT 2 RESPONDENTS AND WORKSHOP PARTICIPANTS

Written public submissions were received from:

Ambulance Service of NSW

Australian Health Insurance Association Limited (AHIA)

Council of Social Services of NSW (NCOSS)

Energy & Water Ombudsman of NSW (EWON)

Health Insurance Restricted Membership Association of Australia (HIRMAA)

Health Sector Union (HSU)

Medical Benefits Fund Limited (MBF)

North Sydney Central Coast Health Area Health Service

Participants in the workshop of 4 August 2005 were:

Tribunal	Dr Michael Keating AC	*Chairman*
	Mr James Cox	*CEO and Tribunal Member*
	Ms Cristina Cifuentes	*Tribunal Member*
	Mr Stephen Lyndon	*Special Adviser*
	Dr Dennis Mahoney	*Program Manager, Transport*
	Mr Gerard O'Dea	*Analyst*
Ambulance Service	Mr Greg Rochford	*CEO*
	Ms Julie Newman	*Director, Finance & Data Services*
	Mr Malcolm Voyzey	*Manager, Business Development*
NSW Health	Mr Ken Barker	*Chief Financial Officer*
Northern Sydney Central Coast Health	Dr Stephen Christley	*Chief Executive*
South Eastern Sydney & Illawarra Health	Prof Debora Picone	*Chief Executive*
Hunter New England Health	Mr Terry Clout	*Chief Executive*
AHIA	Dr Frances Cunningham	*CEO*
HSU	Mr Michael Williamson	*General Secretary*
	Mr Dennis Ravlich	*Manager, Industrial Services*
PIAC	Mr Jim Wellsmore	*Policy Officer*
NSW Treasury	Mr Gerald Kohn	*A/Director, Human Services*
The Cabinet Office	Mr Paul Armstrong	*Principal Policy Advisor*
PricewaterhouseCoopers	Mr Scott Lennon	*Director*
	Mr Vartguess Markarian	*Senior Analyst*

ATTACHMENT 3 DERIVING COST-REFLECTIVE FEE SCALES

This attachment explains how the Tribunal arrived at the fully cost-reflective fee scales discussed in Chapter 3.

A3.1 Total Ambulance Service costs and cases

The Ambulance Service provided a breakdown of costs and case numbers by service for 2003/04. The Service treated or transported more than 750,000 cases that year, at a cost of $366.5m (Table A3.1).

Table A3.1 Total costs and costs per case by service type (2003/04 $million)

	Costs 2003/04 $m	Cases (all cases)	Cost per case $/case
Emergency (road)	287.0	552,057	520
Non-Emergency	46.0	192,796	238
Road total	**333.0**	**744,853**	**447**
Fixed wing	18.3	5,720	3,207
Helicopter	15.1	2,747	5,507
Total	**366.5**	**753,320**	**486**

Note: Totals may not add up due to rounding

A3.2 Fixed and variable costs for all cases

The total cost per case was split into a fixed and a variable component. According to the Ambulance Service, 78 per cent of its total costs are fixed costs and 22 per cent are costs that vary depending on the number of cases treated and the distances travelled. After considering the basis of this split, the Tribunal was satisfied that it is reasonable.

To establish the fixed and variable costs of each service, the variable costs (22 per cent of the total) were 'spread over' the distances travelled to give a variable cost in $/km for Road and Fixed Wing transport. The fixed and variable costs per case are shown in Table A3.2, in both 2003/04 prices and 2005/06 prices.[48] Inter-hospital Helicopter transport is billed in 6-minute intervals, while Primary cases are billed per kilometre travelled. It was therefore not possible to calculate an average variable cost for this service.

[48] An inflation rate of 2.5 per cent was used for both years. The 2004/05 rate is the year-on-year average to June for Sydney. The rate for 2005/06 is a projected rate.

Table A3.2 Fixed and variable cost per case (2003/04$ and 2005/06$)

	Total cost $/case	Fixed cost per case @ 78%	Variable cost per case @ 22%	Average (all cases) km per case[1]	Variable cost per km $/km
2003/04$					
Emergency (road)	520	406	114	28	4.05
Non-Emergency	238	186	52	46	1.15
Fixed wing	3,207	2,502	706	606	1.17
Helicopter	5,507	4,295	1,212	na	nc[2]
2005/06$					
Emergency (road)	546	426	120	30	4.26
Non-Emergency	251	195	55	48	1.20
Fixed wing	3,369	2,628	741	636	1.22
Helicopter	5,786	4,513	1,273	na	nc[2]

1. The distance travelled by road in Fixed Wing cases is included in the Road emergency average
2. Interhospital trips are measured in minutes and primary trips in km. It is therefore not possible to calculate an average

A3.3 The cost of chargeable cases only

These fixed and variable costs apply to all cases, including Inter-hospital, Primary, chargeable and non-chargeable cases. The only difference between the different categories of cases is the average distance travelled per case, which is shown in Table A3.3.

Table A3.3 Average distances (time) travelled per case

	Road		**Fixed Wing[1]**			**Helicopter**	
	Emergency km/case	Non Emerg km/case	Emergency km/case	*by air*	*by road*	Emergency km/case	
All cases	28	46	623	*606*	*17*	na	
Chargeable cases only							
Interhospital	111	73	667	*650*	*17*	108	← minutes
Primary	19	32	784	*767*	*17*	62	← km

1. Most Fixed Wing cases involve road tranport at either end of the flight.

Applying the distances travelled per case to each chargeable category results in the average costs per case shown in Table A3.4 (2005/06 prices).

The calculation of average costs for Fixed Wing cases is complicated by the road transport components of most cases, as most cases involve road transport at either end of the flight.[49] The Ambulance Service estimates that the average distance travelled by road is 17km per case for all cases. In the absence of further information, this value was used for all cases. The average cost per case for Fixed Wing cases shown in Table A3.4 is calculated including the air distance travelled at the Fixed Wing variable cost ($1.22/km) and the road distance at the emergency Road variable cost ($4.26/km). No additional (fixed) cost for the Road service is included, as the magnitude of this cost is unknown and the Tribunal was reluctant to makes its own estimate.

[49] Current billing practice is to charge Fixed Wing cases a single call-out charge and the variable charge for the total distance travelled, whether by air or road.

Table A3.4 Average cost per case, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency $/case	Non Emerg $/case	Emergency $/case	Emergency $/case
2005/06$				
All cases	546	251	3,369	5,786
Chargeable cases only				
Interhospital	897	283	3,496	
Primary	508	234	3,639	

A3.4 Establishing a fully cost-reflective fee scale with a single scale for all Primary emergency cases

The unit costs for Road and Fixed Wing cases shown in Table A3.2 also represent a set of fully cost-reflective charges (with the exception of the variable charge for Helicopters). However, the Ambulance Service argues that a fee scale for Primary emergency cases that differentiates between transport modes does not make sense, since it is not the patient but the Ambulance Service that decides what type of transport to use. The Tribunal agrees that a single fee scale for Primary emergency cases is appropriate.

To establish what a fully cost-reflective fee scale for all Primary emergency cases would be, it was necessary to establish the average cost per Primary emergency case for the relevant chargeable cases. This was done by pooling the number of cases, distances travelled and costs of Primary emergency Road, Fixed Wing and Helicopter cases to arrive at a weighted average fixed cost of $489 per case and $4.37/km.

The Tribunal's preferred fully cost-reflective fee scales are shown in Table A3.5, with a single scale for Primary emergency cases. On these scales, the 'first 16km free' provision no longer applies, but the 'first 30 minutes free' provision on Inter-hospital Helicopter cases remains unchanged.

The variable rate for Inter-hospital Helicopter cases was estimated by using the average variable cost for all cases ($1,273) shown in Table A3.2, and the average trip length of Inter-hospital cases (108 minutes) shown in Table A3.3. Since the first 30 minutes is not charged, the average chargeable time is 78 minutes, or 13 six-minute intervals. The variable rate is therefore:

$1,273 *divided by* 13 six-minute intervals *equals* $98/interval

Table A3.5 Fully cost-reflective fee scales, 2005/06 $

	Road		Fixed Wing	Helicopter
	Emergency	Non Emerg	Emergency	Emergency
Interhospital				
Call-out ($/case)	426	195	2,628	4,513
Variable rate ($/km[1] or 6 minute interval[2])	4.26	1.20	1.22	98
Variable road rate for Fixed Wing cases			*4.26*	
Average chargeable km (min) per case	111	73	667	78
Average charge per case	897	283	3,496	5,786
Primary				
Call-out ($/case)	489	195	489	489
Variable rate ($/km)[1]	4.37	1.20	4.37	4.37
Average chargeable km per case	19	32	784	62
Average charge per case	573	234	3,914	758

1. The variable rate is levied per km travelled (including the first 16km) in all cases except Inter-hospital Helicopter cases.

2. Inter-hospital Helicopter cases are billed per 6-minute interval elapsed after the first 30 minutes. The 78 minutes of chargeable minutes shown in the table is the average flying time less 30 minutes

ATTACHMENT 4 COMMUNITY AMBULANCE CHARGE COST AND REVENUE MODEL

The following table shows how a CAC on residential electricity accounts might be calculated. All dollar amounts are 2003/04 dollars.

Electricity customers

- The electricity customer numbers are the audited numbers for 2003/04. DEUS advised that there are currently 680,000 electricity customers entitled to a pensioner rebate.
- Around 10 per cent of residential accounts can be expected to be exempt because they will be multiple accounts.

Revenue required from a CAC

- The total cost of providing Primary emergency ambulance services was around $271.1m in 2003/04 according data provided by the Ambulance Service.
- The bulk agreements are deducted from the cost of Primary emergency services because these fund some of the services to Primary patients unrelated to a CAC.
- The Motor Accident Authority bulk agreement is assumed to continue essentially as it is.
- The Department of Veterans' Affairs bulk agreement is assumed to be renegotiated along the lines of the Queensland and Victorian agreements (thus increasing revenue considerably).
- The Ambulance Service is assumed to negotiate a bulk agreement with WorkCover to cover Workers' compensation cases. This would be similar in principle to the bulk agreement with the MAA for motor vehicle accidents.

Pensioner discounts

- The table illustrates the effect of a range of pensioner discounts and the level of community service obligation (CSO) attached with each option.
- It assumes that any discount of the CAC for pensioners/Health Care card holders would be met as a CSO by the Government.

Community Ambulance Charge - Full Emergency Cost Build-up

Customer Class	Class Number	% of Total Customers	% of Residential	0% Pensioner Discount + 0% Other Exemptions	0% Pensioner Discount + 10% Other Exemptions	50% Pensioner Discount + 10% Other Exemptions	67% Pensioner Discount + 10% Other Exemptions	75% Pensioner Discount + 10% Other Exemptions	100% Pensioner Discount + 10% Other Exemptions
Residential (including Pensioners)	2,677,780	89.6%	-	$ 91.50	$ 100.14	$ 100.14	$ 100.14	$ 100.14	$ 100.14
Pensioner	680,000	22.8%	25.4%	$ 91.50	$ 100.14	$ 50.07	$ 33.38	$ 25.03	$ -
Business-Small	289,527	9.7%	-	$ -	$ -	$ -	$ -	$ -	$ -
Business-Large	21,433	0.7%	-	$ -	$ -	$ -	$ -	$ -	$ -
Customer Total	2,988,740								

Primary Emergency	$ 271,126,871
MAA Bulk Agreement	$ 13,097,100
DVA Bulk Agreement	$ 8,000,000
WorkCover Bulk Agreement	$ 5,000,000
Total Full Emergency Funding	$ 245,029,771

CAC REVENUE	$ 245,029,771	$ 245,029,771	$ 210,982,642	$ 199,631,330	$ 193,959,078	$ 176,935,514
Full Emergency CSO	$ -	$ -	$ 34,047,128	$ 45,398,441	$ 51,070,692	$ 68,094,256

Exemptions	
Pensioner	680,000
Other %	10%
Other Exemptions Numbers	230,874
Exemptions Total Numbers	910,874

Rebate Options	
Pensioner Discount	0%
Pensioner Discount	50%
Pensioner Discount	67%
Pensioner Discount	75%
100% Pensioner Discount	100%

ATTACHMENT 5 ABBREVIATIONS USED IN THIS REPORT

ABS	Australian Bureau of Statistics
CAA	Convention of Ambulance Authorities
CAC	Community Ambulance Charge
CPI	Consumer Price Index as constructed by the Australian Bureau of Statistics. The context makes clear whether the national or the Sydney CPI is under consideration.
CPP	Cost per patient (calculated by dividing total cost by the number of patients either transported or treated)
CPR	Cost per response (calculated as for CPP but dividing by total responses)
CSO	Community service obligation
DVA	Commonwealth Department of Veterans' Affairs
EAPA	Energy Account Payment Assistance scheme
FTE	Full-time equivalent (as applied to a measure of the workforce that is comparable across jurisdictions).
HIL	Health Insurance Levy
KPI	Key Performance Indicator
MAA	Motor Accident Authority
NMI	National meter indentifier
SAIP	State Ambulance Insurance Plan
SDRO	State Debt Recovery Office
SIDS	Sudden infant death syndrome
TNT	Treat-not-transport. The term refers to patients who are treated by ambulance officers but not transported by an ambulance.