

WESTERN AUSTRALIA'S COMMENTS ON CGC 2008/02-S ASSESSING COMMUNITY AND OTHER HEALTH SERVICES

KEY POINTS

- We believe that a subtraction model is theoretically valid.
 - We agree that non-State expenses can be included in the model even if they are not substitutable for State expenses **provided** the amount subtracted from each State is **equal to** the amount that was included in the standardised total expense for that State.
- We have major concerns with the proposed implementation of the model.
 - The age-sex profile for total health expenses is applied to Community and Other Health Services expenses. However, Community and Other Health Services programs have age-sex profiles that are likely to be “younger” than the age-sex profiles of the other major components of total health (i.e. admitted patient services, aged care homes and pharmaceuticals).
 - Expenses for which there are no age-sex profile data are assumed to have the same profile as expenses for which data are available. In the absence of data, these expenses, which include health promotion campaigns, should be assessed equal per capita.
 - The indigenous adjustment does not pick up the relatively greater health needs of remote indigenous persons.
 - Out-of-pocket expenses by private individuals (both insured and uninsured) are assumed to be proportional to private health insurance ancillary benefit payments (standardised to reflect a uniform benefit for each type of ancillary service).
 - The argument in the discussion paper is based on a logical misconception.
 - Most likely, there is an inverse relationship between per capita out-of-pocket expenses and per capita ancillary benefit payments.
 - Instead of health insurance payments, we suggest that health labour force data be used to estimate the size of the non-government (or non-State) sector in each State, reflecting the labour intensive nature of health care.
 - Alternatively, non-government expenses could be excluded from the assessment.

Concept of the proposed assessment

The Commonwealth Grants Commission (CGC) staff discussion paper provides an updated proposal to use a subtraction model to assess Community and Other Health Services (C&OHS).

Under this model, total C&OHS expenses by all sources - State, Commonwealth and non-government (including both health insurance funds and individuals) – are standardised across the States. Commonwealth and non-government expenses are then subtracted, to give assessed State expenses.

The model is based on the concept that many Commonwealth and non-government health expenses are substitutable for State health expenses. Therefore, higher Commonwealth or non-government expenses will reduce the need for State expenses.

We agree with this concept. The classic example is the substitution between GP services (funded by the Commonwealth and, to some extent, individuals) and State hospital emergency department services. This arises for a number of reasons (cost of GP services, lack of GPs in remote regions, unavailability of after-hours GPs). A subtraction model is ideal for assessing this, because it can capture the substitution without having to assess each reason individually.

The discussion paper argues that the subtraction model does not require all non-State expenses to be substitutable for State expenses.

We agree that non-State expenses can be included in the model even if they are not substitutable for State expenses **provided** the amount subtracted from each State is **equal to** (and hence offsets) the amount that was included in the standardised total expense for that State.

If the amount subtracted differs from the amount included in total expenses, then there will be an impact on assessed State expenses, which would not be appropriate.

Implementation of the proposed assessment

Despite being open to the use of a subtraction model, we have many concerns about how the discussion paper proposes implementing this model.

To give some context to our concerns, we will first present an overview of the proposed assessment, based on our understanding of the discussion paper proposal.

As analysed by the discussion paper, national C&OHS expenses in 2004-05 comprised:¹

| | \$ million |
|--------------------------------|---------------|
| State | 12,080 |
| Commonwealth | 15,227 |
| Private health insurance funds | 1,569 |
| Private individuals | 5,082 |
| Total | <u>33,958</u> |

The discussion paper standardises the above total C&OHS expenses across States using Australian Institute of Health and Welfare (AIHW) data on expenditure by disease.

This AIHW data is for 2000-01 (2004-05 data will be used when available) and includes:

- per capita national total health expenditure cross-classified by age, sex and disease group; and
- national total health expenditure cross-classified by service type and disease group. However, an age-sex breakdown is not provided, and **the CGC has therefore had to assume that the age/sex profile for total health spending in the relevant disease group applies also to the service types that comprise C&OHS.**
 - C&OHS is taken to comprise the AIHW service types of non-admitted services, out of hospital medical services, other professional services, community and public health, and dental.

While the majority of AIHW health expenditure has been “allocated” to disease groups, a significant percentage of expenditure is “unallocated”.

- We understand that, in 2000-01, \$1.2 billion of the unallocated expenditure relates to C&OHS (5.6% of total C&OHS expenditure). **The CGC has effectively assumed that this unallocated expenditure can be standardised across States in proportion to allocated expenditure.**

¹ Based on Table 2 of CGC 2008/02-S.

As proposed in the discussion paper, assessed State expenses are calculated by subtracting from total standardised community health expenses:

- Commonwealth expenses – these are allocated among States according to MBS data; and
- non-government expenses – these are allocated among States according to private health insurance benefit payments.²

The following comments address our main concerns with the proposed implementation described above.

Age-sex profile for total health is applied to community health

Excluding unallocated expenditure, AIHW data shows that C&OHS expenses comprise 39% of total health expenses. This proportion varies among the disease groups, ranging from 15% for maternal conditions to 52% for injuries.

Allocated C&OHS includes presentations at Accident and Emergency departments, outpatient services, population health programs such as immunisations, and mental health services. These programs have age-sex profiles that are likely to be “younger” than the age-sex profiles of the other major components of allocated total health spending, which are:

- admitted patient services;
- aged care homes; and
- pharmaceuticals.

Therefore, allocated C&OHS expenses will have a younger age profile than allocated total health expenses.

We are also concerned that the 2000-01 allocated data are rather dated. We understand that 2004-05 allocated data should be released soon. As 2004-05 data will still be somewhat dated, we suggest that Commission staff test the stability of age-sex disabilities, by comparing results from the old and new data sets.

Unallocated expenses are distributed in proportion to allocated expenses

The CGC applies the age-sex weights that it derived from **allocated** 2000-01 C&OHS spending to **total** (i.e. allocated plus unallocated) 2004-05 C&OHS spending (\$33,958 million in the table above).

In effect, the age-sex profile for allocated C&OHS expenses has been assumed to be the same as for unallocated expenses.

² Weighted by national average insurance benefit for each type of service.

While unallocated C&OHS expenses were \$1.2 billion in 2000-01, these have probably grown substantially since 2000-01.

The unallocated expenses include health promotion activities, which will bear no relation to the age-sex profile of the allocated expenses.

It would be more appropriate to distribute the unallocated expenses equal per capita among States.

Indigenous adjustment does not vary between remote and non-remote

While all indigenous persons have relatively high health needs compared to non-indigenous persons, this disparity is greater in more remote regions.

However, the proposed indigenous adjustment is uniform across all regions, which will understate needs for States with a higher proportion of their indigenous population in remote regions.

It would be more appropriate to develop region-specific indigenous adjustments.

Private individual expenses are distributed by health insurance recipients

The problem

The discussion paper proposes that the amount of non-government expense to be subtracted from each State's expense would be proportional to that State's number of private health insurance ancillary benefit payments (standardised to reflect a uniform benefit for each type of ancillary service).

In 2004-05, private health insurance funds only paid 23.6% or \$1,569 million of the \$6,651 million non-government C&OHS expenditure. Private individuals paid the other \$5,082 million. A further breakdown of these C&OHS expenses is:³

| | Health insurance funds | Private individuals | Total non-government |
|---------------------------|------------------------|---------------------|----------------------|
| | \$m | \$m | \$m |
| Community health | 0 | 116 | 116 |
| Dental | 1,051 | 3,403 | 4,454 |
| Other health practitioner | 518 | 1,508 | 2,026 |
| Public health | 0 | 55 | 55 |
| Total | 1,569 | 5,082 | 6,651 |

³ Based on Table 2 of CGC 2008/02-S.

As health insurance funds made no community health and public health payments, data on ancillary benefit payments would not be relevant to expenses by private individuals on these functions.

The vast bulk of the non-government expenses are for dental and other health practitioner expenses. The amounts paid by private individuals for these services will reflect:

- out-of-pocket payments by insured individuals that are not covered by their health insurance; and
- out-of-pocket payments by uninsured individuals, who must meet the full cost of these expenses.

In effect, the CGC has assumed that out-of-pocket expenses by private individuals (both insured and uninsured) are proportional to private health insurance ancillary benefit payments (standardised to reflect a uniform benefit for each type of ancillary service).

This assumption seems completely untenable.

- Government expenses on dental and other health practitioner services are relatively small, so the cost of these services is largely the responsibility of the recipient. Although many people take out ancillaries insurance to assist with these costs, the majority of the national population does not have ancillaries insurance, and meet the costs from their own pocket as the costs arise.
- **Most likely therefore, there is an inverse relationship between per capita out-of-pocket expenses and per capita ancillary benefit payments.**

In support of its assumption, the discussion paper has pointed out that the percentage distribution of ancillary benefit payments across the different types of services included in C&OHS is very similar to that for total non-government expenses. For example, dental accounts for about 67% of total national C&OHS expense in each case.

- However, these similar distributions say nothing about the level of reliance on insurance versus out-of-pocket spending in each State. It only says that, large or small, ancillary payments have the same general composition as out-of-pocket payments.

We think the following example may help clarify the relationship between insurance payouts and out-of-pocket expenses.

The example builds on the observation that, not surprisingly, benefit payments are relatively high in States with higher insurance coverage, as shown by the following 2004-05 numbers:

| | Ancillaries insurance coverage ^(a) | | | Relative per capita benefit payments ^(b) |
|---------|---|-----------------------|---------------------|---|
| | '000 persons | % of State population | Relative per capita | |
| NSW/ACT | 3,171 | 44.7% | 1.08 | 1.06 |
| Vic | 1,606 | 31.8% | 0.77 | 0.79 |
| Qld | 1,495 | 37.4% | 0.91 | 0.99 |
| WA | 1,141 | 56.6% | 1.37 | 1.15 |
| SA | 743 | 47.9% | 1.16 | 1.32 |
| Tas | 210 | 43.3% | 1.05 | 0.87 |
| NT | 61 | 29.6% | 0.72 | 0.44 |
| Total | 8,428 | 41.3% | 1.00 | 1.00 |

(a) Sourced from Private Health Insurance Administration Council website: <http://www.phiac.gov.au/statistics/membershipcoverage/table3a.htm>

(b) Calculated from non-government expenses estimated in the discussion paper, by dividing each State's per capita expense by the national per capita expense.

For our example, we suppose that per capita private C&OHS spending is generally equal between persons with and without ancillaries insurance, and does not vary across States. (As we show later, there is strong evidence that aggregate per capita private C&OHS spending does vary significantly between States, but not correlated with rates of insurance).

Under our assumption, C&OHS expenditure by the insured and their insurance funds would equal 41.3% (i.e. the proportion of insured persons in Australia, shown in the above table) of total non-government C&OHS expenditure, or \$2,747 million, in 2004-05. States with higher rates of insurance would have a higher per capita share of this spending.

- The 41.3% comprises 23.6% for payments by insurance funds (based on the fact that, in 2004-05, private health insurance funds paid 23.6% or \$1,569 million of the \$6,651 million non-government C&OHS expenditure) and 17.7% for out-of-pocket spending by insured individuals.

The remaining 58.7%, or \$3,904 million, would reflect each State's share of uninsured persons. Per capita spending by uninsured persons would be relatively higher in States with a relatively low share of insured persons.

To illustrate for Victoria:

| | Victoria | Rest of Australia | Total |
|--|--------------|----------------------|----------------|
| Number of persons | | | |
| Insured ('000) | 1,606 19% | 6,822 81% | 8,428 100% |
| Uninsured ('000) | 3,444 29% | 8,534 71% | 11,979 100% |
| Total population ('000) | 5,050 25% | 15,356 75% | 20,407 100% |
| Amounts paid for services to insured persons (41.3% of national total) | | | |
| Paid by health funds (\$m) | 299 | 1,270 | 1,569 |
| Paid by individuals (\$m) | 224 | 953 | 1,178 |
| Total (\$m) | 523 19% | 2,223 81% | 2,747 100% |
| Amounts paid for services to uninsured persons (58.7% of national total) | | | |
| Paid by individuals (\$m) | 1,123 29% | 2,782 71% | 3,904 100% |
| Total amounts paid for services | | | |
| Paid by health funds (\$m) | 299 19% | 1,270 81% | 1,569 100% |
| Paid by individuals (\$m) | 1,347 27% | 3,735 73% | 5,082 100% |
| Total (\$m) | 1,646 25% | 5,005 75% | 6,651 100% |

In this example, although Victoria has a relatively low proportion of insurance payments (corresponding to its relatively low proportion of insured persons), this is offset by a relatively high proportion of out-of-pocket payments, so that in aggregate it has an equal per capita share of non-government expenses.

As noted above, the proportion of spending on particular types of services (e.g. dental) appears similar between insurance payments and out-of-pocket payments. Accordingly, the above table can be adapted to each type of service by multiplying all of the dollar amounts by the proportion of spending on that service type.

- For example, as dental accounts for about 67% of private national C&OHS expenditure for both health funds and individuals, we could multiply all of the dollar amounts in the above table by 67% to derive illustrative dental expenses.
- This does not change the conclusion that, although Victoria has a relatively low proportion of insurance payments, this is offset by a relatively high proportion of out-of-pocket payments, so that in aggregate it has an equal per capita share of non-government expenses.

The above example highlights our points that:

- there is likely to be an inverse relationship between the level of insurance payments and out-of-pocket payments; and
- this issue has no connection to the similarity of the distribution across different service types for insurance payments and private expenses.

Our example is simplistic for two reasons.

- It is unlikely that insured and uninsured persons use C&OHS to the same extent.
- Per capita use of private C&OHS (including both insured and uninsured persons) will differ between States.

Both of these will contribute to differences between the relative per capita insured persons and relative per capita benefit payments quoted in the table above.⁴

Solutions

The size of the private C&OHS sector can be measured by the labour force, as C&OHS is very labour intensive.

Although Western Australia has very high rates of private health insurance and benefit payments, it has one of the lowest levels of private sector provision of C&OHS. Labour force data show that Western Australia has very low private sector provision of GP, specialist and allied health services. This results in reliance on public accident and emergency departments, public outpatient services and public allied health services. This is especially the case in rural and

⁴ We used Victoria for the illustrative example because its share of benefit recipients is only slightly different from its share of insured persons.

remote regions of the State where, in many areas, the private sector provision of community health services is either very small or non-existent.

The size of the C&OHS labour force is detailed in a number of AIHW publications. Two examples of labour force numbers by State in 2005 are:

| | Private sector medical practitioners ⁵ | Clinical psychologists ⁶ |
|-------|--|--|
| NSW | 13,586 | 3,660 |
| Vic | 10,256 | 4,852 |
| Qld | 5,940 | 2,140 |
| WA | 2,978 | 1,273 |
| SA | 3,051 | 1,163 |
| Tas | 1,054 | 225 |
| ACT | 827 | 442 |
| NT | 268 | 186 |
| Total | 37,960 | 13,939 |

The above numbers indicate that Western Australia has significantly less of the national C&OHS labour force than its population share (of about 10%).

We understand that comparable labour force data will become more readily available once national registration arrangements come into effect.

As the services paid for by the non-government sector are constrained by the private sector workforce, we support using labour force data to allocate the non-government community health expenses.

We note that there may be some difficulty in determining labour force numbers that are relevant to just the non-government sector, as the private sector workforce also provides services funded by the Commonwealth. If this were to be a significant problem, then an option would be to allocate all non-State (Commonwealth and non-government) expenses by the private sector workforce. However, this should only be a fall-back option, as there is good quality data on the allocation of Commonwealth expenses by State.

⁵ AIHW, *Medical Labour Force 2005*, Table 17

⁶ AIHW, *Psychology Labour Force 2003*, Table A-1

Alternatively, if the Commission rejects the use of labour force data to allocate non-government expenses, a solution would be to make no assessment for non-government expenses. This could be done by assuming that the expense weights used to standardise total C&OHS expenses are also applicable to:

- non-government expenses – so the non-government expense subtracted from each State would be proportional to that State's standardised total expense; or equivalently
- government expenses – so the standardised expense for each State would only cover State and Commonwealth expenses.

More desirably, AIHW may be able to dissect its age-sex per capita expenses by funding source, which would enable non-government expenses to be readily excluded.