NSW GOVERNMENT | Treasury

NSW Treasury response to CGC staff discussion paper

Review of substitutability levels for the health category

October 2018

Introduction

This paper responds to the Commonwealth Grants Commission (the Commission) Staff Discussion paper 2015-05-S: *Review of Substitutability Levels for the Health Category* (staff paper).

The Commission considers that the scale of a state or territory's (states) private health sector affects fiscal capacity by impacting the level of state spending required to provide the average standard of health services. This adjustment is a function of the degree of assumed similarity (substitutability) between public and private services.

New South Wales Treasury (we) welcomes the Commission's proposal for a more forensic consideration of the substitutability between public and private services. As outlined in our first submission to the Commission's 2020 Methodology Review (our submission), we believe that existing substitutability assumptions are significantly overstated, particularly for non-admitted patient (NAP) and community health services.

In accordance with the Staff paper, we have provided comment on:

- the overall (proposed) approach to assessing substitutability
- the substitutability level for each component, and
- the indicators to measure non-state service usage.

New South Wales Treasury comments

Overall Approach

We consider that the proposed changes to the Commission's methodology would, overall, improve the robustness of the health assessment.

However, we maintain the fundamental concern raised in our submission that the methodology does not acknowledge complementarity across public and private services.

The Commission's conceptual case posits that if health services are provided by both the state and non-state sectors, then the availability of non-state sector services reduces demand for state services. In other words, demand for health services is fixed and split between state and non-state providers.

This is a critical assumption that we strongly dispute. As stated in our submission, health services are increasingly delivered under a model where the use of GPs can induce demand for specialist state services. This would reduce, rather than increase, fiscal capacity, by raising relative use rates. Our submission highlighted two case studies on diabetes management and eating disorders as clear examples of this.

The Commission has not provided the evidence base to impose the condition that demand is fixed. The Commission could, for example, test its hypothesis by using activity data to estimate the relationship between the use of state and non-state services, while controlling for demographic drivers of demand.

Substitutability level for each component

Commission Staff have proposed the following changes to substitutability.

Service	Existing substitutability	Proposed assumption
Admitted patient	15%	15%
Emergency department	15%	15%
Non-admitted patient	40%	20-25%
Community and other health	70%	60-70%

1 Admitted patient services

We note the staff recommendation to maintain 15 per cent substitutability for admitted patient services.

2 Emergency department (ED) services

The substitutability assumption for ED services should acknowledge the temporal distribution of demand. As noted in our submission, 48 per cent of New South Wales ED triage 4 and 5 visits in 2016-17 occurred between 7pm and 7am and on weekends. The substitutability during these periods is likely to be close to zero, as private services are typically closed and patients are unlikely to delay attendance when there is a perceived emergency. The Commission should ensure that substitutability is confined to 'in-hour' attendance.

The substitutability estimate of 15 per cent reflects the fact that GP-type presentations account for 23 per cent of all ED presentations but cost less per presentation due to lower complexity. This assumes that non-substitutable presentations are around 69 per cent more costly than substitutable ones. The Commission could refine this by estimating the cost differential between triage categories using activity-weighted price weights in IHPA's annual price determinations.[1]

3 Non-admitted patient services

We note the staff recommendation to lower the proposed substitutability assumptions for NAP services to 20-25 per cent.

4 Community health services

We dispute the substitutability estimate for community health services due to a lack of supporting evidence, misalignment with how states fund activity, and potential calculation issues.

Definitional issues

In our submission, we recommended that community health services be assessed together with NAP services. This reflects the fact that states are increasingly funding

[1] See IHPA, 2018, National Efficient Price Determination 2018-19

activity on a location neutral basis, and as such mapping expenditure to activity in community health (a location) is a fraught exercise.

This is consistent with the findings in the 2016 Staff issues paper[2] that there are significant inconsistencies with how states report expenditure at the sub-category level for community health. For example, Table 16 of this paper showed that Queensland's expenditure on 'Community Health Centre Services' in 2014-15 was more than double Victoria's and larger than New South Wales, despite a significantly smaller population.

Our key concern is around the assessment for the 'other community health centre' sub-category, which is a broadly-defined residual category, yet is assumed to have very high substitutability and accounts for 48 of 60-70 per cent of the overall substitutability estimate. The Staff Paper defines this as including:

> *"family and child health, community nursing services, chronic disease management, and a limited range of allied health services."*

This definition suggests that expenditure on this sub-category may include ABF-funded NAP activity that occurs in a community health setting (particularly for NAP 40 series clinics, which are most similar in scope). The Staff Paper has described NAP 40 series clinics as *allied health*, which it estimates to have zero substitutability.

As such, we strongly recommend that the Commission further investigate and clarify the nature of activity included in state spending on this sub-category prior to finalising its position. In support of this, NSW Treasury has sought a more detailed breakdown the activity that mapped to the 2016-17 spend on the GFS category *Community Health Services (excluding Community Mental Health)*.

In the absence of further analysis, the Commission should consider a larger discount to reflect not only uncertainty of socio-demographic composition, but also uncertainty over the substitutability assumption and accounting classifications.

Calculation issues

It is unclear how the weighted average substitutability range of 60-70 per cent is derived from the substitutability of the sub categories (as per Table 7 of the Staff Paper). Using the mid-point of the reported substitutability of the sub-categories, we calculate an expenditure-weighted average of 63 per cent and a range of 54-72 per cent (or 58-68 per cent using a 10-percentage point range). See table below.

[2] CGC Staff Research paper: What States do – Community Health (CGC 2016-13-S).

Group of services	Substitutability range	Exp. share	Expenditure-weighted substitutability (%)			
	%	%	CGC	Low	Mid	High
Community health						
Public dental services	L (21-40)	4.6	≈1	1.0	1.4	1.8
Alcohol/other drug services	M (41-60)	3.9	≈2	1.6	2.0	2.3
Community mental health services	L (21-40)	18.8	≈6	3.9	5.7	7.5
Other community health services	VH (81-100)	53.7	≈48	43.5	48.6	53.7
Public health services						
Cancer screening	M (41-60)	3.1	≈2	1.3	1.6	1.9
Organised immunisation	H (61-80)	4.2	≈3	2.6	3.0	3.4
Health promotion	VL (0-20)	4.9	≈1	0.0	0.5	1.0
Communicable disease control	Nil	3.2	≈0	0.0	0.0	0.0
Environmental health	Nil	1.3	≈0	0.0	0.0	0.0
Other public health services	VL (0-20)	2.3	≈0	0.0	0.2	0.5
Total		**100**	**60-70**	**54**	**63**	**72**

Indicators used to measure non-state service usage

We note that the proposed indicators to measure non-state activity are:

- Admitted patient services: private patient separations.
- Emergency department services: bulk-billed benefits paid for GP services.
- NAP services: bulk billed benefits paid for NAP services.
- Community health services: bulk-billed benefits paid for GP services.

Further information and contacts

For further Information or clarification on issues raised in the discussion paper, please contact:

Intergovernmental Relations, NSW Treasury

Email: ffr@treasury.nsw.gov.au