Review of Substitutability levels for the Health Category

Staff Discussion Paper

Background

The Health Category covers state spending on services provided by public hospitals and community health services. The CGC recognises that a state's health expenditure is influenced by the presence of non-state health services. The CGC attempts to account for this influence in its assessment. The degree to which non-state health services influence demand for state health services is known as the 'substitutability rate'. A lower rate means that there is less overlap between services provided by the state and the non-state sectors, and costs borne by states are a more complete representation of what is required of them. In taking into account the substitutability rate, the CGC acknowledges that individuals from different socio-demographic groups (e.g. by income or location) can access health services differently, and this may vary between jurisdictions.

Challenges with determining the appropriate substitutability level

Determining the substitutability rate is challenging.

States provide a wide array of health services, and the level of substitution can vary significantly between service categories (ie. from treatment to treatment). For example, renal dialysis and chemotherapy are provided by both the state and non-state sectors and the degree of substitutability is high; and emergency treatments tend to be only provided by the state sector and the degree of substitutability is low. The lack of research and data on this issue means the CGC is required to use considerable judgement to determine the substitution rate for service categories. Table 1 lists the current substitutability rates for service categories. These were determined in the 2015 Methodology Review.

Table 1 Health Category non-state sector substitutability rates

Service category	Substitutability rate
Admitted patients	15%
Emergency departments	15%
Non-admitted patients	40%
Community health	70%

The evidence for the substitutability rate for admitted patient services, emergency department services and non-admitted patients is stronger than for community health services. For example, the substitutability rate for admitted patients is based on the proportion elective surgery patients with private health cover. But there is no strong evidence to indicate the level of substitution for community health services.

The CGC considers 70% to be a reasonable estimate. This is based on advice from a consultant hired by the CGC to inform the 2015 Methodology Review, who suggested that a substitutability rate of 75% is reasonable. The CGC acknowledges the lack of evidence and, as a result, it applies a further discount to the effects of non-state sector substitution for community health services.

CGC's proposal

The CGC is reviewing the non-state sector substitutability rates as part of the 2020 Methodology Review.

CGC staff propose to retain both the methodology used in the 2015 Methodology Review and the substitutability rates that currently apply to admitted patient services and emergency department services.

CGC staff reaffirm the methodology for determining the substitutability rate for non-admitted patients that was proposed in a previous staff paper for the 2020 Methodology Review. Using this methodology, staff conclude that the substitutability rates for non-admitted patient services it is likely to be 20-25%. This is significantly lower than current rate of 40%.

CGC staff propose to assess the substitutability rate for community health services by evaluating the range of community health services provided by the state and non-state sectors, and the accessibility and cost of these services. The total proportion of substitutable services will be the sum of the substitutability rate for each community health service weighted by its proportion of total expense. Using this approach, the CGC staff estimate that the substitutability rate for community health services is between 60-70%.

Queensland's position

Queensland agrees with the overall approach to estimating substitutability rates proposed by CGC staff. However, considerable judgement is still used to account for policy and non-policy influences that cannot be reliably measured. The substitutability rate for some service categories may be lower.

The CGC should continue to monitor any research or data on this issue and periodically review and refine the substitutability rates.

The CGC could also consider adopting a disaggregated approach to determining the substitutability rate for categories where it is possible to determine the substitutability rate for the individual treatment components. This approach would suit heterogenous service sectors such as community health services and non-admitted patient services.

Admitted patient services

Queensland agrees with the approach of using the proportion of elective surgery patients with private health cover to inform the upper bound for the substitutability rate for admitted patient services. However, the effects of other policy and non-policy influences on the level of substitution rate is less clear.

Given there is limited data on these influences, the assessment could benefit from analysis using a disaggregated approach to determine if the 15% substitutability rate remains reasonable. Alternatively, a small discount (e.g. 12.5%) should be applied to the effect to account for influences which cannot be reliably measured at present.

Emergency department services

Queensland does not have any major concerns regarding the CGC's approach to measure the substitutability rate of emergency departments.

Queensland agrees with the CGC's comment that GP-type presentations are less costly than more complex and severe ED presentations, and the proportion of expenditure on GP-type presentations estimated by the CGC staff (23%) should be reduced to reflect their lower cost.

However, Queensland is uncertain that a substitutability rate of 15% remains appropriate. This implies non-GP-type emergency presentations cost approximately 69% more than GP-type emergency presentations on average. This figure appears to be low, given most GP-type emergency presentations require very little consultation time and resources. A lower substitutability level may be more appropriate for emergency department services.

Non-admitted patient services

Queensland considers the disaggregated approach to determining the level of substitutability for non-admitted patient to be a reasonable approach. Queensland does not have any concerns with the CGC's methodology or the proposed substitutability rate for non-admitted patient services.

Community health services

Queensland supports the CGC's disaggregated approach to this category including a wide range of health services. However, the approach should also account for the differing availability of the services regions. In Queensland, community health services are more widely utilised in regional and remote areas where non-state health services are less prevalent or non-existent.

The proposed substitutability rate for many of the community health services appear to be appropriate for capital cities and inner regional areas, but may be too high in regional and remote areas. Queensland suggests the overall substitutability rates for community health services be lowered to reflect regional differences.