Commonwealth Grants Commission 2020 Methodology Review

Tasmanian Government Submission in response to Staff Discussion Paper (CGC) 2018-05-S -

Review of Substitutability Levels for the Health Category

12 October 2018

CONTENTS

Introduction 1

Admitted Patient Services 2

Emergency Department Services 5

Non-admitted Patient Services 7

Community Health Services 9

Introduction

Tasmania welcomes the opportunity to comment on the Commonwealth Grants Commission 2020 Methodology Review Staff Discussion Paper (CGC 2018-05-S) on substitutability levels for the health category.

The substitutability of public health service providers for non-State (private) service providers is more limited in Tasmania compared to the rest of Australia due to its small dispersed population size, whereby only 40 per cent of the population lives in the Greater Hobart area. The substitutability rates between State and non-State health services are low because Tasmania lacks the population size to support a full range of complex services in both sectors. In Tasmania, the private sector is small and provides a narrower range of economically viable services compared to public hospitals.

These low substitutability rates are primarily due to the diseconomies of scale resulting from a small and dispersed population rather than operational limitations from Tasmanian hospital accreditation conditions, national safety and quality health standards or medical college professional standards. Diseconomies of scale see only one major public tertiary referral hospital (Royal Hobart Hospital) able to provide a full range of services, with the exception of some highly specialised health services which are not delivered in Tasmania and require patients to be transferred interstate.

In Tasmania's North and Northwest there are no emergency department or critical care services provided in the private sector. For example, interventional cardiology and obstetric (birthing) services are only performed at the northern public hospital (Launceston General Hospital) and not in the private sector. In the Northwest public obstetric (birthing) services are provided under contract at the Northwest Private Hospital. These examples underscore the narrower scope of private hospital service provision and the reduced alternatives available for privately insured patients in Tasmania and hence the low levels of substitutability.

The substitutability rate and proposed non-State activity indicators for Tasmanian admitted patient services, emergency department services, non-admitted services and community health services are considered separately and the appropriateness of the component assessment is discussed below.

Admitted Patient Services

Level of substitutability

It is noted that the Commission's general approach is to identify non-State services which influence State's decisions about the level of service provision which is affected by the availability of non-State services. Tasmania agrees with Commission staff that there is a strong conceptual case that some admitted patient services provided in the non-State sector influence the number of similar services that need to be provided in the State sector. However, as discussed in the introduction, in Tasmania's case there is very limited capacity for the non-State sector to provide admitted patient services because of diseconomies of scale and the narrower range of services offered.

The substitutability of services is also effected by sporadic and sustained closures by private hospitals such as the Hobart Private Hospital and Calvary Hospital in Hobart where there has been the closure of medical wards and emergency departments placed on bypass.

For this reason, Tasmania supports, in principle, the Commission staff proposal that the substitutability rate should be no higher than 15 per cent.

Indicator to measure non-State activity

At the recent State visit to Tasmania in September 2018, the Tasmanian Department of Health raised with the Commission and its staff, that the lack of private hospitals in some locations, and the lack of private hospital capacity to undertake some complex admissions, has a significant impact on the provision of public hospital services as this may be the only available alternative for private patients seeking these services. For this reason, Tasmania has reservations about the Commission's measurement of non-State service provision of admitted patient services using data sources that reflect privately insured patients in both public and private hospitals as some public patients who are privately insured are treated as public hospital patients as there are no private hospital alternatives (as detailed in Staff Discussion Paper - Attachment A).

Tasmania notes that jurisdictional comparisons between average public cost weights and average private cost weights, as shown in Table 1 below, are one means of highlighting the differences between State and non-State admitted patient activity. Average cost weights of hospital separations are a proxy measure for the complexity of the case-mix treated by hospitals. A comparison between Tasmanian average public cost weights and the total national average private cost weights shows that complex and more costly admitted patient service are disproportionately provided by the State. This highlights that the cause and cost of privately insured patients data in public hospitals is more complex than that the Commission's approach captures.

Table 1 - Average cost weights, public and private hospitals, by jurisdiction 2013-14 and 2016-17[1]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
Average public cost weight of separations									
2016-17	1.02	0.95	0.95	0.94	1.03	1.07	1.00	0.60	0.97
2013-14	1.05	1.01	1.02	0.96	1.07	1.06	1.04	0.66	1.02
Average private cost weight of separations									
2016-17	0.88	0.84	0.80	0.73	0.85	n.p.	n.p.	n.p.	0.83
2013-14	0.86	0.81	0.79	0.72	0.82	n.p.	n.p.	n.p.	0.81

An issue for Tasmania is that the Tasmanian Government is not fully compensated by private health insurers for private patients in public hospitals. This is because Private health insurers, Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) for private patients are billed by the State according to their scheduled rate as public hospitals which is under a different schedule at a lower rate compared to private hospitals.

Tasmania therefore has reservations about the non-State sector adjustment proposed by Commission staff, in that it assumes privately insured patients using public hospitals have no impact on Tasmanian Government funding or State activity levels of the approximately 124 000 total separations per annum. Of the patients who elect to use private health insurance in Tasmanian public hospitals they account for approximately 22 000 separations and incur costs to the State Government that equates to around one eighth of the total Tasmanian Government funding contribution for all admitted patients (Table 2).

This is not a policy choice of the Tasmanian Government to fund these private patients. Rather it is because these patients cannot access services in the non-State sector and therefore have few alternatives other than to use the State sector.

[1] AIHW (2018) Admitted Patient Care 2016-17: Australian Hospital Statistics (Table 7.2) https://www.aihw.gov.au/reports/hospitals/ahs-2016-17-admitted-patient-care ; AIHW (2015) Admitted Patient Care 2013-14: Australian Hospital Statistics (Table 7.2) https://www.aihw.gov.au/reports/hospitals/ahs-2013-14-admitted-patient-care . n.p. – not published.

Table 2 - Relative scale of private admitted patient services in Tasmanian public hospitals, 2016-17

Tasmanian Government Expenditure	$'000	Separations
Patients using private health insurance	40 379	21 198
All patients	338 949	124 429
Patients using private health insurance as a proportion of all patients	12%	17%

As shown in Table 2, private patients in public hospitals cost the Tasmanian Government approximately $40 million for non-compensable expenses in 2016-17.

From a funding perspective, the best estimate of substitutability for privately funded patients in Tasmanian public hospitals would be that two-thirds of patients be considered public patients and one-third be considered private patients (as shown in Table 3 below).

Table 3 - Funding sources for private admitted patient services in Tasmanian public hospitals, 2016-17[2]

Funding Sources	$'000	Per cent
Tasmanian Government funding	40 379	37
Private funding sources	36 817	33
Australian Government funding	33 037	30
Total cost	110 233	100

Tasmania supports the Commission staff approach of measuring non-State activity for admitted patients with the qualifications noted above. The use of private admitted patient services by privately insured patients' non-State data sourced from the Australian Institute of Health and Welfare (AIHW) and the Australian Prudential Regulation Authority (APRA) to measure non-State sector service provision for admitted patient services is considered fit for the intended purpose.

Tasmania will review Commission staff estimates of the non-State sector adjustment for admitted patients once it becomes available to the States.

[2] Tasmanian Department of Health calculations.

Government funding is calculated using the Independent Hospital Pricing Authority's (IHPA) National Weighted Activity Unit (NWAU). This is split into Tasmanian and Australian government components using the historic share applicable to Tasmania (55:45).

Total cost is calculated using the NWAU without IHPA's revenue adjustments.

Private funding sources are equal to IHPA's revenue adjustments for privately insured patients, which covers funding from private health insurers, MBS, PBS and self-funding by patients. Note, the Australian Prudential Regulation Authority (APRA) reports total Tasmanian private health insurance benefits paid to public hospitals of $21.7 million in 2016-17 for overnight, same day and nursing home type admitted patients. This is consistent with total private funding sources of $36.8 million in Table 3 above.

Emergency Department Services

Level of substitutability

States are obliged under agreements with the Australian Government to provide an emergency service to all presenting patients. On presentation, patients are triaged to prioritise their clinical needs, with triage category 1 being the highest priority through to triage category 5 being the lowest priority. In Tasmania, approximately 38 per cent of all emergency department presentations are triage category 4 and 5. These patients require services that are similar in nature to services that can be provided by General Practitioners (GP-type services).[3] The reason for this high presentation rate for triage category 4 and 5 patients, for people who would be better treated elsewhere, is that there are fewer alternative services available in Tasmania.

In the 2015 Methodology Review, the Commission examined a range of studies to determine the proportion of GP-type presentations, which included the AIHW approach that used patients allocated triage category 4 and 5 as a proportion of total ED patients.

Commission staff again highlight a range of studies to estimate the proportion of GP-type presentations at the emergency department that could be substitutable with GP services. However, the availability of GP services and therefore the potential rates of substitutability between States vary, as shown in Table 4.

Commission staff considers that there is a strong conceptual case that the availability of bulk billed GP services also influences the level of emergency department presentations. Tasmania's bulk billing rate for non-referred GP attendance (excluding Practice nurses) at 76.4 per cent compared to 86.1 per cent nationally, further explain why there is a high rate of GP-type emergency presentations in Tasmania.[4]

[3] Productivity Commission (2018) Report on Government Services, (Table 10A.31 Selected potentially avoidable GP-type presentations to emergency departments).

AIHW(2018) Emergency Department Care 2016-17: Australian Hospital Statistics, (Table 4.1: Emergency Department presentations) https://www.aihw.gov.au/reports/hospitals/ahs-2016-17-emergency-department-care/data

[4] Australian Department of Health (2018) Annual Medicare Statistics – Financial Year 1984-85 to 2017-18 http://health.gov.au/internet/main/publishing.nsf/Content/34A89144DB4185EDCA257BF0001AFE29/$File/MBS%20Statistics%20Financial%20Year%202017-18.xlsx

Table 4 - Number of GPs (full-time equivalent) per 100 000 people[5]

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
2016-17	109.6	107.2	114.1	92.1	109.7	98.3	80.7	86.5	107.0

The rate of non-State substitutability in Tasmania is also limited because there are no emergency department services provided in the private sector in the North and Northwest. Where services are provided they are generally between 9.00 am and 5.00 pm and tend to only treat patients with a lower complexity, with higher complexity patients referred to public hospitals.

Tasmania notes that the potential rate of substitutability for emergency department services varies between States, and in Tasmania it is likely to be at the lower level compared to the national average. However, Tasmania supports in principle the Commission staff proposal that the current substitutability rate of 15 per cent be retained for this assessment.

Indicator to measure non-State activity

Tasmania supports the Commission staff approach to measuring non-State activity for emergency departments with the qualifications noted above. The use of benefits paid for bulk billed GPs to measure non-State sector service provision for emergency presentations is fit for the intended purpose.

Tasmania will review the non-State sector adjustment for emergency department patients once it becomes available.

[5] Productivity Commission (2018) Report on Government Services, (Table 10A.19 Availability of GPs by region).

Non-admitted Patient Services

Level of substitutability

The Commission staff approach to estimate the substitutability for each type of clinic (procedure clinics, medical consultation clinics, and diagnostic clinics) in which non-admitted patients services are provided is welcome as there are different service delivery models and scope to provide these services in both the State and non-State sector. Based on this approach, the overall substitutability rate has been reduced from the current 40 per cent to 20 to 25 per cent.

Tasmania agrees that estimating the level of substitutability for each type of clinic using bulk billing data is appropriate, and the data is fit for this purpose.

However, while Tasmania agrees with the proposed substitutability rate that has been applied to three of the service groups is appropriate and acceptable, it does not agree with the substitutability rate applied to the fourth group (allied health clinics).

Tasmania has concerns with the approach taken for estimating the substitutability rate for allied health services. Commission staff have identified that many non-admitted patient service are directly linked to admitted patient services provided in hospitals and that most State provided allied health services tend to be linked to earlier admitted patient episodes and therefore allied health services are not substitutable. However, if 15 per cent of admitted patients are considered substitutable then it is argued that allied health services that flow from those admitted services are also substitutable. Therefore the estimated substitutability level for allied health clinics should be the same as for admitted patients at 15 per cent rather than zero as presented in Table 5 of the Staff Discussion Paper.

Substitutability is limited between the State and non-State sector because patient eligibility for allied health services is capped under the MBS and is limited to chronic disease or mental health plans. The service cap for eligible patients is five visits for chronic diseases, and ten visits for those with a mental health plan. Additional conditions are placed on people wishing to use allied health services as part of their chronic disease plans, whereby the five visits can only use the following eligible allied health professions:

- Aboriginal Health Workers or Aboriginal and Torres Strait Islander Health Practitioners;
- Audiologists;
- Chiropractors;
- Diabetes Educators;
- Dietitians;
- Exercise Physiologists;
- Mental Health Workers (includes Aboriginal health workers or Aboriginal and Torres Strait Islander Health Practitioners, mental health nurses, occupational therapists, psychologists and some social workers);
- Occupational Therapists;
- Osteopaths; Physiotherapists;
- Podiatrists; Psychologists; and
- Speech Pathologists.

It should also be noted that not all allied health professions are eligible to be providers under the MBS, one example being orthotics and prosthetics.

Applying the 15 per cent substitutability rate for admitted patient services to allied health services would alter the expenditure weighted substitutability level. It is therefore proposed that the overall level of substitutability should be between 25 and 30 per cent.

Indicator to measure non-State activity

Tasmania supports the Commission staff approach of measuring non-State activity for non-admitted patients with the qualifications noted above. The use of the value of bulk billed specialist, pathology and imaging benefits paid to measure non-State sector service provision for non-admitted patient services is fit for the intended purpose.

Tasmania will review Commission staff estimates of the non-State sector adjustment for admitted patients once it becomes available to the States.

Community Health Services

Level of substitutability

Tasmania supports with qualification the Commission staff proposal to determine rates of substitutability for each service area within the community health services component of the health assessment. The Commission has identified that there is a range of substitutability (low, medium, high, very high) for each community health service area shown in Table 6 of the staff discussion paper.

The Tasmanian Government articulated to the Commission and staff visiting Tasmania in September 2018 that the State would, at best, have medium substitutability rates because of low levels of non-State service provision for community health services due to dis-economies of scale and a low population share for many allied health professions providing these services. For example, the low number of GPs per 100 000 people in Tasmania compared to the national average is noted above in the section on Emergency Department services.

Tasmania considers that the Commission's analysis of substitutability for community health services over-States the estimated range of substitutability for Tasmania with the non-State sector because there are few alternative providers. For example, other community health centre services are described as having a very high substitutability level (81-100 per cent). However, this is not the case in Tasmania. For example, the Child Health and Parenting Service is delivered by the State, as there is not an alternative option in the non-State sector, and services provided through GPs are not comparable.

In the absence of specific data to compare the appropriateness of the Commission's current approach, Tasmania supports the rate of 70 per cent substitutability for the community health services assessment and will review the results when they become available.

Indicator to measure non-State activity

Tasmania considers that the current non-State activity indicator (bulk billed benefits paid for GP services) potentially overstates the level of community health services provided by GPs as there are other community service providers that are not captured such as allied health professionals.

However, Tasmania accepts that using available MBS data for bulk billed benefits is fit for purpose in the absence of State-provided community health services data.

Tasmania agrees that the socio-demographic profile of people using these services are highly likely to be different to those using non-State provided services due to age and income. Given the lack of State-provided community health services data to assess these difference in socio-demographic composition, Tasmania supports the continued use of a 25 per cent discount as a placeholder while Commission staff investigate whether some other, more appropriate, discount should apply.