COMMONWEALTH GRANTS COMMISSION 2020 METHODOLOGY REVIEW

Northern Territory Response to
CGC Staff Discussion Paper CGC 2018-05-S – Review of Substitutability Levels for the Health Category

October 2018

Substitutability Levels

The Northern Territory:

- Supports retention of current substitutability levels (15 per cent) for admitted patient and emergency department (ED) services.
- Suggests the basis for evaluating substitutability levels for non-admitted patient (NAP) services should be linkage with an admitted patient episode.
- Supports retention of the current substitutability level (70 per cent) for community health services.
- Reiterates its position that it is the absence of sufficient non-state sector services rather than the absence of sufficient bulk billed services that drives the need for state sector provision of community health services.
- Argues that services provided by salaried doctors under the COAG s19(2) Exemptions Initiative should be excluded from the measures of non-state sector activity for ED and community health services to ensure policy neutrality and to recognise that the subsidised nature of these services means they are not equivalent to private sector providers.

1.1 The impact that the non-state sector has on the demand for state and territory (state) government services is referred to as the substitutability of services. To account for differences in substitutability between jurisdictions, a non-state sector adjustment is made in the admitted patient, NAP, ED and community health service components of the Health category.

1.2 The non-state sector adjustments involve four steps:

i. Determine total state spending on services that are also provided by the non-state sector (substitutable services);

ii. Calculate the level of non-state sector services each jurisdiction would need based on the national profile of privately provided services (assessed levels of services), which is stratified by Indigenous status, remoteness, socioeconomic status (SES) and age (sociodemographic (SDC) groups). This means the calculation accounts for the decrease in access to private health providers with increasing remoteness and avoids double counting of SDC disabilities (by comparing levels of private sector provision across similar SDC groups).

iii. Obtain the actual level of privately provided services in each jurisdiction.

iv. Subtract actual levels from assessed levels of expenditure to determine the assessed impact of the private sector for each jurisdiction. A negative (positive) value indicates a higher (lower) than average impact and is deducted from (added to) a state's assessed fiscal needs.[1]

1.3 Commission staff have reviewed substitutability levels (used in the first step of the adjustment) with *Staff Discussion Paper CGC 2018-05-S* describing the approach used in the review and presenting preliminary findings. This submission provides the Northern Territory's views on the approach, proposed levels of substitutability and current measures of non-state sector activity.

Review Approach

1.4 In general, the Northern Territory is satisfied with the approach taken by Commission staff to reviewing the levels of substitutability. Levels for each component of the Health category were individually reviewed with the process informed by work from the 2015 Review, which considered this matter in greater detail. The review was limited to desktop analysis (no independent advice was sought as occurred in the 2015 Review); however, the Northern Territory considers this is sufficient for the task.

Proposed Levels of Substitutability

Admitted Patient Services

1.5 The staff discussion paper advises that there has been little change in the proportion of Australians with private insurance coverage (47 per cent) and the proportion of public admitted patient separations (60 per cent) of a non-emergency nature since the 2015 Review. Accordingly, the upper bound estimate of the level of substitutability – 28 per cent[2] – remains the same.

1.6 The Commission adopted a final substitutability level of 15 per cent in the 2015 Review due to the potential for policy and non-policy influences. The staff discussion paper proposes to retain the level of substitutability for the admitted patient services adjustment at 15 per cent for the 2020 Review.

1.7 The potential for policy and non-policy influence remains and the Northern Territory supports retention of the current level of substitutability (15 per cent).

ED Services

1.8 As with admitted patients, no change is proposed to the level of substitutability for ED services (15 per cent). Table 3 of the staff discussion paper shows that, based on the Australasian College for Emergency Medicine (ACEM) method, the

[1] Attachment A of the staff discussion paper examples the calculations.
[2] 60% x 47% = 28%.

proportion of GP type ED presentations increases with remoteness and that the average across regions is 23 per cent, but as GP-type presentations are less costly the paper suggests a lower level of substitutability would be more appropriate.

1.9 The estimate of 23 per cent is based on an average across remoteness areas. To some degree, the differences between regions in GP-type presentations will reflect the decrease in access to private health providers with increasing remoteness, which is captured in the SDC disability. The proportion of GP type ED presentations in major cities reflects the level of substitutability where access to private providers is generally greatest and what might be reasonable to expect in any location if a shortfall in private provision did not exist (and health needs were equivalent to those in major cities).

1.10 At 18 per cent, the proportion of GP-type presentations in major cities is similar to the current estimate of 15 per cent. Given this, and that GP-type services are less costly, it appears reasonable to leave the level of substitutability for ED services unchanged.

NAP Services

1.11 Commission staff applied the approach used in the 2015 Review of disaggregating NAP services into broad groups and determining a relevant Medicare service indicator for each group. Commission staff chose four NAP service groups: allied health clinics, diagnostic clinics, procedure clinics and medical consultation clinics.

1.12 The Northern Territory considers diagnostic clinics, which only comprise 1 per cent of expenditure, could be omitted or grouped with medical consultation clinics to simplify the analysis. Other groups appear reasonable.

1.13 Allied health services comprise 31 per cent of expenditure, but are considered to have little substitutability with most services linked to an admitted patient episode and only a limited number of patients being eligible for services subsidised under the Medicare Benefits Schedule (MBS). Remaining services (procedure clinics and medical consultations) are provided by private providers and subsidised under MBS; however, rather than assuming full substitutability, Commission staff base the level of substitutability on the proportion of private sector services that are bulk billed.

1.14 The focus on bulk billing brings in the overlay of income constraints. The Northern Territory questions whether income should be considered in determining the level of substitutability (and in the measures of non-state service use). It is concerned that this is potentially double counting with the SDC disability. It may also be distorting the assessment, an issue which is discussed further in the section below on measures of non-state service usage.

1.15 The Northern Territory considers the approach taken for allied health may better measure substitutability for all NAP services. That is, substitutability will be lower where there is a linkage to an inpatient episode. The Northern Territory suggests Commission staff investigate whether there is data available to determine the proportion of services in procedure and medical consultation clinics that are not linked to an inpatient episode and to use that as the estimate of substitutability.

Community Health Services

1.16 The staff discussion paper notes that the heterogeneous nature of community health services means that it is challenging to determine to what extent non-state sector service provision influences the level of services provided by the state sector. To address this issue, Commission staff identified ten major areas of service provision and derived an expenditure weighted substitutability level (similar to the approach used for NAP services). This resulted in a potentially lower estimate of substitutability – 60 to 70 per cent compared with 70 per cent currently.

1.17 The Northern Territory supports the more detailed analysis, but notes that substitutability levels have been determined with reference to bulk billed services for most service types. If full substitutability (100 per cent) is assumed for services that Commission staff identify as having medium to very high substitutability, the estimate of expenditure weighted substitutability rises to about 75 per cent. This is likely to reflect an upper bound estimate, suggesting that the current substitutability level of 70 per cent is reasonable and need not be changed.

1.18 The Northern Territory notes Commission staff will continue to investigate whether a discount (currently 25 per cent) should be applied to the non-state sector adjustment for community health. The discount is due to uncertainty about how well the SDC profile for state-provided services matches the profile for GP services.

Measures of Non-state Service Usage

1.19 The Northern Territory's response[3] to the *Staff Draft Assessment Paper CGC 2018-01/12-S – Health* raises issues regarding the choice of measures for non-state service usage. The following paragraphs reiterate and expand on some of the issues raised in that response.

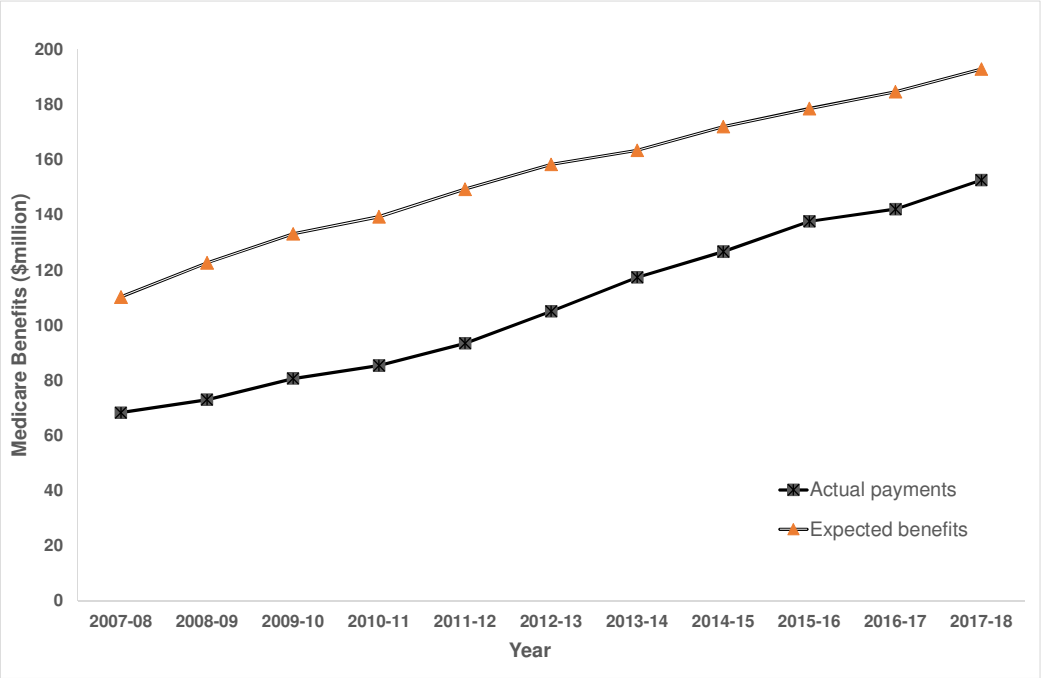
1.20 Northern Territory residents access MBS services at significantly lower levels than average.[4] As shown in Figure 1.1, if Territorians received the same age-

[3] In *Northern Territory Second Submission to the Commonwealth Grants Commission – 2020 Methodology Review August 2018*

[4] The Health Gains Planning unit of the Northern Territory Department of Health has published a number of reports on this issue. These are available at https://health.nt.gov.au/professionals/health-gains (under Health Economics publications).

standardised benefits as nationally, an additional $42.6 million in MBS expenditure would have flowed to the Northern Territory in 2016-17. This funding gap has persisted over time and there has been little narrowing despite the introduction of Commonwealth initiatives to increase access to MBS services such as bulk billing incentives, better arrangements for preventing and managing chronic disease, Indigenous specific MBS items and the Council of Australian Governments (COAG) s19(2) Exemptions Initiative.

Figure 1.1 – MBS Benefits – Actual Payments and Age-standardised Expected Benefits, Northern Territory, 2007-08 to 2017-18



Source: Northern Territory Department of Treasury and Finance (DTF) calculation based on Medicare statistics[5] and Australian Bureau of Statistics (ABS) catalogue no. 3101.0.

1.21 Other indicators also show that access to private sector health providers is relatively low in the Northern Territory, particularly relative to needs.[6] Furthermore, among Australians, Northern Territorians have the lowest life expectancy at birth (Table 1.1), reflecting poor health outcomes in the Indigenous and remote populations. Given this, it would be expected that the Northern Territory would require much greater access to MBS and other health funding (e.g., Indigenous and Remote Health Division (IRHD) grants) to achieve average health outcomes. Consequently, increased access to MBS does not reduce the need for, or replace, Northern Territory Government funding for health services.

[5] Statistics online at http://medicarestatistics.humanservices.gov.au/statistics/mbs_group.jsp.
[6] For further discussion of this issue see the Health chapter in *Northern Territory Second Submission to the Commonwealth Grants Commission – 2020 Methodology Review August 2018*

1.22 It is, therefore, concerning that the Commission's non-state sector adjustments assess the Northern Territory as having above average access to private sector services and as a result, its assessed fiscal needs are reduced. This is the case for all components of the Health category except NAP services where, in recent years, assessed and actual expenses in the non-state sector adjustment are similar.

1.23 Table 1.1 shows that the non-state sector adjustments jointly reduced the Northern Territory's assessed fiscal needs for health services for 2016-17 by $7.3 million or $30 per capita. This is compounded by a reduction from the IRHD adjustment, which reduced the Northern Territory's assessed needs for 2016-17 by a further $41.0 million or $167 per capita.

Table 1.1 – Impact of Non-State Sector Adjustment (2016-17) and Health Outcomes by Jurisdiction

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Non-state sector adjustment[a]								
2016-17 ($ million)	-184.8	121.4	-214.0	160.9	30.0	11.5	82.3	-7.3
2016-17 per capita ($)	-24	19	-44	63	17	22	202	-30
Life expectancy at birth, 2014-16 (years)								
Females	84.6	84.7	84.5	84.8	84.5	82.9	85.2	78.7
Males	80.4	81.2	80.1	80.3	80.4	78.8	81.3	75.6

[a]Excludes IRHD adjustment

Sources: CGC 2018 Update; ABS 3302.0.55.001

1.24 In contrast, the jurisdiction with the highest life expectancy in Australia, the Australian Capital Territory (ACT), is assessed as having below average access to private sector services. Its assessed fiscal needs in 2016-17 were increased by $82.3 million or $202 per capita. This was somewhat offset by a reduction from the IHRD adjustment of $8.3 million or $20 per capita.

1.25 The Northern Territory notes that actual MBS payments for the ACT are lower than its age-standardised expected benefit, but the per capita gap in 2016-17 was $134 per capita compared with $174 per capita for the Northern Territory.[7] Given this, it might be expected that the non-state sector adjustment would increase the ACT's fiscal needs to some degree, but the result for the Northern Territory is counter intuitive, particularly given the much poorer health of its population.

1.26 The Northern Territory is concerned that this perverse result may be driven by the Commission's focus on bulk billed services and that its methods do not account for differences in unmet need between jurisdictions.

1.27 The focus on bulk billing assumes that fee charging private providers have no influence or impact on the level of state provided services. The Northern Territory

[7] DTF calculation based on MBS statistics and ABS 3101.0.

questions whether this is the case, contending that state governments consider overall availability of GPs and other service providers when determining the nature and extent of community service provision (i.e., it is the absence of sufficient non-state sector services rather than the absence of sufficient bulk billed services that drives the need for state sector provision of community health services).

1.28 State government service provision does not hinge on levels of bulk billing. States expect the Commonwealth to address issues about levels of bulk billing rather than responding with an increase in access to their own services when bulk billing rates decrease. Furthermore, despite an upward trend in bulk billing rates since 2004[8], there has not been a downward trend in community health expenditure data[9] over the same period, suggesting that decisions about service provision are influenced by other issues.

1.29 Table 1.2 shows that the focus on MBS bulk billing will be to the detriment of a jurisdiction such as the Northern Territory where a high proportion of the population is low SES, Indigenous and living in remote areas as bulk billing rates for these groups are highest. This reflects the legacy of Commonwealth initiatives to ensure that disadvantaged and vulnerable groups (e.g., concession cardholders, children and the elderly) have greatest access to bulk billed services and recent efforts to increase access to MBS revenue in remote areas and to Indigenous populations.

Table 1.2 – SDC Usage of MBS, Non-State Sector Adjustment, Community Health Component, 2016-17, and Population Profile, ACT and NT

	Bulk Billed MBS $ per capita	Proportion of Population (%)		
		ACT	NT	Aust
Low SES, Non-remote	331	2	4	18
Middle SES, Non-remote	271	44	42	59
High SES, Non-remote	208	54	13	20
Remote Indigenous	266	0	24	1
Remote Non-Indigenous	189	0	17	1
Total	268	100	100	100

Sources: CGC 2018 Update

1.30 The Northern Territory believes the SDC usage profile in Table 1.2 is measuring relative access to bulk billing services within the population, rather than measuring the relative impact of the private sector. While the Commission seeks

[8] The Conversation. *FactCheck: are bulk-billing rates falling or at record levels?* Online article on 9 February 2017 accessed on 4 October 2018 at https://theconversation.com/factcheck-are-bulk-billing-rates-falling-or-at-record-levels-72278.

[9] AIHW. Various *Health Expenditure Australia* reports, community health and other expenditure, current prices accessed on 4 October 2018 at https://www.aihw.gov.au/ and converted to 2016-17 prices using ABS Consumer Price Index for Health (catalogue no. 6401.0).

to ensure that the non-state sector adjustments do not double count with the SDC assessment, considering the bulk billing profile and the result for the ACT, it appears that the adjustments could be unwinding the effect of the SDC assessment.

1.31 A further matter of particular concern to the Northern Territory is inclusion of MBS benefits claimed by salaried doctors in state services and Aboriginal medical services (AMS) under the COAG s19(2) Exemptions Initiative. These benefits are captured in the non-state sector measures for ED and community health services. This has a substantial impact on the result for the Northern Territory. Of the $56.5 million in actual MBS benefits for 2016-17 for the Northern Territory, $8.5 million (15 per cent) is estimated to be due to claiming by salaried health doctors employed by the Northern Territory Department of Health (NT DoH)[10] and a further $13 million (23 per cent) is due to claiming by AMS[11].

1.32 Services provided by NT DoH and AMS are subsidised by the Northern Territory Government. This means the MBS benefits received by these providers do not fund the equivalent level of services as the same benefits received by a private sector provider. Or put another way, for the same service, for example, a GP consultation, the MBS benefit reflects the expense of a private sector provider (states provide no support for these services). However, for the same consultation by a salaried doctor, the MBS benefit is only covering part of the expense.

1.33 The non-state sector adjustments treat these expenses the same. No allowance is made in the Commission's assessment for state subsidisation of services provided under the COAG s19(2) Exemptions Initiative. Furthermore, not all states have chosen to utilise the Initiative, which disadvantages participating states. It means their actual MBS expenses (i.e., step three in paragraph 1.2) are much higher than non-participating states.

1.34 The staff discussion paper confirms that services provided under the COAG s19(2) Exemptions Initiative are included in Medicare bulk billing data, but notes that separating them out may not be practical. The Northern Territory urges Commission staff to further investigate this matter as the inclusion of these services will have a substantial impact on the outcomes of the non-state sector adjustment for participating states, like the Northern Territory. Differences between states in the uptake of the Initiative also has implications for the policy neutrality of the adjustment.

1.35 Finally, access to MBS revenue has not reduced the Northern Territory Government's funding obligations to AMS nor has there been a reduction in its fiscal needs for hospital and community health services. This is due to substantial

[10] Data provided by NT DoH.
[11] DTF Estimate based on examination of annual reports for key AMS in the Northern Territory.

unmet need within the population. By reducing the Northern Territory's assessed fiscal needs for health services, the non-state sector adjustments erode the Northern Territory Government's ability to close the gap in health outcomes, particularly for its Indigenous population.