

Chapter 8 – Future Funding Strategies

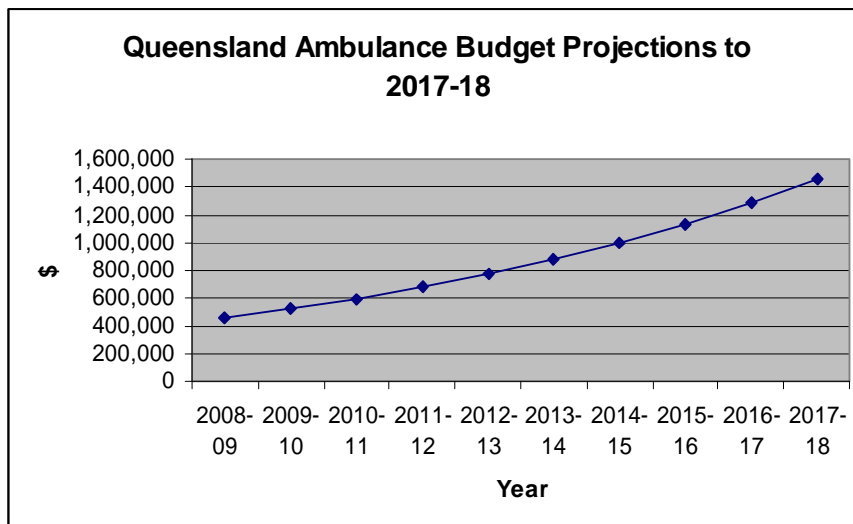
Future Funding Requirements

This section of the report deals with the future funding needs of the Queensland Ambulance Service. These have been assessed with reference to the level of projected demand for ambulance services as well as potential service delivery and efficiency improvements that have been identified by the Audit.

Projections of Future Requirements

As outlined in previous sections, the ambulance budget has grown by an average of 10% per annum for the last several years rising to around 14% per annum over the last couple of years. Projecting expenditure based on the last two year's budget growth results in the QAS budget almost tripling to more than \$1.4 billion in the next ten years as shown in the graph below.

Figure 8.1: QAS Budget Projections



Source: Queensland Treasury

As noted in previous sections of the report, the Community Ambulance Cover levy is providing a decreasing share of the overall ambulance budget as growth in the CAC levy fails to keep pace with increasing demand for services. Instead, the QAS is becoming increasingly reliant on government funding to meet its future funding needs. As a result, the QAS seeks enhancements to its budget as part of the annual budget process. To an extent, this limits its ability to forward plan to meet future service delivery requirements as budgets are adjusted each year and there is no longer term funding certainty.

Alternative Approaches

There are two main alternative approaches to calculating the level of growth funding to be provided to the ambulance service each year. The first approach can be referred to as a needs based funding approach. This approach involves assessing the perceived “need” of the community for ambulance services and developing a growth factor which reflects that need. For example, measuring growth in the population and the impact of changing structures such as the mix of young and old people can provide a broad indication of changes in the need for ambulance services. This is the general approach adopted by the Commonwealth for funding public hospital services.

The other main approach is to fund organisations based on the number of services they provide, the so-called output based funding approach. Under this approach, a service delivery agency's budget varies each year in line with changes in the number of services provided, with increased funding for additional services and reduced funding if service delivery levels fall. This approach has the advantage of providing a close linker between actual service delivery and the level of funding but has an in-built incentive for the organisation to simply produce more services to attract more funding regardless of community need.

The Queensland Ambulance Service had previously undertaken work on a funding methodology for ambulance consistent with an output based funding approach. This work centred on the concept of an economic unit of supply which comprised a mix of inputs including ambulance paramedics, communications staff, administrative support, vehicles and equipment rolled into one package. This concept is discussed in more detail later in this section.

In the Audit's view, it is preferable to fund the ambulance service on a basis which reflects the community's need for services rather than on the basis of the number of services supplied by the agency. This removes any incentive for the ambulance to over-service while at the same time recognising the need to provide adequate funding linked to the community's need for services.

Currently, the QAS has the following level of growth factored into its forward estimates.

Table 8.1: QAS Forward Estimates

Forward Estimates	Year				Growth
	2007-08	2008-09	2009-10	2010-11	
	(\$'000)	(\$'000)	(\$'000)	(\$'000)	
Total Revenue	409,676	426,448	436,782	450,563	10.0%
Total Expenses	404,561	420,684	430,970	445,401	10.1%
Operating result	5,115	5,764	5,812	5,162	

Source: Queensland Treasury

This provides for an increase of around 3.5% per annum or 10% over the next four years well short of the past level of growth in revenues and expenditure. As noted previously, the QAS has tended to underestimate its own source revenue particularly from user charges and grants.

In the Audit's view, it would be reasonable to apply a health type growth factor to funding for ambulance services as a means of providing greater funding certainty and a formula which provides incentives for the QAS to operate efficiently and effectively.

Queensland Health currently receives growth funding based on population growth adjusted for age and sex plus a utilisation factor which recognises people's increasing usage of hospital services. While this factor allows for increased demand for services, it does not take into account the increasing costs of providing ambulance services. The Audit considers that ambulance should receive a growth factor which accounts for increasing costs associated with wage rises and growth in supplies and services costs as well as demand growth costs. This would provide greater certainty and predictability and in particular allow the QAS to plan on a longer term basis for the training and recruitment of additional staff.

Currently, the government's enterprise bargaining framework allows for 4% per annum wage increases. This factor can be applied to the salaries and wages component of the

ambulance budget such that QAS then has the direct incentive to manage EB negotiations in the best interests of the organisation and its staff.

With respect to the supplies and services budget, this has experienced significant growth suggesting costs are in excess of general CPI movements. Given that ambulance is required to purchase medical equipment, drugs and other patient consumables as an essential part of service delivery, applying a health type CPI measure to this component of the budget would be a reasonable approach.

This would result in a composite cost and volume based index being applied to the relevant overall budget as follows:

Cost Factors

- Wages cost factor to wages expenditure (estimated 71% of total budget) plus
- Health CPI factor to supplies and services (estimated 20% of the budget)

Plus

Demand Factor

- Population growth and ageing factor to total budget excluding depreciation, loss on sale of assets (estimated 92% of total budget) plus
- Health usage factor to total budget excluding depreciation, loss on sale of assets (estimated 92% of total budget)

This would give an overall budget growth indexation factor of around 7.5% per annum which is reasonable given the level of population growth and other cost factors faced by the ambulance service.

How Should Funding Be Applied?

This type of funding approach presumes that the QAS is best placed to decide on where resources are allocated to meet service demands. This contrasts with the traditional input based budget approach where governments provide funding for a specified number of inputs such as ambulance officers and vehicles and the agency has limited flexibility to alter the mix of inputs to achieve service delivery outcomes.

The QAS has developed the concept of an economic unit of supply costs as the basis of resource allocation. One unit of supply costs around \$14.7M in recurrent costs. This provides a total of 118 additional staff as follows:

- 70 extra paramedics;
- 7 communications officers
- 12 clinical, supervisory and support staff; and
- 29 operational support positions to cover statutory relief.

It also covers the costs of supplies and services, vehicle running costs, some equipment and a contribution to corporate overhead costs.

The Audit considers it would be preferable for corporate overhead costs to be funded separately and that it is not appropriate to assume that these costs should increase proportionately in line with increasing staffing numbers. However, it also recognised that overheads will need to increase eventually if there is a continued increase in service delivery staffing numbers. It is therefore recommended that a stepped approach be adopted wherein corporate overheads are adjusted after a certain threshold level is reached.

Alternative Funding Approaches for the Queensland Ambulance Service

This section of the report deals with alternative approaches to funding for ambulance services which may be able to improve the financial viability of the service and reduce the funding pressures being experienced.

The Audit has canvassed a range of different funding options including maintaining and enhancing the current budget arrangements through to abolishing the CAC levy and introducing user charges which could potentially be covered by private health funds.

Impact of Funding Arrangements on Choice of Service

The type and level of financial support for ambulance services can influence both the consumption of services and the capacity of the system to meet demand for services. In particular, the way in which services are funded can have a major impact on decisions by consumers about what type of service they use and from whom they acquire those services.

The current funding arrangements for ambulance essentially mean that all ambulance services are free of charge at the point when people use the service. With a free service, there is an obvious incentive to use that service if faced with a decision to use another service for which there is an up-front cost. For instance, it is likely that a number of patients would choose to use a taxi service if this was also free of charge like ambulance services.

However, all non-urgent ambulance transports must be medically authorised and to an extent this assists in ensuring that these services are not over-used. Code 1 and 2 emergency ambulance responses, on the other hand, are sent whenever anyone rings "000". There is no clinical assessment of the patient at the point of call to determine whether they could be better treated by another health provider or referred to the non-emergency ambulance transport service.

Policy Challenges and Objectives

The fundamental challenge is to design a funding system that supports the most appropriate type of response to a person's health care needs. Given the demand pressures on the system, it is particularly important to ensure that ambulance services are available for people who are genuinely ill and that highly trained paramedics and fully equipped ambulances are not being diverted to deal with relatively minor complaints.

The Audit has focussed its attention on examining the implications of a number of key alternative funding strategies for ambulance. The key policy objectives in assessing this particular aspect of the review have been:

- to ensure that funding and payment arrangements encourage the right type of service for people when and where they need it;
- that the capacity of people to pay for the service is taken into consideration; and
- that wasteful and unnecessary consumption of services is limited.

Key Alternative Funding Options

The main options being considered are:

- Option 1 – Continue current arrangements
- Option 2 – Abolish CAC levy and fund through increase in Medicare levy
- Option 3 – Abolish CAC levy and replace with user charges covered by private health insurance
- Option 4 – Retain and/or reduce the CAC levy and introduce a co-payment

The remainder of this section of the report deals with the implications of each of the options being considered, their advantages and disadvantages and associated cost and revenue impacts.

Option 1 – Continue current arrangements

As noted in previous sections of the report, the current funding arrangements for the QAS involve a mix of funding from different sources including government funding from the general Consolidated Fund, funding raised by the CAC levy, and various user charges revenues associated with payments from third parties including Queensland Health, the Department of Veterans Affairs, private companies and individuals.

Rationale for Levy

The levy was introduced at a time when there was growing concern about the viability of the ambulance subscription scheme and its ability to support the ongoing funding of ambulance services. Membership of the scheme had been in decline for a number of years and private health funds were providing coverage for ambulance services as part of their overall products causing more and more people to leave the scheme. The service was also suffering from continued high levels of bad debts from charges levied on people who were not ambulance subscribers. At the time, the CAC levy was introduced, the level of bad debt in QAS had averaged around 20% to 30% per annum.

The levy was seen as an alternative funding source for ambulance services that would provide greater security and certainty of revenue than the previous arrangements. It essentially provided a universal mandatory ambulance subscription scheme for the Queensland population with the amount of the levy roughly approximating the cost of a family subscription to the ambulance service which was around \$90 at the time the CAC was introduced.

It is important to emphasise that the levy was never intended to cover the full cost of ambulance services. It essentially replaced the subscription scheme and a portion of user charges revenue and now covers about one third of the total costs of providing ambulance services to the general community.

The levy was also intended to provide a sustainable funding source for ambulance services based on the fact that it would grow in line with increasing numbers of households (as evidenced by increasing numbers of electricity account holders) and by the general costs of inflation. To date, the levy has grown by an average of 4% per annum while the ambulance budget has grown by roughly 10% per annum. The gap between the two is currently being met from general government sources and will need to continue to be met into the future given the Government's commitment that the levy will not increase by more than CPI.

Advantages/Disadvantages

The advantages of this option are that it provides an ongoing mix of funding for the service most of which is guaranteed by Government. The levy has now been in place for over four years and is accepted by the community as a legitimate funding mechanism which helps support ambulance services.

The combination of a specific purpose levy and general government funding also recognises the community wide benefits of having a level of preparedness of ambulance services available across the State. In this sense, ambulance services can be viewed as a merit good where the Government considers that the broader benefits of using the service are

such that it should not be left to individual consumer preferences but funded more broadly by the Government and taxpayers.

The main disadvantage of this option is that the absence of any price signal is clearly putting upward pressure on demand for ambulance services and leading to over-servicing and poor use of public resources. The levy is also a flat regressive tax with no link between payment of the levy and usage of ambulance services. For example, single households pay the same amount as families regardless of how many more services they may use. There are also anomalies with payments for the levy being attached to items such as billboards and people paying on their business as well as place of residence.

Option 2 – Abolish CAC levy and Fund through Increase in Medicare levy

This option would involve abolishing the CAC levy and having ambulance services funded via an increase in the Medicare levy.

Key Features

The Medicare levy is a Commonwealth tax on individuals which is collected via personal income tax payments. The current levy is set at the rate of 1.5% of a person's taxable income. Most people have to pay the levy although exemptions apply for people on very low incomes.

A Medicare surcharge is also applied to high income earners who do not have an appropriate level of private health insurance cover. This generally equates to an additional 1% of taxable income on top of the 1.5% base Medicare levy.

The Medicare levy does not currently cover the provision of ambulance services. Instead, it provides a funding base to support payments for medical and other services under the Medical Benefits Scheme (MBS) and funding for public hospital services under the Australian Health Care Agreements (AHCAs) with the States and Territories.

The main barrier to pursuing this option is that it would require a nationally agreed approach since the Medicare levy is a Commonwealth tax and any changes would need to apply across all jurisdictions. While this is likely to present difficulties and represents a fundamental shift in the current coverage arrangements for Medicare, as noted in the ACT report, this should not mitigate against it being seriously considered as an alternative funding option. This is especially the case since ambulance services across most jurisdictions are experiencing funding pressures and are an integral part of the overall health system.

However, it is worth noting that the Medicare levy does not meet the full costs of the services it already covers which would militate against it being extended beyond its current scope. Currently, Medicare levy revenue funds around 41% of Commonwealth health expenditure on medical services and benefits (2006-07), while it funds approximately 17% of total health expenditure at the Commonwealth level. Revenue is expected to grow from around \$6.56B in 2005-06 to \$8.33B in 2009-10, an increase of 27% over the forward estimate period (Source: 2006-07 Commonwealth Budget Paper No.1).

Total expenditure on ambulance services in 2005-06, as estimated in the latest Draft Report on Government Services 2007 from the Productivity Commission, was around \$1.4 billion (note the amount is likely to be understated due to reporting differences between jurisdictions). On the basis of the estimated Medicare levy revenue for 2006-07 and assuming that the current levy revenue is generated through the 1.5% general levy, an increase in the Medicare levy of around 0.3% would raise the \$1.4 billion required to fund ambulance services at this point of time.

Advantages/Disadvantages

The main advantage of this option is that it would provide an alternative funding source for ambulance services that was linked to a broad based progressive tax. In doing so, it would spread the burden of meeting the costs of ambulance services on a more equitable basis than the current CAC levy since the tax is paid by individuals (who are the users of ambulance services not households as is the case with the CAC levy) and is paid in proportion to the amount earned by individuals such that lower income people pay a lower amount than high income earners.

A relatively small increase in the levy would provide sufficient funding to replace funding for ambulance services across all States and Territories and provide them with access to a revenue stream which delivers relatively higher levels of growth than current revenue streams. Directing revenue from the Medicare levy to ambulance services also recognises that ambulance services form an integral part of the overall health system.

The key disadvantage is that as with the CAC levy, simply funding through the Medicare levy, would not of itself assist with ensuring that ambulance services were being used appropriately and avoid incentives for over-servicing unless it was accompanied by some kind of additional charge or consumer co-payment. This would be consistent with the manner in which the Medicare levy contributes to the costs of medical services but does not cover the full amount with patients being required to pay an out-of-pocket expense when they access general practitioner and medical specialist services in the community.

Option 3 – Abolish the CAC Levy and Replace with Coverage by Private Health Funds

Under this option, the CAC levy would be abolished and instead ambulance services would be covered by private health insurance or paid for directly by individuals who choose not to be insured. Private health funds provide coverage for ambulance services in all jurisdictions except Queensland and Tasmania.

Key Features

Currently, 41% of the Queensland population have private health insurance. When the CAC levy was introduced in Queensland, ambulance cover was no longer included in private health fund coverage either as part of a comprehensive health insurance package or as a stand-alone product. The Audit was not able to find any evidence that private health insurance premiums were reduced as a result.

Funding ambulance services through such an arrangement is consistent with the way various non-government health services are currently funded including private hospital services, dental and optometrical services. Its basic premise is that consumers are best placed to determine the most appropriate service to meet their needs and that people who are financially better off should contribute through their private health insurance or out of their own pockets to the costs of ambulance services.

This is the option currently under consideration in Tasmania. Tasmania is the only other State apart from Queensland which does not have some form of consumer payment either through a subscription or transport charge for the use of ambulance services. In the 2007-08 budget, the Tasmanian Government announced it would be introducing an ambulance fee for service.

Mechanisms for Payments from Private Health Funds

Private health funds could contribute to the costs of the QAS in a number of ways if ambulance services were covered by private health insurance. In NSW and the ACT, the Government raises a levy on private health funds linked to overall premium revenue rather than charging privately insured people directly when they use the ambulance service. Levies on private health funds raised around \$120M in annual revenue in those jurisdictions in 2005-06 (Private Health Insurance Administration Council, 2006). The costs are built into health insurance premiums and in the case of NSW equate to around \$54 for a single and \$107 for a family.

The alternative is for QAS to introduce user charges on the privately insured which they then insure against with their private health fund. Ambulance only cover was offered in Queensland prior to the levy and is still available in other States with costs ranging from around \$39 for cover for a single person to \$120 for family cover per annum (with the 30% Commonwealth rebate). Not all funds provide cover for non-emergency services and those that do generally charge a co-payment. Some funds also put limits on the number of services that can be claimed each year.

Full Cost Recovery or Subsidised Fees

The new charges could be based on full cost recovery or at a government subsidised rate. The QAS currently charges non-eligible clients for the use of ambulance services on a full cost recovery basis. These equate to \$888 for an emergency transport, \$330 for a non-emergency transport and \$90.50 for treatment with no transport. Additional kilometric charges are also involved.

Rather than basing the charge on full cost recovery, the charges could be linked to the amount of revenue needed to replace the revenue lost from abolishing the CAC levy. To fully replace estimated CAC revenue to QAS in 2007-08, a fee of around \$330 for emergency transports, \$110 for non-emergency transports and \$50 for attendance and treatment only, would need to be put in place. These lower costs may make providing ambulance coverage a more attractive proposition to health insurers.

If pensioners and concession card holders are excluded under a subsidised user charging arrangement, the fee would need to be much higher at \$570 for an emergency transport, \$300 for a non-emergency transport and \$75 for treatment and no transport. Note these are estimates only of the impacts of different arrangements – further detailed modelling of the charges would need to be undertaken if this option was to be seriously pursued

Rather than exempting pensioners altogether from user charges, the Government could consider subsidising the purchase of health insurance for particular groups under such an arrangement.

Advantages/Disadvantages

The main advantage of this option is that it provides a direct link between the usage of the service by the consumer and the payment received by QAS. As such, it would provide much greater incentives for efficiency and service quality improvements than the current arrangements where QAS receives revenue regardless of how many services it provides or the quality of the services provided. It would also assist in moderating demand as private health insurers would manage the payment of services in the same way they manage funding for other insured health services such as hospital, dental, and optometrical services to avoid excessive or over use.

The main disadvantage is that it requires the agreement of health funds to provide coverage for ambulance services in Queensland something which they ceased to do when the CAC levy was introduced. It also raises the potential problem of bad debts for those people who do not privately insure and for one reason or another do not pay ambulance charges. This was seen as a weakness under the previous arrangements.

Option 4 – Retain current arrangements and introduce a co-payment

Under this option, the current funding arrangements for ambulance services would be maintained but would be accompanied by a consumer co-payment paid by people whenever they use the service. This concept is consistent with the view that the levy is a universal insurance product. Most types of insurance require a financial contribution from the individual using the product or service whether it be the excess paid on a household and car insurance when a claim is made or out-of-pocket expenses for private hospital, dental and other general health services.

Key Features

Under this option, it would be possible to reduce the amount of the levy paid by consumers or the levy could be sustained at current levels and revenue raised by the consumer contribution could be introduced to provide an additional revenue stream for the QAS over and above the levy revenue and other sources.

This option recognises that the main challenge confronting the QAS is the unreasonably high level of demand for services seen over the last few years especially with regard to Code 1 and 2 emergency responses. The audit team has not been able to identify a funding base from general government sources that would match the level of growth in demand currently being experienced for ambulance services in Queensland. While the Medicare levy is a higher growth revenue stream than the CAC levy, both fall short of the actual and projected level of demand for ambulance services in Queensland and would require ongoing subsidy from other sources.

In terms of an amount for such a co-payment, there are a number of issues to consider. Firstly, it would need to be sufficient to ensure that people have an incentive to explore the use of alternative transports such as taxi services. At the same time, it should not be so high as to discourage people in genuine need of an emergency ambulance service from accessing the service.

The issue of whether the co-payment should be charged for all services also requires consideration. Western Australia is the only State that has a co-payment for services which operates in conjunction with its subscription scheme and in that State, the co-payment only applies to the use of non-urgent transports (i.e. Code 3 and 4 transports). Consumers, including those who are subscribers to the ambulance service in Western Australia, are currently charged \$50 for each non-urgent transport service they use.

In the Audit's view, any co-payment would need to operate across all services including emergency and non-emergency services. As noted in the demand analysis section of the report, the most significant growth in demand for ambulance services in Queensland has been in the Code 1 and 2 cases not in the non-urgent cases which are declining in real terms.

Should the co-payment cover all services, then the issue arises as to whether it should be differentiated between emergency and non-emergency services and which particular service should be associated with a higher charge. As noted in the financial section of the report,

the cost of providing emergency transports far exceed the costs of providing non-emergency transports. On this basis, it would be reasonable to charge more for an emergency transport than a non-emergency transport. Patients who are treated and not transported would also need to be considered and again would be expected to be associated with a lower charge as actual costs of these services are lower again.

A co-payment also raises considerations around whether any particular user groups should be exempt from the co-payment. From an economic perspective, it would be best if the co-payment was to apply across the board to all user groups to provide an incentive for appropriate usage. However, the Government may wish to provide a discounted rate for certain groups such as pensioners and health care card holders or exempt them altogether from any user charges.

It is estimated that a relatively modest contribution of \$100 for an emergency service, \$50 for a non-emergency service and \$25 for an attendance could raise an estimated \$41.7M for the QAS and be accompanied by a reduction in the levy paid by households of about one-third. Alternatively, the levy could be retained and consumer payments used to provide an additional revenue stream for the QAS. If pensioners were excluded for these co-payments, the revenue would decrease to around \$22M per annum.

An alternative approach would be to retain the levy in full and only charge for non-emergency services and attendances where there is no ambulance transport required. Charges could be similar to above but the amount of revenue raised would be considerably less. This option could be argued on the basis that the levy should only cover the costs of emergency life threatening ambulance services, not non-urgent transports and other general attendances.

Advantages/Disadvantages

The main advantages of a consumer co-payment or contribution are that it provides a price signal which will affect consumer purchasing decisions about the use of ambulance services. As such, it has the ability to discourage inappropriate or excessive usage of ambulance services. It would also provide a more direct link between the revenue earned by QAS and the level of services provided while at the same time preserving the levy revenue to provide certainty and security of funding.

The key disadvantage is that there would be the potential for bad debts associated with non-payment and the administrative costs associated with putting in place a collection mechanism. It would clearly not be desirable to be requiring patients in emergency situations to pay upfront. Payments would need to be levied on the patient after the service has been provided in the case of emergency ambulance services. However, there may be some flexibility to introduce up-front payments for non-emergency services.

Conclusion

There are a range of funding strategies that can be considered for the QAS going forward. This section has attempted to provide an outline of how each of these options might work conceptually and the advantages and disadvantages of each option. Further work would be required on developing any preferred option prior to implementation.

Chapter 8 - Future Funding Strategies Recommendations

Recommendation 8.1

It is recommended that additional funding to meet increased demand be considered for the 2008-09 Budget and that for future years, the Government adopt a growth factor to apply to the QAS budget which accounts for increasing costs and demand pressures and provides greater certainty for the QAS in planning for service enhancements.

Recommendation 8.2

It is recommended the QAS review its economic unit of supply concept such that escalation for corporate services overheads is not automatically applied when additional funding for services is obtained, noting this would also require review of overheads for the Department of Emergency Services and shared service providers.

Recommendation 8.3

It is recommended the Government consider introducing a payment for ambulance services either in the form of a co-payment (accompanied by a reduction in the CAC levy) or by abolishing the CAC levy altogether and introducing user charges which could then be insured against with health funds if demand measures do not deliver appropriate results.