

CHAPTER 13

COMMUNITY AND OTHER HEALTH SERVICES

WHAT IS INCLUDED IN THE COMMUNITY AND OTHER HEALTH CATEGORY?

- 1 The Community and other health services category comprises all health expenses except those relating to admitted patients and patient transport¹. It includes expenses on the administration, inspection, support and operation of non-admitted patient services such as hospital emergency departments and outpatient clinics, community health and public health services. Expenses on superannuation for the staff employed in delivering these services are included, but not depreciation, which is assessed separately.
- 2 Community and other health expenses, including superannuation for State government employees engaged in the provision of these services, were \$13.6 billion in 2008-09. Table 13-1 shows expenses on community and other health services varied between 4.9 per cent in Tasmania to 11.3 per cent in the ACT. The average was 7.9 per cent.

Table 13-1 Community and other health services category expenses, 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Category expense (\$m)	3 826.0	2 867.6	2 951.3	1 858.4	1 167.7	212.4	392.4	314.5	13 590.3
Total (\$pc)	543.35	534.53	678.54	843.18	724.37	424.46	1 128.05	1 418.59	627.97
Proportion of State operating expense (%)	7.6	7.3	8.0	9.7	8.6	4.9	11.3	7.9	7.9

Notes: Tasmania and the ACT expenses reflect a different classification of health expenditure between admitted and non-admitted patients.

Source: Commission calculation using State data.

- 3 Table 13-2 shows the share of State expenses directed to Community and other health services decreased over the assessment period, from 8.3 per cent in 2005-06 to 7.9 per cent in 2008-09.

¹ In consultation with the States, the Commission decided to treat patient transport expenses as part of the Admitted patient services category.

Table 13-2 Community and other health services expenses as a proportion of State operating expenses

	2005-06	2006-07	2007-08	2008-09
Total for category (\$m)	11 174.8	11 344.0	12 293.1	13 590.3
Total operating expenses (\$m)	134 969.0	146 359.0	157 538.0	171 074.5
Proportion of total operating expenses (%)	8.3	7.8	7.8	7.9

Source: Commission calculation using ABS GFS data and State data.

The average service delivery policy

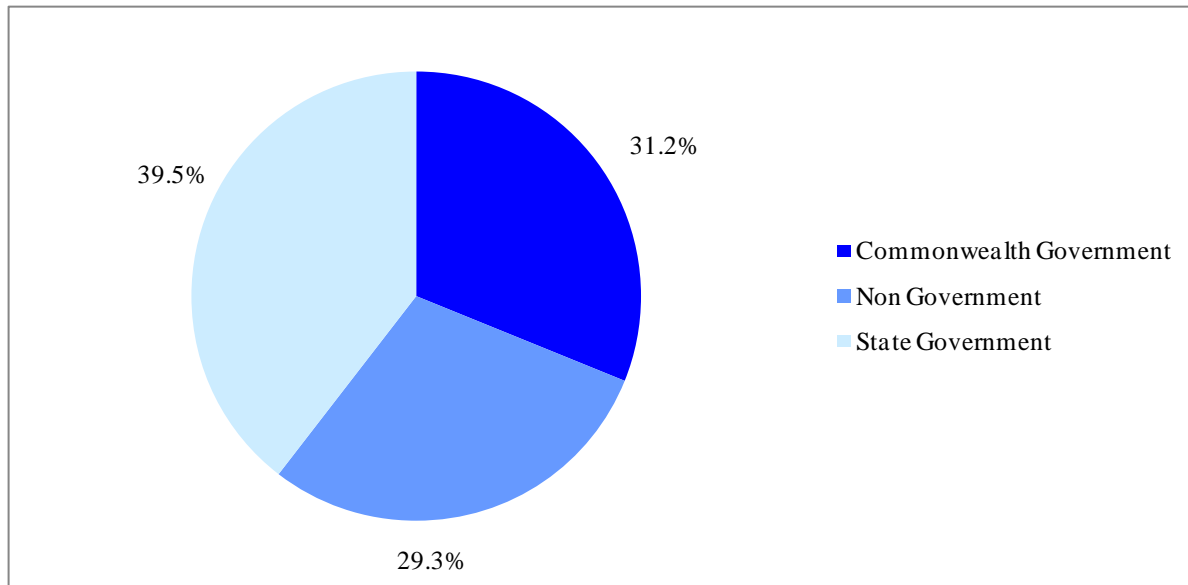
- 4 States provide primary and secondary health care in emergency and outpatient departments in hospitals and through community health services and public health services. States also carry out a range of health programs targeting specific population groups, and promoting public awareness. In all States, these services:
- often provide a first point of contact with the health system, for example, hospital emergency departments;
 - have a particular focus on prevention of illness and/or early intervention, for example, immunisation and cancer screening programs; and/or
 - are intended to maintain a person's independence and maximise their quality of life, for example, through outpatient clinics.
- 5 Some States, such as Victoria and the Northern Territory, tend to provide more of these services through community health centres than through hospitals. This can be due to policy choice, the nature of clients, their location and the size of the service catchment areas.

What is the role of the Commonwealth and non-government providers?

- 6 As shown in Figure 13-1, State government spending on Community and other health services is only part of the total cost of this broad range of services provided to State residents. Some services are funded by the Commonwealth, such as through Medicare. Others are funded by the private sector, largely through private health funds or individual out-of-pocket expenses². Nearly all services funded by the Commonwealth and the non-government sector are provided by non-government organisations and professionals in private practice operating in a regulated market.
- 7 Private provision can be substitutable for State funded services; for example, a deep cut can be stitched by a general practitioner or in an emergency department. Privately provided services in areas which are largely a Commonwealth responsibility, such as optometry, are not regarded as substitutes for State community and other health services.

² Non-government funding sources also include workers' compensation and compulsory motor vehicle third-party insurers, funding for research from non-government sources and miscellaneous non-patient revenue received by hospitals. These are omitted from the assessment.

Figure 13-1 Shares of expenses on community and other health services by sector, 2006-07



Notes: Commonwealth government SPP and NPPs are included in State government expenses.

Non-State government expenses reflect those relating to State-like services.

Source: AIHW, Australian Health Expenditure 2006-07, and State GFS adjusted by the Commission.

- 8 Commonwealth payments to individuals and non-State agencies for State-like community and other health services are not included in State general government sector expenses. However, these payments reduce the amount States need to spend on community and other health services. Their impact on State fiscal capacities should be recognised. However, some Commonwealth outlays, like the Northern Territory Emergency Response (NTER), are specifically required by the Commission's terms of reference not to have an impact on State fiscal capacities.
- 9 Funding from the non-government sector, largely from individual out-of-pocket expenses, may also take pressure off State budgets. When it does, its impact on State fiscal capacities should also be recognised.
- 10 Around 25 per cent of State expenses for health are funded by the Commonwealth through the National healthcare SPP. This payment includes payments previously made for national public health, youth health services and essential vaccines (service delivery). The SPP has a direct impact on State fiscal capacities because it supports State services and the expenses relating to it will be assessed differentially in this category.
- 11 The Commonwealth also makes National partnership payments (NPPs) to States. The treatment of these payments is decided on a case by case basis as they arise, using the Commission's guidelines (see Chapter 5 of Volume 1).
- 12 The following table summarises the treatment of current Commonwealth payments to States. Payments to States of a predominantly capital nature will be addressed in the Investment

chapter. The Adjusted budget chapter provides further information on the treatment of these payments.

Table 13-3 Commonwealth payments to States relevant to the Community and other health services category and their treatment

Payments affecting relativities	Payments not affecting relativities
National SPPs	National partnership payments
National healthcare agreement, including:	Repatriation general hospitals
National public health	Essential vaccines (vaccine purchase)
Youth health services	Hepatitis C settlement fund
Essential vaccine (service delivery)	Health care grants for the Torres Strait
National partnership payments	
Health and hospital workforce reform	
Health services (except for health care grants for the Torres Strait)	
Health program grants	
Other payments	Other payments
Organ and tissue donation	Highly specialised drugs

Note: Programs that have been replaced by programs included in this table are treated in the same way.

Source: Commonwealth of Australia *Budget Paper No. 3, 2009-10*.

ASSESSMENT APPROACH

Overview

- 13 The health needs of State populations are met by a mix of State and private providers. The States provide community and other health services through hospitals and community health centres. Similar services are also available in private institutions which are mainly funded by the Commonwealth, private health insurance funds as well as by individuals' out-of-pocket expenses. Effectively, the States have the 'fall-back' responsibility for providing services not provided by the private sector or in areas where it is uneconomic for private providers to operate.
- 14 Consequently, we have estimated the aggregate need for health services in each State, which is driven by the size of the population and the presence of groups of people who use the services more intensively, such as:
 - elderly people;
 - babies and young children;
 - Indigenous people;
 - people in rural and remote areas; and
 - socio-economically disadvantaged people.

- 15 The need for each State to provide services is then derived by subtracting the amount of non-State provision from its total requirements.

Subtraction model

Conceptual approach

- 16 We have adopted an approach where total expenses on State and State-like community and other health services by all providers are estimated, and allocated to each State, by reference to the costs of providing the services to different population groups and the proportion of the population of each State in those groups. Expenses on State-like services supplied by non-State providers are then deducted to derive the assessed expenses of the States. We call this a subtraction model.
- 17 Most States supported this approach, noting that the subtraction model enables us to appropriately deal with two important aspects that affect State expenses on community and other health services:
- the impact of socio-demographic characteristics on the level of services required and the costs of providing them; and
 - the economic environment which influences the extent of private provision of the services.
- 18 The subtraction model implicitly assumes the services provided by non-State providers are fully substitutable for those available in State funded institutions. We engaged a consultant³ to review the conceptual validity of this assumption. The consultant concluded that the available evidence suggested it was reasonable to assume that the majority of services provided by the States and non-State providers are equivalent and substitutable. Whilst some services are delivered almost exclusively by States, for example hospital emergency department services, private organisations deliver many services similar to those provided by States, for example through general practitioners. These privately provided services can be funded by the Commonwealth, by individuals out-of-pocket or through private health funds, or by a combination of these funding sources. Thus, the consultant concluded that the subtraction model is a valid approach.
- 19 However, New South Wales and the Northern Territory remain concerned that the subtraction model does not reflect their experiences. Specifically, New South Wales argued that the presentations to emergency departments in New South Wales were higher than the national average, as were Medicare-funded services. It said that this contradicts what the model has assumed: that the higher than average level of non-State services should reduce the need for government services. New South Wales used the work of an independent consultant to support its arguments against the conceptual validity of the subtraction model. The Northern

³ Butler, JRG (2008), A review of the proposed approach to the assessment of Community and other health services, a report prepared for the Commonwealth Grants Commission, Australian National University.

Territory noted that increased Commonwealth expenses in the Territory tended to result in more State government expense, not less.

- 20 While accepting the experiences of New South Wales and the Northern Territory, we do not believe they invalidate the subtraction model. The model uses data on what the Commonwealth, the private sector, and the States on average, did in a particular year. Therefore, going forward, it will reflect what States have done. New South Wales and the Northern Territory's arguments are considered in more detail in the *Economic environment section* later in this chapter.

Data and method considerations

- 21 Some States, including Queensland, had argued for an approach that sought to directly measure what States do, using a composite index reflecting eleven factors that affect the range of services in this category. However, as noted by Tasmania, the Community and other health category suffers from a paucity of reliable and robust data. While the national hospital statistics provide data on the use of emergency departments in public hospitals, there are no administrative data that reflect the totality of use of State services in this category. In particular, the data on use of State community and public health services are negligible. This, along with the large differences in the way States deliver services, means implementing the Queensland approach would be difficult.
- 22 On the other hand, data collections for the use of services provided by the non-State sector, such as through Medicare and private ancillary insurance, are more comprehensive. Given that States are not the dominant service providers in the community and other health services area, we adopted a broad approach. This is more consistent with the top down development of less disaggregated assessments as well as the assessment guidelines adopted for this review.
- 23 States also said data deficiencies (such as a lack of administrative data, underestimates of Indigenous use especially in remote areas, and outdated data) could undermine the subtraction model. The consultant identified the desirable features of data required to produce a robust assessment⁴ and concluded that the datasets used in the subtraction model were reliable and fit for purpose. He also noted that using the data to calculate State averages, as we proposed, ensured sufficient independence from State policies.
- 24 However, New South Wales and the Northern Territory's concerns about the model highlight the need to ensure that all material factors affecting the total expenses on community and other health services in each State, regardless of whether the services are provided by State or non-State providers, are recognised and that they are measured on a comparable and consistent basis.

⁴ They were that the data should be from reliable sources and be reasonably comprehensive, comparable and consistent.

- 25 This has been done in the assessment by removing from non-State services those types of services not provided by the States. For example, optometry services are not the responsibility of States and, as such, private provision of these services does not reduce State expenses.
- 26 Whilst we have identified the majority of those non-State expenses, particularly those that are clearly not related to State or State-like services, we cannot be certain that no such services remain in the assessment. The descriptions of Medicare and private insurance ancillary service items, as well as the service categories in the AIHW expenditure database, are not always sufficiently specific. To address this low level of uncertainty, a small discount, 12.5 per cent, is applied to reduce the size of the non-State expenses included in the subtraction model. Such a discount is necessary to enhance the robustness of the substitutability assumption.
- 27 We also ensured the integrity of the assessment, in terms of timing, by having the critical variables (including the health expenses on Indigenous people, non-State expenses and population in the States) measured using data for the same years.

Factors affecting service use and cost

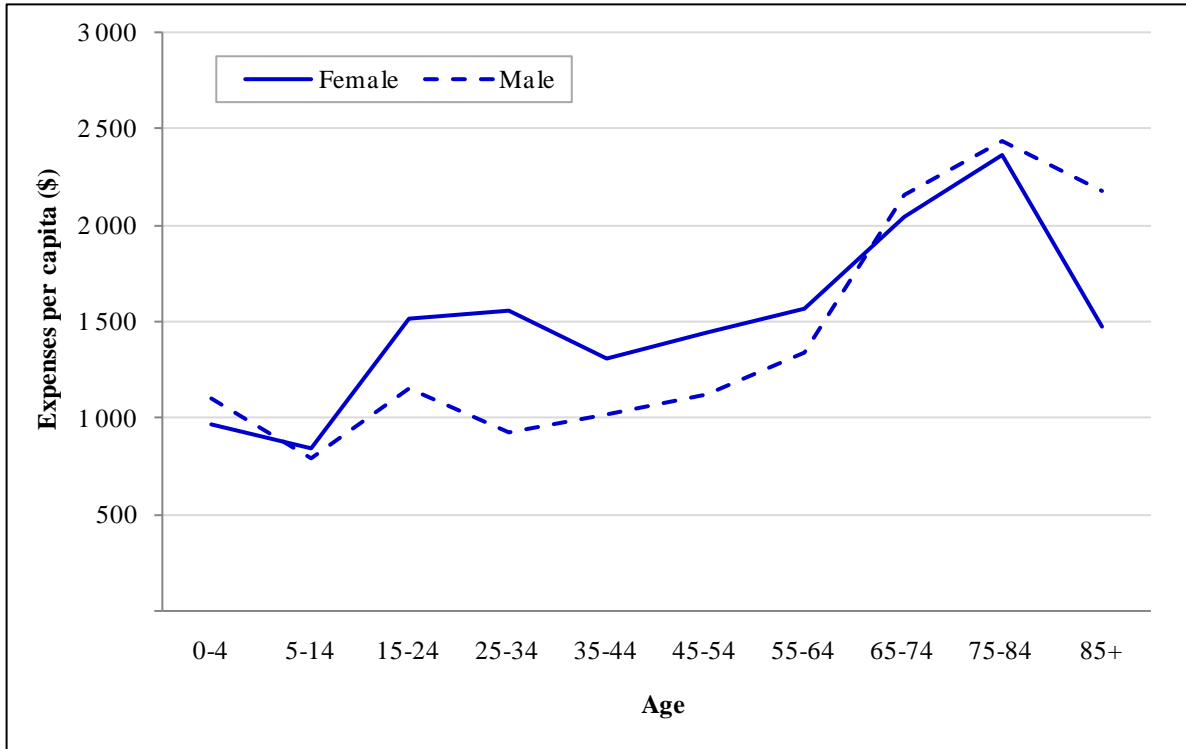
- 28 State submissions indicate the need for health services and the costs of providing them may be affected by factors such as the age, Indigenous status and socio-economic composition of the population, where people live and the economic environment.

Age and sex

- 29 Health experts widely accept that a person's age and sex affects their use of community and other health services. States have agreed that health expenses in each State should reflect the varying demands placed upon health services due to the age and sex composition of State populations. Figure 13-2 shows how expenses per capita on community and other health services vary by age and sex, across all State-like services.
- 30 Measurement of expenses per capita by age and sex relies on the Australian Institute of Health and Welfare (AIHW) publication *Health system expenditure on disease and injury in Australia* and the National Health Survey (NHS). The ABS conducts the survey only every three years. It does not necessarily employ the same data collection methods and procedures each time and so the lag could be longer than three years. As a result, the update of age and sex expense profiles will not be as regular as we would like.
- 31 However, changes over the years are unlikely to be material. A technical paper published with the Productivity Commission research report on *Economic Implications of an Ageing Australia* included a comparison of health expenditure as a proportion of GDP per capita by age groups between developed countries in Europe. The paper suggested that the profiles are relatively consistent in most countries⁵ and importantly, they have been relatively stable over time.

⁵ The Productivity Commission, *Economic Implications of an Ageing Australia*, Technical papers, Chapter 5, Aggregate studies of age and health expenditure.

Figure 13-2 Total comparable Community and other health expenses per capita by age and sex



Source: AIHW Expenditure database, ABS *National Health Survey 2004-05* and ABS ERP June 2007 special data request.

- 32 The Northern Territory was concerned that the use of AIHW and NHS data has led to an urban bias in the proposed age-sex weights. It said that the bias in the AIHW data occurs because there is a greater access to Medicare services in urban areas as opposed to remote areas and that the bias in the NHS data occurs due to the low coverage of remote areas in the survey. It concluded, because health service users in remote areas tend to be younger, the age-sex expense profile was therefore more heavily weighted to older people than it should be. It also said that excluding certain services, such as organised immunisation, from the age-sex expense profile has caused further bias against younger age groups.
- 33 In our view, the AIHW and NHS data have captured the majority of population and health services related to this category. Although the coverage might not be perfect it is unlikely that the pattern of use for those services not included, or the use of services by remote people, is so different (given their small proportion of total population) as to have a material impact on the national average. Therefore, we consider the derived age and sex expense profiles adequately reflect the Australian average distribution of expenses.

Indigenous status

- 34 Indigenous people on average have poorer health than non-Indigenous people, with there being consequent differences between Indigenous and non-Indigenous health expenses per person. The AIHW publication series *Expenditures on health for Aboriginal and Torres Strait Islander peoples* provides reliable data on the size of these differences. It shows the Indigenous share

of national community and other health expenses is about 1.5 times its share of the total population⁶.

- 35 Data on the Indigenous share of health costs is published bi-annually by the AIHW and up to three years in arrears. The Northern Territory has expressed concern that the lag in the AIHW data undermines the objective of a contemporary assessment. It anticipates the Indigenous share of total health expenditure will increase significantly and so the Commission should update its allowances for Indigenous use and costs annually and in a timely manner. At least, it should adjust the old share to make it more contemporary.
- 36 We are aware that flowing from the NTER and the Closing the Gap National partnership payment (NPP), Indigenous health needs will be better identified. However, the Commonwealth has directed through the terms of reference that the NTER payments should not affect the relativities. As a result, these payments should be excluded from calculating the Indigenous allowance even when they are reported in the AIHW publication.
- 37 Therefore, only the increase in own-source State spending, along with non-NTER Commonwealth spending, will be considered in our assessment. Although in recent years a number of States have increased their expenses on Indigenous health in conjunction with the Commonwealth, it is not possible for the Commission to estimate the extent of the increase across all States.
- 38 Given the difficulty in making reliable adjustments to the AIHW publication, along with the potential need to correct inaccurate estimates when data do become available, we decided to rely on the AIHW publication to capture Indigenous influences, although they are not as contemporary as we would like.

Socio-economic status

- 39 Some States said that socio-economic status (SES) and where people live are also important drivers of health expenses and provided evidence to support this conceptual case. However, a person's Indigenous status, location and SES are not totally independent of each other. For example, more Indigenous people than non-Indigenous live in remote regions, and people living in remote regions are generally more socio-economically disadvantaged than people living in more accessible regions.
- 40 Table 13-4 shows the use of community and other health services (in terms of visits per 1000 population) by non-Indigenous people grouped according to their SES quintiles, defined using the ABS Socio Economic Index for Areas (SEIFA) Index of Relative Social Disadvantage (IRSD).

⁶ Derived from AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2006-07*, Table 3.1.

Table 13-4 Visits to health services per 1000 population for non-Indigenous people by SEIFA IRSD quintiles, 2004-05

	Quintile				
	Bottom	2nd	3rd	4th	Top
	No.	No.	No.	No.	No.
Outpatient/emergency department	43.1	30.2	32.1	27.2	28.1
General practitioner	347.2	306.9	288.6	286.1	277.1
Dental	52.6	57.4	63.7	76.8	85.1
Other health practitioners	97.8	105.1	116.8	130.7	139.8
Total health related action	540.6	499.6	501.2	520.7	530.1

Note: Visits made in the two weeks prior to the health survey interview.

Source: ABS, National Aboriginal and Torres Strait Islander Health Survey, 2004-05.

- 41 It shows non-Indigenous people who are frequent users of health services are at either end of the socio-economic spectrum — people with low SES use outpatient, emergency department and general practitioners, more than average but people with high SES have above average use of dentists and health practitioners other than general practitioners. Although the types and mix of services varies between the two groups, it is materially important to recognise the higher use of health services overall by people in the bottom quintile as well as by those in the top two quintiles.
- 42 Results from a similar comparison for Indigenous people are less conclusive, mainly because their relatively low numbers, most evident in urban areas, means they have limited impact on the SEIFA scores for the area they live in. For that reason, we have made an SES adjustment only for non-Indigenous people.

Where people live

- 43 Location has an impact on State community health expenses. In relation to Indigenous people, AIHW data of selected health services expenditure (including hospital services, community health services through Indigenous controlled community health organisations and medical services) by location indicate that remote Indigenous people have higher costs than non-remote Indigenous people. Table 13-5 shows that expenditure per Indigenous person in remote areas is 1.60 times that for Indigenous people in non-remote areas.

Table 13-5 Health expenses for Indigenous people by location, 2004-05

	Remote	Non-remote	Remote to non-remote ratio
	\$pc	\$pc	
Selected health services	3 245.00	2 025.62	1.60

Note: The categories of services included are hospitals, Office of Aboriginal and Torres Strait Island Health grants to Aboriginal Controlled Community Health Organisations and Medical services. For other community and other health type services, it was not possible to allocate expenditures by Australian standard geographical classification remoteness areas.

Source: Table 2.13, AIHW, Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004-05.

- 82 The higher cost per Indigenous person in remote regions reflects the combined effects of:
- a greater use of services by people who live in regional and remote areas compared with people who live in other regions. This is due to their poorer health outcomes and also a result from Commonwealth programs which are more targeted at remote Indigenous people, for example the Office of Aboriginal and Torres Strait Islander Health (OATSIH) funding of Aboriginal Controlled Community Health Organisations;
 - the higher costs of providing State government health services in remote regions due to dispersion, isolation and diseconomies of small scale, which are reflected in the general location cost factors assessed by the Commission; and
 - the more limited access people in remote areas have to health services provided by the non-State sector and their greater reliance on State-provided services. This influence will be captured through the general assessment method developed for community and other health services. However, we consider this influence is small for Indigenous people because they generally have limited access to private health services regardless of where they live.
- 44 We have made a specific location adjustment for Indigenous people based on the AIHW data in Table 13-5. In doing so, we recognise that applying that adjustment and the general location factor could overstate the influences of the location of Indigenous people on State expenses. However, according to the AIHW data, the high use of services by Indigenous people in remote areas is the main driver of their high cost⁷ and so the effect of possible double counting is considered to be immaterial.
- 45 Similar, though older, AIHW data⁸ do not indicate a higher use by remote non-Indigenous people compared to non-remote non-Indigenous people. We, therefore, have not made any additional adjustment for location beyond the general assessments for non-State provision and location effects.

Economic environment

- 46 As discussed in the Overview, State expenses on community and other health services are affected by the extent to which similar services are provided by the private sector. We also noted the distribution of private service providers differs between and within States. For example, private providers tend not to locate in remote regions.
- 47 This is reflected in the actual Medicare Benefit Scheme (MBS) payments which vary considerably between the States. Table 13-6 shows the amount paid per capita in New South Wales is over 10 per cent above average while Western Australia, the ACT and the Northern

⁷ AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004-05*, Table 2.14 shows the hospital separations per 1000 population are 55 per cent higher for remote Indigenous people than the Indigenous average separation rate.

⁸ AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander people, 2001-02*, Table 7.2. Non-Indigenous expenditure by remoteness was not published in the 2004-05 edition of this publication.

Territory received considerably less than the average, coinciding with relatively low general practitioner numbers in those States.

Table 13-6 Actual MBS payments to States, 2007-08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Unreferred attendances (\$pc)	232.34	212.96	200.58	172.14	218.20	193.64	163.56	120.54	210.92
Ratio to average	1.10	1.01	0.95	0.82	1.03	0.92	0.78	0.57	1.00
Specialist attendances (\$pc)	252.60	233.92	210.52	185.15	222.99	197.31	187.11	112.18	226.77
Ratio to average	1.11	1.03	0.93	0.82	0.98	0.87	0.83	0.49	1.00
Total (\$pc)	484.93	446.87	411.10	357.29	441.19	390.95	350.66	232.73	437.68

Note: Specialists attendances include specialists attendance, other allied health, pathology, radiotherapy and therapeutic nuclear medicine and miscellaneous.

Source: Medicare statistics.

- 48 The influences of market conditions including the accessibility to health services and bulk billing rates are captured in the subtraction approach to recognise that the need for State government provided services are partially met by private service provision.
- 49 *Substitutability*. New South Wales argued strongly that there might be circumstances where the Medicare services may not be substitutable for a State provided service and so some MBS contributions do not reduce the States' need. It said that its argument is supported by the data for emergency departments across the States which show presentations in New South Wales are a little higher per capita than the Australian average (Table 13-7).

Table 13-7 Accident and emergency departments, number of presentations, 2007-08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Presentations per 1000 weighted population	328	275	344	364	306	262	304	742	321

Source: New South Wales submission on the draft report (Department of Health and Ageing, *The State of Our Public Hospitals*, June 2009).

- 50 As noted earlier, we have recognised that some MBS services have no impact on State services and so we have excluded MBS expenses which are clearly not related to State-like services. Also we have discounted all remaining non-State expenses including those through Medicare to improve the assumption of substitutability.
- 51 Between the States, we consider that all else being equal, the higher the level of non-State services, the lower the level of State-funded services required to provide the average level of service. However, States have discretion on the actual level of services provided, how they are provided and where they are provided.
- 52 For example, the waiting time at emergency departments, which can be markedly different across States, will influence the recorded presentation numbers. Patients in the ACT wait almost twice as long as patients in other States, which may contribute to the emergency department presentations in the ACT being relatively low. In addition, the comparison of

emergency department presentations is subject to differences in the service delivery model adopted by States. Some States, including New South Wales, tend to deliver health services centred around hospitals. In other States, such as Victoria and the Northern Territory, similar services are likely to be delivered in the setting of community health centres, which are not co-located with hospitals. Further, any comparison is confounded by data comparability problems because this reporting requirement is optional for smaller hospitals in some States like Queensland and Tasmania.

- 53 The fact that the number of presentations to emergency department in New South Wales is higher per capita than the Australian average does not undermine the assumption of substitutability. If the differences in service delivery models, waiting times and reporting requirements are allowed for, there is an inverse relationship between Commonwealth funding and State government expenditure. For example, States such as Western Australia and the Northern Territory, whose Medicare rebates are low, have relatively high emergency department presentations.
- 54 *Market driven demand.* New South Wales also suggested that a range of market drivers would have impacts on the utilisation of health services. For example, the more Medicare services available, the more demand would follow as a result of easy access, public response to the presence of bulk billing and supply inducement.
- 55 However, we do not believe that the higher MBS payments in New South Wales can be explained by accessibility-driven demand because New South Wales does not have a greater number of doctors⁹. Secondly, we are not aware of any evidence that the high level supply of health services has created materially more consumption by patients beyond their actual need. Current literature, including a 2002 Productivity Commission Staff Working Paper and recent research by the Australian Centre for Economic Research on Health¹⁰ concluded that supply driven increases in health services are small. Thirdly, our analysis suggests that the bulk-billing rate is not a driver of overall service levels by itself. While price may influence a person's choice of supplier of medical services, it does not substantially affect the demand for overall health care. The finding is consistent with much research which has shown that health care is rather price inelastic¹¹. In addition, there is insufficient evidence to suggest that current State policies materially affect the actual level of MBS payments received.
- 56 Therefore, we do not consider that any possible impact from market drivers has created materially more community and other health services in any State over and above that already allowed for according to the socio-demographic composition in that State.

⁹ Supporting this, according to the most recent AIHW Medical Labour Force Survey, New South Wales has a lower number of medical practitioners per capita than all States except Queensland and Tasmania. In major cities, New South Wales had the lowest number of medical practitioners per capita of the six States shown.

¹⁰ McRae, I. *Supply and Demand for general practitioner Services in Australia*, ACERH Research Report Number 6, July 2009.

¹¹ Koc, C, A theoretical rationale for an inelastic demand for health care, *Economics Letters*, Vol 82, Issue 1, P9-14, Jan 2004

- 57 *Increased Commonwealth funding in the Northern Territory.* Commonwealth policies sometimes can change the economic environment in a State, and additional funding from the Commonwealth normally reduces State expenses. However, the Northern Territory provided data that showed increased Commonwealth expenses on health affected the Territory differently, owing to its immature health system. This data showed that the Northern Territory's expenses increased 600 per cent more than the increases in Medicare expenses during 2004-05 and 2007-08, but the growth in New South Wales was only 40 per cent more. This is because the increased Commonwealth funding reduced some previously unmet needs which appear to have created further flow-on effects for State services. The Northern Territory Emergency Response appears to have generated such flow-on effects for the Northern Territory's health services. In addition, the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes requires different matching arrangements for particular States which will mean that, for reasons outside their control, some States will be required to spend above the average¹².
- 58 As noted earlier, the policy response from a State to the increased Commonwealth funding over time can vary. Any such response may see the total level of services provided in a State rise to above average levels and this may be warranted to overcome previously unmet needs. However, consistent with the policy neutrality guidelines, its only effect on State GST allocations should be through any flow-on effects on the average State policies and expenses. Our approach is designed to determine how much a State would have needed to spend in a specific year to deliver the average level of services having regard to the overall provision, along with that funded privately and by the Commonwealth in that year.

Other factors affecting the cost of services

Administrative scale

- 59 Administrative scale expenses capture the costs of the minimum level of administration required to provide community and other health services. The estimation of those minimum scale affected costs is set out in the Administrative scale chapter.

Location and service delivery scale

- 60 We consider that influences that vary with location have a differential impact on the cost of providing community and other health services across States. For example, differences between States in the cost of wage and non-wage related inputs to services and differences in wage and non-wage costs between regions within a State have an impact on the average costs incurred by each State. We also consider that influences relating to the costs of providing community and other health services in small population centres, or service delivery scale, have a differential impact on State costs. These influences are measured in a similar way for most assessment categories and the methods are described in the Location chapter.

¹² Details of the funding arrangements and responsibilities are yet to be finalised between the Commonwealth and the States for this NPP.

Cross-border

- 61 Cross-border disabilities reflect the nature and geography of the ACT. Being a large centre surrounded by New South Wales means that the ACT provides many community and other health services to New South Wales residents. For example, the ACT's Queen Elizabeth II Family Centre (QEII) has a high non-ACT resident use because there are no other residential postnatal and early childhood services in surrounding New South Wales.
- 62 The cross-border disability recognises the impact of the net service flows between the two jurisdictions for services where funding agreements are not in place. It has been assessed for this category.

Influences not assessed within this category

Cultural and linguistic diversity (CALD)

- 63 No allowance for CALD influences on community and other health services is included in the assessment because we have been unable to obtain sufficiently reliable data to measure it.
- 64 There is a conceptual case that providing services to CALD patients costs more due to the longer consultations and increased planning and coordination, which are often caused by the need for interpreting services. Victoria said these factors could result in costs similar to those for Indigenous patients. However, we have no data to measure the cost impact because information relating to CALD is not generally collected by service providers or any other data collector.
- 65 In relation to service use, some evidence suggests that the use of community and other health services by the CALD population might be lower than the average. The AIHW has said that people born overseas are relatively healthier than their Australian counterparts because hospital statistics show they have lower death and hospitalisation rates and other positive health indicators¹³. The AIHW refers to this as the 'healthy migrant effect'. Victoria said that due to cultural reasons, certain migrant groups may be more likely to forego primary and preventive health care.
- 66 However, the 2004-05 National Health Survey indicates that people who do not speak English at home use emergency departments, outpatient services, day clinics and general practitioners more intensively than people who speak English and the greater use is about 20 per cent. There are some reservations about the reliability of the National Health Survey data. For example, the sample of people who do not speak English at home is small and there are high errors around the results. Also the results are affected by the fact that the higher use is probably due to older migrants who tend to have a lower socio-economic status than the more recent migrants. Some of those effects are captured by the age and socio-economic status allowances.

¹³ AIHW, *Australia's Health, 2008*, pp 91-92. In 2005-06, the age-standardised total hospital separation rate for Australian-born patients was 20 per cent higher than for the overseas born population.

- 67 Overall, we are uncertain about how service use by people with a CALD background differs from others. Consequently, we are unable to determine the combined influences from any higher costs associated with CALD populations and possible lower use of services. Nevertheless, even allowing for upper bound estimation that the average per capita expense for people born overseas and who do not speak English at home was 30 per cent above those for other people, the impact on GST shares is not material for any State in this category.
- 68 However, across the categories, the impact of recognising CALD meets the materiality requirements of the assessment guidelines. Consequently, a single broad allowance has been made for CALD in the Other expenses category. See the Other expenses chapter for more detail on this adjustment.
- 69 Victoria also highlighted the complex, specialised needs of humanitarian refugees (a subgroup of CALD people) and the high cost of providing services to them.
- 70 We accept that humanitarian refugee migrants impose additional costs on States and that some States may have more of them than others. However, we do not intend making allowances for humanitarian refugees because the relatively small numbers of these migrants suggest any allowance would not materially affect the GST distribution and we have no reliable data to indicate where they actually live.

THE ASSESSMENT METHOD

- 71 We have measured the assessed expenses required by States to deliver community and other health services at national average levels by recognising population characteristics and other factors that materially affect aggregate expenses on these services in each State and the extent to which those services are funded from non-State sources. We have assessed disabilities for two expense components in this category:
- service expenses — recognising socio-demographic composition and economic environment combined, location and cross-border disabilities; and
 - other expenses — recognising administrative scale factors.
- 72 Table 13-8 sets out the assessment structure for the category, the disabilities that have been assessed and the relative size of each component, using data for the 2008-09 assessment year. The component weights will be adjusted annually in accordance with actual expenses.

Table 13-8 Category structure, Community and other health services, 2008-09

Component	Component weight	Disability	Influence measured by disability
Service expenses	99.45 %	Socio-demographic composition Cross-border Service delivery scale Location	Recognises that use and cost of State provided community and other health services differ among different population groups. Recognises the cost to the ACT of providing community and other health services to people who are NSW residents. Recognises the cost of providing services in small population centres. Recognises the differences in the cost of providing labour and non-labour resources between States and to different areas within a State.
Other expenses	0.55	Administrative scale	Recognises the unavoidable costs each State incurs to provide the policy and administrative infrastructure necessary to provide the minimum unavoidable service, regardless of the size of the task.

Note: The socio-demographic composition factor in service expenses also includes the effects of costs met by the non-State sectors.

Source: Commission calculation.

Service delivery expenses

73 Service delivery expenses are over 99 per cent of the average expenses for the category. The assessed service delivery expenses for each State were derived by:

- allocating the aggregate service delivery expenses between States on the basis of their population shares (that is, equal per capita); and
- adjusting for:
 - the effects of interstate differences in the socio-demographic composition of State populations (allowances for the different expenses per person incurred in providing services to the young and the elderly, male or female, Indigenous people living in remote and non-remote areas; non-Indigenous people with high or low socio-economic status; and intrastate and interstate differences in the economic environment);
 - the use of ACT services by residents of New South Wales; and
 - the effects on costs of location, including interstate and regional differences, as well as service delivery scale.

74 These calculations are summarised in Table 13-9.

Table 13-9 Service expenses component, Community and other health services, 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Service expenses (\$m)	4 397.5	3 350.4	2 716.3	1 376.5	1 006.7	312.4	217.2	138.4	13 515.5
Socio-demographic composition (a)	0.90314	0.97312	1.03253	1.19632	0.95979	1.18148	1.10786	1.85060	
Cross-border	0.99730	1.00000	1.00000	1.00000	1.00000	1.00000	1.05473	1.00000	
Service delivery scale	0.99585	0.99261	1.00177	1.01056	1.01421	1.00742	0.98740	1.07079	
Location factor	1.00952	0.97943	0.99139	1.03062	0.98646	0.97794	1.00884	1.19427	
Assessed expenses (\$m)	3 968.0	3 158.6	2 775.7	1 709.0	963.3	362.4	252.0	326.5	13 515.5

(a) The proportional impact for each State reflecting its service population shares and associated service costs. Also included are the impacts of the differential costs met by the non-State sectors.

Source: Commission calculation.

75 Details of how each disability factor has been calculated are provided in the following sections.

Calculating the socio-demographic factor (including economic environment effects)

76 Socio-demographic composition disabilities, along with economic environment disabilities, were calculated using a subtraction method which involves the following steps:

- estimate total national expenses on State and State-like community and other health services;
- estimate total expenses in each State by allocating the national expenses among them on the basis of the socio-demographic composition (SDC) of their populations;
- estimate the expenses in each State funded by the Commonwealth government;
- estimate the expenses in each State funded by non-government sources; and
- calculate assessed State expenses as the difference between the estimated total expenses and the estimated non-State expenses in each State.

77 The factors recognised in each step and the sources of data used to measure them are shown in Table 13-10. Subsequent sections outline how each step was implemented.

Table 13-10 Socio-demographic composition calculation factors

Steps	Factors recognised	Data source
1. National total expenses	State expenses	State GFS
	Commonwealth expenses and non-government expenses	Medicare statistics; AIHW health expenditure database; and Department of Health and Ageing
2. Total assessed expenses in each State	Age and sex	AIHW - allocated health expenditure by disease groups; NHS
	Indigeneity and location	AIHW - Indigenous health expenditure
	Socio-economic status	ABS NHS
3. Assessed Commonwealth expenses in each State	Medical services	MBS statistics - rebates
	Aboriginal and Torres Strait Islander grants	Department of Health and Ageing
4. Assessed non-government expenses in each State	Medical services	MBS statistics
	Expenses by insured	PHIAC benefits statistics - difference between fee charged and benefit rebate; and NHS (for NSW and the ACT split)
	Expenses by non-insured	PHIAC membership statistics; and NHS (for NSW and the ACT split)
5. Assessed State expenses	equals 2 - 3 - 4	

Note: This approach also captures the effects of economic environment disabilities.

Source: Commission decision.

Step one — estimate total national expenses

- 78 Total national expenses are the aggregate expenses by the Commonwealth, the States and other providers of community and other health services similar to those normally provided by the States. It is the sum of:
- State expenses on their community and other health services as shown in ABS Government Finance Statistics (GFS) data;
 - Commonwealth expenses on medical services, in particular through Medicare, discounted by 12.5 per cent;
 - Commonwealth Aboriginal and Torres Strait Islander health grants, discounted by 12.5 per cent; and
 - non-government expenses on medical services, dental services, other health practitioners, and public health, discounted by 12.5 per cent.
- 79 State expenses were taken from our usual source of data on State expenses, the ABS GFS. These expenses include State expenses funded by specific purpose and national partnership payments received from the Commonwealth that have an impact on the relativities.
- 80 Details of Commonwealth expenses on medical services were obtained from Medicare statistics and the annual report of Department of Health and Ageing. We identified expenses incurred through Medicare that were comparable to the community and other health services

normally provided by States. Most Medicare expenses on health services excluded from our assessment were related to optometry, operations and incentive payments. Details of Commonwealth grants on Aboriginal and Torres Strait Islanders health were provided by the Department of Health and Ageing.

- 81 Non-government expenses on Medical services were calculated as the difference between the fees charged for the selected Medicare services and the benefit rebates paid. Other non-government expenses were obtained from the AIHW, which publishes health expenditure by source of funding and type of service each year¹⁴. The expenditure database is considered reliable by health policy makers and used extensively.

Step two — estimating total expenses in each State

- 82 This step allocates the total national expenses across the States in accordance with the socio-demographic profile of their population. This step allows for the differences between the States in features of their population that materially affect community and other health expenses (age-sex composition, Indigeneity and the socio-economic status of the non-Indigenous population).
- 83 *Age-sex.* The Commission originally proposed using a broad indicator based on AIHW national health expenditure data for each major disease group¹⁵ and service to measure the effects of the age and sex composition of the population. However, after considering a submission from Western Australia, we concluded that approach was not sufficiently accurate. This is because the data were heavily influenced by expenses on admitted patients and pharmaceuticals where the age expense profile of patients is very different from that for community and other health services.
- 84 Consequently, a more detailed approach was adopted in which the age-sex expense profile for community and other health services was created by amalgamating the profiles for the following six service types:
- out-of-hospital medical services;
 - dental services;
 - community health;
 - public health;
 - non-admitted services (emergency department and outpatient clinic); and
 - other health practitioner (OHP) services.
- 85 The AIHW has provided the expense profiles for the first four components.
- 86 We derived the others using AIHW data on total costs for non-admitted services and other health practitioner services, which we allocated to age-sex groups using data from the ABS

¹⁴ AIHW, Health Expenditure Australia series.

¹⁵ AIHW, *Health system expenditure on disease and injury in Australia, 2000-01*, second edition. The 2004-05 edition of this publication has not been released.

National Health Survey (NHS) on the number of visits to non-admitted or other health practitioner services.

- 87 Our approach assumes the NHS provides an accurate picture of the use of non-admitted and other health practitioner services and that all services have the same average cost across age-sex groups.
- 88 Victoria and Tasmania do not support the assumption of uniform average cost. The Northern Territory would also prefer us to base the calculations on emergency department unit record data which it considers to be more robust than the NHS data. We did not do so because the data are not available for all States and do not cover outpatient clinics or other health practitioner services. It would also be more complex. In addition, the use patterns by age and sex observed in the administrative use data on emergency departments are similar to those observed in the NHS data. As the AIHW¹⁶ has used the same methods as we have, we consider the approach sufficiently reliable.
- 89 *Indigenous/location*. The AIHW series of publications *Expenditures on health for Aboriginal and Torres Strait Islander peoples* provides the most reliable and robust data on health expenditure on Indigenous people. It shows that at the national level, the Indigenous share of community and other health expenses is about 1.5 times its share of the total population.
- 90 Since there are no explicit data that show community and other health services expenses on remote and non-remote Indigenous people, we estimated the extra cost incurred on remote Indigenous people using AIHW data for a range of selected health services¹⁷. We consider these data are representative because expenditure on these services includes more than 85 per cent of the total expenditure on community and other health services for Indigenous people.
- 91 Indigenous remote and non-remote cost weights were derived so that when they are applied to the age-sex expense profile, the share of national community and other health expenses attributed to Indigenous people equals the share calculated from the AIHW data¹⁸. Recognising the additional costs incurred in providing these services to remote Indigenous people is material.
- 92 This region-specific method is strongly supported by Western Australia and the Northern Territory. However, others were concerned about the inclusion of admitted patients expenditure in the calculations and proposed discounting on the basis of data reliability.

¹⁶ <http://www.aihw.gov.au/publications/hwe/dcmudcis93-94/dcmudcis93-94-c04.pdf> .

¹⁷ AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples*, 2004-05, page 25. Categories of services for which it was possible to allocate expenditures by Australian Standard Geographical Classification remoteness areas are hospitals, OATSIH grants to Aboriginal Controlled community Health Organisations, Medical services, Pharmaceutical Benefit Scheme pharmaceuticals and high level residential care. Expenditure on the first three categories of services is used in the calculation.

¹⁸ Derived from AIHW, *Expenditures on health for Aboriginal and Torres Strait Islander peoples*, 2006-07, Table 3.1.

- 93 We consider discounting the Indigenous effect to exclude admitted patients influence is not warranted because there is no evidence suggesting admitted patient services are more location related than non-admitted patients and community health services among Indigenous people.
- 94 Queensland argued the calculations should be based on data on State expenses on Indigenous people rather than expenses by all providers because, since States managed over 60 per cent of Indigenous health program expenditure, it would better reflect the additional costs they face. We consider that could overstate the Indigenous influences. The Queensland suggestion would imply the effect from the lack of access to non-State providers by Indigenous people on State government expenses would be taken into account when deriving the total expenses in the State. However, the same effect would also be captured when expenses by non-State providers are deducted from the State's total under the subtraction model, leading to State Indigenous expenses being overstated. Our approach was supported by New South Wales, Victoria and Tasmania.
- 95 *Allowing for the effects of the socio-economic status of the non-Indigenous population.* The ABS NHS provides the only national data on SES and the use of health services. The NHS includes the Socio-Economic Index for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD). However, because it only reflects service use (not cost), we assumed that all services have the same average cost regardless of the SES of the patient.
- 96 The SES adjustment was calculated by applying different use rates to relevant State populations. The use rates were calculated by:
- combining non-Indigenous people in the bottom and two top quintiles as the high use SES group, and non-Indigenous people in the middle two quintiles as the low use SES group; and then
 - deriving the relative use rates for each non-Indigenous age and sex group by low use SES and high use SES people on the basis of the relative number of health visits per 1000 population for each SES group for the particular age band.
- 97 While income may have provided an alternative measure of SES, we considered the IRSD to be better because it captures more of the influences on a person's lifestyle (which in turn better reflects that person's likely health status) than just income.
- 98 Table 13-11 shows that New South Wales, South Australia, Tasmania and the Northern Territory were assessed as having higher than average total community and other health expenses, while Victoria, Queensland, Western Australia and the ACT were assessed as having below average total expenses.

Table 13-11 Total assessed community and other health expenses per capita by State, 2006-07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Total health expenses	1 363.83	1 351.72	1 352.88	1 358.97	1 377.75	1 377.43	1 339.75	1 619.32	1 361.74

Source: Commission calculation.

Step three — estimate Commonwealth expenses in States

- 99 Relevant Commonwealth expenses include:
- Commonwealth expenses on selected medical services, largely through Medicare rebates; and
 - Aboriginal and Torres Strait Islander grants generally made to Aboriginal community health organisations.
- 100 These are Commonwealth own purpose expenses not paid to State governments, but affecting State fiscal capacities in this category because they fund services that would otherwise need to be provided by the States. These Commonwealth expenses were reduced by 12.5 per cent before we allocated them across the States.
- 101 The actual distribution pattern of Aboriginal and Torres Strait Islander grants to States reflects the extent to which they reduce the need for State provided services and we have used this in the calculation.
- 102 Commonwealth expenses on selected medical services were allocated across States using Medicare statistics. We consider that was appropriate because:
- rebates paid by Medicare Australia under the Medical Benefits Scheme (MBS) were more than 95 per cent of Commonwealth expenses on selected medical services;
 - the rebate levels are the same across all States and regions; and
 - the data are reliable and published regularly.
- 103 Queensland has brought the Commission's attention to the Council of Australian Government (COAG) 19(2) exemption agreement between the Commonwealth and some States (Queensland, Western Australia and the Northern Territory). Under this initiative, public hospitals and community health centres in some remote regions have obtained exemptions from the Health Insurance Act section 19(2), and gained access to Medicare rebates for services.
- 104 The COAG 19(2) is consistent with other section 19(2) exemption programs which are designed to increase primary care services funded by the Commonwealth Government. Since Medicare does not cover the total cost, the extra costs, for example due to location influences have been met by the State government.
- 105 Although the Medicare payments under these programs are not easily identifiable, following advice from the Department of Health and Ageing, we have determined that their impact is sufficiently small that they do not pose a need for any adjustment.
- 106 Table 13-12 shows that Commonwealth medical expenses were above average for New South Wales and Victoria, and below average for the other States. It also shows that the Aboriginal and Torres Strait Islander payments were above average for Queensland, Western Australia, South Australia, ACT and the Northern Territory and below average for New South Wales, Victoria and Tasmania.

Table 13-12 Assessed Commonwealth expenses on Community and other health per capita, 2006-07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Commonwealth medical	461.04	417.64	384.51	341.99	410.30	363.38	331.92	210.83	412.36
Commonwealth Aboriginal and Torres Strait Islander	6.66	4.45	12.85	21.55	15.77	10.87	18.88	214.02	11.94

Source: Commission calculation.

Step four — allocating non-government expenses across States

107 As for the Commonwealth expenses, we discounted the total non-government expenses by 12.5 per cent and then allocated the reduced amount across States. Initially we proposed allocating them using a broad indicator based on private health insurance rebates for ancillary services. However, after several rounds of consultations with the States, we decided to make the assessment in three parts.

- Individuals' 'out of pocket' expenses plus contributions from private medical insurance towards medical services are about 20 per cent of total non-government expenses. They have been allocated in the same way as the associated Commonwealth contributions (that is using the State proportions of MBS payments) because they cover the same services and it ensures the allocation is not affected by regional pricing effects.
- The expenses for non-medical services that are covered by private health fund ancillary benefit policies are around 40 per cent of non-government expenses. These have been allocated across States using data on the number of ancillary benefit recipients provided to the Private Health Insurance Administration Council (PHIAC) by the health insurance organisations, with those figures weighted by the national fees charged for each category of service¹⁹. This process recognises the different costs of each type of service without being affected by differences between States or regions in State policies, service fees or benefits paid. We consider it a better indicator of actual activity levels compared with other possible alternatives, such as the medical labour force.
- The remaining 40 per cent of non-government expenses consist of 'out of pocket' expenses of uninsured people or expenses on items not covered by health insurance policies. We allocated these expenses across States according to their proportions of an adjusted uninsured population. From the number of uninsured people in each State we deducted uninsured Indigenous people living in non-remote areas and uninsured Indigenous and non-Indigenous people living in remote and very remote areas. This

¹⁹ However, since PHIAC statistics on ancillary insurance are published for New South Wales and the ACT combined we had to apportion the combined New South Wales and the ACT ancillary benefit recipients data using data on ancillary insurance coverage from the National Health Survey. We consider those data are a reliable reflection of the actual use of ancillary services because, unlike hospital cover, ancillary cover cannot be used as an instrument for tax purposes and people who purchase it usually expect to use the services.

adjustment recognises that these people have a lower propensity to use, or less access to, non-government services at their own expense²⁰.

- 108 Table 13-13 shows that the distribution of non-government medical expenses is the same as that for Commonwealth medical expenses, with New South Wales and Victoria being above average and the other States below average. New South Wales, Western Australia, South Australia and the ACT were assessed as having greater than average non-government insured expenses, with Victoria, Queensland, Tasmania and the Northern Territory were assessed as having below average expenses. Victoria and Queensland were assessed as having above average non-government non-insured expenses, with the other States being assessed as having below average expenses in this area.

Table 13-13 Assessed non-government expenses per capita, 2006-07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Non-government medical	82.96	75.15	69.19	61.53	73.83	65.38	59.72	37.93	74.20
Non-government insured	166.39	129.45	154.24	172.38	210.25	136.69	178.65	70.77	157.24
Non-government non-insured	160.24	200.80	175.86	117.04	150.55	164.63	153.75	88.83	167.61

Source: Commission calculation.

Step five — calculate assessed State expenses

- 109 We calculated the assessed State government expenses by subtracting the Commonwealth and non-government expenses allocated to each State from the estimated total expenses on community and other health services in that State. State shares of expenses were then used to calculate the socio-demographic composition factor. Table 13-14 illustrates the calculation.

²⁰ The AIHW data indicate that in 2004-05 almost all health services provided to Indigenous people were managed through government programs, suggesting that Indigenous people rarely use non-government services at their own expense. The ABS *National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2004* shows that private ancillary health insurance coverage for Indigenous people in non-remote areas averages nine per cent. Following this, we assume that no Indigenous people living in remote and very remote areas are insured. The AIHW *Medical Labour Force Survey 2005* found that the supply of medical specialists is limited in remote and very remote areas, which would restrict access to services by people living in those regions.

Table 13-14 The derivation of socio-demographic composition (SDC) factors, 2006-07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total/Ave
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
A. Total health expenses	9 417.1	7 057.8	5 676.7	2 871.5	2 184.8	679.4	456.9	347.8	28 692.0
B1. Cwlth medical	3 183.4	2 180.6	1 613.4	722.6	650.7	179.2	113.2	45.3	8 688.4
B2. Cwlth Aboriginal and Torres Strait Islander	46.0	23.2	53.9	45.5	25.0	5.4	6.4	46.0	251.5
C1. Non-govt medical	572.8	392.4	290.3	130.0	117.1	32.2	20.4	8.1	1 563.3
C2. Non-govt insured	1 148.9	675.9	647.2	364.2	333.4	67.4	60.9	15.2	3 313.2
C3. Non-govt non-insured	1 106.4	1 048.5	737.9	247.3	238.7	81.2	52.4	19.1	3 531.5
Assessed State government expenses (A-B1-B2-C1-C2-C3)	3 359.5	2 737.2	2 334.0	1 361.8	819.9	313.9	203.5	214.1	11 344.0
Estimated resident population (million)	6.9	5.2	4.2	2.1	1.6	0.5	0.3	0.2	21.1
Assessed State govt expenses (\$pc)	486.5	524.2	556.2	644.5	517.1	636.5	596.8	997.0	538.4
SDC factor	0.90368	0.97370	1.03315	1.19703	0.96037	1.18219	1.10852	1.85171	1.00000

Notes: This approach also captures the effects of economic environment disabilities. SDC factors shown in this table are based on June 2007 populations and so differ from the factors for other assessment years.

Source: Commission calculation.

Location and service delivery scale

- 110 The location disability captures the effects of factors that affect the cost of providing services in more remote areas, and interstate differences in the cost of inputs. The derivation of these factors is described in the Location chapter. The service delivery scale disability captures the effects of factors that affect the costs of providing services in small population centres. The derivation of this factor is described in the Service delivery scale chapter.
- 111 The general location factors are applied to the assessed State expenses on community and other health services. Queensland and the Northern Territory argued for the general location effect being assessed conjointly with the socio-demographic composition influences to derive the total community and other health expenses in the States.
- 112 However, we have no reliable data upon which to derive a location cost adjustment for Commonwealth expenses or for non-government expenses. In addition, conceptually, if the location cost impacts were accurately attributed to each line of the subtraction model, this should yield the same result as applying the general location adjustment only to State expenses. Therefore, for simplicity, location cost effects have largely been excluded from the subtraction model and are only applied once State expenses have been assessed. We have achieved this as the MBS rebate is uniform across regions and the private health insurance benefit schedule is also similar.

Cross-border

- 113 The cross-border factor is calculated by increasing the ACT population by a proportion of the population in surrounding areas of New South Wales and reducing the New South Wales population by the same amount.
- 114 We consider that people tend to make greater use of local community and other health services facilities. Only those services that are specialised, not readily available elsewhere in the region, are likely to be heavily used by cross-border populations. While New South Wales residents represent around 30 per cent of patients treated in ACT hospitals, a much lower proportion of the New South Wales catchment population is likely to use ACT community and other health services. Data supplied by the ACT indicated that 9.5 per cent in 2006-07 and 11 per cent in 2007-08 of community health occasions of service were for non-ACT residents. This is equivalent to approximately 30 per cent of the population of the following statistical local areas in the surrounding parts of New South Wales: Queanbeyan, Palerang, Cooma-Monaro, Goulburn-Mulwaree and Yass Valley. We have used our general approach to calculate cross-border factors.
- 115 The cross-border factor is not applied to emergency department and outpatient (non-admitted) expenses because the provisions in the Australian Health Care Agreement (and its successor agreement) allow for bilateral agreements between States for the cross-border use of hospital services. The proportion of expenses not relating to non-admitted patient services was estimated, using GFS data, to be consistent over the period from 2003-04 to 2008-09 at around 60 per cent of category expenses. As updated data on these non-admitted patient services will not be available over the period of the review, we will fix the proportion of expenses to which cross-border factors will apply at 60 per cent.

Other expenses

- 116 The other expenses comprise the administrative scale affected expenses, as adjusted for the effects of interstate differences in wage costs (the calculation is shown in the Administrative scale chapter). The result is shown in Table 13-15.

Table 13-15 Other expenses component, Community and other health services, 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Administrative scale expenses	9.4	9.2	9.0	9.3	9.1	8.9	9.5	10.3	74.8
Assessed expenses	9.4	9.2	9.0	9.3	9.1	8.9	9.5	10.3	74.8

Source: Commission calculation.

Bringing the category together

- 117 Table 13-16 brings the assessed expenses for each component together to derive the total assessed expenses for each State for the category.

Table 13-16 Assessed expenses, Community and other health services, 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Service expenses	3 968.0	3 158.6	2 775.7	1 709.0	963.3	362.4	252.0	326.5	13 515.5
Other expenses	9.4	9.2	9.0	9.3	9.1	8.9	9.5	10.3	74.8
Total	3 977.4	3 167.7	2 784.8	1 718.4	972.4	371.3	261.5	336.8	13 590.3
Assessed expenses (\$pc)	564.9	590.5	640.2	779.6	603.2	742.2	751.8	1 519.4	628.0
Cost of service provision ratio	0.89950	0.94028	1.01955	1.24152	0.96060	1.18189	1.19714	2.41947	1.00000

Source: Commission calculation.

118 Table 13-17 summarises the category factors. It shows for each disability how the expenses per capita in each component and in total are affected by differences in State characteristics. Disability factors below one indicate a State is assessed to need to spend less than average. Disability factors above one indicate States are assessed to need to spend more than average.

119 Table 13-16 and Table 13-17 show that service expenses and the differences between the States in the socio-demographic composition and economic environment are the main drivers of differences in assessed expenses in this category.

Table 13-17 Category factor, Community and other health services, 2008-09

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Service expenses (component weight = 99.45 %)									
Socio-demographic composition	0.90314	0.97312	1.03253	1.19632	0.95979	1.18148	1.10786	1.85060	1.00000
Cross-border	0.99730	1.00000	1.00000	1.00000	1.00000	1.00000	1.05473	1.00000	1.00000
Service delivery scale	0.99585	0.99261	1.00177	1.01056	1.01421	1.00742	0.98740	1.07079	1.00000
Location	1.00952	0.97943	0.99139	1.03062	0.98646	0.97794	1.00884	1.19427	1.00000
Component factor	0.90233	0.94275	1.02186	1.24161	0.95689	1.15992	1.15989	2.35830	1.00000
A. Weighted component factor	0.89737	0.93756	1.01624	1.23478	0.95162	1.15354	1.15350	2.34533	0.99450
Other expenses (component weight = 0.55 %)									
Administrative scale	0.38715	0.49373	0.60097	1.22537	1.63150	5.15091	7.92995	13.47304	1.00000
Component factor	0.38715	0.49373	0.60097	1.22537	1.63150	5.15091	7.92995	13.47304	1.00000
B. Weighted component factor	0.00213	0.00272	0.00331	0.00674	0.00898	0.02835	0.04364	0.07414	0.00550
Category factor [A+B]	0.89950	0.94028	1.01955	1.24152	0.96060	1.18189	1.19714	2.41947	1.00000

Source: Commission calculation.

WHAT IS THE IMPACT ON THE GST DISTRIBUTION?

120 Table 13-18 shows the extent to which the assessment for this category moves the distribution of the GST away from an equal per capita distribution. It shows that New South Wales,

Victoria and South Australia are assessed as needing to spend less than the average per capita amount to deliver the average level of community and other health services. Conversely, Queensland, Western Australia, Tasmania, the ACT and the Northern Territory are assessed as needing to spend more than the average.

Table 13-18 GST impact, Community and other health services

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Redist
Dollars million	-413.0	-187.8	49.6	306.7	-37.3	53.6	41.5	186.6	638.0
Dollars per capita	-57.92	-34.39	11.14	135.59	-22.88	106.24	117.57	823.98	28.97

Note: The difference from an equal per capita assessment derived using 2006-07 to 2008-09 assessed expenses and 2009-10 GST.

Source: Commission calculation.

121 The driver for each State is different. As can be seen from Table 13-11, Table 13-12 and Table 13-13, the impact of non-State provision is generally greater than the impact of the distribution of different population groups. Some of the main drivers of the redistributions for each State are:

- New South Wales and South Australia each have higher than average levels of private provision of services;
- Victoria has a lower than average proportion of Indigenous people, along with fewer than average people living in remote and very remote regions;
- Western Australia and the Northern Territory each have an above average Indigenous population share, much of which live in remote areas, combined with lower than average levels of private provision of services; and
- Tasmania and the ACT each have lower than average levels of private provision of services.

122 Table 13-19 shows State proportions of Indigenous people and people living in remote (including very remote) regions, along with the proportion of people with private ancillary benefits cover and the number of full-time workload equivalent (FWE) general practitioners. These drivers are indicative of the accessibility of State populations to private services.

Table 13-19 Indicative demographic and economic drivers, Community and other health services, 2006-07

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
Indigenous population (%)	2.25	0.66	3.54	3.42	1.80	3.81	1.29	30.33	2.50
Remote population (%) (a)	1.18	0.11	3.35	6.28	2.47	0.56	0.00	38.86	2.31
High use SES (%) (b)	62.51	60.47	56.60	61.10	57.63	54.10	77.49	63.70	60.37
Age 65+ (%)	13.64	13.46	12.18	11.86	15.20	14.81	9.73	4.88	13.12
Ancillary insurance coverage (%) (c)	46.57	35.45	39.20	57.47	49.33	43.86	46.57	30.74	43.42
FWE GP per 1000 population (no.) (d)	0.94	0.84	0.85	0.71	0.89	0.79	0.66	0.48	0.86

(a) Remote includes people living in remote and very remote regions.

(b) High use SES includes most disadvantaged, second least disadvantaged and least disadvantaged SEIFA quintiles.

(c) New South Wales and the ACT coverage is their combined coverage.

(d) FWE is Full-time work equivalent, a measure of service provision taking into account doctor workload.

Source: ABS ERP June 2007; Private Health Insurance Administration Council; Department of Health and Ageing.

123 Table 13-20 provides a summary of how the different components of the assessment move State GST shares away from an equal per capita distribution.

Table 13-20 Reasons for difference from EPC — Community and other health services

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Redist
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Socio-demographic composition factor	-400.5	-86.0	82.7	256.0	-38.2	52.8	21.9	111.2	524.6
Cross-border factor	-11.2	0.0	0.0	0.0	0.0	0.0	11.3	0.0	11.3
Service delivery scale factor	-17.2	-23.4	4.5	13.9	13.4	2.1	-2.6	9.3	43.2
Location factor	44.8	-61.9	-22.4	31.2	-12.7	-6.4	2.3	25.1	103.4

Source: Commission calculation.

124 Table 13-21 provides a summary of the main reasons for changes in the GST distribution since the 2009 Update. It shows that for most States, method changes have had the largest effect of the distribution of GST.

Table 13-21 Changes since the 2009 Update — Community and other health services

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Redist
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Shortening the review period	2.5	-1.4	-9.7	10.8	-3.4	-3.4	1.7	2.9	17.9
Method changes	-326.6	20.3	39.7	184.3	9.2	43.2	35.1	-5.2	331.7
State circumstances	-30.8	-20.4	9.8	33.3	-6.6	2.6	1.5	10.5	57.8
Total	-354.8	-1.5	39.9	228.3	-0.9	42.4	38.2	8.3	357.1

Source: Commission calculation.

125 The main change in the method is the way in which the private provision of services is recognised in the assessment. The 2010 Review assessment method has utilised a wider range

of total health services and private provision data to compensate for the limited data available on the use of State services. These data enable us to better estimate the use of State services.

- 126 In addition, we have captured the impact of private provision on State services by recognising the throughput of private providers, not only their numbers. We have recognised that, while New South Wales does not have more doctors, their throughput is considerably higher than the average. This acts to decrease the share of GST required by this State. The new method also recognises that Western Australia, Tasmania, the ACT and the Northern Territory not only have relatively fewer general practitioners, but also have difficulties in attracting and retaining other health professionals. This acts to increase the GST shares of these States. The increase in the GST share of the Northern Territory has been more than offset by the effect of downward revisions to total State spending from 2005-06 to 2007-08, following a change of treatment of the Commonwealth NPP on essential vaccines (vaccine purchase).
- 127 Further, in this review we have used annual estimated resident population data (ERP) disaggregated by age, sex, Indigeneity and socio-economic status to estimate the required expenses in each State. This change captures the population changes in States and thus better matches overall State service needs with those met by non-State providers. As a result, the assessment recognises that a shortage of private health providers is compounded when the population grows at a faster rate, leading to a greater need for the provision of State-provided services.
- 128 The category has grown faster than the growth of GST revenue. Therefore, Table 13-21 shows GST being redistributed to the States whose disabilities are above average, namely Queensland, Western Australia, Tasmania, the ACT and the Northern Territory, and away from the other States.
- 129 The proportion of expenses for community and other health services on Indigenous people has increased over the assessment period. This is consistent with GST revenue being redistributed to States with above average Indigenous populations, such as Western Australia and the Northern Territory, and away from States with below average proportions of Indigenous people, such as Victoria and South Australia. In addition, lower private service growth compared to population growth has acted to increase the GST share of Queensland, Western Australia and the Northern Territory. Conversely, continued higher than average private service provision despite reductions in population share has acted to decrease the GST share of New South Wales, Victoria and South Australia.

UPDATE PROCESS

- 130 We recommend that data used in this assessment be updated when new data become available to ensure the relativities remain as contemporary and consistent with the circumstances of the States as possible. On this basis, we recommend:

- The AIHW Indigenous health expenses data, published biannually (currently four years in arrears), be used to calculate Indigenous weight and Indigenous remote weight.
- Total health expenses, Commonwealth expenses, non-government expenses, along with estimated population data be updated to the year of Indigenous health expenses.
- The age and sex profile be updated according to the schedule of the National Health Survey.

SIMPLIFICATION

131 In the Community and other health services category, simplification has been achieved by this single assessment replacing two separate assessments. The two separate assessments in the 2004 Review (Non-inpatient and community health services and Population and preventive health) comprised a dozen components. Where a diverse range of third party data were integrated with some State data in the 2004 Review assessments, the new assessment eliminates any dependence on data directly sourced from States. Proxy measures and judgment are used in the new assessment to develop a broad indicator of assessed State expenses, adjusted by a small number of common factors. Nonetheless, fewer judgments have been required.

FURTHER INFORMATION

- 132 Background material in support of this assessment is published on the Commission's website. That material includes the following documents, released for comment in the development of this assessment, together with State submissions responding to those documents:
- Staff discussion paper *2007/21-S Assessing Community and other health services for the 2010 Review*;
 - Staff discussion paper *2007/32-S*, supplement to *2007/21-S*;
 - Staff discussion paper *2008/02-S*, supplement to *2007/21-S* and *2007/32-S*;
 - Staff discussion paper *2007/36-S Health as a single category*;
 - Commission position paper *2008/20 Community and other health services*; and
 - *2010 Review Draft Report*.