

Health

Overview

- 1 On 27 June 2023, the Commission issued a [consultation paper](#) on the draft health assessment. The Commission considered changes since the 2020 Review and their implications for the assessment method.
- 2 The Commission proposed to retain the 2020 Review assessment method with changes to the assessment of community and public health expenses.
- 3 A summary of state and territory (state) responses to each consultation question is included below, as well as the Commission's draft position and the draft 2025 Review assessment method.
- 4 State submissions can be viewed [here](#).

Consultation questions

Q1. Do states agree that in a post-pandemic environment, the hospital and patient transport assessments remain fit for purpose?

State views

- 5 States said that there were no ongoing implications for the health assessment from the COVID-19 pandemic. Queensland, Western Australia and the ACT said that the impacts of the pandemic were only temporary. The Northern Territory said that the impacts of COVID-19 were significant, but do not warrant a long-term departure from existing methods.
- 6 New South Wales said that, without a clear alternative data source being both available and reliable, National Weighted Activity Unit data remain the appropriate data source for the assessment. Tasmania said that the assessments use data based on national weighted activity units from different health service settings and continue to be reliable measures of the use and cost of services by socio-demographic group.

Commission draft position

- 7 On the basis of feedback provided by the states, the Commission considers there are no ongoing implications from the COVID-19 pandemic for the health assessment.

Q2. Do states agree that the proposed changes to the community and public health assessment in this paper will contribute to making the assessment more responsive to developments affecting this part of the health system?

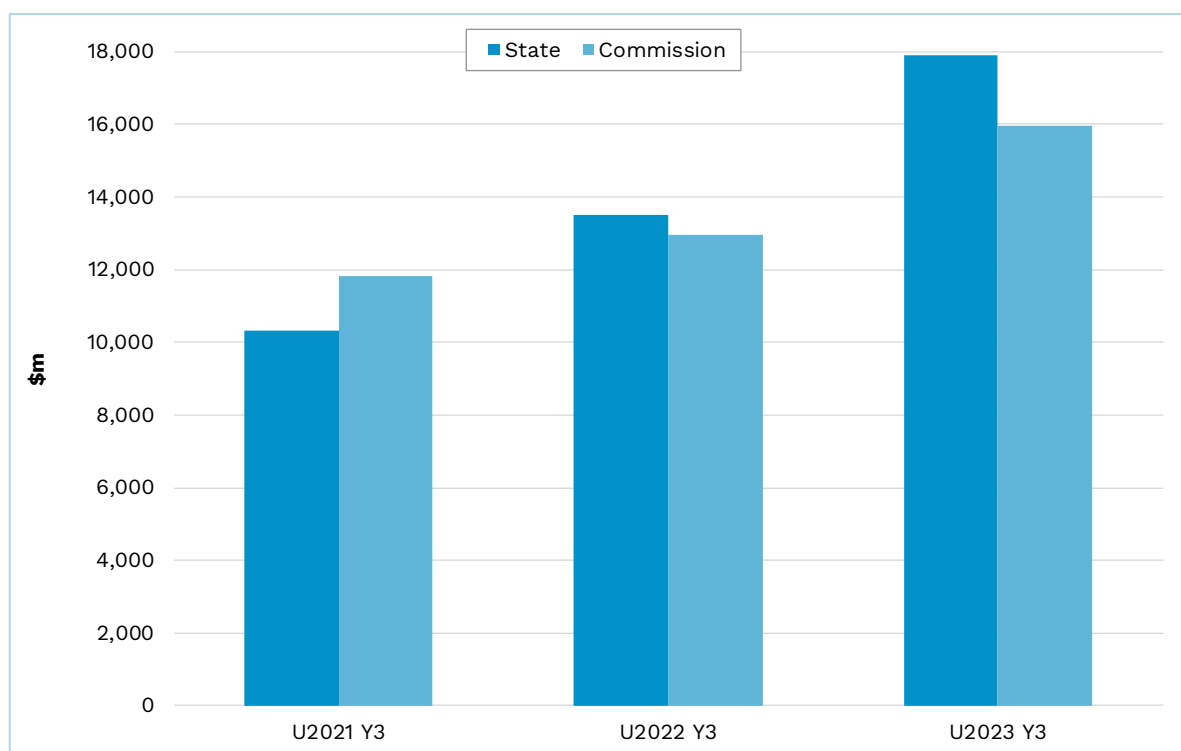
State views

- 8 States said they were generally supportive of efforts to improve the responsiveness of the health assessment, although some states said they have significant concerns with the specific proposal put forward by the Commission. The Northern Territory said the assessment should be built assuming medium to long-term stability in the health system rather than to maximise resilience to exceptional shocks.
- 9 New South Wales and the ACT said that the proposed changes to the community and public health assessment would contribute to making the assessment more responsive to changes in this part of the health system. Victoria said these changes will improve the accuracy of the assessment, at least in part. Queensland said it supported the Commission's efforts to make the assessment more responsive.
- 10 Western Australia said it did not see any benefit in making an assessment more responsive to poor measures of need. To improve responsiveness, Western Australia and the ACT said they supported the Commission's proposal to use state-provided health component expense data for the latest data year rather than assuming all components grow at the same rate as the overall health category.
- 11 South Australia said any indicator that is based on proxy data will not completely capture what is actually occurring. It said the robustness of a proxy will depend on how well it tracks what is trying to be measured in a policy neutral way. It said there is merit in investigating alternative measures that better capture changes in community health, provided this is based on robust, consistent and reliable data; and it is not policy influenced.
- 12 Tasmania said it agreed that during the COVID-19 pandemic there was a significant public health response by the Australian and state governments. It said the current community and public health assessment did not capture the COVID-19 shock because it uses a proxy indicator: emergency department triage categories 4 and 5 national weighted activity unit data. It said that during the pandemic, emergency department presentations were restricted, while community and public health expenditure increased significantly.
- 13 While Tasmania supported changes to the assessment to make it more reflective of actual service use, and therefore better able to respond to developments affecting community and public health, it said it did not agree that the proposed changes are more reliable than the current proxy.

Commission response

- 14 The Commission assesses GST relativities over 3 assessment years. In expense assessments, for the third assessment year, the Commission usually aggregates state data to the category level and increases component level expenses for the second assessment year by the growth in category level expenses. This is done to limit the size of data revisions in the subsequent update due to changes made to state data by the ABS. However, if there are significant differences in spending growth between components, a better outcome may be to allow the assessments to try to capture this effect.
- 15 In the health assessment, spending on community and public health and hospital services are aggregated to the category level. During the COVID-19 pandemic, spending on community and public health did not always move in line with spending on hospital services. This resulted in differences between the expenses used by the Commission in year 3 compared with if it had used the community health data provided by states. For example, in 2019–20 (year 3 for the 2021 Update), state-provided spending data were lower than the Commission’s estimate. In 2021–22 (year 3 for the 2023 Update), state-provided data were higher (Figure 1).
- 16 In addition to considering changes in the method for calculating component weights, the Commission has also considered other changes to make the assessment more responsive to changed circumstances. The Commission’s response to state views on other proposed changes to the community and public health assessment are discussed subsequently.

Figure 1 Community and public health expenses (gross)



Source: Commission calculations using state-provided expense data on a Government Finance Statistics basis.

Commission draft position

- 17 Events that may lead to significant variation in the growth of the components in the health assessment are likely to be rare. For the 2025 Review, the Commission considers it better to maintain the existing approach, which minimises data revisions between updates. The Commission could switch to using state-provided year 3 data when a relevant shock has occurred. This has been done for the past 3 updates in the services to industry assessment in response to the large increase in state spending on COVID-19 business support.
- 18 The Commission will continue to explore other options to improve the responsiveness of the health assessment, including by reducing reliance on proxy indicators of activity.

Q3. Do states consider the experiences with the COVID-19 pandemic have implications for the health assessment?

State views

- 19 New South Wales and Victoria said that state spending associated with COVID-19 should be assessed on an actual per capita basis.
- 20 New South Wales said that state responses to COVID-19 were jointly agreed and aligned to the National Partnership on COVID-19 Response. During the acute stage of the pandemic in 2019–20 and 2020–21, prior to widespread vaccination, all states

pursued a zero-COVID-19 policy. Differences in responses between states therefore reflected differences in circumstances rather than policy.

- 21 New South Wales said that certain areas of Australia were more impacted by COVID-19 due to their status as major domestic and/or international transport hubs, higher population density, and other factors which may have promoted the spread of COVID-19 further.
- 22 New South Wales said that drivers of state expenditure on COVID-19 mitigation and response were epidemiological. It said spending patterns across Australian health systems reflected the presence of viral outbreaks. It said spending did not reflect standard cost drivers, such as remoteness, Indigeneity, or the presence of non-state services.
- 23 Victoria said that, in responding to COVID-19, state expenses were driven by uncontrollable and random impacts of the virus, following nationally agreed frameworks. It said expenses did not follow the Commission's drivers for health expenditure in the 2020 Review methods, being more concentrated in major cities and younger, non-Indigenous residents.
- 24 New South Wales said that COVID-19 related costs should include quarantine expenses incurred by New South Wales on behalf of other states that have not been reimbursed.
- 25 Victoria said that, to take account of the Commission's inability to change its methods between reviews, a retrospective adjustment should be made to fully take account of the differential impact of COVID-19 on state health expenses. It said, unless this was done, COVID-19 spending from 2019–20 and 2020–21 would never be assessed accurately and 2021–22 would only be assessed accurately once out of 3 assessment years.
- 26 The ACT said that the COVID-19 pandemic revealed the need for flexibility in assessment methods in response to major shocks in the health assessment. The ACT supported the Commission investigating alternative data sources to identify drivers of the use and cost of services, including due to a public health threat.

Commission response

- 27 The terms of reference for the 2021, 2022, 2023 and 2024 updates did not provide for a change in assessment method in response to COVID-19. Consequently, Commonwealth payments associated with the National Partnership on COVID-19 Response were treated as no impact since the COVID-19 spending was not specifically assessed. The 2020 Review health assessment was applied to state funded spending under the National Partnership on COVID-19 Response.
- 28 With the flexibility to change the health assessment in response to COVID-19 following the 2025 Review, the Commission is able to use an alternative assessment for assessing state spending related to COVID-19.

29 The Commission has stated previously how it would assess COVID-19 related spending if permitted under the terms of reference for an update. For example, in the 2023 Update New Issues discussion paper, it stated:

‘If terms of reference allow for a change in method to respond to COVID-19:

- treat the Commonwealth payments under the National Partnership on COVID-19 Response as impact; and
- assess state spending associated with the national partnerships on an actual per capita basis.’¹

30 The basis of this position was that:

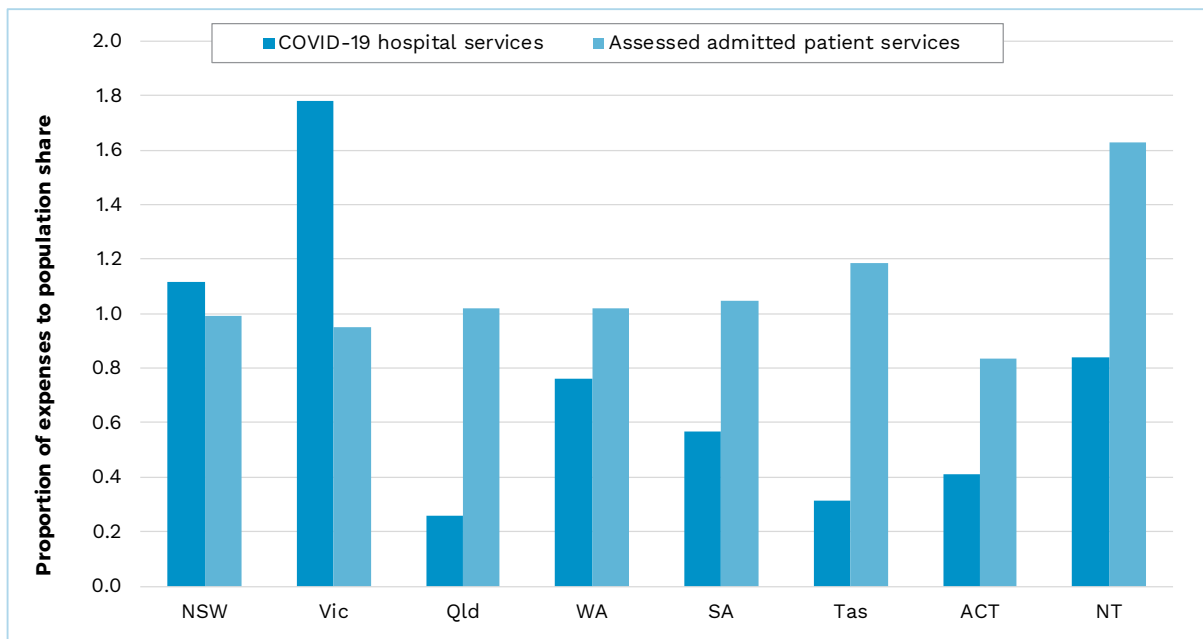
- the differences in spending between states on COVID-19 cannot be fully explained by the Commission’s health assessment of state spending needs on health services more broadly
- the Commission considered state responses to the COVID-19 pandemic largely reflected circumstances outside of state control rather than policy choices.

31 For the 3 assessment years for the 2024 Update, Figure 2 and Figure 3 compare the distribution of state spending associated with the National Partnership on COVID-19 Response with the distribution of spending needs under the health assessment, for hospital and public health services respectively. Significant differences exist between the distribution of state spending on COVID-19 and the distribution of spending needs resulting from the Commission’s health assessment methods.

32 Introducing flexibility to change assessment methods in response to shocks such as the COVID-19 pandemic is covered in the chapter on flexibility to consider method changes between reviews.

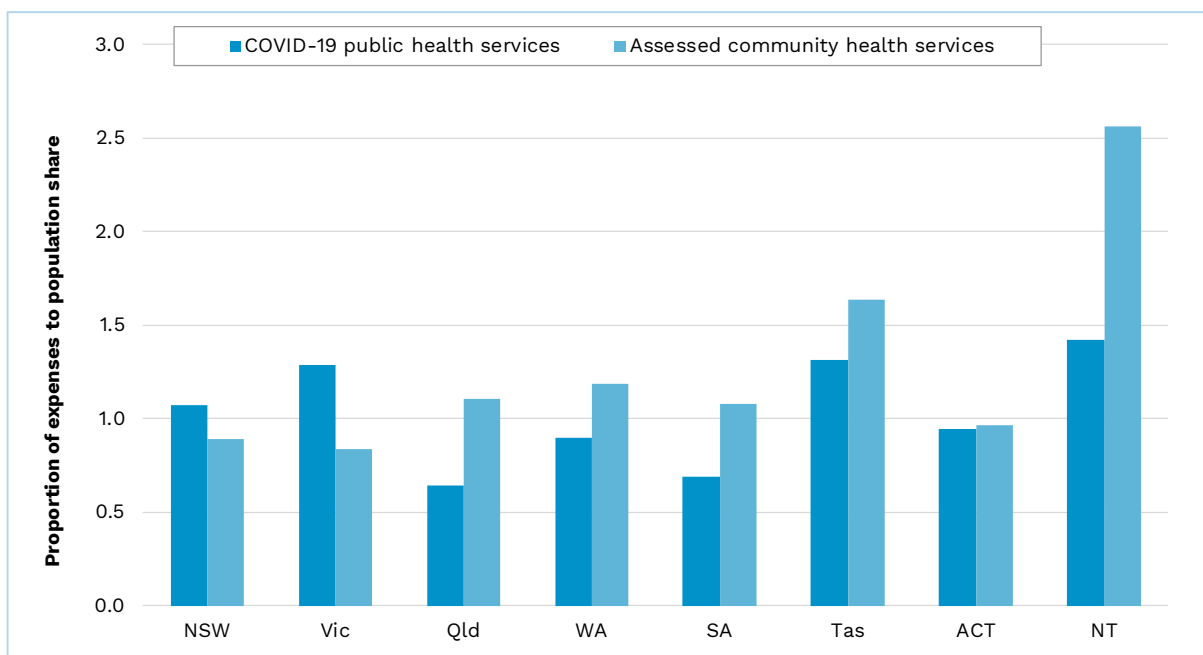
¹ Commonwealth Grants Commission (CGC), [Discussion Paper - 2023 Update New Issues.pdf \(cgc.gov.au\)](#), CGC, Australian Government, 2023, accessed 14 June 2024, p13.

Figure 2 COVID-19 public hospital services spending (2020–21, 2021–22 and 2022–23) versus Commission’s assessment of needs for admitted patient services



Source: Commission calculation using reconciled National Health Funding Body National Partnership on COVID-19 Response expenses, assessed admitted patient expenses and ABS population data.

Figure 3 COVID-19 public health spending (2020–21, 2021–22 and 2022–23) versus Commission’s assessment of needs for community and public health spending

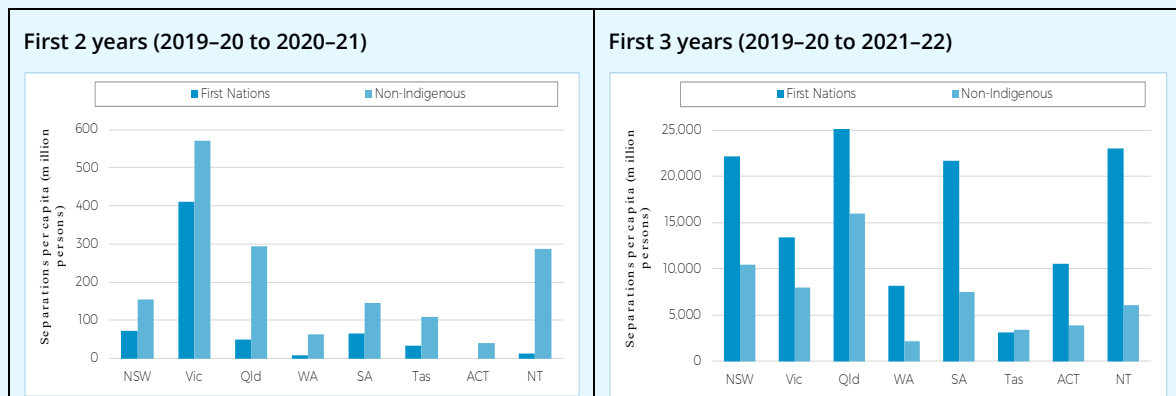


Source: Commission calculation using reconciled National Health Funding Body National Partnership on COVID-19 Response expenses, assessed community health expenses and ABS population data.

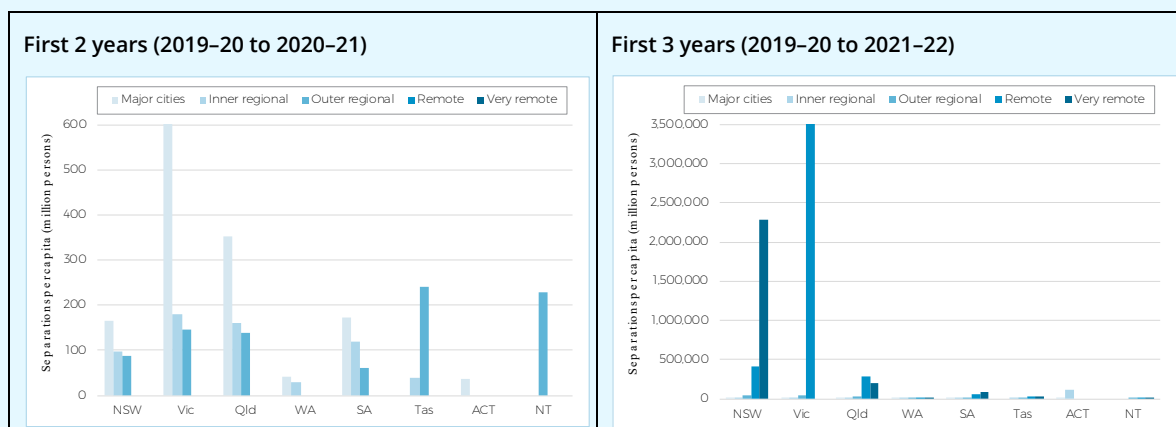
Box 1 Changing impact of COVID-19

The charts show the changing impact of COVID-19 by select socio-demographic composition groups, by state, as measured by admitted patient separations. Total COVID-19 admitted patient separations in 2021–22 were 263,425, far in excess of the separations during 2019–20 (2,628) and for 2020–21 (4,718). More recent data on deaths covering 4 years to 30 September 2023 show a similar pattern with the impact by location and socio-demographic driver evolving over time. This fluidity and the magnitude of the change between years means there was a mismatch between needs assessed in the assessment period and those in the application period.

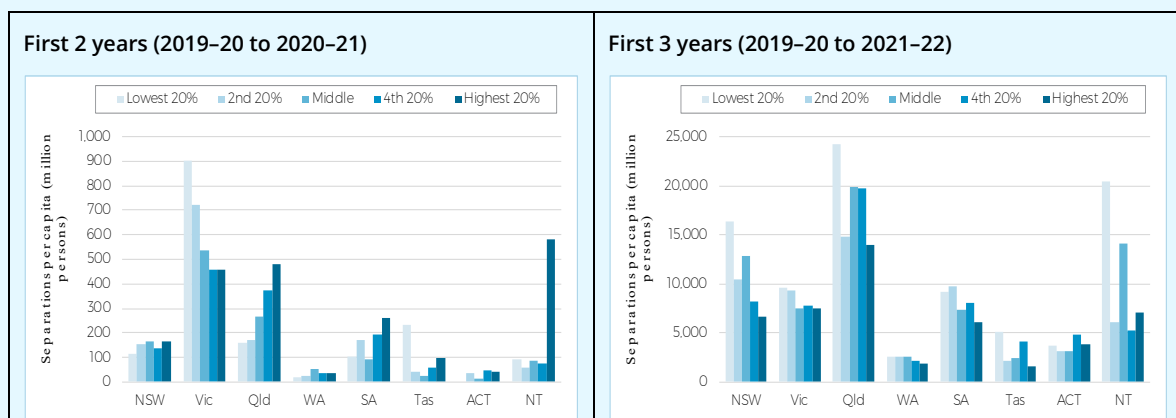
Admitted patient separations with a COVID-19 diagnosis by Indigenous status



Admitted patient separations with a COVID-19 diagnosis by remoteness



Admitted patient separations with a COVID-19 diagnosis by socio-economic status



Source: Australian Institute of Health and Welfare, National Hospital Morbidity Database, 2019–20 to 2021–22.

Commission draft position

- 33 The Commission considers that, for the 2025 Review, a separate assessment of state spending on COVID-19 related public hospital and public health services would result in a better assessment of state expense needs.
- 34 The Commission proposes to treat the Commonwealth payments for public hospital and public health services under the National Partnership on COVID-19 Response as impact and assess state spending associated with the national partnership on an actual per capita basis. Commonwealth payments to maintain private hospital viability will continue to be treated as out of scope because they are not related to a usual state responsibility for which needs are assessed.
- 35 The reconciled value of the payments would be used rather than the estimates published in the Commonwealth's Final Budget Outcome, as they are a more accurate reflection of state spending. Ideally, national weighted activity units with a COVID-19 diagnosis should be removed from the data used in other components of the health assessment for the assessments years in which there is a separate COVID-19 assessment. However, given this adds complexity and that the number of national weighted activity units with a COVID-19 diagnosis is likely to be small, this adjustment would not be made.²
- 36 The National Partnership on COVID-19 Response ceased in 2022–23. The separate assessment of state spending under the national partnership will continue until the 2027 Update when 2022–23 drops out of the Commission's assessment year period. The 2025 Review includes the 3 assessment years 2021–22 to 2023–24, and there will be a separate assessment of state spending on COVID-19 related hospital and public health services in 2021–22 and 2022–23. In the 2026 Update, there will be a separate assessment on COVID-19 spending only for 2022–23 because 2021–22 will drop out of the assessment period. For the 2027 Update, 2022–23, the last year for the National Partnership on COVID-19 Response, will have dropped out of the assessment period.
- 37 Victoria is seeking a retrospective adjustment to the GST distribution in the 2021–22 to 2024–25 application years, with this adjustment reflected in the GST distribution for the 2025–26 application year. The Commission does not consider it has the mandate to apply the assessment retrospectively. The assessment of state expenses related to COVID-19 was considered by the Commonwealth Treasurer in consultation with states on the terms of reference for the 2021 Update and subsequent updates. The terms of reference for these updates did not allow for method changes to assess COVID-19 related expenses differently.

² Australian Institute of Health and Welfare, [Admitted patient care: 2019–20 separations with a COVID-19 diagnosis; Admitted patient care: 2020–21 separations with a COVID-19 diagnosis; Admitted patient care: 2021–22 separations with a COVID-19 diagnosis](#), Australian Institute of Health and Welfare, accessed 14 June 2024.

38 The Commission does not propose to include unpaid quarantine expenses in the assessment. The Commission does not have the mandate to adjudicate disagreements between states on issues beyond its terms of reference.

Q4. Do states agree to:

- **use the Australian Institute of Health and Welfare data on community mental health activity, adjusted to compensate for lack of cost weights, to determine per capita use rates for mental health services?**
- **for the balance of the component, expand the current proxy to include non-admitted patient services?**
- **continue to apply a discount of 12.5% to the community health socio-demographic assessment?**

Direct measure of specialised community mental health activity

State views

39 New South Wales, Victoria, South Australia and the ACT said they supported the use of a direct measure of community health activity in the community and public health assessment.

40 New South Wales and the ACT said they supported adjustments to the data to account for a lack of cost weights. New South Wales said it was specifically seeking to account for the different costs associated with the age of patients.

41 Victoria said that the current proxy for activity (emergency department triage categories 4 and 5) is not based on sufficient evidence.

42 South Australia said its support was subject to the Commission being able to develop a robust adjustment to compensate for the lack of cost weights, particularly for services in remote areas.

43 Queensland, Western Australia, Tasmania and the Northern Territory said they did not support the proposal.

44 Queensland said that the activity data are not fit for purpose because these reflect the service availability of public specialised mental health care rather than actual need for community mental health services. It said it expected that the unmet need would be higher in regional, rural and remote areas. This is because there are significant shortages in the allied health workforce in regional and remote Australia. It said emergency department activity data are likely to be more reflective of actual community mental health services need.

45 Western Australia said it was concerned with the exclusion of services delivered through non-government organisations.

- 46 Tasmania said that the collection is not complete or comparable between and across jurisdictions. Tasmania also referred to recent analysis of community mental health services data by the Independent Health and Aged Care Pricing Authority's Technical Advisory Committee, which found that there is considerable variability and data reliability issues with states' reporting.
- 47 The Northern Territory said it had concerns with the consistency of reporting between states and the sensitivity of the proposed approach to the choice of number of service contacts or number of patients using state services. The Northern Territory said that if contacts are used, the database is likely to undercount remote service costs. This is because remote service provision often requires specialists to travel considerable distances at high cost, which results in a service model based on less frequent, but higher intensity, contacts. A simple count of contacts would likely under-represent both costs and the intensity of services. Patients would be a superior measure, though would still require service delivery scale adjustments and remoteness loadings.
- 48 Lack of cost weights was a common concern for the states that did not support the Commission's proposal.

Commission response

- 49 The Commission looks at the services states provide on average and identifies the factors outside a state's control such that the state needs to spend more (or less) to provide the average level of services. The Commission does not assess what states require to meet unmet demand for services. As such, Queensland's comment that specialised community mental health services do not capture the unmet need for community mental health services is not relevant to the decision on whether to adopt the Australian Institute of Health and Welfare data to measure average service levels. What is relevant is if gaps or inconsistencies in the data mean that these are not representative of service use by location and socio-demographic characteristics.
- 50 As regards Tasmania's reference to recent analysis of community mental health data, the dataset being critiqued by the Independent Health and Aged Care Pricing Authority's Technical Advisory Committee is not the one that the Commission proposes to use. The Independent Health and Aged Care Pricing Authority's data on community mental health care include information on episodes of patients receiving mental health care that are associated with Australian public hospital services. Community mental health is currently block funded although some specialised community mental health care services are transitioning from a block funding to an activity-based funding model.³ The Independent Health and Aged Care Pricing Authority's dataset may eventually be fit for purpose for the Commission to use in

³ Independent Health and Aged Care Pricing Authority, Pricing Framework for Australian Public Hospital Services 2023–24, [Pricing framework 2023-24](#), Independent Health and Aged Care Pricing Authority, 2022, accessed 14 June 2024, p.19.

the health assessment, but additional time is required to improve the quality and quantity of activity and cost data.

- 51 Further information on the issues with consistency in reporting between states, raised by Tasmania and the Northern Territory, can be found in the Community Mental Health Care Database 2020–21 data quality statement.⁴ In summary:
- There is some variation in the types of service contacts included in the data. For example, some states may include written correspondence as service contacts while others do not.
 - The Indigenous status data should be interpreted with caution due to the varying quality of Indigenous identification across jurisdictions reporting to the database. While all states consider the quality of Indigenous status data to be acceptable, most acknowledge that further improvement is required. Indigenous status is missing for 4.9% of contacts in the 2020–21 National Community Mental Health Care Database.
 - Data are reported by the jurisdiction that delivered the service and therefore may include people receiving services in one jurisdiction who reside in another. These cross-border flows are particularly relevant when interpreting ACT data.
 - There is variation across jurisdictions in the coverage of services providing contact data and the estimated service contact data coverage.
- 52 In the Community Mental Health Care Database 2020–21 data quality statement, all states estimate that 85–100% of in-scope community mental health care services provided contact data to the collection, and overall service contact data coverage for jurisdictions was estimated to be between 86–100%. During discussions, the Australian Institute of Health and Welfare indicated that service contacts are likely to be more related to expenses than number of patients.
- 53 Of significant concern to the Commission, as pointed out by Western Australia, Tasmania and the Northern Territory, is that the services covered by the Australian Institute of Health and Welfare data do not represent the full range of specialised community mental health services provided by states.
- State-provided specialised community mental health services include ambulatory services, residential services, grants to non-government organisations and other indirect expenditure such as for suicide prevention programs.
 - The activity data available from the Australian Institute of Health and Welfare covers ‘ambulatory services’, that is those services delivered in non-residential and non-admitted patient care settings. Examples include counselling, psychological/psychosocial therapies, mental or behavioural assessment, and group psychotherapy.
- 54 The Productivity Commission’s *Report on Government Services* data on services for mental health show that these services represent about 66% of state spending on all

⁴ Australian Institute of Health and Welfare, [Community mental health care NMDS 2020–21: National Community Mental Health Care Database, 2022: Quality Statement \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024.

specialised community mental health care in 2021–22.⁵ If the share of ambulatory services in total specialised community mental health services was reasonably consistent across remoteness areas (and across other socio-demographic groups), it would represent a reasonable indicator of total specialised community mental health care activity. However, ambulatory services are predominantly provided in major cities and inner regional areas and are much less common in outer regional and remote areas.

- 55 Specialised community mental health services in outer regional and remote areas are often delivered by non-government organisations. The Productivity Commission’s *Report on Government Services* community mental health data show that state spending on these services represents 11% of total state spending on community mental health. The Commission explored the feasibility of using the Australian Institute of Health and Welfare’s National Mental Health Establishments expenditure data as the indicator of activity for the services provided by non-government organisations. However, the expense data cannot be disaggregated by socio-demographic variables such as socio-economic status, Indigenous status, or remoteness, and hence cannot be used in the assessment.
- 56 The remaining share of specialised community mental health services are made up of residential services (11% of state spending) and other indirect spending (also 11% of spending). There are no suitable activity data available for these services.
- 57 The concerns raised by states about the lack of costs weights for episode length and complexity to better account for the different costs of patient contacts, as well as costs associated with patient socio-demographic composition, are also relevant.
- 58 The Commission has explored the potential to use the Australian Institute of Health and Welfare’s National Mental Health Establishments expenditure dataset. However, this cannot be used to add cost weights due to differing scope between the activity and expenditure datasets.
- 59 In the absence of a service-specific cost gradient to take account of higher costs of providing services as remoteness increases, the Commission could apply the general regional cost gradient or a combination of the emergency department regional cost gradient and the non-admitted patient regional cost gradient (to be consistent with the proposed proxy indicator for the balance of community and public health expenses – see discussion below).
- 60 The Commission applies the general gradient to categories where a conceptual case exists that costs increase with remoteness, but reliable regional costs are not

⁵ The *Report on Government Services* and Australian Institute of Health and Welfare have expenditure data on state specialised community mental health services, more disaggregated than expenditure data from the Government Finance Statistics. See Report on Government Services, [13 Services for mental health data tables 2021-22](#), Table 13A.3, Report on Government Services, Productivity Commission, 2024, accessed 14 June 2024. Australian Institute of Health and Welfare, [Data tables: Expenditure on mental health-related tables 2020-21](#), Table Exp.1, Australian Institute of Health and Welfare, 2024, accessed 14 of June 2024.

available.⁶ A discount would be applied (25%), as is done in other assessments where the general gradient is used, in recognition that the cost components used in the general gradient are only a proxy for actual service costs.

61 The service delivery scale adjustment would also be applied to the activity data.

Commission draft position

62 The Commission proposes to introduce a direct measure of the use and cost of specialised community mental health activity for ambulatory services only. It will become a sub-component of the community and public health assessment.

63 The Commission considers the Australian Institute of Health and Welfare activity data on specialised community mental health ambulatory services are not representative of activity on all specialised community mental health services. Although in aggregate ambulatory services represent a sizeable share of total state spending on specialised community mental health services (66%), they account for a larger share of total services in major cities and inner regional areas and a much lower share of total services in outer regional and remote areas. Therefore, using this as an indicator of activity for all spending on specialised community mental health services would overestimate spending in major cities and inner regional areas and underestimate spending in other areas.

64 The activity data on the other specialised community mental health services are not fit for purpose. The residential mental health care collection has far fewer people and episodes, with one state providing around half of all episodes.

65 As such, the Commission proposes that only state spending needs on ambulatory specialised community mental health services would be assessed using the ambulatory services activity data from the Australian Institute of Health and Welfare. These expenses represent around 66% of state spending on specialised community mental health services. The remainder of state spending on specialised community mental health services would be assessed using a proxy indicator of activity (discussed below).

66 The Commission considers that service costs are likely to increase with remoteness. In the absence of service specific cost weights, the choice of cost gradient comes down to either using the general regional cost gradient or a combination of the emergency department and non-admitted patient regional cost gradients. In the absence of any information on how ambulatory community mental health service costs vary with remoteness, the Commission will take a conservative approach and apply the general regional cost gradient and service delivery scale adjustments to the activity data on specialised community mental health services.

67 Box 2 provides a summary of the Commission's position on the assessment method.

⁶ For details on proposed changes to the general regional cost gradient refer to the geography chapter.

Box 2 Proposed steps to implement the community mental health assessment

Spending on ambulatory community mental health services. Government Finance Statistics on community mental health are not disaggregated by type of service. However, a breakdown is available from the Productivity Commission's *Report on Government Services: mental health services*. The data on the share of ambulatory community mental health services, for each state and year, would be applied to Government Finance Statistics expenses on community mental health.

The balance of expenses would be calculated as community and public health expenses less the Commission's estimates of ambulatory community mental health service expenses.

Adjustments for regional costs and service delivery scale. Adjustments would be applied to the Australian Institute of Health and Welfare ambulatory activity data, with regional costs based on the general gradient.

Socio-demographic composition assessment. National use rates on ambulatory community mental health service expenses (disaggregated by Indigenous status, remoteness, socio-economic status and age) would be multiplied with state populations to get assessed expenses for each assessment year.

Combined assessed expenses. Assessed expenses on ambulatory community mental health services would be combined with assessed expenses for the balance of the assessment for community and public health based on proxy activity data.

Discount. A low discount of 12.5% would continue to be applied to the proxy activity data. The activity data on ambulatory community mental health services would not be discounted.

Wage adjustments. Adjustments for differences in state wages would be applied to the combined assessed expenses.

Proxy for the balance of the assessment

Refer to Commission draft position in the next section.

Expanding the current proxy for activity to include non-admitted patient services

State views

- 68 New South Wales, Victoria, Queensland and the ACT said they supported an expansion of the current proxy of activity for community and public health to include non-admitted patient services, in addition to emergency department services.
- 69 New South Wales said that the sole use of emergency department triage categories 4 and 5 does not reflect an appropriate socio-demographic composition profile of community health usage.
- 70 Victoria said the current proxy is not based on sufficient evidence and supports the Commission exploring alternative approaches and data sources.

- 71 Although Queensland said it supported the expansion of the proxy indicator, it said that there was a lack of evidence supporting the change (that is, data demonstrating the similarities in usage and cost profiles for community and public health services and non-admitted patient services). As such, and to avoid overcorrecting, emergency department activity should have a larger weighting than non-admitted patient services (75:25).
- 72 South Australia said it had in-principle support for the proposal but had concerns with the quality of non-admitted patient data. It said the data should be used at the aggregate rather than patient level.
- 73 Western Australia said there is much more consistency between service delivery for emergency departments and community and public health. It said in remote regions, many non-admitted patient services are provided virtually, whereas both emergency department and community and public health services are almost always provided by practitioners on location.
- 74 Tasmania said it did not support the proposal because of the likely differences in the socio-demographic composition of patients using community and public health services and non-admitted patient services.
- 75 The Northern Territory said it did not support the proposal because non-admitted patient activity is likely to under-represent use of community and public health services in remote and very remote areas and because the services of the 2 settings are vastly different. Community health services are the most geographically accessible service for remote persons. Remote clinics are also able to be accessed on a 'walk in' basis without need for prior appointments or referrals.

Commission response

Socio-demographic use rates

- 76 In the absence of an actual measure of community and public health activity, the Commission is seeking a proxy indicator that has health service use rates for each socio-demographic group that are broadly in line with actual use rates of community and public health services.
- 77 There is some information on the use of community and public health services by socio-demographic group (see Table 1 and Box 3). This shows that there is no consistent pattern of usage of community and public health services, or common target population groups for public health activity. There is no way of aggregating the usage information and therefore no way of determining an overall pattern of socio-demographic use.

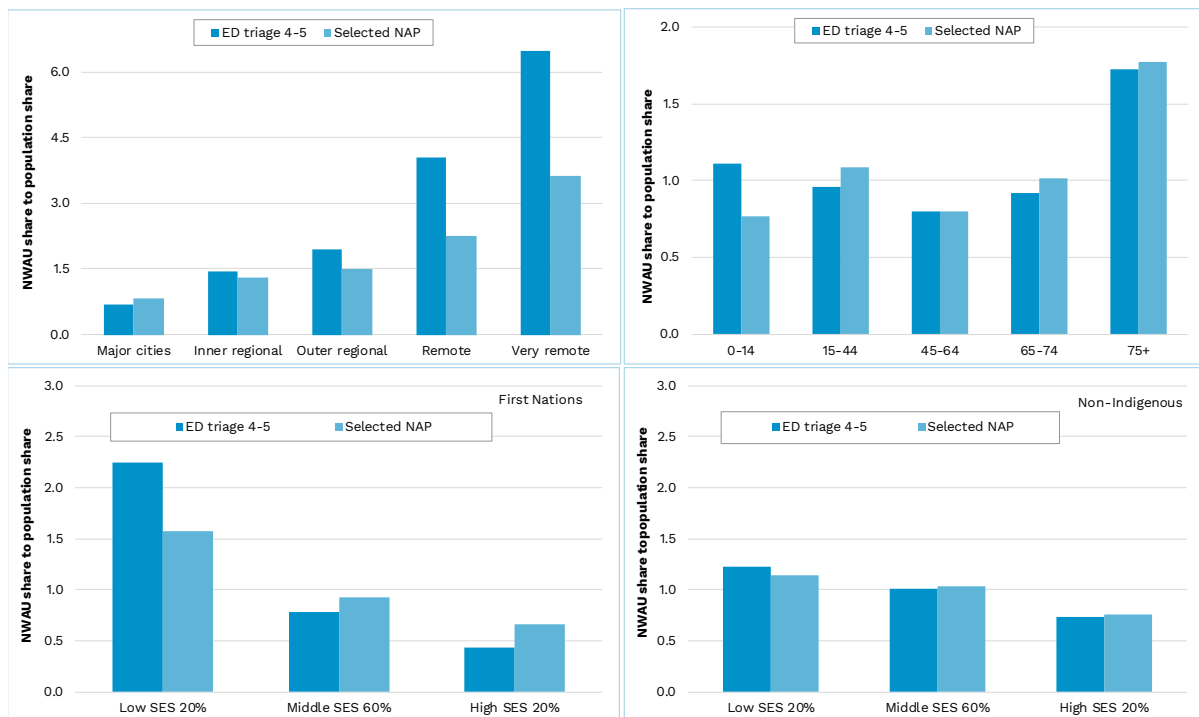
Table 1 Higher use or targeting of community and public health services by socio-demographic group

Group of services	Usage (or targeting) of services by socio-demographic groups			
	Age	Remoteness	SES	Indigenous status
Community health services				
Public dental services	Younger	Urban	Lower SES	First Nations
Alcohol and other drug services	Younger	Remote	-	First Nations
Public podiatry	Older	Urban	Lower SES	-
Child and maternal health clinics	Younger	Urban	Lower SES	Non-Indigenous
Public health services				
Cancer screening	20+	Urban/regional	Higher SES	Non-Indigenous
Organised immunisation (targeting)	Younger	-	-	First Nations
Selected health promotion (targeting)	-	Regional /remote	Lower SES	First Nations
Communicable disease control (targeting)	Older	-	Lower SES	First Nations
Environmental health (targeting)	-	-	-	First Nations

Note: Selected health promotion, communicable disease control and environmental health use indirect measurements of the usage of services. Blank rows indicate either that there was no bias for any population group or that there was conflicting information on the usage of the service.

- 78 The alternative proxy indicators being considered are emergency department triage category 4 and 5 national weighted activity units (the existing proxy) or a combined emergency department/non-admitted patient measure.
- 79 The socio-demographic use rates for the current indicator and proposed additional measure based on selected non-admitted patient services are shown in Figure 4. The patterns of usage are broadly similar. Compared with selected non-admitted patient services, usage of emergency department triage category 4 and 5 services increases more with remoteness, is higher among low socio-economic status First Nations people, and is higher for the youngest age group.

Figure 4 Socio-demographic use rates for alternative proxy indicators, 2021–22



Note: Selected non-admitted patient services include Tier 2 groups identified as similar to community health services.

Source: Unpublished Independent Health and Aged Care Pricing Authority, National Weighted Activity on emergency department triage category 4 and 5 and non-admitted patients; ABS population data.

- 80 The diversity of community and public health programs and limited existing information on the socio-demographic usage of the programs make it difficult to determine whether a hospital-based indicator of activity would be a reasonable proxy for community and public health activity (outside of ambulatory community mental health care). However, the only options available to the Commission at this stage are hospital-based activity measures.
- 81 For the 2020 Review, data provided by some states indicated that emergency department activity data would provide a reasonable proxy for community and public health activity. At that time, the National Weighted Activity Unit data for non-admitted patient services were not considered sufficiently reliable to be used in the health assessment. As such National Weighted Activity Unit data for non-admitted patient activity were not in scope as a proxy indicator of community and public health activity at the start of the 2020 Review.
- 82 In the 2021 Update the Commission decided that National Weighted Activity Unit data for non-admitted patient activity were sufficiently reliable to use in the health assessment. Therefore, this measure of hospital activity can now be considered as a potential proxy for community and public health activity.

Service types and accessibility

- 83 The merits of broadening the proxy indicator to include all, or a subset of, non-admitted patient services have been assessed on the basis of similarity of service types and level of access to non-admitted patient services compared with

community and public health services. This is on the assumption that if service types and access levels are similar then socio-demographic usage patterns would be similar.

- 84 The types of non-admitted patient services identified as having some similarity to community health services are listed in Table 2. These services include medical consultations (series 20) and allied health services (series 40). The full list of non-admitted patient services is provided in Table A-1.

Table 2 Non-admitted patient services similar to community health services, 2021–22

Tier 2	Non-admitted patient service	Community health service	% weighted separations
Medical consultations			
20.13	Palliative care	Community/home nursing services	1.9
20.32	Breast	Cancer screening (bundled with main svc)	1.6
20.40	Obstetrics – pregnancy w/o complications	Family and child health services	3.5
20.44	Infectious diseases	Communicable disease control	4.2
20.49	Geriatric evaluation and management	Community/home nursing services	1.2
20.50	Psychogeriatric	Community mental health services	0.0
20.52	Addiction medicine	Alcohol and other drug services	1.7
20.57	COVID-19 response	Communicable disease control	5.3
Allied health			
40.02	Aged care assessment	Community/home nursing services	(a)
40.09	Physiotherapy	Allied health services	5.5
40.10	Sexual health	Sexual health services	1.0
40.13	Wound management	Community/home nursing services	4.1
40.23	Nutrition/dietetics	Allied health services	2.2
40.24	Orthotics	Allied health services	0.6
40.25	Podiatry	Allied health services	1.4
40.27	Family planning	Family and child health services	(b)
40.28	Midwifery and maternity	Family and child health services	13.9
40.29	Psychology	Community mental health services	1.7
40.30	Alcohol and other drugs	Alcohol and other drug services	4.4
40.31	Burns	Community/home nursing services	0.1
40.32	Continence	Continence services	0.6
40.33	General counselling	Community mental health services	(b)
40.34	Specialist mental health	Community mental health services	(c)
40.35	Palliative care	Community/home nursing services	5.2
40.36	Geriatric evaluation and management	Community/home nursing services	1.1
40.37	Psychogeriatric	Community/home nursing services	0.0
40.38	Infectious diseases	Communicable disease control	0.9
40.51	Breast	Cancer screening (bundled with main svc)	0.5
40.55	Paediatrics	Family and child health services	2.1
40.56	Falls prevention	Community/home nursing services	0.1
40.57	Cognition and memory	Community/home nursing services	0.4
40.58	Hospital avoidance programs	Chronic disease management	8.5
40.60	Pulmonary rehabilitation	Chronic disease management	0.4

Tier 2	Non-admitted patient service	Community health service	% weighted separations
40.63	COVID-19 response	Communicable disease control	25.3
40.64	Chronic pain management	Chronic disease management	0.5
Total			100.0

Note: a)-not priced, b)-out of scope, c)-block funded.

For a complete list of Tier 2 non-admitted patient services see [Table A-1](#).

The list includes community mental health services. Although the proposal has a separate sub-component on community mental health, this only accounts for 80% of state spending on community and public health, leaving the remainder on residential mental health services, grants to non-government organisations and other indirect expenditure unaccounted.

Community health services include breast screening which is a diagnostic service, but diagnostic services are not measured separately in the hospital activity data, being bundled with the requesting specialist service. Hence breast medical consultations and allied health services (20.32 and 40.51) were included to represent breast screening.

Source: Commission calculation using IHACPA price weights and separations from AIHW Non-admitted patient care tables.

85 Based on the relative cost of the different types of non-admitted patient services, it is likely that allied health non-admitted patient services would be more closely related to community health services than medical consultations. The price weight for medical consultation services relative to comparable allied health services ranges from 1.2 to 1.9, indicating the higher complexity of medical consultation services (Table 3).

Table 3 Price weights for selected medical consultations and allied health services, 2021–22

Medical consultations	Price weight	Allied health	Price weight
20.40 Obstetrics – pregnancy without complications	0.0414	40.28 Midwifery and maternity	0.0339
20.52 Addiction medicine	0.0382	40.3 Alcohol and other drugs	0.0275
20.13 Palliative care	0.0701	40.35 Palliative care	0.0430
20.49 Geriatric evaluation and management	0.0864	40.36 Geriatric evaluation	0.0464
20.44 Infectious diseases	0.0903	40.38 Infectious diseases	0.0506
20.29 Orthopaedics	0.0413	40.44 Orthopaedics	0.0293
40.51 Breast	0.0746	40.51 Breast	0.0406
20.11 Paediatric medicine	0.0682	40.55 Paediatrics	0.0439
20.57 COVID-19 response	0.0903	40.63 COVID-19 response	0.0506

Source: Independent Health and Aged Care Pricing Authority, National Weighted Activity Unit data calculator for non-admitted activity (2021–22).

86 On the information available, there appears to be a closer relationship in service types between community health services and non-admitted patient services provided by allied health professionals and clinical nurse specialists.

87 In terms of accessibility, information on wait times for some community and public health services is shown in Table 4. All services require bookings or referrals, which involve some waiting time. The wait times vary according to the type of service. The majority of services involve medium length wait times (1 to 3 months), waiting for booking dates or waiting to reach the age eligibility for the service.

Table 4 Estimated wait times for community health services

Group of services	Wait time	Explanation
Public dental	Very long	AIHW provides data for the medium wait times of all states, the national average being 630 days. ⁷
Alcohol and drug services	Medium	Phone counselling is instant, in-person counselling and assessments have weeks of wait times on average, whilst rehab has very long wait times. However, counselling and assessments are the most common services.
Cancer screening	Medium	The wait between a positive screen and diagnostic assessment for bowel cancer is 58 days based on the national median. Breast cancer has a quicker screening process but only for the targeted age bracket of 50-74. ⁸
Organised immunisations	Medium	Organised immunisations are mainly scheduled for children and apply to specific age brackets. Bookings and catch-up immunisations are available as well, however normally immunisations apply to specific age brackets.
Public podiatry	Medium	Limited information. Allied health and other community health providers suggest medium wait times.
Maternal child and family health	Medium	Scheduled visits for maternal child health, where bookings are made according to the age bracket of the child.

Note: Very long: 6+ months, long: 3-6 months, medium: 1-3 months, short: 1-4 week(s), instant 1-7 days.

- 88 Non-admitted patient services also require referrals and bookings. In contrast, emergency departments are staffed 24 hours a day and do not require referrals. In 2022–23 50% of patients were seen within 20 minutes and 90% of patients were seen within 2 hours and 4 minutes.⁹
- 89 Access times across community health services are therefore likely to be generally more in line with wait times for non-admitted patient services than emergency department services.
- 90 Queensland considered there was limited evidence to support the inclusion of non-admitted patient services in the proxy. To not overcorrect, Queensland suggested a 75:25 weighting for the emergency department and non-admitted patient combined proxy. This would compare to a weighting of 26:74 if all non-admitted patient services were included.
- 91 However, the Commission is not proposing to include all non-admitted patient activity in the proxy indicator, only those services that are similar to community and public health, as discussed earlier. The ratio would be based on the relative amount of activity in emergency department triage category 4 and 5 and the subset of non-admitted patient services in each year. On the basis of the analysis presented

⁷ Australian Institute of Health and Welfare, [Oral health and dental care in Australia, Dental care - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports/10/oral-health-and-dental-care-in-australia), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024.

⁸ Australian Institute of Health and Welfare, [National Bowel Cancer Screening Program monitoring report 2023, Data - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports/10/national-bowel-cancer-screening-program-monitoring-report-2023), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024, p4.

⁹ Australian Institute of Health and Welfare, [Emergency department care - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports/10/emergency-department-care), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024.

earlier, the Commission does not consider the proposed approach is overstating the weight given to non-admitted patient service activity.

- 92 South Australia proposed that the data on non-admitted patient activity be used at the aggregate level. This option cannot be implemented because patient-level data are needed to allow activity to be cross-classified by socio-demographic composition group.

Commission draft position

- 93 The Commission proposes to broaden the proxy indicator of community and public health activity (outside of ambulatory community mental health) to include a combination of emergency department triage category 4 and 5 plus a subset of non-admitted patient allied health services similar to community health services, as outlined in Table 2. Based on the share of activity on these services, the proxy would be around 55% emergency department triage category 4 and 5 and 45% non-admitted patient services.¹⁰

Separate assessment of public health

State views

- 94 New South Wales, Victoria and Tasmania said that public health expenses should be assessed separately to community health expenses. New South Wales and Victoria said that public health expenses should be assessed equal per capita.
- 95 New South Wales said public health services are relatively standardised, with only minor variations for targeted groups. It said there is little evidence that different groups require materially different expenditure or involve varying degrees of complexity. It said that communicable disease control and environmental health are standardised services, provided in a near-equivalent manner for all citizens. It said that while cancer screening, organised immunisation, and health promotion have some targeted expenditure for socio-demographic cohorts, these drivers would be significantly less than for other elements of community and public health services.
- 96 Victoria said that, conceptually, community health and public health are different services, with different drivers. It said community health services are often delivered through local health clinics that provide primary care and related services for local communities. It said, in contrast, public health generally relates to state-wide services and functions, aimed at improving the wellbeing of all residents of a state generally. These public health programs may be targeted to specific groups, however, predominantly are whole-of-state activities. It said public health services are not the same as hospital services, which is the current proxy data used in the assessment.

¹⁰ Based on unpublished Independent Health and Aged Care Pricing Authority national weighted activity units for 2021–22.

Commission response

- 97 In considering the views of New South Wales, Victoria and Tasmania the Commission considered the conceptual case, materiality and practicality by investigating what states do in terms of their spending on public health services, and data availability.
- 98 A key question for the Commission is whether an equal per capita approach (as proposed by New South Wales and Victoria), or a proxy measure based on hospital activity, is a better measure of drivers of differences between states in spending on public health. In examining this question, the Commission considered key public health services and whether they were population based or targeted.
- 99 The Commission found that state-delivered public health programs generally have some degree of national coordination and are often jointly funded with the Commonwealth. As such, priorities for the programs are largely policy neutral. However, there is not a consistent pattern of socio-demographic use or targeting across different programs. This makes it challenging to decide whether a hospital-based measure of activity, which would reflect higher use of services by First Nations people, people living in remote and low socio-economic status areas and older people, is a better proxy for activity in public health programs than state populations.
- 100 A range of factors determine the targets for, and use of, public health programs and services. Some programs are not necessarily targeted at particular socio-demographic population groups. The priorities for some programs change over time as health priorities change. In some cases, the socio-demographic groups making the most use of public health services do not necessarily align with the target groups for the programs.

Box 3 Public health services

Cancer screening. The population-based screening programs for breast, cervical and bowel cancers are run through partnerships between Commonwealth and state governments. The programs target certain groups where evidence shows that screening helps to reduce ill health and deaths from cancer.

- The breast and bowel cancer screening programs target an older cohort (40+) than the cervical cancer screening (20+).
- After adjusting for age, participation in bowel and breast cancer screening was highest in regional areas and lowest in very remote areas. For cervical cancer screening, participation was highest in major cities and declined with remoteness.
- Participation in bowel and cervical cancer screening was highest for people living in the highest socio-economic areas. Participation in breast cancer screening did not vary much by socio-economic status.

- Participation in each of the programs was higher among non-Indigenous people than First Nations people.¹¹

Organised immunisation. State governments are responsible for the coordination and oversight of organised immunisation programs, some of which are jointly funded by the Commonwealth. The performance benchmarks for the Essential Vaccines Schedule of the Federation include targets for children and First Nations people.¹²

Communicable disease control. Commonwealth and state governments fund communicable disease control activities, but states have primary responsibility for detecting and controlling communicable diseases. The national strategy for communicable disease control identifies target population groups. High priority areas include populations that suffer a disproportionately high burden of communicable diseases including First Nations people, the elderly, people of lower socio-economic means, and immunocompromised people, such as refugees and immigrants.¹³

Selected health promotion. Health promotion encompasses a combination of actions to enable individuals and communities to increase control over and improve their health.¹⁴ State governments have their own public health laws, which aim to protect, promote and improve the health and wellbeing of the public, which are usually enforced by local government. State governments are also responsible for delivering preventive health services such as cancer screening, school-based immunisation programs and implementing settings-based measures for example, smoke-free laws.¹⁵ Priority populations for the National Preventative Health Strategy are:

- First Nations people
- culturally and linguistically diverse people
- lesbian, gay, bisexual, transgender, queer or questioning, intersex and/or other sexuality and gender diverse people
- people with mental illness
- people of low socio-economic status
- people with disability
- rural, regional and remote.¹⁶

¹¹ Australian Institute of Health and Welfare, [National Cervical Screening Program monitoring report 2023 \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2023, accessed 14 of June 2024. Australian Institute of Health and Welfare, [BreastScreen Australia monitoring report 2023 \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024. Australian Institute of Health and Welfare, [National Bowel Cancer Screening Program monitoring report 2023, Data - Australian Institute of Health and Welfare \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024.

¹² Australian Institute of Health and Welfare, [Essential vaccines: performance report 2021-22 \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2023, accessed 14 June 2024.

¹³ Department of Health, [National-framework-for-communicable-disease-control.pdf \(health.gov.au\)](#), Department of Health, The Australian Government, 2014, accessed 14 June 2024, p18.

¹⁴ Australian Institute of Health and Welfare, [Health promotion and health protection - Australian Institute of Health and Welfare \(aihw.gov.au\)](#), Australian Institute of Health and Welfare, 2022, accessed 14 June 2024.

¹⁵ Ibid.

¹⁶ Department of Health, [National Preventive Health Strategy 2021-2030](#), Department of Health, The Australian Government, 2021, accessed 14 June 2024.

Environmental health. Environmental health encompasses the assessment and control of those environmental factors (physical, chemical, biological) that can potentially affect health. Environmental health risks are largely managed by an array of complementary Commonwealth and state and agencies. One of the principles of the Environmental Health Standing Committee’s *Strategic Plan 2020–2023* is improving the health of First Nations people. The strategic plan also states a commitment to safeguarding the health of populations that are particularly vulnerable to certain environmental hazards, such as children, the elderly, and people with disabilities.¹⁷

101 Table 5 provides information on the targets for, and use of, public health programs and services by the socio-demographic groups used in the health assessment. Data limitations mean there is no way of aggregating data on service usage to determine an overall pattern of socio-demographic use for public health services.

Table 5 Higher use or targeting of public health services by socio-demographic group

Group of services	Usage (or targeting) of services by socio-demographic groups			
	Age	Remoteness	SES	Indigenous status
Cancer screening	20+	Urban/regional	Higher SES	Non-Indigenous
Organised immunisation (targeting)	Younger	-	-	First Nations
Selected health promotion (targeting)	-	Regional /remote	Lower SES	First Nations
Communicable disease control (targeting)	Older	-	Lower SES	First Nations
Environmental health (targeting)	-	-	-	First Nations

Note: Selected health promotion, communicable disease control and environmental health use the indirect measurement of targeted population groups as an indicator of the usage of services. No target indicates that there was no bias to any population group in state and/or national strategies.

102 Public health spending has increased in recent years, from 1.4% of total spending in 2014–15 to 6.6% in 2021–22. Spending priorities also changed significantly during the COVID-19 pandemic (Table 6). A large increase in spending on communicable disease control meant it accounted for around half of state spending on public health in recent years compared with less than 20% at the time of the 2020 Review (Table 13). Spending on organised immunisation and selected health promotion was also much higher in 2021–22 than earlier years. The socio-demographic targets for these programs are also likely to have changed as priorities shifted to responding to the pandemic.

¹⁷ Environmental Health Standing Committee (enHealth) of the Australian Health Protection Principal Committee, [Environmental health standing committee \(enHealth\) – Strategic plan](#), Environmental Health Standing Committee (enHealth) of the Australian Health Protection Principal Committee, 2020, accessed 14 of June 2024, p7.

Table 6 Public health expense weights, various years

	2014–15, 2015–16	2019–20	2020–21	2021–22
	%	%	%	%
Cancer screening	16	12	6	4
Organised immunisation	22	16	12	16
Selected health promotion	26	19	15	17
Communicable disease control	17	30	50	51
Environmental health	7	6	5	2
Other public health services	12	17	13	11
Total	100	100	100	100
Proportion of total health spending	2	2	4	7

Source: Unpublished data, Australian Institute of Health and Welfare; [Data cube: Health Expenditure in Australia](#).

Commission draft position

103 For the 2025 Review the Commission proposes to use a hospital-based proxy (see previous section for details) for public health activity rather than an equal per capita assessment. The Commission considers that, on balance, using the same proxy indicator as for community health (outside of ambulatory community mental health) is simpler and produces a reasonable estimate of state spending needs, given the information available on use or targeting of public health programs. The application of the 12.5% discount to the community and public health assessment (outside of ambulatory community mental health) would be appropriate given the offsetting socio-demographic use and targeting across public health programs (see below for the Commission decision on the discount).

12.5% discount for the community and public health assessment

State views

- 104 Most states supported the continuation of a 12.5% discount for the community and public health assessment. New South Wales said the prior reduction in this discount from 25% was not clearly evidenced at the time of the 2020 Review and it would not be appropriate to reduce the discount further.
- 105 Western Australia said the Commission should not discount the portion of the assessment that uses Australian Institute of Health and Welfare community mental health activity data, as the lack of cost weights means the assessment would already be understated.
- 106 The Northern Territory said that an equal per capita assessment is not supported by either the current proxy or the alternative data, making a discount problematic. It acknowledged that the Commission’s reason for continuing the discount is consistent with its discounting guidelines.

Commission draft position

- 107 The reliance on a proxy measure of activity for a significant share of community and public health expenses justifies a continuation of the 12.5% discount. It would be applied only to the share of the assessment that relies on proxy data (covering around 80% of total community and public health expenses). The expenses assessed using the direct measure of activity (ambulatory community mental health) would not be discounted.

Q5. Do states support the use of Australian Institute for Health and Welfare data to update the non-state services substitutability level for the emergency departments component, while retaining the 2020 Review method for other components?

State views

- 108 States presented mixed views on the specific proposal for updating the non-state substitutability level for the emergency departments component. In addition, most states raised concerns with the general approach, or elements of the approach, that the Commission uses to assess the impact of non-state health services on state health expense needs.

Alternative conceptual framework

- 109 New South Wales, in a supplementary submission, said that there is an absence of robust and reliable data supporting the conceptual case for a non-state sector adjustment for health services. However, the data used for the analysis covered a few years only and so cannot be considered a comprehensive assessment.
- 110 New South Wales presented data on the relationship between state hospital services (admitted patient, emergency department and non-admitted patient services) and similar services provided by the non-state sector. Given the absence of evidence that increased non-state sector provision of health services reduced the need for the state sector to provide services, New South Wales said the Commission should reconsider its application of the adjustment. It said the adjustment should be removed or heavily discounted.
- 111 Western Australia said the Commission's approach to recognise the influence of non-state sector health services provision on state health spending needs was fundamentally wrong and presented an alternative conceptual framework.
- 112 Western Australia said that states respond to the existing level of non-state services. The Commission should therefore be trying to estimate the proportion of non-state services that are substitutable rather than the proportion of state expenses that are substitutable. One implication of Western Australia's model is that, unlike the

Commission's approach, the cost to patients of services in the non-state sector is not a relevant consideration in determining substitutable services.

113 In Western Australia's model, calculating the size of the non-state sector adjustment requires:

- an estimate of the share of non-state services that are also provided by the state (substitutability level)
- an estimate of the unit cost of substitutable state services (to calculate the public cost equivalent of these non-state services) – New South Wales also said this in its supplementary submission
- an estimate of the deficit/surplus of non-state service provision (assessed compared with actual services).

114 Queensland said that the relationship between state and non-state sector health provision is more nuanced than Western Australia's analysis would suggest and that any non-state sector service provision is likely to be at the margin. Thus, the current proportions used by the Commission already likely reflect a ceiling for this activity.

115 Queensland said the changes proposed to the substitutable expenses formula by Western Australia are based around the assumption that the majority of non-state sector activity could be absorbed by the state sector. However, capacity constraints would indicate that only part of existing public sector activity would be displaced.

Other overall concerns with the non-state sector adjustment

116 New South Wales said that state and non-state services being comparable is not the same as these services being perfect substitutes. Instead, the level of actual substitution in practice is lower than the level of potential substitution, citing the use of public health services by people with private health insurance. In a supplementary submission, New South Wales went further and said that the available data do not support the conceptual case that a relationship exists between the provision of state and non-state service provision.

117 New South Wales said the potential substitutability does not fully account for factors that impact the use of comparable services. These include:

- non-state services encourage additional demand for substitutable state health services rather than offsetting existing state demand
- the timely availability of non-state services
- non-state services not always having sufficient capacity to fully replace all state substitutable services
- patient decision-making being outside of state sector control, with patient preferences for state services stemming from both perception and health literacy.

118 New South Wales said that to recognise that comparable services are not 100% substitutable, the Commission should apply a general discount to its calculation of the proportion of substitutable expenses in each component.

- 119 New South Wales said that there should also be a reduction to non-state substitutability levels to account for the impact of patient perception on substitutability and that there is a conceptual case for integrating patient health literacy into the non-state sector adjustment.
- 120 New South Wales proposed that the lower of non-state or state sector expenditure for each component should represent the upper limit on potential substitutable expenditure rather than using state sector expenditure as the upper limit. It said that this would reflect that the state sector does not benefit from substitution beyond the non-state sector's capacity to supply services.

Commission response

- 121 In the 2015 Review, as part of the move to a direct assessment approach for all state health services, the Commission introduced an adjustment to take account of different levels of non-state provision of health services between states. This was on the assumption that states with below-average non-state service provision faced additional costs.
- 122 Since then, the influence of the non-state health sector has been taken into account in 2 ways.
- The socio-demographic composition assessment reflects the higher use and cost of providing public health services to some population groups, some of which is due to differences in access to non-state services. For example, one reason why state expenses per capita are higher in more remote areas is because of lower provision of services by the non-state sector in these areas.
 - Differences in non-state provision between states are picked up through the non-state sector adjustment. Assessed health expenses resulting from the socio-demographic composition assessment are either decreased or increased depending on whether the use of actual non-state health services exceeds, or falls short of, the assessed use of non-state health services.
- 123 A key challenge in determining the appropriate size of the non-state sector adjustment is that it is not possible to quantify how many health services need to be provided. Not all health procedures that are performed need to be performed by the state sector. As such, the provision of a service by the non-state sector does not necessarily mean that fewer state services are needed.¹⁸ This is taken into account in the approach the Commission has used since the 2015 Review as well the approach advocated by Western Australia.
- 124 Western Australia has taken a different approach to the relationship between the substitutability level and indicator of non-state sector activity.
- 125 In the Commission's approach, the substitutability level is the share of state expenses that are influenced by the non-state sector. In Western Australia's

¹⁸ For relevant recent research see, Melbourne Institute Applied Economic & Social Research, *Effects of private health insurance on waiting time in public hospitals: wp2023n09.pdf (unimelb.edu.au)*, MELBOURNE INSTITUTE Applied Economic & Social Research, University of Melbourne, 2023, accessed 14 June 2024.

approach it is the share of non-state sector expenses that can be undertaken by the state sector.

- 126 In the Commission's approach, the indicator of non-state sector activity is intended to provide a broad measure of the differences in the availability of non-state services between states. It is not intended to be a precise measure of the volume or value of substitutable services. In Western Australia's approach, the volume and value of substitutable services are intended to be precise measures of the saving to states from the presence of non-state services.
- 127 Given the different conceptual approach by the Commission and Western Australia for estimating the differing levels of non-state sector provision between states, the Commission does not consider it valid to say that one or the other of the approaches is fundamentally flawed or incorrect.
- 128 The Commission acknowledges that Western Australia presented a conceptually valid alternative method for determining the extent to which the non-state sector reduces the need for state health spending.
- 129 The Commission and Western Australia agree that not all services provided by non-state health services influence the level of service provision of the state sector. Both the Commission's current and Western Australia's proposed methods assess the difference between an actual and assessed measure of substitutable services provided by the non-state sector.
- 130 The method proposed by Western Australia is a more direct approach than the Commission's. As a result, it is highly reliant on accurate activity and public cost data being available. To identify substitutable services, information is needed on the specific types of services provided in the state and non-state sectors. In addition, data on service costs are required to estimate the public cost equivalent of substitutable non-state services. The availability of the data needed to implement Western Australia's approach varies across the components in the health assessment, with good data on admitted patient services and poor data on community health services.
- 131 The 2 approaches may produce similar outcomes if analogous assumptions are applied.
- 132 Separate to the submission made by Western Australia, the Commission agrees that the factors identified by New South Wales are likely to impact the extent to which non-state services reduce demand for state health services. These factors are not quantifiable, although in a supplementary submission New South Wales presented data that supported an argument that no substitutability existed between state and non-state service provision. This will be considered in the judgements the Commission makes on the substitutability levels in each component of the health assessment in the 2025 Review.

- 133 In regard to New South Wales' point that the non-state sector adjustment should not exceed actual non-state provision, it is relevant that the indicators of non-state sector activity used by the Commission do not represent the full scope of non-state sector services. The non-state sector indicator is intended to provide a broad indication of the amount of non-state sector health service provision across socio-demographic drivers, not a precise measure of the volume or value of substitutable services.

Commission draft position

- 134 The Commission considers that the current approach underpinning the non-state sector adjustment, while pragmatic, remains appropriate for the 2025 Review. Given the available data and the uncertainty about the relationship between state and non-state health provision, the current approach is likely to produce a more reliable adjustment than the approach advocated by Western Australia. The Commission will, however, seek to improve on its current approach based on the feedback from states, as discussed below.
- 135 The broad range of comments by states on the factors influencing the non-state sector adjustment, along with the evidence presented by New South Wales in its supplementary submission of no relationship between state and non-state health service provision, problems with the data used by the Commission, and the significance of the non-state sector adjustment on GST distribution, suggest that more detailed consideration of this element of the health assessment is warranted between reviews.

Updating the non-state services substitutability level for emergency departments

State views

- 136 All states except Western Australia and the Northern Territory broadly supported the Commission's proposed approach for updating the emergency department non-state sector substitutability level.
- 137 In a supplementary submission, New South Wales said the decision to go to a general practitioner (GP) or an emergency department is influenced by a wide range of price and non-price factors. For example, it said that data indicate that the lack of availability of GPs in rural areas results in higher numbers of emergency department presentations. It also said that the provision by the non-state sector of specialist services (such as pathology and imaging services) should be taken into account in estimating the non-state sector substitutability level for the emergency department services assessment.
- 138 Victoria said it would prefer that the Commission contract an expert to review this approach for the 2025 Review, potentially recommending a way to update the

Australasian College for Emergency Medicine's method or another similar method in the absence of the data required to make a straightforward update.¹⁹

- 139 Western Australia said that the Australian Institute of Health and Welfare's method for measuring substitutable services could not be assumed to move consistently with the Australasian College for Emergency Medicine's (existing) method.²⁰ The Northern Territory said that the substitution rate should remain at 30%.
- 140 Further, Western Australia said that separate substitutability levels should be used for each remoteness region. Both the Australian Institute of Health and Welfare's and Australian College of Emergency Medicine's methods show increasing substitutability levels as remoteness increases.

Commission response

- 141 The Australasian College for Emergency Medicine's and Australian Institute of Health and Welfare's methods calculate the proportion of emergency department presentations that are potentially treatable by GPs. The Australasian College for Emergency Medicine's method is based on self-referred, non-ambulance presentations with a medical consultation time less than one hour. The Australian Institute of Health and Welfare's method is based on self-referred, non-ambulance, police or community service emergency department presentations classified as triage 4 and 5 (less urgent). Given the similarity in the methods, it is reasonable to expect that there would be similarities in movement in the Australasian College for Emergency Medicine's and Australian Institute of Health and Welfare's indicators. Updating the substitutability level using the Australian Institute of Health and Welfare's indicator is preferable to not updating it.
- 142 Separate substitutability levels for each remoteness area would add further complexity to an already complex adjustment to take account of differences in non-state sector service provision between states. It would also require actual non-state sector service provision disaggregated by remoteness area. The proposal should form part of the more detailed consideration of this element of the health assessment between reviews.
- 143 Both the Australasian College for Emergency Medicine's and Australian Institute of Health and Welfare's methods focus on the proportion of emergency department presentations that are potentially treatable by GPs. Broadening the analysis to include non-state sector specialist services in addition to GP services, as proposed by New South Wales, should also form part of the more detailed consideration of the non-state sector adjustment between reviews.

¹⁹ The method developed by the Australasian College for Emergency Medicine defined a GP-type presentation at an emergency department to be any self-referred, non-ambulance patient with a medical consultation time less than one hour.

²⁰ The method developed by the Australian Institute of Health and Welfare defined a GP-type presentation to an emergency department as any self-referred, non-ambulance, police or community service presentations classified as triage 4 and 5 (less urgent).

- 144 The Commission explored the possibility of engaging an external expert to review the approach, but this did not prove feasible within the timeline of the 2025 Review.

Commission draft position

- 145 For the emergency departments component, the Commission proposes to update the substitutability level using the Australian Institute of Health and Welfare's method for measuring substitutable services. This method produces an estimate of 13%, similar to the level from the 2020 Review (15%). The Commission proposes to maintain the substitutability level at 15%.

Admitted patients

State views

- 146 New South Wales said that the indicator of non-state sector activity used in the admitted patient assessment (private patient separations funded by private health insurance) is likely to be policy influenced. This was based on a comparison of state shares of separations funded by private health insurance with state shares of the population with private health insurance. This analysis showed that some states had much lower shares of separations funded by private health insurance than would be suggested by their private health insurance coverage.
- 147 New South Wales also said that the Commission should not use separate sources of data to measure actual and assessed non-state sector activity. It said use of Australian Prudential Regulation Authority data on actual service provision, rather than Australian Institute of Health and Welfare data, had a material effect on the non-state sector adjustment.
- 148 Victoria said it was concerned with the use of judgement in deciding the substitutability level.
- 149 Victoria said it agrees that there may be a conceptual case that the calculated rate is too high, as not all who have private insurance use it when they go to a public hospital for admitted patient services, for example, due to potential out-of-pocket fees.
- 150 Victoria said that without further evidence, it considered that discretionary judgement cannot be applied to the substitutability level. It said if the Commission concludes an adjustment is warranted on conceptual grounds, then the standard discounting approach should be applied. Victoria said the low discount of 12.5% should be applied to the non-state sector adjustment overall.
- 151 Queensland proposed using private patient bed days rather than separations as the indicator of non-state sector activity for admitted patient services. It said hospital separations provide no indication of the different costs of treating patients for different types of ailments. Queensland said that bed days provide more information on the relative costs of service provision and therefore provide a better indicator of non-state sector activity than separations.

- 152 Western Australia suggested broadening the indicator of non-state sector activity to include self-insured private patients, in addition to private health insurance-funded patients. As these patients would have the choice of being public patients (just like patients with private health insurance), they also substitute for public patient separations. Western Australia also said the Commission should include both people with private health insurance and those that self-insure in the group of people that could use non-state health services, when estimating the substitutability level.
- 153 Queensland did not support the inclusion of self-insured patients in the substitutability level as this group is not considered to be comparable with patients covered by private health insurance.
- 154 Western Australia said it was not appropriate for the Commission to reduce the calculated substitutability rate (23–27%) to 15%, a reduction of 33–44% based on judgement. Western Australia suggested a 12.5% discount (for low unreliability) or a 25% discount (for medium unreliability) was more reasonable.
- 155 Queensland said it agrees with the Commission’s view that the 23–27% range is likely overstated.
- 156 Tasmania and the Northern Territory supported retaining the 2020 Review methodology to update the substitutability levels for admitted patients.

Commission response

- 157 The estimated share of comparable services (the proportion of admitted patient services that are also undertaken in the non-state sector) remains at between 50% and 60%, using the latest available data.²¹
- 158 Several other factors need to be taken into account to determine the extent to which these services are substitutable and therefore reduce demand for state admitted patient services.
- 159 The cost of hospital services is one factor. The Commission previously stated that a person without private health insurance would rarely attend a private hospital, regardless of the availability of private health services in their state. The national rate of private health insurance hospital cover (currently 45%) was applied to the share of comparable state and non-state services to determine a potential substitutability level.
- 160 However, there are also some patients that are prepared to pay the full cost of private services (self-funded patients). The private activity funded by self-funded patients (around 3.6% of total public and private hospital activity) should also be

²¹ Australian Institute Health and Welfare, Admitted patient care 2022-23, why do people receive care?, [Admitted patients - https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients](https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients), 2022-23, Australian Institute Health and Welfare, 2023, accessed 14 June 2024.

taken into account in estimating the substitutability level.²² The proportion of people with private health insurance cover or who self-funded their admitted patient treatment is estimated at 49%.

- 161 For the 2025 Review, the Commission proposes to reduce the share of comparable services from 50–60% to 25–29%, after taking account of the private health insurance coverage rate and self-funded hospital activity.
- 162 This range would be an upper bound. Not all privately insured patients choose to utilise their private health insurance due to policy excesses and gap payments charged by specialists. The range of factors identified by New South Wales (listed in paragraph 117) also suggest the substitutability level should be lower.
- 163 Given the significant uncertainties associated with determining the extent to which non-state funded services reduce demand for state services, an alternative approach would be to limit the concept of substitutability to circumstances where there is a clearer relationship between non-state and state funded services.
- 164 One option is to limit the concept of substitutability to just the private patients that are treated in public hospitals. In 2020–21, around 12% of public hospital separations were privately funded.²³ Non-state sources of funding for these patients accounted for around 8% of public hospital funding, excluding Commonwealth payments under the National Health Reform Agreement and relevant national partnership agreements.²⁴
- 165 The Commission considers that the substitutability level resulting from this approach (8%) should be seen as a lower bound rather than the best estimate for the admitted patient non-state sector substitutability level. Activity in private hospitals would relieve some pressure on public hospitals, even though the extent is uncertain.
- 166 Determining the best estimate for the substitutability level between the upper bound of 25–29% and the lower bound of 8% is a judgement call. The Commission has not been able to identify a reason to change from a substitutability level of 15%.
- 167 In terms of the indicator of non-state sector activity, the Commission agrees with Queensland that an indicator of activity that takes account of factors that contribute to per-person service costs would be better than hospital separations. Queensland suggested bed days, however expenses (as measured by medical benefits paid by private health insurance funds) may provide additional information on the level of

²² Australian Institute Health and Welfare, Admitted patient care 2022–23: Costs and funding, [Admitted patients - ...~https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients](https://www.aihw.gov.au/reports-data/myhospitals/sectors/admitted-patients), Table S7.2: patient days by funding source, public and private hospitals, states and territories, Australian Institute Health and Welfare, 2023, accessed 14 June 2024.

²³ Ibid.

²⁴ Australian Institute Health and Welfare, Health expenditure Australia, 2020–21, [Health expenditure Australia 2020–21, Summary - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/reports-data/health-expenditure-australia), Australian Institute Health and Welfare, 2022, accessed 14 June 2024.

complexity associated with the cost of treating patients and other factors that affect costs.

168 Table 7 provides information on the consistency of average expenses per separation across states. Using data on medical benefits paid per separation by diagnosis-related group for 5 states, the ratio of state benefits paid to the Australian average was calculated. The proportion of separations close to 1.0 indicates how close expenses in each state are to the Australian average. For example, for New South Wales and Queensland, a large proportion of separations (80% for New South Wales and 86% for Queensland) have average benefits between 90%–110% of the national average. Based on the 80–120% threshold, the proportions for all 5 states are 84% or higher.

169 The implication for the Commission of using expenses as a proxy indicator of activity when there are differences in average expenses per separation across states is that a state with above-average per separation expenses will appear to have a higher level of activity than a state with below-average expenses per separation, for an equivalent level of activity (standardised casemix).

Table 7 Private hospital benefits paid per separation by state: ratio to national average, 2022–23

Ratio to Australian average benefits per separation	Proportion of separations (%)				
	NSW	Vic	Qld	WA	SA
0.3	0.0	0.2			0.2
0.4	0.0	0.0	0.0	0.0	0.4
0.5	0.0	1.1	0.2	0.1	1.0
0.6	0.4	0.6	0.1	1.2	1.5
0.7	2.3	2.3	0.3	0.5	10.3
0.8	8.0	28.8	4.2	2.0	34.1
0.9	23.4	29.6	37.2	23.0	19.0
1.0	48.2	15.4	44.1	12.7	9.6
1.1	8.0	2.8	5.0	16.9	12.6
1.2	7.3	12.9	4.0	29.4	9.1
1.5	2.2	6.1	4.6	10.3	1.7
2.0	0.1	0.1	0.2	3.1	0.2
2.5	0.0	0.1	0.0	0.4	
3.0		0.0	0.0	0.2	0.0
3.5				0.1	
within 90 - 110%	80	48	86	53	41
within 80-120%	95	89	95	84	84
within 70-150%	99	98	99	95	97

Note: Statistics for the ACT, Northern Territory and Tasmania are not reported due to confidentiality reasons.

Source: Department of Health [Hospital Casemix Protocol Annual Report \(Preliminary\) 2022-23](#), Table 10.

170 Table 8 compares 4 potential measures of admitted private patient activity – separations, bed days, and 2 measures of expenses. Private patient expenses include both privately insured and self-insured patients, as it would be appropriate to align the indicator of activity with the factors considered in calculating the substitutability level.

Table 8 State share of private patient assessed need: alternative indicators, 2021–22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	%	%	%	%	%	%	%	%	%
Separations (a)	32.4	26.1	19.4	10.7	7.1	1.9	2.1	0.4	100.0
Bed days (a)	32.5	26.1	19.2	10.6	7.3	1.9	2.0	0.3	100.0
Expenses (a)	32.3	25.9	19.5	10.6	7.2	2.1	2.0	0.4	100.0
PHI and self-funded expenses	32.3	25.9	19.5	10.6	7.2	2.1	1.9	0.4	100.0

(a) Privately insured or PHI-funded.

Source: Commission calculation using AIHW data on private separations, bed days and expenses.

171 Table 9 shows the distribution of actual activity by state based on separations and expenses. State breakdowns of actual activity are only available for separations and expenses, not bed days or self-insured patients.

Table 9 State share of private patient actual activity: alternative indicators, 2021–22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	%	%	%	%	%	%	%	%	%
Separations	31.3	23.8	22.7	10.4	7.6	2.4	1.3	0.4	100.0
Expenses	30.6	23.3	21.4	12.7	7.9	2.3	1.4	0.5	100.0

Source: Commission calculation using APRA data on privately insured patient separations and expenses.

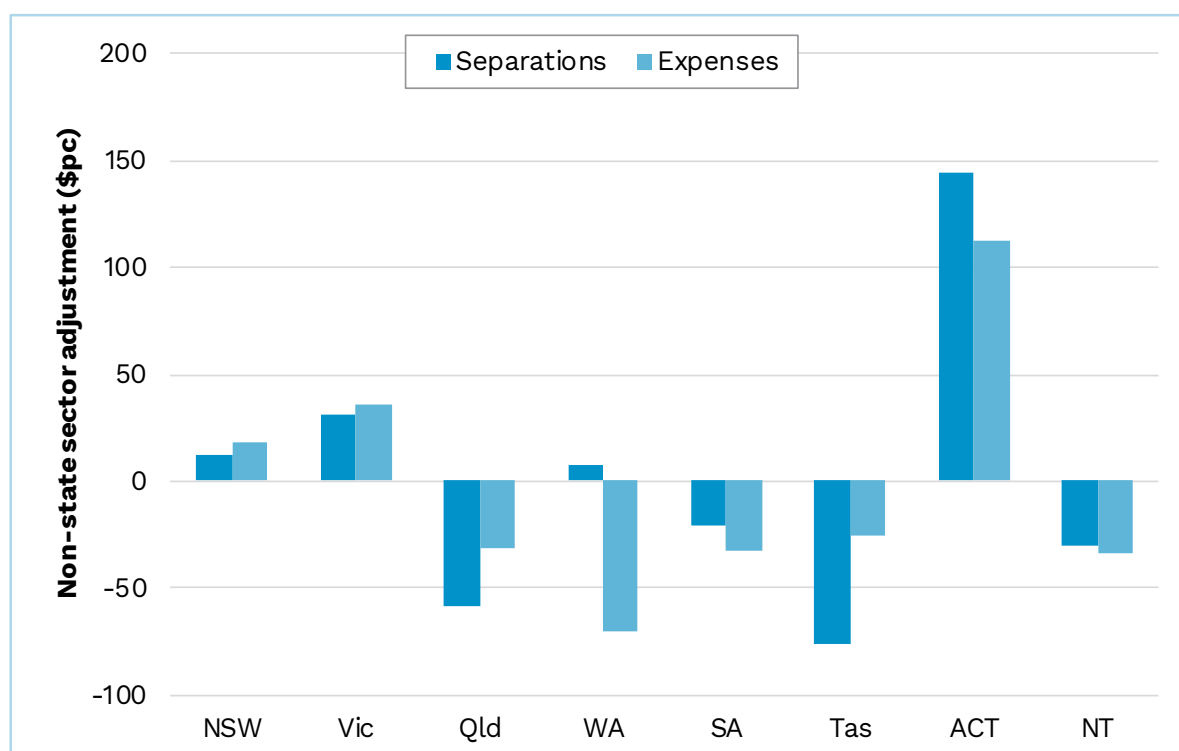
172 Table 10 and Figure 5 show the difference between assessed and actual activity for the alternative measures (the non-state sector adjustment). The choice of indicator would likely result in a material change (\$12 per capita) to the distribution of GST for Queensland, Western Australia, Tasmania and the ACT.

Table 10 Admitted patient non-state sector adjustment: alternative indicators, 2021–22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Separations	99	207	-305	22	-38	-44	65	-7	0
Expenses	152	239	-166	-194	-58	-15	51	-8	0
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Separations	12	32	-58	8	-21	-76	144	-30	0
Expenses	19	36	-31	-70	-32	-26	112	-34	0
Difference	7	5	26	-78	-11	51	-32	-4	0

Source: Commission calculation using Australian Institute of Health and Welfare and Australian Prudential Regulation Authority data on privately insured patient separations and expenses.

Figure 5 Admitted patient non-state sector adjustment: alternative indicators



Source: Commission calculation using Australian Institute of Health and Welfare and Australian Prudential Regulation Authority on privately insured patient separations and expenses.

- 173 Further work is needed to understand why the relationship between hospital activity funded by private health insurance and private health insurance coverage differs across states. This work could form part of the more detailed consideration of the non-state sector adjustment between reviews.
- 174 The Commission uses data from the Australian Prudential Regulation Authority on actual hospital activity funded by private health insurance because the data available from the Australian Institute of Health and Welfare are not disaggregated for the 3 smallest states (Tasmania, the ACT and the Northern Territory). Australian Institute of Health and Welfare data are required to calculate assessed activity funded by private health insurance because disaggregated data cross-classified by socio-demographic group are required. The 2 data series were broadly aligned prior to COVID-19 and then started to deviate. As part of the work between reviews on the non-state sector adjustment, the Commission will monitor the exiting data series to see if they realign once the COVID-19 affected activity has passed, as well as explore alternative indicators of non-state sector activity.

Commission draft position

- 175 After updating these data to calculate the share of admitted patient services that are also undertaken in the non-state sector and reducing this share by the proportion of people that have private health insurance or self-fund their private hospital treatment, the Commission estimated that the upper bound for the non-state sector substitutability level was 25–29%. The Commission also estimated that the lower bound was around 8%, based on private patient funding of public

hospital activity. In the absence of information to determine a precise figure, the Commission used judgement to propose that 15% remains the appropriate estimate for the substitutability level.

- 176 An ideal measure of private patient activity does not exist (there is not an equivalent to the national weighted activity unit used to measure public patient activity). Hospital separations take no account of complexity and other factors that contribute to the cost of a hospital service. Patient bed days would be an improvement on separations, but data on actual private patient bed days by state are not available.
- 177 The Commission proposes to use expenses measured by benefits paid by private health insurance funds as the proxy indicator of private patient activity. This measure is not ideal due to differences across states in average benefits paid for equivalent hospital services, as shown in Table 7. However, given the relatively small differences in benefits paid for equivalent hospital services across states, expenses are considered to provide a better measure of activity than separations.

Non-admitted patients

State views

- 178 Queensland supported the reduction in the non-admitted patient substitutability rate from 30% to 25%. It said the Commission's approach in the 2020 Review to determine the substitutability rate for non-admitted patients was comprehensive and rigorous. Queensland agrees that this method can be relied upon again and used with updated data for the 2025 Review.
- 179 Western Australia said the Commission is mixing up the proportion of state services that are comparable with the proportion of non-state services that are substitutable. It said multiplying these by each other is meaningless.
- 180 Western Australia and South Australia said that the assumption that half of non-admitted patient services are linked to a previous hospital attendance is overstated, while the ACT said the assumption could be reviewed.
- 181 The Western Australian Health Department's best estimate of outpatient activity that is linked/related to an inpatient episode is in the range of 10–15%, depending on the number of days from the inpatient episode. High level analysis of 2022–23 administrative data by the South Australian Department for Health and Wellbeing indicates that the proportion of non-admitted patients with a previous admitted patient episode in South Australia is likely to be around 25%.
- 182 In addition, South Australia said the 50% assumption does not take into account that not all non-admitted patients with a prior hospital admission are accessing a non-admitted service because of that admission. As some previously admitted patients access non-admitted patient services for conditions not related to their admission, simply applying a proportion based on total non-admitted and admitted

patient episodes does not accurately capture the concept the Commission is seeking to reflect through the 50% discount.

- 183 On this basis, South Australia said the Commission should investigate the appropriateness of the 50% discount. This could be based on administrative data from the states, with an appropriate adjustment if required, to recognise that not all outpatients with a previous hospital admission seek non-admitted patient services because of the admission.
- 184 Tasmania supported retaining the 2020 Review methodology to update the substitutability levels for non-admitted patients.
- 185 The Northern Territory said there is a weak conceptual case for an assumption that a service with a nominal out-of-pocket cost ceases to be substitutable with state services.
- 186 The Northern Territory said that there is a significant degree of discretion required in determining substitutability ratios and submits that the substitutability ratio of 30% should continue for non-admitted patients.

Commission response

- 187 For non-admitted patients, the Commission uses the mid-point of 2 methods to determine the non-state sector substitutability level.

Method 1: comparable state services

- 188 This method first estimates 'comparable' services based on the similarity of services undertaken in public hospitals and the non-state sector. The amount of comparable services that are likely to be 'substitutable' are then estimated based on the likelihood of patients choosing to use non-state services rather than state services.
- 189 In the 2020 Review the Commission considered that the proportion of state services that were also undertaken in the non-state sector (that is, comparable services) was around 70%. Using the latest available data, the equivalent figure has reduced to 65%, mainly due to the lower expenditure share of consultation clinics, where comparable non-state services are available (Table 11).

Table 11 Estimating comparable services (method 1)

Group of services	Share of activity	Average expense per service	Share of expenses	Substitutable service available (a)	NAP substitutability (b)
	%	\$	%		%
Procedure clinics	12	592	21	Yes	21
Consultation clinics	38	406	44	Yes	44
Allied health clinics	50	248	35	No	0
Potential substitutability (%)					65
Proportion of related AP and NAP episodes to total NAP episodes					43
Actual substitutability (%)					36

(a) Although all state-provided allied health services are also available in the private sector, most are linked to an earlier admitted patient episode. In addition, only a very limited number of patients who meet specific eligibility requirements (for example, those with a chronic medical condition or with an assessed mental disorder) are eligible for Medicare allied health items. State provided allied health services are generally not substitutable.

(b) Actual substitutability = potential substitutability * (1-proportion of related non-admitted and admitted patient episodes).

Source: Commission calculation using Australian Institute of Health and Welfare and non-admitted patient care tables, 2019–20 to 2022–23; Independent Health and Aged Care Pricing Authority National Hospital Cost Data Collection Public sector infographic, 2018–19 to 2020–21.

190 However, the share of services that are comparable is likely to be greater than the share that is substitutable. Patients requiring more complex treatment, or procedures associated with rare diseases, may have no option but to be treated in public hospitals. Also, patients who had commenced treatment in a public hospital may prefer to access follow-up non-admitted patient services in the public system.

191 In the 2020 Review, to estimate substitutable services, the Commission decided to halve the share of services considered comparable on the basis of survey data that showed about 50% of non-admitted patient services were for people that also received admitted patient services.

192 However, as South Australia pointed out, the survey data the Commission used as the basis for this estimate do not accurately capture the concept the Commission is seeking. Not all non-admitted patients with a hospital admission would be accessing the non-admitted service because of that admission, as these may be unrelated.

193 The Commission asked states for data on the share of related non-admitted and admitted patient episodes. Data provided by 6 states indicate that the relevant proportion is 43% — that is, 43% of patients that accessed non-admitted services had a prior related hospital admission. This implies that of the comparable non-admitted patient services (65% of total services), 37% may be substitutable.

194 The Commission liaised with states to achieve consistency in how the estimates were made, but perfect alignment in approaches was not possible. The Commission tested the sensitivity of results by varying state inputs where data caveats indicated possible inconsistency but ended up with substitutability levels that rounded up to 30%.

Method 2: affordable services

195 The Commission considers that the cost of services in the non-state sector is a relevant factor in determining the level of substitutable services. To get a sense of

the extent that non-state services are affordable, the proportion of similar non-state services (private operations and specialist services) that are bulk billed is calculated.

196 Western Australia said it was not appropriate to use the proportion of non-state services that are bulk billed to determine the proportion of state services that are substitutable. If the Commission intended to use this to determine the exact value of state services that are substitutable, Western Australia’s criticism would be valid. However, private operations and specialist services are only intended to provide a broad indication of the amount of non-state sector health provision, not a precise measure of the volume of substitutable services. The rate of bulk billing for these services provides an indication of the extent to which patients may use these services rather than state services if cost is a factor for them.

197 In the 2020 Review the alternative substitutability level based on affordable non-state services was 22%. The equivalent figure now is slightly lower at 20% (Table 12).

Table 12 Estimating affordable services (method 2)

Group of services	Share of activity	Average expense per service	Share of expenses	Substitutable service available	NAP substitutability
	%	\$	%	%	%
Procedure clinics	12	592	21	22	4.6
Consultation clinics	38	406	44	34	15.1
Allied health clinics	50	248	35	0	0
Total					20

Source: Commission calculation Australian Institute of Health and Welfare non-admitted patient care tables, 2019–20 to 2022–23; Independent Health and Aged Care Pricing Authority National Hospital Cost Data Collection Public sector infographic, 2018–19 to 2020–21; Medicare annual statistics state and territory, 2019–20 to 2022–23.

Commission draft position

198 As in the 2020 Review, the Commission proposes that the final estimate for the substitutability level be the midpoint between the 2 methods.

199 Based on the latest available data from 5 states, method 1 produces a substitutability rate of 37% and method 2 a rate of 20%, with a midpoint of 28%. The midpoint is close to the 2020 Review value of 30%. The Commission proposes to maintain the substitutability level at 30% for the 2025 Review.

Community and public health

State views

200 The Northern Territory said that the health services provided by Commonwealth funded First Nations community health organisations should not be taken into account in the non-state sector adjustment for community and public health.

201 The Northern Territory said that the assessment of non-state health services is overly simplistic. It said the quality of the primary health network differs significantly

between states and Commonwealth funding of First Nations community health organisations are partly intended to address these differences by increasing the availability of health services. It also said by assuming each First Nations person in a remote area requires the same number of non-state community health practitioners, the Commission is implicitly assuming there are no differences in primary health care between states other than remoteness.

- 202 The Northern Territory said that the predominant purpose of Commonwealth spending in the Northern Territory is to offset the much lower non-government sector spending compared with other states. It said the Northern Territory receives around 30% less Medicare Benefits Scheme funds than the national average.

Commission response

- 203 The non-state sector adjustment for community and public health consists of 2 elements. One element assesses differences between states in the provision of services funded by the Commonwealth's Medicare Benefits Scheme. The second element assesses differences between states in the provision of services funded by the Commonwealth's Indigenous Australians' Health Program and delivered by Aboriginal Community Controlled Health Services.
- 204 To the extent that the Northern Territory receives less Medicare Benefits Scheme funds than the national average, this will be taken into account in the first element of the non-state sector adjustment.
- 205 Commonwealth-funded health services alleviate pressure on state services in the same way as privately-funded services.
- 206 In regard to the indicator to measure how activity differs between states, data exist on the number of clients using services by these organisations as well as the number of episodes. Employment levels are used by the Commission because it considers they take better account of the resource intensity of different types of services.
- 207 Since the release of the health consultation paper, expense data for 2019–20 to 2021–22 have become available, allowing the non-state sector substitutability level for the community and public component to be updated. Expense weights for several years are provided in Table 13. The values for the later years show that expenses on some elements of community health are heavily COVID-19 affected. The last row of the table shows the substitutability level corresponding to the expense weights for each year.

Table 13 Community and public health expense weights

Group of services	2014-15, 2015-16	2019-20	2020-21	2021-22
	%	%	%	%
Community health services				
Public dental services	5	3	2	2
Alcohol and other drug services	4	3	2	2
Community mental health services	19	18	16	13
Other community health services	54	55	47	40
Public health services				
Cancer screening	3	3	2	2
Organised immunisation	4	3	4	7
Selected health promotion	5	4	5	7
Communicable disease control	3	6	16	22
Environmental health	1	1	2	1
Other public health services	2	4	4	5
Total	100	100	100	100
Substitutability level	63	62	53	49

Source: Unpublished data, Australian Institute of Health and Welfare.

- 208 The Commission proposes to maintain the substitutability ranges for the individual health services that make up the community and public health component (see Table 14).
- 209 The calculation of the substitutability level using 2019–20 expense weights are provided in Table 14. Using the mid-point of substitutability ranges for each individual health service, the calculated value for the community and public health non-state sector substitutability level is 61.9%. This is largely unchanged from the 2020 Review (62.5%). The Commission proposes to again round down the value to 60%.

Table 14 Estimated substitutability level, Community and public health, 2025 Review

Group of services	Substitutability range	Share of expenses 2019–20	Expense weighted substitutability
	%	%	%
Community health services			
Public dental services	Low (21–40)	3	0.9
Alcohol and other drug services	Medium (41–60)	3	1.5
Community mental health services	Low (21–40)	18	5.4
Other community health services	Very high (81–100)	55	49.8
Public health services			
Cancer screening	Medium (41–60)	3	1.3
Organised immunisation	High (61–80)	3	2.3
Selected health promotion	Very low (0–20)	4	0.4
Communicable disease control	Nil	6	0.0
Environmental health	Nil	1	0.0
Other public health services	Very low (0–20)	4	0.4
Total		100	61.9

Source: Commission calculation using unpublished 2019–20 Australian Institute of Health and Welfare expense data.

Commission draft position

- 210 The Commission proposes to continue to include the Commonwealth-funded services provided by First Nations community health organisations in the separate adjustment for Community Controlled Health Services. The use of these services is not included in the broader non-state services adjustment.
- 211 The COVID-19 pandemic has distorted state spending on community and public health. As such, the Commission proposes to use 2019–20 data to update the calculation of the substitutability level rather than data for more recent years. The non-state sector substitutability level for the community and public health component for the 2025 Review is proposed to remain at 60%.
- 212 The substitutability levels and indicators proposed for the 2025 Review are summarised in Table 15.

Table 15 Proposed substitutability levels and indicators, 2025 Review

	Substitutability	Indicator	Change since 2020 Review?
Admitted patients	15%	Private patient expenses	Yes - to indicator
Emergency departments	15%	Bulk billed GP benefits paid	No
Non-admitted patients	30%	Bulk billed operations and specialists benefits paid	No
Community health	60%	Bulk billed GP benefits paid	No

Other issues raised by states

Socio-demographic composition assessment

Greater reliance on actual state health activity

- 213 The Northern Territory said that the health assessment should rely less on socio-demographic cohort-averaged national weighted activity units and more on actual state national weighted activity unit shares.
- 214 The Northern Territory said that the primary reason for differences between the state and the national average national weighted activity units by cohort is uncaptured variation in the underlying health of the population within each cohort. The Northern Territory said that it had substantially poorer baseline health than in equivalent remote, First Nations and aged populations in other states. For example, the Northern Territory has the highest age-standardised rates of admission for kidney-related disease, bone, joint and muscular diseases, and injury, poisoning and other external causes. The Northern Territory said that the reasons for these outcomes include lack of aged care services, overcrowded housing and high rates of homelessness, unique geographic circumstances, and patient behaviour.
- 215 The Northern Territory said the design of national weighted activity units already alleviates policy neutrality concerns through national price averaging and accounting for the complexity of activity. It said that the result of averaging is that the Northern Territory's assessed national weighted activity units are around 20% lower than its actual national weighted activity units.
- 216 The Northern Territory said that assessed needs should be apportioned in line with actual national weighted activity unit shares, with consideration given to developing appropriate adjustments to recognise under-servicing.
- 217 Alternatively, if adjustments to actual national weighted activity units are considered necessary but cannot be developed in time for the 2025 Review, the Northern Territory suggested that approaches to mitigate the limitations of the current methodology include:
- blending average and actual national weighted activity unit shares (for example, 50% actual and 50% assessed), or
 - discounting by limiting the impact of national weighted activity unit averaging (for example, so that averaging does not redistribute more than a set proportion of actual national weighted activity units).
- 218 Queensland supported the Northern Territory's analysis and proposed solution. It said that the current averaging process masks meaningful variations among states and that actual national weighted activity units are a more genuine reflection of underlying health needs.
- 219 Queensland said that its population had a disproportionately higher underlying health need compared with the average of other states. It said that despite the

disproportionate and challenging health need in Queensland, the current averaging process assesses the state as having a healthier population than it actually does, and attributes higher health activity to a policy choice that implies an ‘overservicing’ of Queensland’s health needs. It said the current assessment fails to rationalise why, despite this implied overservicing, Queenslanders continue to have poorer health outcomes than the national average.

Commission response

- 220 The health assessment uses national weighted activity units, disaggregated by socio-demographic groups, at a national level to estimate a policy neutral average level of state health spending. Underpinning this approach is an assumption that people in similar circumstances are likely to use health services at a similar rate.
- 221 The Northern Territory presented evidence that this is not the case for its remote, First Nations population, based on age standardised death rates and hospital admissions for 3 disease groups. It also presented information on the difference between assessed and actual national weighted activity units, which showed the Northern Territory’s assessed national weighted activity units being around 20% lower than the actual national weighted activity units, implying that it overservices its population.
- 222 The Commission does not currently have access to actual state national weighted activity units. However, state hospital expenses are related to actual national weighted activity units. Most hospitals are funded based on the national efficient price of hospital services and the volume of services performed in hospitals, measured by national weighted activity units.²⁵ However, if a hospital is providing services below the national efficient price, states have reduced costs, and vice versa. A comparison of state actual and assessed expenses is shown in Table 16.
- 223 Based on the 2020 Review method there are reasonably large differences between actual and assessed expenses for multiple states in addition to Queensland and the Northern Territory. This may suggest that the 2020 Review approach was missing drivers of need for socio-demographic groups in addition to those identified by Queensland and the Northern Territory.

Table 16 Ratio actual to assessed hospital expenses, 2021–22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Admitted patients	0.86	1.16	1.04	0.96	1.07	0.75	1.19	1.06	1.00
Emergency departments	1.10	0.91	0.85	1.47	0.52	1.03	1.55	0.82	1.00
Non-admitted patients	1.12	0.87	0.88	1.35	0.50	1.21	1.30	1.16	1.00

Source: Commission calculation, 2024 Update using the 2020 Review method.

²⁵ Some hospitals are block funded.

- 224 The Commission agrees that using national averaging for expense assessments could miss state-specific differences in service needs. This is more likely to be the case for smaller states because they have less influence on the national average. Further work to understand the extent of these issues is needed.
- 225 One problem with the solution proposed by Queensland and the Northern Territory is that actual state national weighted activity units can be influenced by state policy decisions.
- 226 The National Weighted Activity Unit was developed by the Independent Health and Aged Care Pricing Authority to allow different hospital activities to be expressed as a common unit of activity and to set the pricing of public hospital services. The national weighted activity unit accounts for differences in the complexity of patients' conditions or procedures and individual patient characteristics that lead to increased costs.²⁶
- 227 Differences between states' hospital activity, as measured by actual national weighted activity units, can occur due to differences in the complexity of procedures performed, differences in the share of higher cost patients treated, and/or differences in the number of procedures performed. The actual number of procedures performed can potentially be influenced by policy choices, for example the resourcing decisions of states. As such, actual state national weighted activity units are not a policy neutral measure of assessed GST needs.

Commission draft position

- 228 The issues raised by Queensland and the Northern Territory are fundamental to the reliability of the health assessment. If people in similar circumstances are likely to use health services at significantly different rates, there is a conceptual case for developing an alternative method for assessing state health expense needs. Exploring this issue could form part of the Commission's proposed work program between reviews.
- 229 The solution proposed by Queensland and the Northern Territory is problematic because of the potential for actual national weighted activity units to be influenced by state policies.
- 230 The Commission will continue to use socio-demographic cohort-averaged national weighted activity units in the health assessment for the 2025 Review and work with states between reviews on the issues identified by Queensland and the Northern Territory, and potential solutions.

²⁶ Australian Institute of Health and Welfare, [Glossary - Australian Institute of Health and Welfare \(aihw.gov.au\)](https://www.aihw.gov.au/glossary), Australian Institute of Health and Welfare, 2024, accessed 14 June 2024.

Culturally and linguistically diverse (CALD) populations

- 231 Victoria said that culturally and linguistically diverse populations use health services more than other population groups and therefore the Commission should work with states to establish a method for taking account of this in the health system.
- 232 Victoria presented evidence that culturally and linguistically diverse residents have a greater burden of disease and place more demand on mainstream health services than the rest of the population.
- 233 Victoria acknowledged the difficulty in quantifying the impact of diverse residents on state services due to the challenges in identifying and defining culturally and linguistically diverse populations. For assessing health expenses needs, Victoria suggested focusing on refugees and people seeking asylum, temporary residents and people with low English proficiency.
- 234 Separately, Victoria presented evidence that culturally and linguistically diverse residents have difficulty accessing a range of government services due to cultural and language barriers. It argued the expenses states incur in supporting culturally and linguistically diverse populations should be assessed separately based on the culturally and linguistically diverse populations of states.
- 235 In 2021–22, the Victorian Government committed \$103.3 million in funding for programs that support its multicultural communities. Victoria spent \$30 million on interpretation and translation services, of which 67% (\$21.3 million) was provided by the Department of Health primarily for translation services.

Commission response

- 236 In the 2015 and 2020 reviews the Commission considered whether cultural and linguistic diversity should be included as a driver of state spending.
- 237 In 2015, the Commission accepted the contention by Victoria and New South Wales that people with poor English have a higher cost of using services than people proficient in English. However, in attempting to find strong evidence for a culturally and linguistically diverse driver, the Commission identified that while costs are often higher for culturally and linguistically diverse populations, use rates are generally lower.
- 238 For health services, using Victorian data on all admitted patient separations, the Commission found in the 2015 Review that use and cost varied considerably for people born in different countries. The net effect of this is that disaggregating non-Indigenous hospital use by country of birth has a virtually negligible effect on New South Wales (+\$3 per capita) and Victoria (-\$4 per capita).
- 239 Across a range of services, the Commission determined that there was variability in usage between birthplace groups. There was evidence that while some birthplace groups have higher-than-average use and/or cost for at least some services, other birthplace groups have lower use and/or costs. However, there was no strong

evidence about which states' mix of birthplace groups would lead to above-average cost profiles, and which would lead to below-average cost profiles.

240 The Commission concluded in the 2015 Review that it no longer accepted the conceptual case that states with large culturally and linguistically diverse population have universally higher costs, and as such no longer made any assessment of culturally and linguistically diverse populations. The Commission discontinued using language spoken at home in the post-secondary education category and the general assessment of culturally and linguistically diverse in the other expenses category.

241 In the 2020 Review, the Commission considered the influence of cultural and linguistic diversity in several assessments.

- In the welfare assessment, the Commission accepted the conceptual case that services to culturally and linguistically diverse people impose an additional cost on states. However, the absence of comprehensive and reliable cost data along with culturally and linguistically diverse use data limited the Commission's ability to develop a culturally and linguistically diverse assessment.
- In the housing assessment, the Commission found that using culturally and linguistically diverse people as a driver did not have a material impact on GST distribution.
- In justice there were difficulties in collecting information that both define a culturally and linguistically diverse prisoner and a relative cost weight. The only known culturally and linguistically diverse information on prisoners was country of birth. The Commission considered being born overseas is not an adequate way to define the culturally and linguistically diverse population, as many people born overseas have good English and do not require an interpreter. Likewise, there are many people born in Australia, particularly among the First Nations population in the Northern Territory, who require additional resources due to cultural and linguistic differences.

242 The analysis presented by Victoria justifies retesting the materiality of cultural and linguistic diversity as a driver of need. A more comprehensive analysis can now be undertaken of the impact of a culturally and linguistically diverse population driver on the health assessment, using country of birth as the indicator of culturally and linguistically diverse status.

243 However, it is a significant and sensitive issue that would require consultation with states, including on the choice of countries of birth to include in the different use groups (high cost/low cost or high/medium/low cost). For example, Victoria suggests the Commission focus on refugees and people seeking asylum, temporary residents and people with low English proficiency. However, this information is not collected from people that use state hospital services, so judgement would be needed to relate these factors back the information available on country of birth. Once appropriate specifications were determined, there would then likely be a considerable lag in obtaining the relevant data.

244 If a driver has a material impact on GST distribution for any state across all categories, it is included in all assessments where there is a conceptual case for its

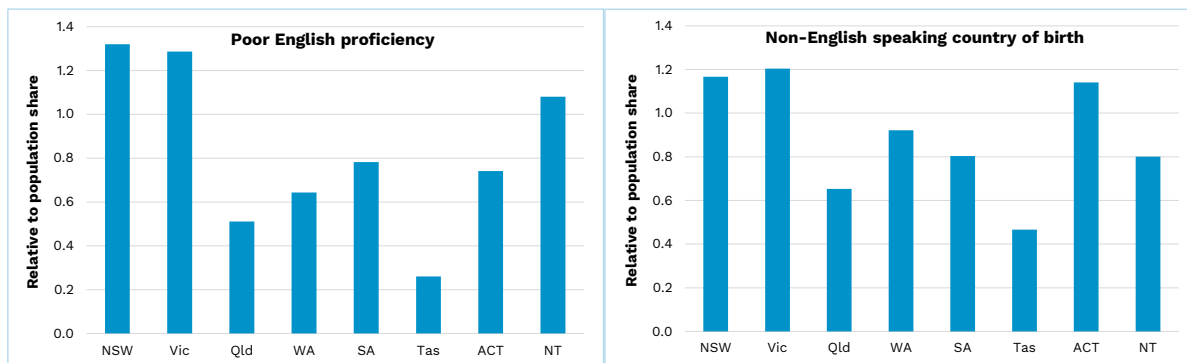
inclusion, and reliable and robust data, regardless of its materiality in individual assessments.²⁷

245 In regard to Victoria’s suggestion for a separate assessment of expenses states incur on multicultural health services and language support associated with all government services, the Commission has undertaken an indicative assessment of these expenses, on the assumption that all states spend at the same per capita level as Victoria.

246 Two options for defining culturally and linguistically diverse were considered – English proficiency and non-English speaking country of birth.

247 The analysis showed that while the prevalence of culturally and linguistically diverse people varied significantly by state (Figure 6), the level of spending across all services was not sufficient to result in a materially different distribution of GST compared with an equal per capita distribution (Table 17 and Table 18).

Figure 6 Prevalence in the population



Source: ABS 2021 Census data; Commission judgement was required in determining the list of non-English speaking countries.

Table 17 GST impact – English proficiency

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Natl spend on CALD (\$m)	217	171	55	36	29	3	7	5	523
EPC share CALD spend (\$m)	165	133	107	56	37	12	9	5	523
Difference from EPC (\$m)	53	38	-52	-20	-8	-9	-2	0	0
Difference from EPC (\$pc)	7	6	-10	-7	-4	-15	-5	2	0

Source: Commission calculation using Victorian data and ABS 2021 Census data.

Table 18 GST impact – country of birth

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Natl spend on CALD (\$m)	192	160	70	52	29	5	11	4	523
EPC share CALD spend (\$m)	165	133	107	56	37	12	9	5	523
Difference from EPC (\$m)	27	27	-37	-4	-7	-6	1	-1	0
Difference from EPC (\$pc)	3	4	-7	-2	-4	-11	3	-4	0

Source: Commission calculation using Victorian data and ABS 2021 Census data.

²⁷ CGC, [2025 Methodology Review - Commission's position on fiscal equalisation, supporting principles and assessment guidelines.pdf \(cgc.gov.au\)](#), CGC, Australian Government, 2023, accessed 14 June 2024, p19.

Commission draft position

- 248 The Commission considers there is a conceptual case that people from different cultures have different use rates of state health services.
- 249 A substantial amount of work is required to incorporate this driver into the health assessment, including consultations with states. In particular, the choice of countries of birth to include in the low/medium/high use groups is sensitive. In addition, the Commission's disaggregated estimated resident population data would need to be further disaggregated by country of birth. The Commission proposes to consider how cultural and linguistic diversity affects state service costs as a part of its proposed forward work program.
- 250 The Commission does not propose to separately assess state spending on multicultural and language services in the 2025 Review as it is unlikely to result in a material impact on GST distribution.

Modifying age groups

- 251 New South Wales said the Commission should consider whether to modify the existing 3 oldest age groups in the health assessment to better capture the effect of age on state health expenses. Given the ageing of the Australian population, New South Wales suggested groups should be 45–69, 70–79 and 80+ rather than the existing 45–64, 65–74 and 75+.

Commission response

- 252 The impact of splitting the oldest age group was tested using admitted patient activity data. The highest age group was disaggregated into 75–84 and 85+. The other age groups could not be modified as the data currently available do not have a further breakdown. Splitting the highest age group did not have a material impact as the small number of people aged over 85 offset their higher costs (Table 19). Applying the same analysis to all hospital components did not make a material difference.

Table 19 Impact of disaggregating highest age group, health assessment, 2021–22

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Scenario (\$m)	17,966	13,867	12,202	6,079	4,409	1,621	763	955	57,862
Base (\$m)	17,955	13,855	12,222	6,085	4,403	1,621	764	957	57,862
Difference (\$m)	12	12	-20	-6	6	0	-1	-2	0
Difference (\$pc)	1.4	1.8	-3.9	-2.2	3.3	-0.6	-2.2	-8.1	0.0

Source: Commission calculation using 2021–22 data on Independent Health and Aged Care Pricing Authority National Weighted Activity Units, ABS population data and GFS expenses.

Commission draft position

- 253 The Commission proposes to maintain the existing age groups for the 2025 Review as splitting the oldest age group does not have a material impact. This will be retested in the next review.

Clustered design of Victoria's health system

- 254 Victoria said that it is not appropriate to apply remoteness weights to national weighted activity units when residents travel from more remote areas for treatment in hospitals located in less remote areas.
- 129 Victoria's health system follows a clustered design, where specialised and high-cost services and facilities are located in higher density areas closer to Melbourne's central business district. This clustering of services allows for efficiency in service delivery. Victoria said it would be inappropriate to apply a regional cost weighting to these services, as they are not provided in remote areas, despite being for residents from those areas.

Commission draft position

- 255 The Independent Health and Aged Care Pricing Authority applies cost weights for patients travelling from regional and remote areas to major cities for treatment because states incur additional costs in providing services to these people. It is appropriate that the Commission recognise these costs in its assessments.

Discounting the assessment of the National Health Reform Agreement

- 256 The terms of reference for the annual update of GST relativities require the Commission to assess Commonwealth payments to states under the National Health Reform Agreement (see below).
- 257 Queensland said that a portion of the payment is used to fund hospital services that states are providing because of shortfalls in the provision of Commonwealth-funded primary and aged care services. Specifically:
- Low acuity emergency department presentations. Queensland estimated 60% of these presentations could have been cared for via urgent care clinics or GP appointments. The cost to Queensland hospitals was estimated at \$310 million.
 - Potentially Preventable Hospitalisations. These are hospitalisations that could have been prevented through the provision of appropriate health interventions and early disease management in primary care and community-based care settings (including by GPs, medical specialists, dentists, nurses, and allied health professionals). The cost to Queensland hospitals was estimated at \$548.9 million.
 - Long stay patients. These are patients who has been in hospital for more than 35 days and no longer need active treatment. These patients usually require a level of care that could be appropriately provided in the community but may not be available. The cost to Queensland hospitals was estimated at \$290–\$445 million.
- 258 Queensland said the Commission should discount the assessment of the National Health Reform Agreement payments by a minimum of 12.5% on the basis that some of the funding is effectively being used to provide services for which states are not responsible.

Commission response

- 259 In 2021–22, Commonwealth payments under the National Health Reform Agreement amounted to around 46% of Queensland’s total spending on admitted patient services or 42% of admitted patient and emergency department spending. Apportioning the costs identified by Queensland on the basis of a Commonwealth/state funding split of 35:65 to 43:57, around 7–10% of the Commonwealth payment is used to fund these costs.
- 260 The Commission uses a discount when it has concerns with the data used in the assessment or the assessment method. It is not appropriate to apply a discount for the problem that Queensland has raised.
- 261 There may be a case to not assess a proportion of the Commonwealth payment on the basis that it is funding services that are not a usual state responsibility and for which needs are not assessed. This is the approach the Commission takes with Commonwealth payments that address structural disadvantage (such as the stock of social housing in remote First Nations communities).
- 262 The National Health Reform Agreement would need to specify the amount of funding that relates to non-state functions.

Commission draft position

- 263 If the Commonwealth and states can agree that a portion of the National Health Reform Agreement Commonwealth payment funds hospital services that are not a state responsibility, and that share of the payment is specified in the agreement, then the Commission will treat that amount as a no impact payment.
- 264 The share of spending that is funded by states on hospital services that are a Commonwealth responsibility will continue to be assessed by the usual drivers of need. State needs to spend on these hospital services are likely to be best estimated by the usual health assessment methods.

Non-hospital patient transport

- 265 Victoria said the assessment of non-hospital patient transport costs is flawed because it assesses Western Australia and the Northern Territory to need more than double their actual spending.
- 266 Victoria presented evidence using data from the 2020 Review that higher spending in remote areas does not relate to higher remote population shares.
- 267 Victoria said that expenses on non-hospital patient transport should be assessed in the admitted patient assessment.

Commission response

- 268 Large differences between actual and assessed expenses are not necessarily an indication that the assessment is mis-specified. Actual expenses are affected by

state policy choices, the efficiency of service provision and the accuracy of expense reporting. However, large differences can justify a review of the assessment.

- 269 Aeromedical services and the Patient Assistance Transport Scheme are provided disproportionately to people in remote and very remote regions. This is the main reason why the Commission has assessed expenses associated with these services separately to other hospital expenses.
- 270 If the activity associated with aeromedical services and the Patient Assistance Transport Scheme were included in national weighted activity units, this would add weight to Victoria's argument that the expenses be included in the admitted patient assessment.
- 271 The activity associated with patient transport are included in the admitted patient national weighted activity units, and the remoteness costs weights produced by the Independent Health and Aged Care Pricing Authority include the cost of patient transport.²⁸ However, states submit patient transport costs inconsistently and this may not be fully reflected in state data submissions. It is not clear if the patient transport costs used to calculate national weighted activity units include aeromedical services, the Patient Assistance Transport Scheme or both, or whether these costs are classified elsewhere (that is, not identified as a transport cost).
- 272 The classification system for the National Hospital Cost Data Collection issued in 2023 now specifies that patient transport costs for aeromedical services and the Patient Assistance Transport Scheme are in scope and should be submitted.²⁹ However, it may take time for states to comply fully.

Commission draft position

- 273 Given the uncertainty about the extent that activity associated with patient transport are included in the admitted patient national weighted activity units, the costs associated with aeromedical services and the Patient Assistance Transport Scheme will be kept separate and assessed using the current method for the 2025 Review.
- 274 The Commission will continue to engage with the Independent Health and Aged Care Pricing Authority between reviews to determine whether an alternative approach is appropriate in future.

Adjustments for state bilateral cross-border arrangements

- 275 Victoria said it is a net exporter of hospital treatment to other states and territories, so there are consistent funding inflows for interstate patients. Victoria said it supports the Commission's current adjustment for cross-border health flows for

²⁸ Independent Health and Aged Care Pricing Authority, [Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2022-23](#), Independent Health and Aged Care Pricing Authority, 2021, accessed 14 June 2024, p20. Independent Health and Aged Care Pricing Authority, [Australian Hospital Patient Costing Standards Version 4.1 - Part 1 - Standards](#), Independent Health and Aged Care Pricing Authority, 2021, accessed 14 June 2024, p37.

²⁹ Independent Health and Aged Care Pricing Authority, [Australian Hospital Patient Costing Standards Version 4.2 - Part 1 - Standards](#), Independent Health and Aged Care Pricing Authority, 2023, accessed 14 June 2024, p40.

Commonwealth payments under the National Health Reform Agreement. However, Victoria questioned the extent to which this fully captures state-to-state cross border payments.

- 276 Victoria requested the Commission examine how the state-to-state funding flows for health services impact its assessments and confirm for states they align with the relevant clause of the National Health Reform Agreement.

Commission response

- 277 Commonwealth payments are an important source of revenue available to states and are taken into account when determining each state's fiscal capacity and GST share. In general, the higher the value of Commonwealth payments a state receives, the less its requirement for GST revenue.
- 278 The National Health Reform Agreement funding is shared by the Commonwealth and states. Section A111 of the National Health Reform Agreement relates to the funding arrangements for National Health Reform Commonwealth funding for cross-border activity. It specifies that the state where a patient normally resides should meet the cost of hospital services.
- 279 The Commission uses cross-border expense data provided by the National Health Funding Body to make cross-border adjustments to the National Health Reform Commonwealth payments. The adjustments ensure that the payment states are recorded as receiving only include services provided to their own residents. States that are net providers of health services to residents of other states have their National Health Reform payments reduced, so they are not penalised for their spending on services provided to residents of other states.
- 280 The Commission does not make any adjustment to the state share of National Health Reform funding. Bilateral agreements are in place to compensate states for the services provided to residents of other states. There is no need for the Commission to do anything about the state share of National Health Reform funding.

Commission draft position

- 281 The Commission proposes to continue to use cross-border data to apply cross-border adjustments to the National Health Reform Agreement Commonwealth payments. No further action is required to address Victoria's concerns.

Draft 2025 Review assessment method

- 282 Table 20 shows the proposed structure of the 2025 Review health assessment.

Table 20 Proposed structure of the health assessment

Component	Driver	Influence measured by driver	Change since 2020 Review?
Admitted patients	Socio-demographic composition	Recognises that the use and cost of services varies by age, socio-economic status, remoteness, and Indigenous status.	No
	Non-state sector (a)	Recognises that non-state funded health services such as private health insurance funded hospital services affect state health spending.	Yes. Change to indicator
	Wage costs	Recognises differences in wage costs between states.	No
Emergency departments	Socio-demographic composition	Recognises that the use and cost of services varies by age, socio-economic status, remoteness, and Indigenous status.	No
	Non-state sector (b)	Recognises that non-state health services, such as general practitioners (GPs), affect state health spending.	No
	Wage costs	Recognises differences in wage costs between states.	No
Non-admitted patients	Socio-demographic composition	Recognises that the use and cost of services varies by age, socio-economic status, remoteness, and Indigenous status.	No
	Non-state sector	Recognises that non-state health services, such as specialists and private health professionals affect state health spending.	No
	Wage costs	Recognises differences in wage costs between states.	No
Community and public health	Ambulatory community mental health services (c)	Recognises that the use and cost of services varies by age, socio-economic status, remoteness, and Indigenous status.	Yes
	Balance of the component – socio-demographic composition (c)	Recognises that the use and cost of services varies by age, socio-economic status, remoteness, and Indigenous status.	Yes
	Non-state sector	Recognises that non-state health services, such as general practitioners (GPs), affect state health spending.	No
	First Nations grants adjustment	Recognises the impact of Commonwealth grants to Aboriginal Community Controlled Health Organisations.	No
	Cross-border	Recognises the net cost that the ACT incurs in providing services to NSW residents.	No
	Wage costs	Recognises differences in wage costs between states.	No
Non-hospital patient transport	Socio-demographic composition	Recognises that remoteness influences service use.	No
	Wage costs	Recognises differences in wage costs between states.	No
National Partnership on COVID-19	Actual per capita	Recognises that state spending under the National Partnership on COVID-19 reflected circumstance beyond state control.	Yes

- (a) The Commission proposes that the non-state sector adjustment for admitted patients be based on privately insured patient expenses, instead of privately insured patient separations.
- (b) The Commission proposes a change in data source based on Australian Institute of Health and Welfare data on the proportion of emergency department presentations that are potentially treatable by GPs.
- (c) The Commission proposes these changes to the assessment of community and public health: use the Australian Institute of Health and Welfare data on ambulatory community mental health to determine per capita use rates for mental health services for the socio-demographic groups used in the health assessment; and expand the current proxy for activity (emergency department triage categories 4 and 5) to include selected non-admitted patient services, applied to the balance of the component.

Indicative distribution impacts

- 283 The impact of the proposed COVID-19 and non-COVID-19 changes to the health assessment are presented separately because of the particular circumstances associated with the separate assessment of state expenses on COVID-19.
- 284 First, there is a significant reduction in state spending on COVID-19 related health services between the assessment years for the 2024 Update and the assessment years relevant for the 2025–26 GST distribution (to be included in the final report of the 2025 Review). Consequently, rather than providing an indication of the impact of the change in terms of the impact on the 2024 Update, using the assessment years for the 2025 Review is more appropriate.
- 285 Second, given the COVID-19 Commonwealth payment to the states ended in 2022–23, the separate assessment of COVID-19 related health expenses would cease in the 2027 Update. To gain a better indication of the ongoing impact of the proposed non-COVID-19 changes to the health assessment, this impact has been calculated ignoring the COVID-19 change.

Impacts from non-COVID-19 changes

- 286 The indicative impact of the proposed changes to the health assessment on GST distribution in 2024–25, other than those related to the separate assessment of state spending on COVID-19, is shown in Table 21.
- 287 Community and public health expenses are proposed to be assessed using different measures of activity.
- 288 Broadening the proxy indicator of community and public health activity results in higher assessed spending needs for states with relatively larger shares of their population in less remote areas or in higher socio-economic status cohorts, or with relatively larger shares of non-Indigenous or younger people.³⁰
- 289 Assessing expenses on ambulatory specialised community mental health using a direct measure of the use of these services results in higher assessed spending needs mainly for states with relatively larger shares of their population in less remote areas.
- 290 The proposed change to the indicator of admitted patient non-state activity affects the estimates of states' actual non-state sector activity as well as their assessed non-state sector activity, with the non-state sector adjustment being the difference between these 2 measures.³¹
- 291 Using updated data on New South Wales residents' use of ACT services increases GST distribution to the ACT and reduces it for New South Wales.

³⁰ See Figure 4 for more information.

³¹ See Table 8, Table 9 and Table 10 for more information.

292 Using updated data on the split between state spending on hospital and non-hospital patient transport reduces expenses for non-hospital patient transport compared with the 2024 Update. This reduces GST distribution to states that are assessed to need to spend more than their per capita share on non-hospital patient transport.

Table 21 Indicative impact on GST distribution of proposed non-COVID-19 changes (disaggregated), 2024–25

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total Effect
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Community health use indicator	58	23	-34	27	-7	-11	31	-88	139
New ambulatory community mental health assessment	98	79	-26	-68	-18	-35	-2	-28	177
Admitted patient non-state sector indicator	68	34	138	-239	-17	33	-17	-1	274
Cross border	-10	0	0	0	0	0	10	0	10
Non-hospital patient transport	9	7	-1	-9	0	1	0	-7	17
Total	223	143	78	-289	-42	-12	23	-123	466
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Community health use indicator	7	3	-6	9	-4	-19	65	-341	5
New ambulatory community mental health assessment	11	11	-5	-23	-9	-59	-5	-110	6
Admitted patient non-state sector indicator	8	5	25	-81	-9	56	-35	-4	10
Cross border	-1	0	0	0	0	0	22	0	0
Non-hospital patient transport	1	1	0	-3	0	2	0	-26	1
Total	26	20	14	-98	-22	-20	47	-481	17

Note: The analysis assumes no change to the assessment of COVID-19 related health spending. Based on no change to the wage costs assessment. The effect of these changes is shown in the wage costs chapter. The GST pool and population estimates are equivalent to those used in the 2024 Update. The data included in the table have not been subject to full quality assurance processes and as such, should be treated as indicative only. Indicative GST impacts are provided for illustrative purposes only and should not be used to predict impacts on GST distribution for 2025–26.

Impacts from COVID-19 changes

293 Table 22 shows the indicative impact on the GST distribution in 2025–26 (compared with the 2024 Update) of the proposal to separately assess state spending on COVID-19.

294 The change in distributions shown in the table are the net effect of:

- assessing revenue from the Commonwealth payment under the National Partnership on COVID-19 Response on an actual per capita basis compared with the no impact treatment of the payment in the 2024 Update
- assessing state spending of the Commonwealth payment on an actual per capita basis compared with the exclusion of this spending from the assessment in the 2024 Update

- assessing state spending from own-source revenue on COVID-19 on an actual per capita basis compared with assessing it in the health assessment in the 2024 Update.

295 Over 2021–22 and 2022–23, New South Wales, Victoria, Tasmania and the Northern Territory spent more than their per capita share on COVID-19 related health services. Under an actual per capita assessment method, these states have higher-than-average assessed expenses for COVID-19 health services. When compared with how these expenses were assessed under 2020 Review methods, Tasmania and the Northern Territory receive less GST.

Table 22 Indicative impact on GST distribution of proposed COVID-19 changes (disaggregated), 2025–26

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total Effect
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
Commonwealth payment for COVID-19	-144	-193	268	14	64	-7	7	-10	353
State spending of Commonwealth payment	144	193	-268	-14	-64	7	-7	10	353
State own source COVID-19 spending	201	283	-306	-52	-75	-23	-2	-25	484
Net effect of treatment of COVID-19	201	283	-306	-52	-75	-23	-2	-25	484
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Commonwealth payment for COVID-19	-17	-27	48	5	34	-11	14	-37	13
State spending of Commonwealth payment	17	27	-48	-5	-34	11	-14	37	13
State own source COVID-19 spending	24	40	-55	-18	-40	-39	-5	-96	18
Net effect of treatment of COVID-19	24	40	-55	-18	-40	-39	-5	-96	18

Note: Based on no change to the wage costs assessment. The effect of these changes is shown in the wage costs chapter.

The GST pool and population estimates are equivalent to those used in the 2024 Update.

The data included in the table have not been subject to full quality assurance processes and as such, should be treated as indicative only.

Indicative GST impacts are provided for illustrative purposes only and should not be used to predict impacts on GST distribution for 2025–26.

The indicative impacts are based on the reconciled value of the Commonwealth payments under the National Partnership on COVID-19 Response.

Attachment A: Tier 2 classification 2021–22

Table A-1 Tier 2 classification v7.0 2021–22

Group and Class	Description
Procedures	
10.01	Hyperbaric medicine
10.02	Interventional imaging
10.03	Minor surgical
10.04	Dental
10.05	Angioplasty/angiography
10.06	Endoscopy – gastrointestinal
10.07	Endoscopy – urological/gynaecological
10.08	Endoscopy – orthopaedic
10.09	Endoscopy – respiratory/ear, nose and throat (ENT)
10.10	Renal dialysis – hospital delivered
10.11	Chemotherapy treatment
10.12	Radiation therapy – treatment
10.13	Minor medical procedures
10.14	Pain management interventions
10.15	Renal dialysis – haemodialysis – home delivered
10.16	Renal dialysis – peritoneal dialysis – home delivered
10.17	Total parenteral nutrition – home delivered
10.18	Enteral nutrition – home delivered
10.19	Ventilation – home delivered
10.20	Radiation therapy – simulation and planning
Medical consultations	
20.01	Transplants
20.02	Anaesthetics
20.03	Pain management
20.04	Developmental disabilities
20.05	General medicine
20.06	General practice and primary care
20.07	General surgery
20.08	Genetics
20.09	Geriatric medicine
20.10	Haematology
20.11	Paediatric medicine
20.12	Paediatric surgery
20.13	Palliative care
20.14	Epilepsy
20.15	Neurology
20.16	Neurosurgery
20.17	Ophthalmology
20.18	Ear, nose and throat (ENT)
20.19	Respiratory
20.20	Respiratory – cystic fibrosis
20.21	Anti-coagulant screening and management
20.22	Cardiology

Group and Class	Description
20.23	Cardiothoracic
20.24	Vascular surgery
20.25	Gastroenterology
20.26	Hepatobiliary
20.27	Craniofacial
20.28	Metabolic bone
20.29	Orthopaedics
20.30	Rheumatology
20.31	Spinal
20.32	Breast
20.33	Dermatology
20.34	Endocrinology
20.35	Nephrology
20.36	Urology
20.37	Assisted reproductive technology
20.38	Gynaecology
20.39	Gynaecological oncology
20.40	Obstetrics – management of pregnancy without complications
20.41	Immunology
20.42	Medical oncology – consultation
20.43	Radiation therapy – consultation
20.44	Infectious diseases
20.45	Psychiatry
20.46	Plastic and reconstructive surgery
20.47	Rehabilitation
20.48	Multidisciplinary burns clinic
20.49	Geriatric evaluation and management (GEM)
20.50	Psychogeriatric
20.51	Sleep disorders
20.52	Addiction medicine
20.53	Obstetrics – management of complex pregnancy
20.54	Maternal foetal medicine
20.55	Telehealth – patient location
20.57	COVID-19 response
Diagnostic imaging	
30.01	General imaging
30.02	Magnetic resonance imaging (MRI)
30.03	Computerised tomography (CT)
30.04	Nuclear medicine
30.05	Pathology (microbiology, haematology, biochemistry)
30.06	Positron emission tomography (PET)
30.07	Mammography screening
30.08	Clinical measurement
Allied health	
40.02	Aged care assessment
40.03	Aids and appliances
40.04	Clinical pharmacy
40.05	Hydrotherapy

Group and Class	Description
40.06	Occupational therapy
40.07	Pre-admission and pre-anaesthesia
40.08	Primary health care
40.09	Physiotherapy
40.10	Sexual health
40.11	Social work
40.12	Rehabilitation
40.13	Wound management
40.14	Neuropsychology
40.15	Optometry
40.16	Orthoptics
40.17	Audiology
40.18	Speech pathology
40.21	Cardiac rehabilitation
40.22	Stomal therapy
40.23	Nutrition/dietetics
40.24	Orthotics
40.25	Podiatry
40.27	Family planning
40.28	Midwifery and maternity
40.29	Psychology
40.30	Alcohol and other drugs
40.31	Burns
40.32	Continence
40.33	General counselling
40.34	Specialist mental health
40.35	Palliative care
40.36	Geriatric evaluation and management (GEM)
40.37	Psychogeriatric
40.38	Infectious diseases
40.39	Neurology
40.40	Respiratory
40.41	Gastroenterology
40.42	Circulatory
40.43	Hepatobiliary
40.44	Orthopaedics
40.45	Dermatology
40.46	Endocrinology
40.47	Nephrology
40.48	Haematology and immunology
40.49	Gynaecology
40.50	Urology
40.51	Breast
40.52	Oncology
40.53	General medicine
40.54	General surgery
40.55	Paediatrics
40.56	Falls prevention

Group and Class	Description
40.57	Cognition and memory
40.58	Hospital avoidance programs
40.59	Post-acute care
40.60	Pulmonary rehabilitation
40.61	Telehealth – patient location
40.62	Multidisciplinary case conference - patient not present
40.63	COVID-19 response
40.64	Chronic pain management

Source: Independent Health and Aged Care Pricing Authority, [Tier 2 non-admitted services classification 2021-22](#), Independent Health and Aged Care Pricing Authority, 2020, v7, accessed 14 June 2024.