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Victorian submission to CGC 2025 Review

COVID-19 Health investment

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1. Introduction

In June 2024, the Commonwealth Grants Commission (CGC) provided states the draft report of its 2025 methodology review. Victoria provided its response in August, as well as further responses to addendums on transport and mining in September.

Since providing its response to the draft report, Victoria has become aware of consequential technical issues with the treatment of COVID-19 related health expenditure in the investment assessment which were not discussed in the Commission's consultation papers or draft report. Following further examination of the draft report's underlying calculations, and consultation with CGC staff, Victoria has prepared this supplementary submission to augment its previous submissions.

Victoria strongly supports the draft report's proposed methods for treating COVID-19 related health recurrent expenditures. However, the draft report did not discuss the implications of this assessment for health investment.[1]

To avoid unintuitive and unintended impacts, Victoria recommends the CGC does not include COVID-19 related expenses in its calculation of the health investment stock factor. This supplementary response outlines Victoria's rationale for this recommendation in further detail below. Victoria's views are that the draft report's proposed assessment of COVID-19 related health investment:

- is not appropriate as it would only capture the downwards trend in investment as the pandemic unwound, missing Victoria's high assessed investment in 2020-21
- does not reflect responses to the pandemic, which were less capital intensive than the assessment assumes
- is inconsistent with the CGC's views on COVID-19 related investment in the services to industry and transport assessments.

Victoria's recommendations

- Victoria recommends the CGC does not include COVID-19 related expenses in its calculation of the health investment stock factor.

2. Victoria would be unfairly disadvantaged by incorporating COVID-19 health expenses into investment for the 2025 Review

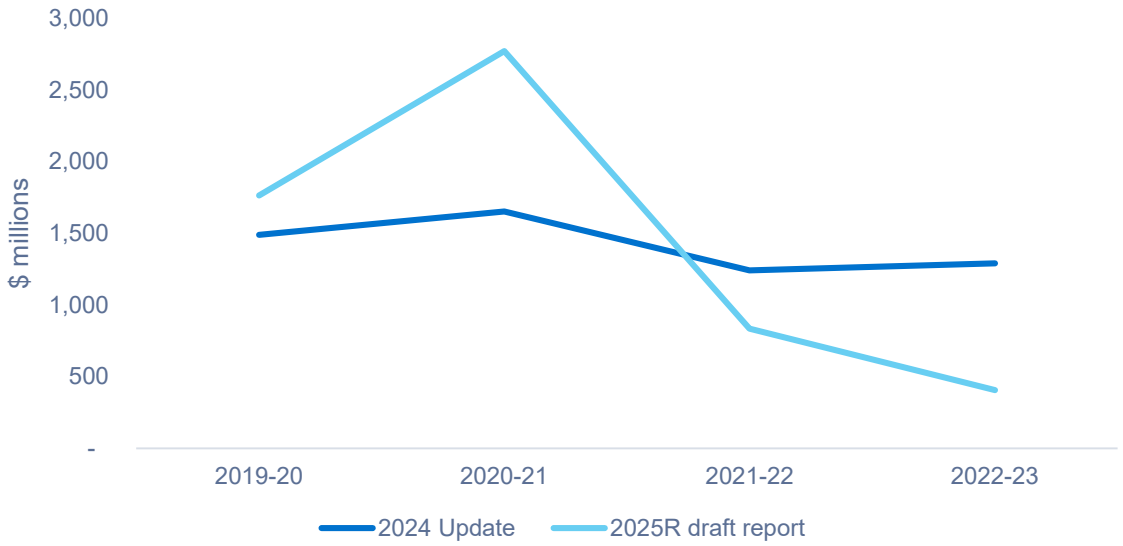
The draft report's investment assessment includes a significant increase in Victoria's health investment requirement in 2020-21, followed by a significant decline, see Figure 1 below. This is as a

[1] Previous consultation from the CGC on the treatment of states' COVID-19 response spending from the 2022 and 2023 New Issues papers also did not consider the impacts on the investment assessment. https://www.cgc.gov.au/sites/default/files/2022-03/New%20issues%20in%20the%202022%20Update%20-%20with%20title%20page.pdf and https://www.cgc.gov.au/sites/default/files/2023-03/New%20Issues%20in%20the%202023%20Update%20%20%281%29.pdf

result of the CGC's approach to assessing investment which directly applies the drivers of recurrent expenditure, and the disproportionate impacts of the pandemic on Victoria in that year.

From 2020-21 to 2022-23 the draft report assesses that Victoria's health investment falls from $2.8 billion to $400 million, a decline of around 80 per cent. Large variance may be appropriate to reflect the nature of the pandemic and states' responses, however Victoria does not consider the draft report's assessment is representative of reality or how COVID-19 responses unfolded.

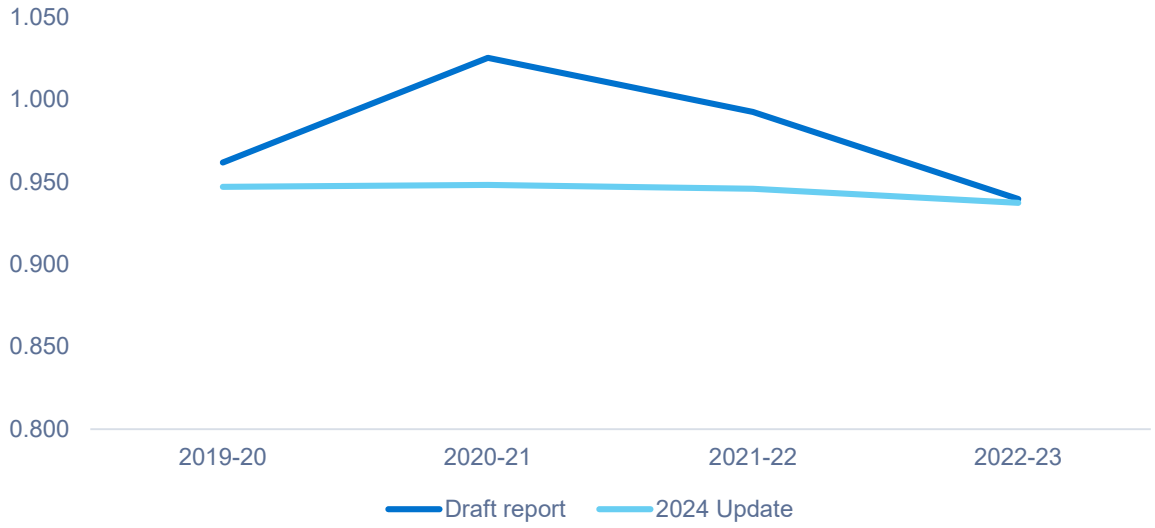
Figure 1: Victoria's assessed health investment from the 2025 Review draft report and 2024 Update



Source: CGC 2024 Update and 2025 Review draft report

In the underlying calculations for the draft report, COVID-19 related operating expenditure is included in the health investment stock factor. The stock factors represent a population weighting for cohorts that require higher infrastructure investment. By including COVID-19 related expenses, Victoria's stock factor is increased compared to the 2024 Update, see Figure 2 below.

Figure 2: Victoria's assessed closing health investment stock factor



Source: CGC 2025 Review draft report and 2024 Update report

However, despite its stock factor being higher across all years presented in the draft report, Victoria's assessed investment dramatically falls, after temporarily increasing. This is due to the calculation of assessed investment as the difference between 'opening' (start of year) and 'closing' (end of year) capital stocks. Opening stocks are calculated with reference to the previous year's stock factors. For example, the opening stock in 2021-22 is the closing factor from 2020-21.

Victoria's health investment stock factor is very high in 2020-21 (due to its assessed greater need from higher COVID-19 expenses) but falls in following years as the COVID-19 response wound down (reflecting lower COVID-19 related spending). This means Victoria's 'opening' stock factor for 2021-22 is very high, and higher than its 'closing' stock factor. As such, its required investment is lower (compared to at the 2024 Update), as the opening capital stock is relatively high compared to the closing stock. The same is true for 2022-23, with a relatively high opening stock from 2021-22 and lower closing stock due to the tapering of pandemic responses.

The implication is that because Victoria made significant investments in 2020-21, it requires less investment in later years. The assumption is the new capital from 2020-21 can be used to accommodate future growth or be sold.

Victoria considers this will lead to an unintended outcome in the context of the CGC's 2025 review and that incorporating COVID-19 recurrent expenditures into the health investment assessment using the standard approach to assessing investment is not appropriate. It would only capture the downwards trend in Victoria's investment as the pandemic unwound, missing Victoria's high assessed investment need in 2020-21 as the CGC was unable to apply these methods in earlier updates. This is because the 2025 Review period commences with an assessment of the years 2021-22 to 2023-24, missing 2020-21.

In addition to this timing issue, Victoria questions whether COVID-19 related spending should be included in the investment stock factor, given COVID-19 responses were not capital intensive and did not result in the significant increase in investment the draft report implies. This is discussed further in the following section.

The result is that Victoria may lose significant GST revenue in 2025-26 due to the decline in its health investment stock factor from 2020-21. This will potentially counteract the impact of the increased

assessed health recurrent expenditure need Victoria gains due to the recognition of its COVID-19 requirement. This would also doubly disadvantage Victoria for the disproportionate impacts of the pandemic, after the Commission was previously not able to assess its much higher need in recent updates being constrained by the terms of reference.

3. COVID-19 health responses were less capital intensive than the assessment suggests

The draft report's methods assume that increases in COVID-19 recurrent expenditure translated to capital requirements in the same proportion as typical health expenditure. Victoria does not consider this is the case, as COVID-19 responses were less capital intensive.

While states operated under significant uncertainty, responses to the pandemic recognised it to be a time-limited impact to the health system. There was not sufficient time to respond with significant new infrastructure in the same proportion as recurrent expenditures. For example, significant new hospitals were not built solely responding to COVID-19. Rather, responses made use of existing infrastructure, repurposed for pandemic needs and returned to their typical uses after the pandemic.

The draft report's assessment methods imply due to its significant assessed investment in 2020-21, Victoria either requires less investment in future (as it can use the 'COVID-19 infrastructure' for future growth) or can sell the assets to recoup investments. Victoria considers neither of these outcomes reflect the actions taken by states to mobilise existing infrastructure capacity on a temporary basis. Given infrastructure needs were largely met through reprioritisation of existing asset capacity, there is not significant additional or spare infrastructure that can accommodate future growth in health infrastructure needs.

While Victoria made significant purchases of new medical equipment including personal protective equipment (PPE) and specialist medical tools like ventilators, these were not as significant as the draft report's investment assessment suggests. They also did not create spare capacity in the hospital system after the pandemic as assumed by the assessments, either as they are specific tools to respond to the pandemic (and unable to accommodate later more general growth in health demand) or were consumables with limited use like PPE.

3.1 Actual COVID-19 related health investment by Victoria

Victoria's budget papers demonstrate a focus on service-based responses to the pandemic, rather than infrastructure investment. Victoria's 2020-21 Budget highlights significant expenditure of $2.9 billion in the Coronavirus (COVID-19) health response initiative, under the public health output (operating expenditure). The 2020-21 Budget highlights funding for "meeting additional demands on the health system at the peak of recent increases in case numbers" including "to support frontline healthcare workers, and service responses to help minimise the spread of coronavirus (COVID-19). Support is also provided for increased testing capacity and optimisation of Victoria's pathology and supply chain processes."[2]

In comparison, the corresponding Coronavirus (COVID-19) health response asset initiative is only $16.3 million. The only other COVID-19 specific asset initiative under the former Department of Health

[2] https://s3-ap-southeast-2.amazonaws.com/budgetfiles202021.budget.vic.gov.au/2020-21+State+Budget+-+Service+Delivery.pdf

and Human Services (DHHS) in the Victorian 2020-21 Budget was $10 million for the Coronavirus (COVID-19) mental health responses.[3]

The Victorian Department of Health 2020-21 Annual Report notes additional capacity was created to respond to the pandemic partly by accelerating the existing capital program, but also substantially by reprioritising existing capacity. It states: "The department worked in partnership with hospitals to activate uncommissioned capacity, purchase private capacity, reconfigure and optimise public hospitals, recommission former closed sites and accelerate new projects in the capital program to increase capacity for care."[4] Many of these strategies would result in infrastructure reverting to a prior use after a pandemic surge (for example, private capacity and accelerated pre-existing projects for other purposes). There would be limited 'spare' capacity post-pandemic Victoria could use to accommodate future growth as the draft report's assessment suggests.

The Victorian Department of Health has provided data on total capital investment responding to the COVID-19 pandemic, see Figure 3 below. The data show COVID-19 related investment in Victoria peaked at $153 million in 2020-21.

Through 2019-20 and 2020-21, Victoria made capital investments in the procurement of equipment and consumables for state hospitals. These included PPE, essential pharmaceuticals and pathology consumables, as well as intensive care unit (ICU) equipment like suction units, resuscitation, intubation, and defibrillator trolleys. From 2020-21 the Victorian Health Building Authority also managed COVID-19 related infrastructure works, for example recommissioning the former Peter MacCallum Cancer Institute to bring additional bed capacity. This work included re-establishing plumbing and power services, facilitating building access and ensuring compliance with safety standards.[5]

Later in the pandemic, the figures for 2022-23 and 2023-24 include investment to meet the need for surges in elective surgery across the state as part of the COVID Catch Up Plan.[6]

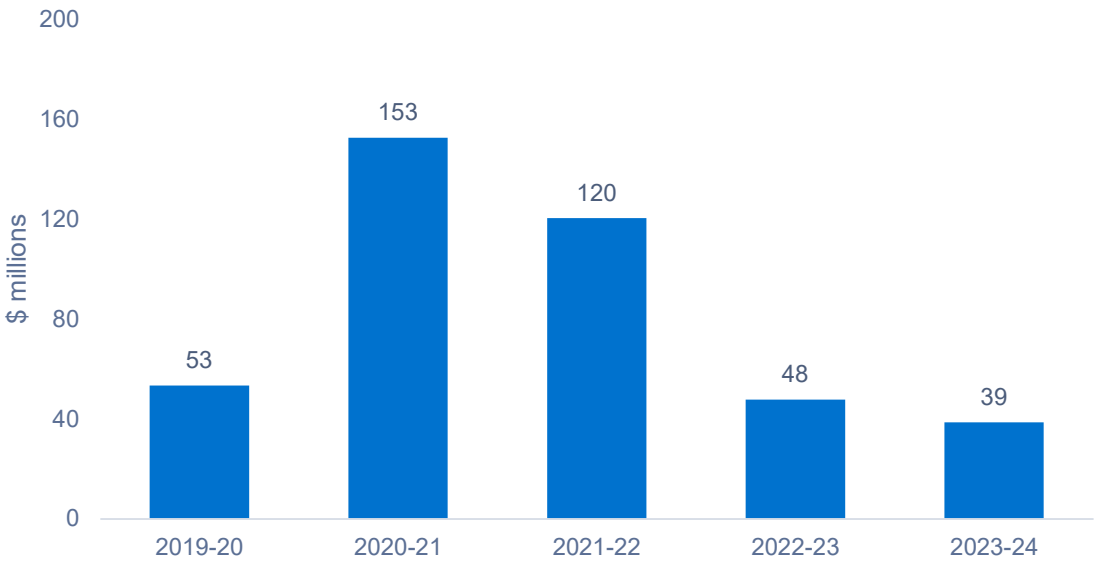
[3] It is important to note, there were many other initiatives in the DHHS and other portfolios that contributed to responding to the COVID-19 pandemic, however only the noted asset initiatives specifically refer to COVID-19 in their title, and the public health output initiative is the single largest specifically COVID-19-named initiative in the 2020-21 Budget. https://s3-ap-southeast-2.amazonaws.com/budgetfiles202021.budget.vic.gov.au/2020-21+State+Budget+-+Service+Delivery.pdf

[4] https://www.health.vic.gov.au/sites/default/files/2021-10/department-health-annual-report-2020-21.pdf

[5] https://www.vhba.vic.gov.au/news/supporting-the-coronavirus-response-in-victoria

[6] https://www.premier.vic.gov.au/covid-catch-plan-deliver-patients

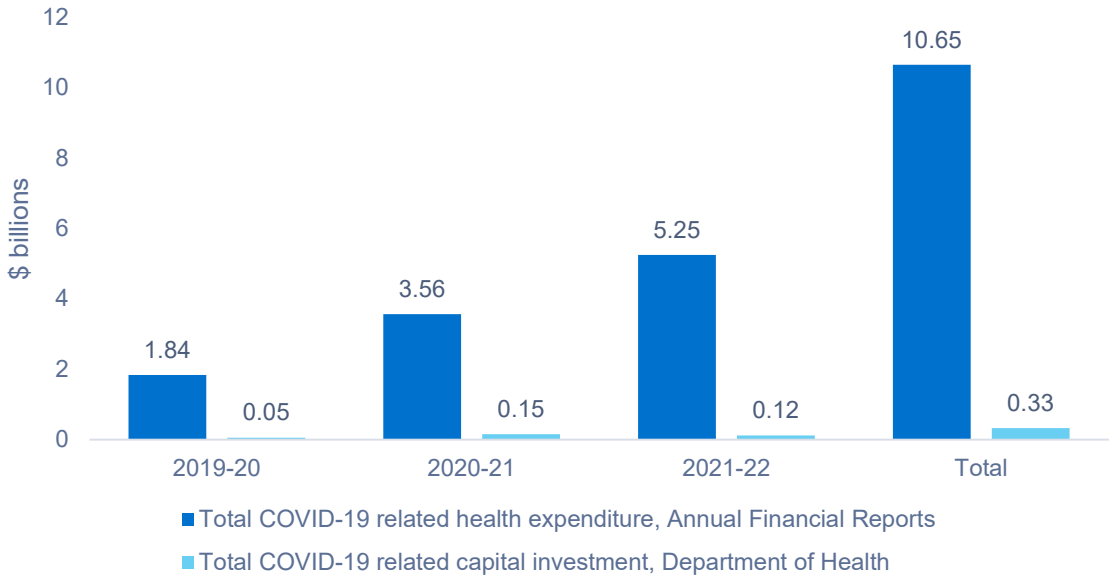
Figure 3: Victorian total COVID-19 related capital investment from the Department of Health



Source: Victorian Department of Health

Figure 4 shows Victoria's total COVID-19 related capital investment compared to total COVID-19 related health spending. The figure shows the capital components were relatively small compared to the total pandemic health response, comprising less than 5 per cent of total COVID-19 related spending each year and only $153 million at its peak in 2020-21.

Figure 4: Victoria's state COVID-19 related health expenditure and investment



Source: Victorian Department of Health and Victoria's COVID-19 reporting from 2019-20, 2020-21 and 2021-22 Annual Financial Reports

New infrastructure was also limited by the constraints of the pandemic. Victoria's 2020-21 Budget notes that while there was significant infrastructure investment, "The coronavirus (COVID-19) pandemic has had an impact on the delivery of the Government's capital program in the short to

medium term as worksites have adjusted to safety requirements."[7] The Victorian Health Building Authority provided advice on health capital works during the pandemic, including cautioning against works that may increase the spread of the virus (through contact of workers on site for example) and limiting works that may affect the supply of ICU or critical care beds (by temporarily closing them or posing a risk to services requiring shutdowns for example).[8]

3.2 Comparison to the NPCR

The draft report notes the CGC will base its definition of COVID-19 related state spending as spending covered by the National Partnership on COVID-19 Response (NPCR), which Victoria supports for the assessment of operating expenses.[9] The NPCR clearly states its included services, which do not include significant capital components. The NPCR covers:

- COVID-19 related hospital activities (in-scope hospital activities as defined by the NHRA):
    - Respiratory clinics
    - Hospital services regardless of the setting – hospital, home or residential facility
    - Bringing forward elective surgery, including the purchase of public surgery in private hospitals, in excess of the elective surgery performed by a state or territory public hospital system in 2018-19
    - Testing and diagnostics.
- COVID-19 related public health activities:
    - Additional health services expenditure, including COVID 19-related costs of care outside hospitals, when providing health services to rural, remote and/or Indigenous patients
    - Additional expenditure for paramedic and ambulance service when compared to the same period in the year before
    - Personal protective equipment for staff and those in need, where consumption is greater than the same period in the 2018-19 year
    - Services provided in a primary care and/or community health setting, to manage the outbreak of COVID-19
    - Emergency public health response staffing support for any aged care facility, with the Commonwealth share to increase to 100 per cent of the cost should the support be required for longer than three days
    - Transport costs, including medical related transport in rural and remote areas, where they are higher compared to the same period in the 2018-19 year
    - Minor capital expenditure for the purchase of respiratory equipment and establishment of respiratory clinics.[10]

Note all of the items covered are for operating expenditure items, other than the "minor" purchase of medical equipment under public health. The proposed assessment in the draft report does not reflect this, implying Victoria's health investment more than tripled from pre-pandemic levels in 2018-19 to

[7] https://s3-ap-southeast-2.amazonaws.com/budgetfiles202021.budget.vic.gov.au/2020-21+State+Budget+-+Strategy+and+Outlook.pdf
[8] https://www.vhba.vic.gov.au/sites/default/files/2020-12/VHHSBA-Health-technical-advice-HTA-2020-002-Infrastructure-activities-during-pandemic-Dec-2020.pdf
[9] Noting, in response to the draft report Victoria highlighted that its actual COVID-19 related health expenditure was higher than accounted for under the NPCR.
[10] https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-04/covid-19_response_vaccine_amendment_schedule.pdf

2020-21 due to COVID-19. In relation to the hospital services of the NPCR, the NHRA does not cover capital costs.

4. Including COVID-19 related health investment is inconsistent with other assessments

The CGC has already made the decision to not apply COVID-19 expenditures to the services to industries investment stock factor, as it considered the programs did not require additional capital investment. The same conclusion should be made the in case of health investment.

The CGC also recognised the relative stability of infrastructure investment with respect to the pandemic in the transport addendum to the draft report. It stated: “As investment decisions are determined over a longer timeframe, the effects of COVID-19 have not exerted as significant an impact.”[11] Victoria considers the same principle applies to health infrastructure.

[11] https://www.cgc.gov.au/sites/default/files/2024-08/2025%20Review%20-%20Draft%20Report%20-%20Transport%20addendum_Final.pdf

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