

# Health

## Review outcomes

- The following changes were made to the assessment.
  - A new, temporary component will be introduced to assess expenses associated with the National Partnership on COVID-19 Response. The usual drivers in the health assessment do not adequately reflect state expense needs for COVID-19–related hospital and public health services.
  - A direct measure of activity for ambulatory community mental health services within the community and public health component will be introduced. This will provide a more accurate estimate of service use by socio-demographic groups than the previous hospital-based proxy indicator. The general regional cost gradient will be used to take account of increased service delivery costs as remoteness increases.
  - The proxy indicator of activity for the remainder of community and public health will be broadened to include a subset of non-admitted patient activity, in addition to triage category 4 and 5 emergency departments activity. As many non-admitted patient services are similar to community health services, this will provide a better estimate of community and public health activity than emergency departments triage category 4 and 5 services alone.
  - Substitutability levels for the non-state sector adjustments for admitted patients, emergency departments, non-admitted patients and community and public health will be updated to reflect new data and minor modifications to the methods.
  - For the non-state sector adjustment associated with Commonwealth-funded First Nations community health organisations, actual expenses will be used to measure non-state sector assessed expenses. This results in no adjustment to socio-demographic assessed expenses from this element of the non-state sector adjustments.
  - A low discount of 12.5% will be applied to the non-state sector adjustments for the admitted patient, emergency department, non-admitted patient and community and public health components. The discount reflects issues with the quality of the data and the robustness of the methods for non-state sector adjustments.
  - Updated data will be used to re-estimate the split between hospital and non-hospital patient transport expenses and the net value of cross-border community health services provided by the ACT to New South Wales residents.
- The Commission considered but did not change the following.
  - The socio-demographic composition assessment of state expenses on hospitals and non-hospital patient transport services will not change, with no ongoing implications from the COVID-19 pandemic identified for these assessments.

- Public health expenses will continue to be assessed together with community health services (other than specialised community mental health) using a hospital-based proxy indicator of activity.
- The low discount of 12.5% will be retained for the socio-demographic composition assessment of state expenses on community and public health, other than expenses on ambulatory community mental health services. The discount recognises that activity is measured by a proxy indicator of activity.
- The separate assessment of expenses on non-hospital patient transport services will continue. However, if the costs associated with these services are incorporated by the Independent Health and Aged Care Pricing Authority in the national weighted activity units before the next review, expenses on non-hospital patient transport services will be assessed in the admitted patient services component.
- The proxy indicators of activity for non-state services will be retained.
- The existing age groups for the socio-demographic assessment of health expenses will be retained. Splitting the oldest age group was tested but it did not have a material impact on GST distribution. The other age groups could not be modified due to limitations with the data.
- The full payment under the National Health Reform Agreement will continue to be treated as impact, in line with the Commission’s framework for the treatment of Commonwealth payments.
- No adjustments will be made to the state shares of National Health Reform funding to recognise cross-border service use. Bilateral agreements are in place to compensate states for the services provided to residents of other states.
- Component expenses for the third assessment year will continue to be estimated based on the growth in category level expenses.
- As part of the Commission’s forward work program, it will work with the states to:
  - review the health assessment framework in preparation for the next methodology review
  - explore the evidence on the relationship between the provision of health services by the private sector and the Commonwealth government, and the amount of state spending on health services
  - explore in detail the evidence on health service needs of people in similar socio-demographic groups across states
  - consider the basis for cultural and linguistic diversity as a driver of state expenses, including health expenses, and appropriate definitions and data for any measure.

## Introduction

- 1 On 6 July 2024, the Commission published the [Draft Report](#) for the 2025 Methodology Review.
- 2 The Draft Report included a detailed analysis and response to issues raised by states and territories (states) in their [submissions](#) on the Commission's [consultation paper](#).
- 3 State submissions on the Draft Report can be viewed [here](#).
- 4 This chapter includes:
  - an overview of the issues considered throughout the review
  - the Commission's response and decision on each issue
  - GST impacts of method changes.
- 5 A description of the assessment method, incorporating the changes made in the 2025 Review, can be found in the health chapter of the *Commission's Assessment Methodology*.

## Issues considered

### Suitability of the hospital and patient transport assessments post-pandemic

- 6 The Commission sought state views on whether the hospital (admitted patients, emergency departments and non-admitted patients) assessments and the non-hospital patient transport assessments remained fit for purpose following the COVID-19 pandemic. The Commission proposed no ongoing changes to the health assessment in response to the pandemic.

#### State views

- 7 States said that there were no ongoing implications for the health assessment from the COVID-19 pandemic.
- 8 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.
- 9 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 decision

- 10 The Commission will make no ongoing changes to the hospital and patient transport assessments in response to the COVID-19 pandemic.

## Improving the responsiveness of the community and public health assessment

- 11 The Commission sought state views on whether the proposed changes to the community and public health assessment (discussion of the changes starts at paragraph 43) would make it more responsive to significant developments (such as a pandemic) affecting that part of the health system.
- 12 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. The Commission considered alternative approaches to estimating component expenses in the third assessment year to improve responsiveness.
- 13 In the Draft Report the Commission proposed no changes to make the community and public health assessment more responsive, other than the change to the assessment of ambulatory specialised community mental health services.

## State views

- 14 States 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 to use a direct measure of activity for ambulatory specialised community mental health services.
- 15 Western Australia said it did not see any benefit in making an assessment more responsive to poor measures of need.
- 16 South Australia said any indicator that is based on proxy data would not completely capture what is actually occurring.
- 17 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 2020 Review community and public health assessment did not capture the COVID-19 shock because it uses a proxy indicator.
- 18 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.

## Commission response

- 19 If there are significant differences in spending growth between components, it may be better to allow the assessments to try to capture this effect. This has been done for the past 4 updates in the services to industry assessment in response to the large increase in state spending on COVID-19 business support.
- 20 The Commission could switch to using state-provided year 3 data when a relevant shock occurs. However, events that may lead to significant variation in the growth of component expenses in the health assessment are likely to be rare.

## Commission decision

- 21 The Commission will maintain the 2020 Review approach, which minimises data revisions between updates.

## Assessment of state spending on COVID-19–related health services

- 22 The Commission considered state views on whether expenses related to COVID-19 health services should be assessed differently.
- 23 The Commission proposed treating the Commonwealth payments for public hospital and public health services under the National Partnership on COVID-19 Response as impact and assessing state spending associated with the national partnership on an actual per capita basis.

## State views

- 24 Most states referred to their previous comments on this issue during consultations on the 2021, 2022 and 2023 updates of GST revenue sharing relativities.
- 25 New South Wales, Victoria and the ACT said that state spending associated with COVID-19 should be assessed on an actual per capita basis.
- 26 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. New South Wales said differences in responses between states therefore reflected differences in circumstances rather than policy.
- 27 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, being more concentrated in major cities and younger, non-Indigenous residents.
- 28 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. Victoria said that a resolution to this issue through the 2025 Review is

necessary, as the review will set relativities for 2025–26 which include 2021–22 data, the most significant year for Victoria’s COVID-19 spending.

- 29 Victoria and 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.
- 30 Some states said an actual per capita assessment of COVID-19–related expenses was not appropriate because state spending was policy influenced. Queensland and Western Australia said the expenses should be assessed equal per capita. South Australia said that if a separate assessment of COVID-19 based on an actual per capita approach was adopted, the maximum discount must be applied to reflect policy neutrality and data quality concerns.
- 31 Queensland said that an equal per capita assessment for COVID-19–related expenses is appropriate given the lack of evidence on differences in state need. Queensland said a range of factors indicate that the substantial differences in spending across jurisdictions reflect different health-related policy positions by individual jurisdictions. Queensland said to ignore the potential impacts of policy decisions made by individual jurisdictions, in particular New South Wales and Victoria, in the context of COVID-19 responses would clearly violate the horizontal fiscal equalisation principle of policy neutrality.
- 32 Western Australia said that different state policies contributed to most of the differential impact of COVID-19. Western Australia said the evidence showed that the National Partnership on COVID-19 Response funding bore no relationship to the number of COVID-19 cases in each state, and state baselines on preparedness and equipment were different. Western Australia said various international and national studies and public commentators supported its position that policy differences between states were significant and led to different outcomes.
- 33 Western Australia said that the Commission had stated in the 2023 Update that it could not identify any drivers of COVID-19 state spending. It said the Commission’s gambling tax assessment also struggles with a lack of identifiable drivers and significant policy differences. It suggested COVID-19 spending should therefore be assessed equal per capita like gambling revenue.
- 34 South Australia said that it disagrees with the view that responses to COVID-19 were driven by state circumstances alone. Both state circumstances and policy choices drove COVID-19 impacts. South Australia said that in previous consultation processes it (and a number of other states) provided examples and independent opinions that supported the view that the policy decisions made by states did have a significant impact on COVID-19 case numbers and associated expenditure. South Australia said that as the effects of COVID-19 were impacted by policy decisions, any alternative assessment approach would need to be based on reliable policy neutral data but

that no alternative policy neutral assessment approach had been identified. South Australia said that adoption of an actual per capita assessment approach for health expenditure would only be appropriate if policy choices were consistent and this was not the case during the pandemic years.

## Commission response

- 35 There are diverse views among the states as to whether state health spending on COVID-19 largely reflected state policy or state circumstances. The Commission recognises that it is not possible to point to definitive evidence one way or the other, or to separately identify what spending was influenced by policy choices. It ultimately comes down to a matter of judgement, taking into account the circumstances and uncertainties associated with the pandemic.
- 36 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.
- 37 With the flexibility to change the health assessment in response to COVID-19 following the 2025 Review, the Commission was able to use an alternative assessment for assessing state spending related to COVID-19.
- 38 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.’
- 39 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.
- 40 States incurred health costs related to the pandemic that were not within the scope of the national partnership. However, the Commission will limit the actual per capita assessment only to the expenses covered by the national partnership because it provides assurance that spending was broadly consistent between states.
- 41 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 3-year assessment period.

### **Commission decision**

- 42 The Commission will 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.

### **Direct measure of specialised community mental health activity**

- 43 The Commission originally proposed that activity in ambulatory specialised community mental health programs be used to assess state spending needs for all community mental health services. The 2020 Review method used proxy data to estimate activity, namely, lower priority hospital emergency department services.
- 44 The Commission modified its original proposal to only use activity in ambulatory specialised community mental health programs to assess state spending on community mental health services in an ambulatory setting.

### **State views**

- 45 States had diverse views on the proposed direct measure of specialised community mental health activity.
- 46 New South Wales, Victoria and the ACT supported the use of the direct measure of activity. Other states raised a range of issues with the activity data. Specifically:
- the activity and expense data were not reported consistently by states and therefore were not suitable for assessing GST needs
  - activity in ambulatory specialised community mental health services was not representative of activity in other forms of community mental health services, particularly in outer regional and remote areas
  - the activity data should not be used because of the lack of cost weights.
- 47 New South Wales said the remoteness gradient should be derived from the remoteness weights for emergency department and non-admitted patient services rather than the general regional cost gradient. Victoria said the general regional cost gradient should not be applied or at least discounted by 50% because there is no evidence that costs increase with remoteness. Western Australia said the general regional cost gradient should not be discounted because a portion of the gradient is derived from health services.

### **Commission response**

- 48 The Commission concluded that the data on specialised community mental health ambulatory services were not representative of activity for all 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 services in major cities and inner regional areas and a much lower share of 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.

- 49 The Commission therefore modified its original proposal and narrowed the use of the activity data to assess spending only on ambulatory specialised community mental health services.
- 50 The Commission concluded that, notwithstanding concerns raised by states about the activity data on spending for ambulatory specialised community mental health services, these data would likely produce a better estimate of state GST needs than an activity indicator based on hospital activity.
- 51 The Commission applied the general regional cost gradient to the activity data to take account of increased service delivery costs as remoteness increases. The general regional cost gradient was considered a better indicator of how costs change with remoteness than a hospital-based regional cost gradient. A discount of 25% to the gradient is applied in all assessments where the general regional cost gradient is used, in recognition that the cost components used to calculate the general regional cost gradient are only a proxy for actual service costs.

### **Commission decision**

- 52 The Commission will introduce a direct measure of community mental health activity for ambulatory services only. The ambulatory community mental health assessment will be a sub-component of the community and public health assessment.

### **Expanded proxy measure of activity for the residual community and public health services**

- 53 The Commission originally proposed the use of a broader proxy indicator of activity based on a combination of emergency department and non-admitted patient services to assess expenses on community and public health other than ambulatory specialised community mental health.
- 54 The Commission modified the original proposal to include only a subset of non-admitted patient services in the proxy indicator.

### **State views**

- 55 Some states welcomed efforts to improve the assessment of community and public health and provided qualified support for broadening the proxy, although they acknowledged there was limited evidence to support the proposal.

- 56 Some states said that emergency department services are more representative of community health services than non-admitted patient services, particularly in remote and very remote areas.
- 57 Victoria said that, given the lack of relationship of the hospital-based proxies to public and community health, the Commission should assess these components as equal per capita.
- 58 South Australia said the weighting of non-admitted patient services in the proxy indicator should be reduced due to problems with the data.
- 59 Tasmania said the Commission's analysis of similarities between community and public health services and non-admitted patient services did not take account of large variations in access times within community and public health programs. Tasmania said that activity of COVID-19 clinics should not be included in the proxy indicator for community and public health because the Commission had proposed a separate assessment of COVID-19 expenses.

### **Commission response**

- 60 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 are hospital-based activity measures or an equal per capita assessment.<sup>1</sup>
- 61 In the 2015 and 2020 reviews, the Commission decided to use emergency department triage category 4 and 5 services as the proxy indicator of activity for community and public health services based on the similarity of the services in the 2 health settings. At the time of these reviews, non-admitted patient services were not considered for the proxy indicator because the national weighted activity unit data for non-admitted patient services were not sufficiently reliable.
- 62 Non-admitted patient national weighted activity unit data are now reliable and the Commission has been using these data to assess expenses on non-admitted patient services since the 2021 Update. For the 2025 Review, analysis was undertaken to determine whether including non-admitted patient services would improve the proxy for public health activity (outside of ambulatory community mental health care).
- 63 The merits of broadening the proxy indicator to include all, or a subset of, non-admitted patient services were 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 was on the assumption that if service

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<sup>1</sup> The socio-demographic use rates for the emergency department triage category 4 and 5 services (the proxy indicator in the 2020 Review method) are broadly similar to the subset of non-admitted patient services most similar to community health services. However, 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.

types and access levels are similar then socio-demographic usage patterns would be similar.

- 64 On the information available, there appears to be a reasonably close relationship between community health services and non-admitted patient services provided by allied health professionals and clinical nurse specialists. In terms of access times, community health services were found to be generally more in line with wait times for non-admitted patient services than emergency department services.
- 65 Given expenses related to the National Partnership on COVID-19 Response will be removed from the community and public health component until the 2027 Update, the proxy indicator of activity would be improved by removing the COVID-19 non-admitted patient services.
- 66 In regard to the option of an equal per capita assessment, the Commission reviewed available information on the use and targeting of community and public health services by socio-demographic group. It concluded that socio-demographic use rates for emergency department triage category 4 and 5 services and non-admitted patient allied health services are likely to produce a better estimate of assessed expenses for community and public health than assessing the expenses using state population.

### **Commission decision**

- 67 The Commission will 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 (Attachment A, Table A-1). Activity in the COVID-19 clinics will be excluded from the list of non-admitted patient allied health services in the proxy indicator of community and public health while there is a separate assessment of COVID-19 expenses.

### **Separate assessment of public health**

- 68 The Commission considered state views on public health expenses being assessed separately to community health expenses. In the 2020 Review method, expenses on community and public health were assessed using a proxy indicator (national weighted activity units for emergency department triage category 4 and 5 services).
- 69 The Commission proposed to continue assessing public health expenses with community health expenses, but to broaden the proxy indicator of activity to include a subset of non-admitted patient services.

### **State views**

- 70 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.

- 71 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. If the Commission decided not to assess public health expenses on an equal per capita basis it should reduce the influence of socio-economic status and age, while retaining an unchanged First Nations driver.
- 72 Victoria said that 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.

### **Commission response**

- 73 The key issue the Commission considered was whether an equal per capita assessment of public health, 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.
- 74 The Commission's analysis showed that state-delivered public health programs do not have a consistent pattern of socio-demographic use or targeting across different programs. This makes it difficult to determine 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.
- 75 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.
- 76 On balance, the Commission concluded that 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.

### **Commission decision**

- 77 The Commission will use a hospital-based proxy (see previous section for details) for public health activity rather than an equal per capita assessment.

## **12.5% discount for the community and public health assessment**

- 78 The Commission proposed that the 12.5% discount for the community and public health assessment be retained for the share of the assessment that relies on proxy activity data (covering around 80% of total community and public health expenses).

## State views

- 79 Most states supported the continuation of a 12.5% discount for the community and public health assessment. New South Wales said the reduction in this discount from 25% in the 2020 Review was not clearly evidenced at the time and it would not be appropriate to reduce the discount further.
- 80 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.
- 81 South Australia said the discount should also cover the assessment of ambulatory community mental health expenses.
- 82 The Northern Territory did not support the discount as moving the assessment closer to equal per capita was not appropriate.

## Commission response

- 83 The Commission considered that reliance on a proxy measure of activity for a significant share of community and public health expenses justifies a continuation of a discount.

## Commission decision

- 84 The Commission will retain a 12.5% discount. It will 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) will not be discounted.

## Non-state sector adjustment – conceptual framework

- 85 The Commission proposed that the conceptual basis for the non-state sector adjustments remained appropriate.

## State views

- 86 New South Wales said that there is an absence of robust and reliable data supporting the conceptual case for a non-state sector adjustment for health services. It said the adjustment should be removed or heavily discounted.
- 87 Victoria supported retaining the current general approach and giving further consideration of the non-state sector adjustment as part of the forward work program. Victoria said this is a complex topic that has not been afforded sufficient time and resources for an overhaul as part of the 2025 Review. It considered the debate around the interpretation of the non-state sector adjustment to be evidence that the Commission could improve its communication of the conceptual basis and operation of the non-state sector adjustment. Victoria did not support discounting the non-state sector assessments, given they considered them to be largely

unchanged or improved from the 2020 Review methods when they were not discounted.

- 88 Queensland supported reviewing the non-state-sector adjustment in detail before the next methodology review. Queensland said significant problems exist with the non-state-sector adjustment, from data issues to its conceptual foundations, but conceded that the significance of the adjustment warrants a considered reappraisal, which was not feasible before the finalisation of the 2025 Review. Queensland supported discounting of the non-state sector adjustments and recommended a higher discount for the admitted patient adjustment.
- 89 Western Australia said the Commission's approach to recognising the influence of non-state sector health services provision on state health spending needs was fundamentally wrong and presented an alternative conceptual framework. It 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. Western Australia did not support discounts to the non-state sector adjustments on the basis that it is not clear that the data for these assessments are less reliable than for other assessments.

### **Commission response**

- 90 The non-state sector adjustment was introduced in the 2015 Review on the assumption that states with below-average non-state service provision faced higher costs.
- 91 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.
- 92 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. 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. 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.
- 93 The Commission considers that the current approach underpinning the non-state sector adjustments is pragmatic and remains appropriate. Given the issues raised by states with the evidence on the extent of the relationship between state and non-state health service provision, problems with the data and the robustness of the method, and the significance of the impact on GST distribution, discounts will be

introduced (see below for details) and further work will be undertaken on this issue as part of the forward work program.

### **Commission decision**

- 94 The Commission will retain the 2020 Review approach underpinning the non-state sector adjustments, with the introduction of a discount of 12.5% for the adjustment in each component (see discussion below).
- 95 The Commission will further consider this issue as part of its forward work program.

### **Non-state sector adjustment – admitted patients**

- 96 The Commission considered a proposal by Queensland to change the indicator of non-state sector activity to private patient bed days to better account for case complexity. Queensland 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.
- 97 Due to difficulties obtaining bed days data for the 3 smallest states, the Commission proposed to use benefits paid by private health insurance funds as the proxy indicator of private admitted patient activity.
- 98 The Commission also considered state concerns with other aspects of the admitted patient non-state sector adjustment. The Commission proposed a lower bound for the non-state sector substitutability level based on private patients that are treated in public hospitals.

### **State views**

- 99 New South Wales, Victoria, Queensland, Tasmania and the ACT supported the proposed use of benefits paid by private health funds as a proxy of private admitted patient activity because it better captured the complexity of hospital procedures. Western Australia and South Australia opposed the proposal.
- 100 Western Australia said benefits paid by private health insurers vary among states due to factors other than cost driven by complexity. Western Australia said it has high private health insurance benefits, but low private bed days per separation. It said it appears that Western Australian private hospitals charge more than the national average for treatments of the same complexity, reflecting the market dynamics of a fairly concentrated group of private hospital operators, the majority insurance provider being not-for-profit, and possibly higher costs faced by private hospitals.
- 101 South Australia said that, given the significance of this component, any method changes should be based on high quality, consistent data that are not policy influenced. It was not convinced that the proposed private patient expense data meet this requirement.

- 102 New South Wales said that non-state sector activity is likely to be policy influenced and separate sources of data should not be used to measure actual and assessed non-state sector activity.<sup>2</sup>
- 103 Victoria said that judgement should not be used to adjust the substitutability level. If an adjustment is warranted on conceptual grounds, then the standard discounting approach should be applied. Victoria said a discount of 12.5% should be applied, but if not, the calculated substitutability rate of 17.5% should be used. Queensland did not support the use of the calculated rate. Western Australia also supported a discount rather than a judgement-based reduction in the substitutability level.
- 104 Western Australia said the Commission should include both people with private health insurance and those who self-insure in the group of people that could use non-state health services, when estimating the substitutability level.

### Commission response

- 105 The Commission proposed using private patient benefits paid rather than bed days as the indicator of non-state sector activity for the calculation of the admitted patient non-state sector adjustment. Benefits paid can potentially provide more information than separations or bed days on the relative costs of service provision, and therefore provide a better indicator of non-state sector activity.
- 106 Benefits paid would only be a reliable indicator of activity if states had comparable average benefits paid for equivalent hospital services. However, states varied in their share of separations that had above or below the national average benefits paid. Victoria and South Australia had a large share of separations below the national average and Western Australia a large share above the national average. The Commission concluded that benefits paid could not be considered an unbiased measure of non-state sector activity.
- 107 The Commission updated the 2020 Review method estimate of the non-state sector substitutability level with the latest available data and incorporated activity associated with self-funded patients. This method is considered the upper bound of substitutability.
- 108 The Commission calculated a second method to estimate the substitutability level, where the concept of substitutability was limited to just private patients treated in public hospitals. This second method is considered the lower bound of substitutability.
- 109 The Commission accepted that rounding substitutability levels to the nearest 5% as proposed in the Draft Report added an unnecessary step to the calculation.

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<sup>2</sup> The data to calculate assessed expenses use Australian Institute of Health and Welfare data, while the data on actual activity use Australian Prudential Regulation Authority data (as the Australian Institute of Health and Welfare does not disaggregate data for Tasmania, the ACT and the Northern Territory). To preserve commercial confidentiality for the private hospitals in the Australian Capital Territory and the Northern Territory, the Australian Institute of Health and Welfare data for private hospitals in the Australian Capital Territory and the Northern Territory will be suppressed.



## Commission decision

- 110 The Commission will use private patient separations for private health insurance-funded admitted patients in private and public hospitals as the proxy indicator of non-state sector activity in the admitted patient component.
- 111 The Commission will include activity associated with self-funded patients, in addition to activity associated with private health insurance-funded patients, to estimate the substitutability level.
- 112 The Commission will use a substitutability level of 17%, which is the midpoint of the 2 methods used to estimate substitutability.
- 113 A discount of 12.5% will be applied due to uncertainty with the reliability of the data and the robustness of the method for the admitted patient non-state sector adjustment.

## Non-state sector adjustment – emergency departments

- 114 The Commission sought state views on using the Australian Institute of Health and Welfare-based method to update the estimates of the non-state sector substitutability level for emergency departments. This was because updated estimates were only available for the Australian Institute of Health and Welfare-based method and not the Commission's preferred approach used in the 2020 Review, which was based on Australasian College for Emergency Medicine data.<sup>3</sup>
- 115 The Commission also considered state views on alternative approaches to estimating the non-state sector substitutability level for emergency departments.

## State views

- 116 Most states broadly supported the Commission's proposed approach for updating the emergency department non-state sector substitutability level.
- 117 New South Wales said 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.
- 118 Victoria said the Commission should have contracted an expert to review the approach.
- 119 Western Australia said that separate substitutability levels should be used for each remoteness region.

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<sup>3</sup> The Australasian College for Emergency Medicine-based and Australian Institute of Health and Welfare-based methods calculate the proportion of emergency department presentations that are potentially treatable by GPs. The method using Australasian College for Emergency Medicine data is based on self-referred, non-ambulance presentations with a medical consultation time less than one hour. The method using Australian Institute of Health and Welfare data is based on self-referred, non-ambulance, police or community service emergency department presentations classified as triage 4 and 5 (less urgent).

- 120 New South Wales and Victoria said the Commission should use the exact number produced by the formula for the non-state sector substitutability level rather than round to the nearest 5%.

### **Commission response**

- 121 The Commission considered that the Australian Institute of Health and Welfare data could be used as a proxy to update the non-state sector substitutability level for emergency departments. It considered it better to update the estimate of substitutability using more recent data.
- 122 Separate substitutability levels for each remoteness area, as proposed by Western Australia, would add further complexity to an already complex adjustment. It would also require actual non-state sector service provision disaggregated by remoteness area. The proposal will be considered as part of the health assessment element of the Commission's forward work program.
- 123 The approaches used in the past 2 reviews 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 will also form part of the more detailed consideration of the non-state sector in the Commission's forward work program.
- 124 The Commission explored the possibility of engaging an external expert to review the non-state sector adjustment for emergency departments, but this was not feasible within the timeframe for the 2025 Review.
- 125 The Commission accepted that rounding of substitutability levels to the nearest 5% as proposed in the Draft Report added an unnecessary step to the calculation.

### **Commission decision**

- 126 For the emergency departments component, the Commission will retain the 2020 Review method to determine the non-state sector substitutability level but will use data from the Australian Institute of Health and Welfare to update the calculations. This method produces an estimate of 13%.
- 127 A low discount of 12.5% will be applied due to uncertainty with the reliability of the data and the robustness of the method for the emergency department non-state sector adjustment.

### **Non-state sector adjustment – non-admitted patients**

- 128 The 2020 Review used 2 methods to estimate the non-state sector substitutability level for the non-admitted patient component.
- The first method looks at the likelihood of patients using non-state services rather than state services based on how comparable services are in the 2 sectors and whether the non-admitted patient service is connected to a prior admitted patient service. In the 2020 Review, survey data were used in the calculation.

- The second method looks at the likelihood of patients using non-state services rather than state services based on the affordability of non-state services.

## State views

- 129 In relation to the first method for estimating substitutability used in the 2020 Review, 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 should be reviewed.
- 130 Victoria said a discount of 12.5% should be applied due to inconsistencies in the assumptions states used in producing data on related non-admitted and admitted patient episodes.
- 131 Western Australia said the second method used by the Commission for estimating the substitutability level should be dropped as it is a poor method and the first method already reflects affordability of non-state services. If it is retained it should not be given the same weight as the first method.
- 132 New South Wales and Victoria said the Commission should use the exact number produced by the formula for the non-state sector substitutability level rather than round to the nearest 5%.

## Commission response

- 133 To address states' concerns with the first method for calculating the substitutability level, the Commission asked states for data on the share of related non-admitted and admitted patient episodes. The data provided by 6 states were used to update the estimate of the substitutability level.
- 134 As regards Western Australia's comments, the Commission recognises that using the proportion of non-state services that are bulk billed will not provide an exact value of state services that are substitutable. However, the objective is to obtain a broad indication of the amount of non-state sector health provision rather than 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. The higher the bulk billing rate, the more affordable are non-state services, and hence the higher the substitutability between state and non-state services.
- 135 The Commission accepts that rounding substitutability levels to the nearest 5% adds an unnecessary step to the calculation.

## Commission decision

- 136 The Commission will use a substitutability level for non-admitted patients of 28%, which is the midpoint of the 2 methods used to estimate substitutability.

- 137 A low discount of 12.5% will be introduced reflecting uncertainty with the reliability of the data and the robustness of the method for the non-admitted patient non-state sector adjustment.

## **Non-state sector adjustment – community and public health**

- 138 The 2020 Review method for 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.
- 139 The Commission proposed a change to the non-state sector adjustment for grants to First Nations community health organisations and the introduction of a discount for the other element of the non-state sector adjustment.

### **State views**

- 140 New South Wales and Victoria questioned the Commission's decision to round down the calculated substitutability rate to 60% (the Commission's calculation was 61.9%) for the first element of the non-state sector adjustment.
- 141 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 (the second element).
- 142 The Northern Territory said that the assessment of non-state health services is overly simplistic. 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.
- 143 The Northern Territory said that if the adjustment is maintained, assessed non-state sector services should be estimated with socio-economic status as a driver in remote and very remote areas.
- 144 New South Wales did not support a change to the non-state sector adjustment for grants to First Nations community health organisations. Given the non-state sector adjustments will be considered as part of the forward work program, it said significant changes should not be made ahead of that process.

### **Commission response**

- 145 The Commission accepts that the proposed rounding of the substitutability level in the first element adds an unnecessary step to the calculation.

- 146 Commonwealth-funded health services alleviate pressure on state services in the same way as privately funded services.
- 147 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.
- 148 The Commonwealth allocates grants to First Nations community health organisations taking into consideration the socio-economic status and remoteness of the region. Given the Commission does not have reliable data on socio-economic use rates in remote and very remote areas, it is likely that the actual distribution of First Nations Commonwealth grants produces a better estimate of assessed non-state expenses than the method used by the Commission.

### **Commission decision**

- 149 The Commission will use a substitutability level of 62% for the first element of the non-state sector adjustment for the community and public health component.
- 150 A low discount of 12.5% will be applied due to uncertainty with the reliability of the data and the robustness of the method for the community and public health non-state sector adjustment.
- 151 The Commission will use the actual distribution of First Nations Commonwealth grants as the estimate of non-state sector assessed expenses. This means the non-state sector adjustment for Commonwealth grants to First Nations community-controlled health organisations will be zero.

### **Greater reliance on actual state health activity**

- 152 The Commission considered state proposals to make greater use of actual state health activity to estimate assessed expenses. It proposed exploring this issue as part of the Commission's forward work program.

### **State views**

- 153 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.
- 154 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.
- 155 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. Therefore, assessed needs should be apportioned in line with actual national weighted activity unit shares.

- 156 Queensland 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.
- 157 Queensland said that national weighted activity unit funding caps (targets), as negotiated through the National Health Reform Agreement and calculated by the Commonwealth Contribution Model, are policy-neutral measures of assessed need. These activity targets consider the underlying health need of a state's population. The actual national weighted activity units up to and including the national cap should be considered policy neutral and used as the volume indicator in the calculation of assessed need. The national weighted activity units over and above the national caps should be assessed using national weighted activity units averaging.

### Commission response

- 158 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.
- 159 The Commission accepts it is possible 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 is needed to understand the extent of these issues.
- 160 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. This is why the Commission adopts methods that do not rely on actual expenses or activity when assessing state spending needs.
- 161 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.<sup>4</sup>
- 162 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.

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<sup>4</sup> Australian Institute of Health and Welfare (AIHW), [Glossary - Australian Institute of Health and Welfare](#), AIHW website, 2024, accessed 14 June 2024.

163 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 looking at alternative methods for assessing state health expense needs.

### **Commission decision**

164 The Commission will continue to use socio-demographic cohort-averaged national weighted activity units in the health assessment.

165 The Commission will explore the issue of greater reliance on actual state health activity as part of its forward work program.

### **Culturally and linguistically diverse (CALD) populations**

166 The Commission considered state views on expanding the socio-demographic drivers of health expenses to include culturally and linguistically diverse populations and/or the addition of cost weights for service provision to culturally and linguistically diverse populations. The Commission proposed exploring this issue as part of the Commission's forward work program.

### **State views**

167 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.

168 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 expense needs, Victoria suggested focusing on refugees and people seeking asylum, temporary residents and people with low English proficiency.

### **Commission response**

169 The analysis presented by Victoria justifies retesting the materiality of cultural and linguistic diversity as a driver of need. A more comprehensive analysis can 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.

170 However, it is a complex issue that would require consultation with states, including on the choice of countries of birth to include in the analysis.

### **Commission decision**

171 The Commission considers that, while there is a conceptual case that people from different cultures have different use rates of state health services, a substantial amount of work is required to determine how this driver could be reliably

incorporated into the health assessment. The Commission will consider how cultural and linguistic diversity affects state service costs, including health costs, as a part of its forward work program.

## **Age grouping for socio-demographic assessment**

172 The Commission considered state views on changing the age groupings in the socio-demographic assessment of expenses. The Commission proposed no changes.

### **State views**

173 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**

174 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. Applying the same analysis to all hospital components did not make a material difference.

### **Commission decision**

175 The Commission will retain the existing age groups for the socio-demographic assessment of health expenses.

## **Clustered design of Victoria's health system**

176 The Commission considered state views on the use of remoteness weights for remote patients treated in major cities.

### **State views**

177 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.

### **Commission response**

178 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.



## **Commission decision**

179 The Commission will continue to use cost weights for patients travelling from remote areas for treatment.

## **Treatment of the National Health Reform Agreement**

180 The Commission considered state views on the treatment of Commonwealth payments under the National Health Reform Agreement. The Commission proposed no changes.

### **State views**

181 Queensland said that a portion of the Commonwealth payments under the National Health Reform Agreement are used to fund hospital services that states are providing because of shortfalls in the provision of Commonwealth-funded primary and aged care services.

182 Queensland said the services in question are state services, but demand for them is being increased because of failings in Commonwealth-supported sectors.

183 Queensland said the Commission does not assess differential need to provide state services because of failings of Commonwealth-supported sectors. As such, the proportion of the National Health Reform Agreement payments which go towards managing services that exist because of failings of Commonwealth-supported sectors should also not be assessed. The Commission should treat the Commonwealth payment as 12.5% no impact, 87.5% impact.

### **Commission response**

184 The terms of reference for the annual update of GST relativities require the Commission to treat Commonwealth payments to states under the National Health Reform Agreement as impact. The Commission does not have the discretion to treat a portion of the payment as no impact.

## **Commission decision**

185 In line with the terms of reference, the Commission will treat the full Commonwealth payment under the National Health Reform Agreement as impact.

## **Non-hospital patient transport**

186 The Commission considered state views on the non-hospital patient transport assessment. The Commission proposed no changes at this stage but proposed that the method be changed between reviews to assess non-hospital patient transport costs in the admitted patient assessment if data changes allowed.

## State views

- 187 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. Victoria said that expenses on non-hospital patient transport should be assessed in the admitted patient assessment.
- 188 Victoria said the 2025 Review should allow for method changes to remove the non-hospital patient transport category if it is clear ahead of the next review that the national weighted activity unit data incorporate the costs associated with aeromedical services and the Patient Assistance Transport Scheme.
- 189 Some states supported the proposal but said the Commission should consult with states before making a change between reviews. Queensland said any changes should wait until the next review. Tasmania said it does not provide data on aeromedical services or the Patient Assistance Transport Scheme activity to the Independent Health and Aged Care Pricing Authority and there would be considerable work required to be able to report these data in future.

## Commission response

- 190 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.
- 191 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.
- 192 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.
- 193 The activity associated with some types of patient transport are included in the national weighted activity units, and the remoteness costs weights produced by the Independent Health and Aged Care Pricing Authority include the cost of some types of patient transport.<sup>5</sup> However, states submit patient transport costs inconsistently and the costs associated with aeromedical services and the Patient Assistance Transport Scheme may not be fully reflected in state data submissions.

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<sup>5</sup> 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, p 20; 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, p 37.

## Commission decision

- 194 Given the uncertainty about the extent that activity associated with patient transport are included in the national weighted activity units, the Commission decided that costs associated with aeromedical services and the Patient Assistance Transport Scheme will be kept separate and continue to be assessed using the 2020 Review method.
- 195 However, the 2025 Review health assessment method will allow for the assessment of expenses associated with aeromedical services and the Patient Assistance Transport Scheme as part of the admitted patient component. This is contingent on verification that all states are providing the data that the Independent Health and Aged Care Pricing Authority needs to incorporate the aeromedical services and the Patient Assistance Transport Scheme activity into the national weighted activity units. It is also contingent on the data being available for all 3 years of the assessment period when any such method change is implemented in a future update. The Commission will consult with states as part of an annual update New Issues process before implementing any change.
- 196 Separately, some data used in the health assessment are only updated in a review on the assumption that the nature of service provision is stable over time. This includes data used to estimate the split between hospital and non-hospital (aero-medical transport and Patient Assistance Travel Schemes) patient transport expenses. Using updated data reduces expenses for non-hospital patient transport compared with the 2020 Review method.

## Adjustments for state bilateral cross-border arrangements

- 197 The Commission considered state views on whether the existing cross-border adjustment in the health assessment fully captures state-to-state cross-border payments. The Commission proposed no changes.

### State views

- 198 Victoria said it supports the Commission's current adjustment for cross-border health flows for Commonwealth payments under the National Health Reform Agreement. However, Victoria questioned the extent to which this fully captures state-to-state cross-border payments.
- 199 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

- 200 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 includes 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.

201 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 decision

202 The Commission will make no changes to the assessment in relation to state-to-state funding flows.

203 Separately, a cross-border adjustment is applied to community and public health services between the ACT and New South Wales. The net value of cross-border services provided by the ACT to New South Wales residents is re-estimated at each review. This amount is added to the ACT's assessed expenses and removed from New South Wales'.

## GST impacts of method changes

204 The impact on the GST distribution from the method changes is shown in Table 1.

**Table 1** Impact on GST distribution of method changes, health, 2024-25 to 2025-26

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total effect
	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m	\$m
COVID-19 assessment	209	293	-324	-45	-78	-23	-4	-28	502
Community health use indicator	42	49	-22	-26	-4	-11	6	-34	97
New ambulatory community mental health assessment	93	65	-39	-33	-14	-35	14	-52	172
Changes to non-state sector adjustment	-36	53	-85	-1	11	-16	12	63	139
Discounting of non-state sector adjustment	40	-22	48	-40	-8	1	-20	1	90
Cross-border	-10	0	0	0	0	0	10	0	10
Non-hospital patient transport	-58	31	25	-14	-12	16	1	10	84
<b>Total</b>	<b>280</b>	<b>469</b>	<b>-398</b>	<b>-159</b>	<b>-104</b>	<b>-68</b>	<b>19</b>	<b>-39</b>	<b>768</b>
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
COVID-19 assessment	24	41	-57	-15	-41	-40	-7	-109	18
Community health use indicator	5	7	-4	-9	-2	-19	12	-130	3
New ambulatory community mental health assessment	11	9	-7	-11	-7	-61	30	-200	6
Changes to non-state sector adjustment	-4	7	-15	0	6	-28	24	244	5
Discounting of non-state sector adjustment	5	-3	8	-13	-4	2	-42	4	3
Cross-border	-1	0	0	0	0	0	21	0	0
Non-hospital patient transport	-7	4	4	-4	-6	29	2	38	3
<b>Total</b>	<b>32</b>	<b>65</b>	<b>-69</b>	<b>-52</b>	<b>-55</b>	<b>-117</b>	<b>39</b>	<b>-153</b>	<b>28</b>

Note: Changes to the wage costs assessment are not included. These are shown in the wage costs chapter of *Review Outcomes*.

## COVID-19 assessment

205 The largest source of change is the separate assessment of COVID-19 health expenses. The disaggregated effects of the method change for assessing COVID-19 expenses and the change in treatment of the Commonwealth payment under the National Partnership on COVID-19 Response is shown in Table 2.

**Table 2 Impact on GST distribution of the COVID-19 assessment, health, 2024-25 to 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	-154	-206	287	15	67	-7	7	-10	377
State spending of commonwealth payment	154	206	-287	-15	-67	7	-7	10	377
State own source COVID-19 spending	154	206	-287	-15	-67	7	-7	10	377
Moving expenses to the COVID-19 component	55	87	-37	-30	-11	-30	3	-38	145
<b>Net effect of treatment of COVID-19</b>	<b>209</b>	<b>293</b>	<b>-324</b>	<b>-45</b>	<b>-78</b>	<b>-23</b>	<b>-4</b>	<b>-28</b>	<b>502</b>
	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc	\$pc
Commonwealth payment for COVID-19	-18	-29	50	5	35	-12	15	-39	14
State spending of commonwealth payment	18	29	-50	-5	-35	12	-15	39	14
State own source COVID-19 spending	18	29	-50	-5	-35	12	-15	39	14
Moving expenses to the COVID-19 component	6	12	-6	-10	-6	-52	7	-148	5
<b>Net effect of treatment of COVID-19</b>	<b>24</b>	<b>41</b>	<b>-57</b>	<b>-15</b>	<b>-41</b>	<b>-40</b>	<b>-7</b>	<b>-109</b>	<b>18</b>

206 The impact of this method change is limited largely to the distribution of GST in 2025–26. This is because COVID-19 health expenses decline significantly after 2021–22 and this year drops out of the assessment period for the distribution of GST in 2026–27.

207 The change in distributions is 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 using the 2020 Review health assessment method in the 2024 Update
- the effect of moving relevant expenses from other components of the health assessment to the COVID-19 component.

208 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. For New South Wales and Victoria, this results in an increase in assessed GST needs because under the 2020 Review method they were assessed to need less than their population share of health expenses. However, for Tasmania and the Northern Territory, their assessed needs were larger under the 2020 Review method than an actual per capita assessment method and so they receive less GST.

## Other method changes

- 209 Two changes are being made to the assessment of community and public health expenses. First, the proxy indicator of activity will be broadened to include a subset of non-admitted patient services, in addition to emergency department triage category 4 and 5 services. The effect on GST distribution from this change is shown in Table 1 against the *community health use indicator* label. Second, ambulatory community mental health services will be separately assessed using a direct measure of service use rather than a proxy indicator based on emergency department triage category 4 and 5 services. The effect on GST distribution from this change is shown in Table 1 against the *new ambulatory community mental health assessment* label.
- 210 These changes provide a better estimate of ambulatory community mental health activity and the balance of community and public health activity than emergency departments triage category 4 and 5 services. The changes to the community and public health assessment affect the Commission's estimate of the amount states spend on these services for each socio-demographic group. Compared with the proxy measure of activity used in the 2020 Review method, per capita spending at the national level on ambulatory community mental health services and the balance of community and public health services will now be estimated to be relatively higher for people living in less remote areas or in higher socio-economic status cohorts, as well as for non-Indigenous people and younger people. States with relatively larger shares of these socio-demographic groups in their population (New South Wales, Victoria and the ACT) will see an increase in their assessed GST needs.
- 211 Queensland, Western Australia, South Australia, Tasmania and the Northern Territory are assessed to need more than their per capita share of the GST distribution from the ambulatory community mental health services and the balance of community and public health services. However, under the 2020 Review method their assessed expense needs were even higher. Therefore, the change in method will see a reduction in assessed GST needs for these states.
- 212 The effect on GST distribution from 2 changes to the non-state sector adjustment are grouped together in Table 1 against the *changes to non-state sector adjustment* label.

- 213 The first change to the non-state sector adjustments relates to Commonwealth grants to First Nations community-controlled health services. Setting this adjustment to zero increases the assessed GST needs of states that received grants that exceeded what they were assessed to need under the 2020 Review method (Victoria, South Australia, the ACT and the Northern Territory).
- 214 The second change is to not round non-state sector substitutability levels to the closest 5%.
- 215 The substitutability levels for admitted patient and community and public health services have been estimated at 17% and 62% respectively. Rounding would have brought these estimates to 15% and 60% respectively, unchanged from the 2020 Review method. A higher substitutability level means an estimated larger contribution from the non-state sector, and therefore a lower estimate of state expense needs. The non-state sector adjustment is calculated as the difference between assessed and actual non-state expenses. Therefore, states that have assessed non-state expenses greater than actual expenses will receive an increase in GST distribution. For admitted patients, these are Victoria, Western Australia and the ACT. For community and public health, it is Western Australia, South Australia, Tasmania and the ACT.
- 216 The substitutability levels for emergency department and non-admitted patient services have been estimated at 13% and 28% respectively. Rounding would have brought these estimates to 15% and 30% respectively, unchanged from the 2020 Review method. A lower substitutability level means a smaller estimated contribution from the non-state sector and therefore a larger estimate of state expense needs. This increases assessed GST needs for states that had actual expenses exceeding assessed expenses. For both emergency department and non-admitted patient adjustments these are New South Wales, Victoria and Queensland.
- 217 Applying a 12.5% discount to the non-state sector adjustments reduces the influence of these adjustments on the distribution of GST (*discounting of non-state sector adjustments*).
- 218 Using updated data on New South Wales residents' use of ACT services increases the assessed GST needs of the ACT and reduces it for New South Wales (*cross-border*).
- 219 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 2020 Review method. This reduces GST distribution to states that are assessed to need to spend more than their per capita share on non-hospital patient transport (*non-hospital patient transport*).

# Attachment A

**Table A-1 Non-admitted patient services similar to community health services**

Tier 2	Non-admitted patient service	Community and public health service
40.09	Physiotherapy	Allied health services
40.10	Sexual health	Sexual health services
40.13	Wound management	Community/home nursing services
40.23	Nutrition/dietetics	Allied health services
40.24	Orthotics	Allied health services
40.25	Podiatry	Allied health services
40.28	Midwifery and maternity	Family and child health services
40.29	Psychology	Community mental health services
40.30	Alcohol and other drugs	Alcohol and other drug services
40.31	Burns	Community/home nursing services
40.32	Continence	Continence services
40.35	Palliative care	Community/home nursing services
40.36	Geriatric evaluation and management	Community/home nursing services
40.37	Psychogeriatric	Community/home nursing services
40.38	Infectious diseases	Communicable disease control
40.51	Breast	Cancer screening (bundled with main service)
40.55	Paediatrics	Family and child health services
40.56	Falls prevention	Community/home nursing services
40.57	Cognition and memory	Community/home nursing services
40.58	Hospital avoidance programs	Chronic disease management
40.60	Pulmonary rehabilitation	Chronic disease management
40.63	COVID-19 response	Communicable disease control
40.64	Chronic pain management	Chronic disease management

Note: Activity in COVID-19 clinics will not be included in the community and public health proxy for the assessment of GST relativities for 2025–26 and 2026–27 when expenses under the National Partnership would be assessed separately.

Source: Commission decision based on [Tier 2 non-admitted services classification 2021-22](#).