Report on Commonwealth-state financial arrangements in health care

230913

1. There are two main types of Commonwealth payments to the states and territories: tied and untied grants. [1] In 2022-23 total Commonwealth payments to the states totalled $169 billion, with just over half (52%) paid as general revenue assistance (or untied grants), with the remainder as tied grants (sometimes called Specific Purpose Payments).[2]
2. In this section I will start by briefly describing overall hospital funding then describe the two types of grants, and how they are allocated to states, first describing tied grants and then discussing the more important untied grants, pointing out that the allocation of untied grants is critical to the overall flow of funds from the Commonwealth to the States.
3. In 2020-21 (the latest year for which consistent data is available), over $70 billion was spent on public hospital care in Australia (see Table 1).[3]

Table 1: Sources of funding, public hospital services, 2020-21

	National Health Reform Agreement (and other minor grants)	State government	All other	Total
NSW	7,689	11,299	1,735	20,722
Australia	27,421	37,295	5,810	70,526

Source: Australian Institute of Health and Welfare (2022), Health expenditure Australia 2020-21 (Canberra: AIHW).

4. Just over half of this funding is from state sources, with just under 40% from payments made to state governments by the Commonwealth government, the overwhelming amount of these being grants made under the National Health Reform Agreement (99%). The balance includes payments by individuals or their insurers (including payments for private patients in public hospitals), and payments under various compensation arrangements such as transport accident insurance or workplace compensation insurance.
5. The current National Health Reform Agreement covers the period 1 July 2020 to 30 June 2025. It is the latest iteration in a series of Agreements between the Commonwealth and the

[1] Hereafter the term 'state' will refer to both states and the two mainland territories which participate in horizontal fiscal equalisation (the Australian Capital Territory and the Northern Territory).
[2] Australia. Treasurer and Minister for Finance, *Budget Paper No. 3: Federal Financial Relations* (Canberra: Parliament of Australia, 2023), Table 1.1, page 6.
[3] Australian Institute of Health and Welfare, *Health expenditure Australia 2020-21* (Canberra: AIHW, 2022).

states which describe how funds will flow from the Commonwealth government to the states for public hospital services, and what commitments the states will make under the Agreement.

6. The current Agreement is very similar to the previous Agreements covering the period since 2014.
7. The most important commitment in the National Health Reform Agreement is that people will be able to access care in public hospitals in a timely way without a direct charge – the core Medicare promise. This commitment has been in place since the Hawke government introduced Medicare in 1984, building on the introduction of Medibank by the Whitlam government and addressing the slow dismantling of Medibank by the Fraser Government.[4]
8. The Commonwealth government uses the National Health Reform Agreement – as it has used previous Agreements – to effect its Medicare commitment of assuring access to public hospital care without charge to patients.
9. As briefly mentioned above (paragraph 14), Commonwealth government payments to states can be classified into two broad categories:
    a. Commonwealth grants related to a particular program, purpose, or objective, such as the National Health Reform Agreement payments, are known as 'Specific Purpose Payments' and are authorised under Section 96 of the Constitution.[5] The Commonwealth government may apply conditions to these grants.
    b. The Commonwealth government also makes grants without conditions that state governments can allocate in accordance with their own priorities. The grants to states from revenue from the Goods and Services Tax (GST) is the main current example of an 'untied' grant, accounting for 99.5% of untied grants.[6]
10. There are a large number of Specific Purpose Payments, each with its own accountability arrangements, including Agreement-specific outcome or output outcome measures, and each with its own formula for allocating funds to the states, with those formulae typically developed within the line agency (Commonwealth department) responsible for policy in that field. The formula used in the National Health Reform Agreement is discussed below.

National Health Reform Agreement

11. Because public hospitals are essentially a state responsibility, Medicare, and its predecessor Medibank, could only be implemented with support of the states. As mentioned above (paragraph 21), this was achieved through negotiation of Commonwealth-State agreements, the current iteration of which are termed National Health Reform Agreements, with the first negotiated from 1 July 2012, with subsequent ones starting in 2017 and 2020. The current Agreement is under review in advance of negotiations for a new Agreement commencing 1 July 2025.
12. When it was first negotiated, the National Health Reform Agreement was designed to
    a. Slowly increase the proportion of Commonwealth funding for hospitals by sharing the costs of growth in hospital spending on a 50:50 basis which was planned to slowly

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[4] Stephen Duckett, "Chopping and changing Medibank part 1: Implementation of a new policy," *Australian Journal of Social Issues* 14, no. 3 (1979); Stephen Duckett, "Chopping and changing Medibank part 2: An interpretation of the policy making process," *Australian Journal of Social Issues* 15, no. 2 (1980). [SCI.0011.0564.0001] [SCI.0011.0568.0001]

[5] Scott Bennett and Richard Webb, *Specific purpose payments and the Australian federal system* (Research Paper No. 17 2007-2008, Canberra: Parliament of Australia, Parliamentary Library, 2008). [SCI.0011.0567.0001]

[6] Australia. Treasurer and Minister for Finance, *Budget Paper No. 3: Federal Financial Relations.*; I am including in GST payments the payments to effect a guarantee that no state's GST will be less than the previous GST distribution formulae; the other equalisation payments are primarily royalty payments to Western Australia.

increase the Commonwealth's share of hospital funding. This 50:50 sharing was abolished in the Budget of 2014 continuing the share of 45 (Commonwealth):55 (states) included in the initial National Health Reform Agreement; [7] and

b. drive improvement in efficiency of public hospital services through the national adoption of a system known as activity-based funding and setting a 'National Efficient Price' to be used in Commonwealth-state payments.
    i. In brief, under activity-based funding hospitals are paid according to their activity. This obviously requires that activity be measured, and for acute inpatient services this is done using a classification system known as Diagnosis Related Groups, which as its name implies clusters patients into groups based on their diagnosis and other factors such as the procedures performed. There are other classification systems for other activities of hospitals. For example, patients might be allocated to DRG I33B, Hip Replacement for Non-Trauma, Minor Complexity or to DRG O60C Vaginal Delivery, Minor Complexity.

13. Activity-based funding was first introduced in Australia in Victoria in the early 1990s.[8] Prior to the introduction of activity-based funding in Victoria, public hospitals negotiated 'health service agreements' with the state Health Department. Unfortunately, an independent review by a parliamentary committee found that there was 'little tangible evidence to indicate that they have tackled the problems of discrepancies in hospital performance and... have not achieved a significant move away from historical patterns of funding'.[9]
14. The National Health and Hospitals Reform Commission recommended the adoption of activity-based funding for public hospitals nationally,[10] which was effected through the National Health Reform Agreements.
15. The Agreement serve an important symbolic purpose of increasing the attention paid to the efficiency of public hospitals, regardless of whether the flow of funds to a state was in fact determined, in reality, by the Agreement. This symbolic purpose was reinforced by state Treasury Departments in some states allowing the Health department to keep all additional revenue gained from the Agreement (and bear any losses).
16. Payments under the National Health Reform Agreement are provided under a variety of bases but year on year growth in total payments is principally allocated to states based on growth in activity, with activity measured in terms of relativities (known as National Weighted Activity Units) and paid at a 'National Efficient Price' determined by what is now the Independent Health and Aged Care Pricing Authority (IHACPA). The increase in Commonwealth payments is set at 45% of the costs of growth in activity paid at the National Efficient Price.

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[7] Because this si less than the contemporary Commonwealth share of funding of hospitals, this will lead to a declining Commonwealth share of costs over time.

[8] Duckett, Stephen (1995), 'Hospital payment arrangements to encourage efficiency: The case of Victoria, Australia.', Health Policy, 34, 113-34. [SCI.0011.569.0001]

[9] Economic and Budget Review Committee (1992), *Hospital services in Victoria: Efficiency and effectiveness of health service agreements: the impact of the mix of public and private patients on the funding of the public hospital system* (35th Report to Parliament of Victoria) (Melbourne: Government Printer), page xv.

[10] National Health and Hospitals Reform Commission (2009), *'A Healthier Future for All Australians – Final Report of the National Health and Hospitals Reform Commission'*, (Canberra).

17. Since 2017 growth in these grants to states in total (and where appropriate to individual states) have been capped at 6.5% per annum.[11] New South Wales did not hit this cap in the period 2017-18 to 2021-22.[12]
18. For inpatient activity, the National Weighted Activity Units are based on Diagnosis Related Groups, with other types of hospital activity been described using other classification systems.
19. For those functions for which no activity measures have been developed or agreed, or where activity-based funding might be problematic (small hospitals are an example), IHACPA develops a 'National Efficient Cost' measure which is used to inform block grants (rather than activity payments) to states. Teaching, Training, and Research is currently funded under a block grant.
20. The National Health Reform Agreement and publications of the IHACPA set out in voluminous detail how funds under the Agreement flow. Mr Olney's affidavit also summarises these processes.

Allocating untied grants

21. The Commonwealth government has made untied grants to the states from the beginning, initially per capita grants of 'surplus revenues'. However, federation, specifically a uniform external tariff and freedom of Interstate trade, impacted differentially on the fiscal position of the states. The second decade of federation saw the Commonwealth government make special payments to states particularly affected by the imbalance between their revenue and their spending (WA and Tasmania). The original basis for the grants was partly political, and by the late 1920s, arguments for a more technocratic basis, examining 'needs', had developed.[13]
22. Obviously, the costs of providing services to a dispersed population are greater than to a concentrated population so one would expect it to cost more to provide roads and healthcare in Western Australia per head of population compared to Victoria. But on the other hand, Western Australia might find it easier to raise taxes to pay for those services because of its greater mineral wealth. So, there is inequality between the states in both the costs of providing services and raising money to pay for them. This is known as *horizontal fiscal inequity.*
    a. The term horizontal fiscal inequity parallels another term, *vertical fiscal inequity*, which relates to the policy issue that the balance between tax raising capacity and program responsibilities is different for the Commonwealth and states. The former has significant tax raising capacity, e.g., through income tax on individuals and companies and sole ability to raise excise taxes, relative to its responsibilities and the states are in the reverse position.

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[11] Amanda Biggs, *Recent developments in federal government funding for public hospitals: a quick guide*, Australian Parliament. Parliamentary Library (Canberra, 2018). [SCI.0011.0565.0001]
[12] National Health Funding Body (2022), 'NHR payments for each State and Territory – Five year trend', (Canberra: NHFB).
[13] R.L. Mathews and W.R.C. Jay, *Federal finance: Australian fiscal federalism from Federation to McMahon*, Second Edition ed. (Melbourne: Thomas Nelson, 1972).; Commonwealth Grants Commission, *Equality in diversity: History of Commonwealth Grants Commission*, second ed. (Canberra: AGPS, 1995).; Vijaya Lakshmi Ramamurthy, "Australian federalism and the use of tied grants: case studies of public hospitals and schools" (PhD Curtin University, 2012). [SCI.0011.0566.0001]

23. The Commonwealth Grants Commission (CGC) was established by Commonwealth legislation 90 years ago to address this problem of horizontal fiscal inequity.[14] Essentially the CGC identifies factors which affect the cost of providing services (such as geographic dispersion, but also the characteristics of the population such as the age distribution) and factors which affect the revenue raising capacity of a state (such as mineral resources) and uses those as part of a process known as *horizontal fiscal equalisation.*
24. Specifically, the objective of horizontal fiscal equalisation is that:

> The assessment of State relative fiscal capacities, for informing the GST distribution, will be determined for each State such that, after allowing for material factors affecting revenues and expenditures, each would have the fiscal capacity to provide services and the associated infrastructure at the same standard, if each made the same effort to raise revenue from its own-sources and operated at the same level of efficiency.[15]

25. The allocation of GST revenue is the mechanism by which the problem of horizontal fiscal inequity is addressed.
26. Although the GST is levied as a Commonwealth tax, the revenue from the GST is, after deductions for costs of raising the tax, fully allocated to states, with the distribution of the GST being designed to reduce horizontal fiscal inequities.
27. The CGC acts as a type of umpire - within the constraints of its terms of reference - to calculate what are fair shares for all the states and territories taking into account relative needs.
28. A key underlying principle of horizontal fiscal equalisation is 'policy neutrality': equalisation is based on 'average policies' and that specific state policies (to levy higher or lower taxes, to be more or less extensive in service provision) are state choices. Specifically:

> a State's incentive to change its own policies in the expectation of increasing its grant share (that is, engage in grant seeking behaviour) is limited to the effect of its policies on the average. Under the Commission's approach, there are no allowances for differences between the average policy and a State's own policy. To the extent that those differences lead to increased costs, States are responsible for funding those additional costs. If those differences lead to reduced costs, States retain the benefit of the cost savings[16].

29. In line with the 'policy neutrality' principle, the CGC approach is one which equalises the *capacity* of states to meet needs, not whether the state actually does so. That is, how the state spends the money it receives is up to the state, held to account through state processes (including elections).
30. The allocation of GST revenue is paid to the states as an untied grant so the state can allocate it against its priorities as it sees fit.
31. The CGC process leads to a set of 'relativities' which is used to determine the distribution of the revenue from the GST to each state. Essentially the relativities are weights assigned to each state and territory which convert into a percentage entitlement of total GST revenue.

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[14] The *Commonwealth Grants Commission Act*; Downing, R. J. (1935), 'The Work of the Commonwealth Grants Commission', *Res Judicatae*, 1 (2), 155-61; Commonwealth Grants Commission, *Equality in diversity: History of Commonwealth Grants Commission*.

[15] Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 2 — Methodology for measuring State fiscal capacities (Part A)* (Canberra: CGC, 2020).; page 38.

[16] Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 2 — Methodology for measuring State fiscal capacities (Part A).*; page 52

32. The process for developing the relativities is discussed below, see also Table 5.
33. The CGC updates its findings every year in the light of new data (such as population estimates) and issues a new set of relativities each year based on the latest data. The CGC conducts a more fundamental review of its formula and approach every five years; the last such review was in 2020 and another review has just commenced.

Cost of provision

34. The first step in the CGC process is to identify the cost factors in each area of policy (health, roads) which impact on providing a broadly equivalent standard set of services.[17] The aim is to identify those factors which are outside the control of the state or territory (i.e. not 'state policy factors') and so identify what it would cost a state, at average efficiency, to provide a standard package of services.
35. In terms of health care, the CGC groups services into five broad categories:
    b. Admitted patient services (i.e. hospital inpatients, including patients admitted for same-day care such as care for patients admitted for endoscopies);
    c. emergency departments;
    d. non-admitted patient services (including hospital outpatient services);
    e. community and public health services;
    f. non-hospital patient transport.
36. There is no special assessment of need for 'Teaching, Training, and Research' functions of hospitals, as these costs are deemed to be included in the other aspects of health care as assessed by the CGC.
37. For 'admitted patient services', the CGC recognises three key factors which influence the cost of provision:
    g. Socio-demographic composition, recognising that Indigenous status and low socio-economic status of State populations, age and where people live affect the use and cost of services; and
    h. Non-State sector provision recognising that privately provided services, such as private hospitals, may substitute somewhat for publicly provided services and so reduce costs to the state; and
    i. Wage costs differences among states.[18]
38. In its 2020 assessment, the CGC estimated that on average across Australia it cost $1,893 per capita to provide the standard package of admitted patient services, slightly less in New South Wales, taking into account the factors outlined above (see Table 2).

Table 2: Commonwealth Grants Commission admitted patient services assessment

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Assessed expenses ($m)	15,118	11,663	9,724	4,963	3,521	1,231	662	751	47,632

[17] Essentially an average package, but this is being phased in from 2021-22 to a standard based on what is provided in the better of New South Wales or Victoria in terms of standard. *Ibid*, page 71. The phase in will be completed in 2026-27.

[18] Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 2 — Methodology for measuring State fiscal capacities (Part B)* (Canberra: CGC, 2020). Page 135

Assessed expenses ($pc)	1,881	1,787	1,925	1,904	2,020	2,314	1,563	3,058	1,893

Source: Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 2 — Methodology for measuring State fiscal capacities (Part B)* (CGC, 2020), Table 15-13, page 150

39. The CGC does not break down the admitted patient services category into types of admitted patients (e.g. maternity care or orthopaedic care), or the classes of expenditure (laboratory services vs ward services). That is, the assessment of need for spending on admitted patient services is based on differences in total spending on admitted patients across states, and the legitimate drivers of differences in spending, not drivers of component parts of that spending.
40. The CGC undertakes a similar process to assess the costs of providing other aspects of public hospital services including care in emergency departments and outpatient care (non-admitted services).

Paying for provision

41. As identified above table 1, more than half of the costs of providing public hospital services is met by the state government from its own sources, including untied grants and revenue it raises. The main sources of state and territory revenue are shown in Table 3.

Table 3: Sources to pay for state services, 2018-19

	$m	$pc
Revenue from Commonwealth government		
GST revenue	65,160	2,589
Other Commonwealth payments	40,446	1,607
Subtotal	*105,606*	*4,196*
State own-source revenue		
Payroll tax	25,685	1,021
Land tax	10,507	417
Stamp duty on conveyances	17,943	713
Insurance tax	5,571	221
Motor taxes	8,046	320
Mining revenue	15,506	616
Other revenue	49,949	1,985
Net borrowing/lending	-19,311	-767
Subtotal	*113,896*	*4,526*
Total	*219,502*	*8,722*

Source: Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 2 — Methodology for measuring State fiscal capacities (Part B)* (CGC, 2020), Table 32-1, page 479

42. The CGC recognises that states differ in their capacity to raise revenue, for example because of differences in mineral resources or in their capacity to raise payroll tax. In line with its treatment of state policy differences generally, The CGC takes these differences into account in assessing the state's ability to pay for the standard set of services. State choices about revenue raising (e.g., policies about exemption thresholds) are not taken into account in assessing capacity to raise funds.
43. States also attract differing per capita amounts of specific purpose payments from the Commonwealth government.

44. Specific purpose payments are allocated on a variety of bases which may not reflect the costs of paying for a standard set of services.[19] The CGC is directed by its terms of reference to take specific purpose payments into account in making its recommendations.
45. Clause 8 (a) of the CGC Terms of Reference for its 2020 Review issued by then Treasurer Morrison instructed the CGC that Natural Health Reform payments 'should affect the relativities, recognising that the payments provide the states with budget support for providing standard state services'.[20]
46. The CGC divides Commonwealth payments to states into those which 'impact' the GST distribution and those that don't. Essentially, if the Commonwealth payment supports services normally provided by states, and the CGC assesses needs for those services, then the Commonwealth payments impacts the distribution of the GST.[21] Payments under the National Health reform Agreement are in this category.
47. The CGC describes its process and reasoning thus:

> As well as the GST, the Commonwealth makes other payments to the States for specific purposes (PSPs). Equalising the fiscal capacity of the States to provide services requires that the Commission take account of the total expenditure and investment each State would incur to provide the average level of services and the revenue available to finance it. This includes the revenue States can collect from their own tax bases under average policies and the revenue they receive through PSPs. *To the extent that a State receives above average per capita amounts of PSPs, less GST is required to equalise its fiscal capacity. Conversely, if a State receives below average amounts of PSPs, it requires more GST* (emphasis added).[22]

48. The principle here is that if a state gets more from the National Health Reform Agreement payments than it would from a CGC-type assessment of need, this should be adjusted out.
49. Essentially this means that specific purpose payments and the GST allocation offset each other. The more a state receives in a specific purpose payment – such as the National Health Reform Agreement payments – the less it needs in terms of GST revenue to pay for the standard package of services provided to its residents.

Bringing the CGC processes together

50. The purpose of horizontal fiscal equalisation is to bring states on to an equal footing in terms of their ability to meet the needs of their residents. In so doing, the CGC first identifies needs as discussed above, and then identifies the fiscal capacity (i.e., their ability to attract or raise revenue) to meet those needs.

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[19] The Grants Commission has refined its processes about handling specific purpose payments over time, see, for example, Butler, J. R. G. (1992), 'Specific Purpose Payments and the Commonwealth Grants Commission', *Economic Record*, 68 (2), 165-80. [SCI.0011.0563.0001]

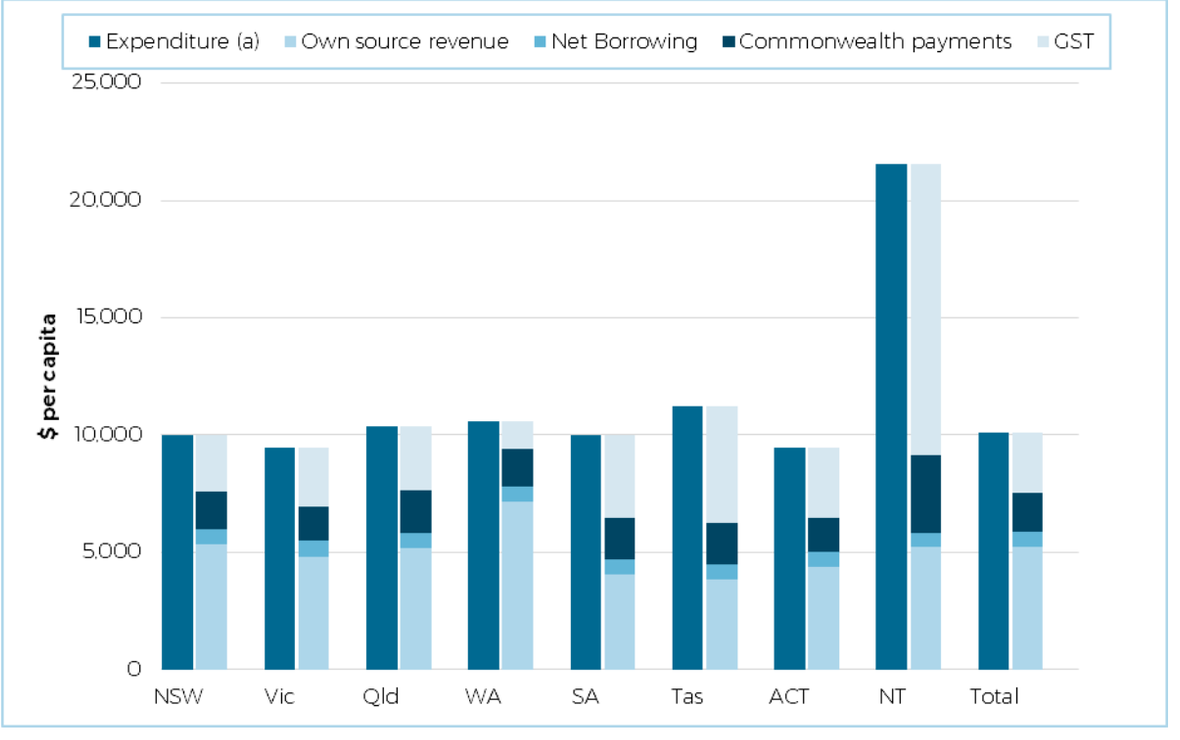
[20] Similar clauses have been included in previous Terms of reference, e.g. the Terms of Reference for the 2015 Review issued by then Treasurer Swan included almost identical words as quoted as applying to National Health Reform payments as clause 3(a): the only difference was that 'state and territory services' replaced 'state services'.

[21] Commonwealth Grants Commission, *The framework for the treatment of Commonwealth payments in GST distribution (Research paper 5)* (Canberra: CGC, 2022).

[22] Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities: 2020 Review. Volume 1 — GST revenue sharing relativities for 2020 21* (Canberra: CGC, 2020). Page 15

51. The CGC brings the cost/need and revenue sides together and identifies a gap between what it costs states to provide services and their ability to raise revenue, including their ability to attract Commonwealth specific purpose payments.
52. The distribution of GST payments partially addresses that gap, that is the GST payments act as a top-up between available state and territory revenue (including Commonwealth specific purpose payments) and legitimate service costs.
53. The GST pool is a fixed amount, based on the amount of taxable goods sold and services provided. The CGC recommends how much each state should be paid from the available GST toward the costs of providing services. That is, the CGC aims to achieve a fair distribution of the available pie through the calculation of GST relativities for each state and territory so that all state residents are able to have equitable access to state-provided services, such as public hospitals.
54. The CGC illustrates this process using Figure 1.[23]

Figure 1: Illustrative budgets



Source: Commonwealth Grants Commission, Report on GST Revenue Sharing Relativities: 2020 Review. Volume 1 — GST revenue sharing relativities for 2020 21 (CGC, 2020), Figure 1-1, page 2. Note (a): expenditure includes expenses and investments.

https://www.cgc.gov.au/sites/default/files/2021-11/2._2020_methodology_review_draft_report_-_main_report_-_web.pdf

figure 2.1

[23] A similar graph is published in the most recent update, taking into account a guarantee to Western Australia for the amount of GST revenue it will receive so its revenue is above its assessed costs. See Commonwealth Grants Commission, *GST Revenue Sharing Relativities 2023 Update: GST Relativities for 2023–24* (Canberra: CGC, 2023). Figure 1-1, page 16.

55. For the CGC, assessed population need is the starting point, with assessed need being slightly higher in Queensland and Western Australia per capita than in NSW, due to factors such as dispersion of the population and the proportion of First Nations Australians.
56. The second stage is how a state can pay to meet that need, the contributing factors being own-source revenue, borrowing, specific purpose payments, and the balancing item, the GST distribution.
57. The CGC describes Figure 1 as showing:

> that the per capita GST requirement for each State is the difference between the State's total assessed expenditure (expenses and investment) and the sum of its assessed own-source revenue, assessed net borrowing and Commonwealth payments. Any additional payments received by a State that are quarantined from the Commission's processes increase the fiscal capacities of that State relative to the other States.[24]

58. The GST allocation is determined by what is necessary (in terms of the relative allocation from the GST pool), to enable a state to provide the standard set of services to its residents. The GST allocation is thus a residual after taking into account state own-source revenue and Commonwealth specific purpose payments to the state.
59. Any increase in either a state's ability to raise own source revenue or its ability to attract Commonwealth specific purpose payments will reduce its need for GST payments and vice versa.
60. In its 2020 Review Report the Commission identified how changes in Specific Purpose Payments changed requirements for GST allocations (see Table 4).

Table 4: Changes in the illustrative GST distribution due to changes in Commonwealth payments, 2020-21

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Redist
	$m	$m	$m	$m	$m	$m	$m	$m	$m
National Health Reform funding	72	134	-267	0	61	13	1	-14	281
Road infrastructure - National Network	108	14	13	-15	-123	2	1	0	138
Rail infrastructure - National Network	7	11	51	5	-78	2	1	0	78
Remote Indigenous housing	-21	-29	20	20	-2	-2	-2	17	57
Quality Schools - government	-22	37	-15	0	3	3	2	-8	45
Road infrastructure - Other Roads	1	31	8	-19	-19	-4	0	0	41
Health and hospital fund	-16	22	-12	-2	-3	-5	-1	17	38
Investment Growth Package - new investments	-15	-12	26	-2	-3	0	1	5	32
Skilling Australians Fund	-16	13	10	-1	-3	-1	-1	0	23
Sustainable Rural Water Use and Infrastructure Program	8	-17	10	3	1	-2	-3	0	23

[24] *Ibid,* pages 1-2

Other	10	3	-8	-2	-8	-8	2	10	25
Total	**116**	**209**	**-164**	**-13**	**-174**	**-1**	**1**	**27**	**352**

Source: Commonwealth Grants Commission, Report on GST Revenue Sharing Relativities: 2020 Review. Volume 1 — GST revenue sharing relativities for 2020 21 (CGC, 2020), Table 2-7, page 15

61. Table 4 shows that Queensland lost $267 million dollars in the 2020 GST distribution review because of changes in National Health Reform payments. I will use this Queensland example to show the interaction of the GST distribution and National Health Reform payments.
62. The National Health Funding Body publishes data on the National Health reform Agreement payments.
63. The National Health Funding Body data shows that between 2015-16 and 2018-19 (the latter being the base year for the 2020 review), total National Health Reform Agreement payments to Queensland increased by 21% compared to an average increase across all other states and territories of 17.4%.[25]
64. Queensland increased its share of Commonwealth payments under the National Health Reform Agreement from 21% to 24% over this period.
65. However, this faster growth in National Health Reform Agreement payments for Queensland then impacted on the GST distribution, leading to the reduced share of the GST distribution.
66. National Health Reform Payments to Queensland increased by $2.1 billion dollars over the 2015-16 to 2018-19 period. If they had increased at the same rate as other states, they would have increased by $1.7 billion, a difference of $346 million.
67. If there had been no other changes in factors the CGC takes into account, Queensland would have lost this same amount in its GST allocation. However, over this period other factors changed (e.g., Queensland's population) and so some, but not all, of the growth in Queensland's National Health Reform Agreement funding reflected changes in factors the CGC takes into account.
68. The net effect is that Queensland did not, after GST redistribution, accrue the full $346 million initially paid under the National Health Reform payments, but effectively gained only what was due under the CGC formula.
69. Essentially the CGC consider Queensland's needs independently of the National Health Reform Agreement formula. The two approaches are different and yield different outcomes for Queensland. But the CGC approach is what matters in the end because the increase in the National Health Reform payments is overridden by the needs as assessed by the CGC.
70. Because the increase of $346 that Queensland received under the National Health Reform Agreement is greater than CGC assessed need, $267 million of that was clawed back and redistributed to other states through the GST formula (see table 4).
71. The CGC describes these changes as 'flow on effects' onto the untied grant from the changed distribution of the tied grant (National Health Reform Agreement).
72. These 'flow-on' effects mean that any change in specific purpose payments will always impact on GST payments, what is at issue is the magnitude of the impact.
73. Specifically, an increase in specific purpose payments will always have an offsetting reduction in GST payments: if the costs to provide a standard package of services are unchanged, greater revenue from specific purpose payments means less is required from the GST

[25] National Health Funding Body (2022), 'NHR payments for each State and Territory – Five year trend', (Canberra: NHFB).

balancing item. The magnitude of the effect is partly determined by how much change is occurring in other states.

74. The outcome of the GST process is a set of relativities for distributing GST revenue. These relativities convert into a share of the total GT funding pool, and thus into a GST payment to the states. Table 5 shows the 2023-24 numbers.[26]

Table 5: GST relativities, shares and estimated GST distribution, 2023–24

	GST relativities	GST shares (%)	GST allocation ($m)
New South Wales	0.92350	28.8	24,870
Victoria	0.85169	21.8	18,796
Queensland	1.03118	21.1	18,220
Western Australia	0.70000	7.5	6,482
South Australia	1.39463	9.8	8,420
Tasmania	1.79080	4.0	3,409
Australian Capital Territory	1.19540	2.1	1,831
Northern Territory	4.98725	4.9	4,219
Total	**1.00000**	**100.0**	**86,248**

Source: Commonwealth Grants Commission (2023), *Occasional Paper No.9: GST distribution to states and territories in 2023–24* (Canberra: CGC). Page 3

75. The CGC process is a data-driven one and necessarily involves lags between data becoming available and the CGC calculations. The CGC published its 2023-24 relativities, shares and allocations in March 2023 drawing on data up to the 2021-22 year, including the 2021 census, so there is a two-year lag between data becoming available and relativities being affected.
76. Summing up, the GST is the most significant flow of funds from the Commonwealth to the states. This flow takes into account and overrides the formulae in each of the specific purpose payments.
77. That is, although the formula published in the National Health Reform Agreement is important, especially for its symbolic effect in terms of focussing states on the efficiency of their public hospitals, the flow of funds under the National Health Reform Agreement is essentially irrelevant in terms of a state's total revenue, as that is determined by the GST formula.

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[26] Note: This table does not include additional allocations to Western Australia to ensure that its allocation was at least 70% of GST collected in that state, and other states were no worse off.

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