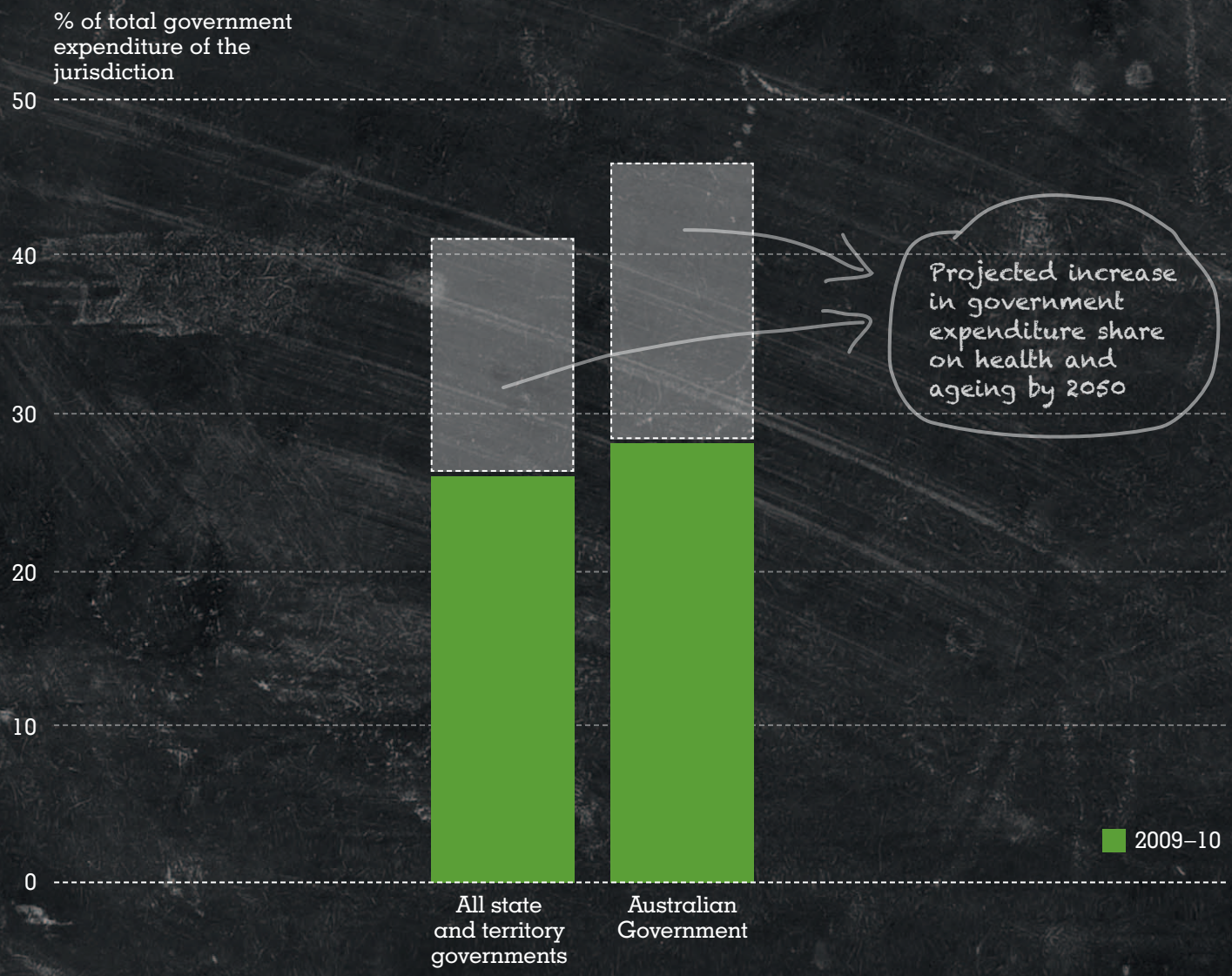
Business Council of Australia

Long-term Funding of Health and Ageing

The Rising Pressure on Commonwealth and State Budgets



When the growth of health and aged care spending as a proportion of federal, state and territory budgets is examined, it is clear that if no action is taken, the Australian community will face tough decisions about the funding and availability of those services in the future.

As shown by previous research[1] commissioned by the Business Council of Australia that used the most recent Intergenerational Report (IGR), without action these intergenerational pressures will see Australian governments collectively running deficits of $70 billion a year by 2050 and facing ballooning debt. A new IGR would provide more updated budget projections.

The federal election environment should provide an opportunity to discuss the policies that will be important to ensure an affordable, efficient and effective health and aged care system that delivers the services Australians expect into the future. While recent debate has focused on the funding of new government programs, there has been far less focus on the substantial long-term funding pressures in health and aged care.

It is a task that must begin to be addressed in the forthcoming federal budget. As the BCA's 2013–14 Budget Submission recently highlighted, the execution of the government's fiscal strategy is not working and needs a major rethink.

New spending since 2009 has built up to a $49 billion drag on the budget, and on top of that the Gonski school funding reforms and National Disability Insurance Scheme costs could add another $17 billion a year once they are fully up and running.

When the costs associated with a growing and ageing population are added – of which spending on health and aged care is a major part – the community is entitled to know how these things are going to be paid for.

The rapid growth in health and aged care spending both of itself and relative to other areas of expenditure is an important concern for both government and the whole community. While spending in this area is expected to increase as the population ages and as expectations of health and aged care services rise, what will be important is that the spending is efficient and meets the needs and preferences of the community.

To better understand the size of this expenditure over time and its relative impact on the Commonwealth, state and territory budgets, the BCA commissioned Deloitte Access Economics to produce a short research paper. The paper, 'An Intergenerational Report for the States', mirrors the approach of Treasury's Intergenerational Report of 2010, providing more depth and detail on health and aged care and the scale of expenditure increases at the federal, state and territory levels.

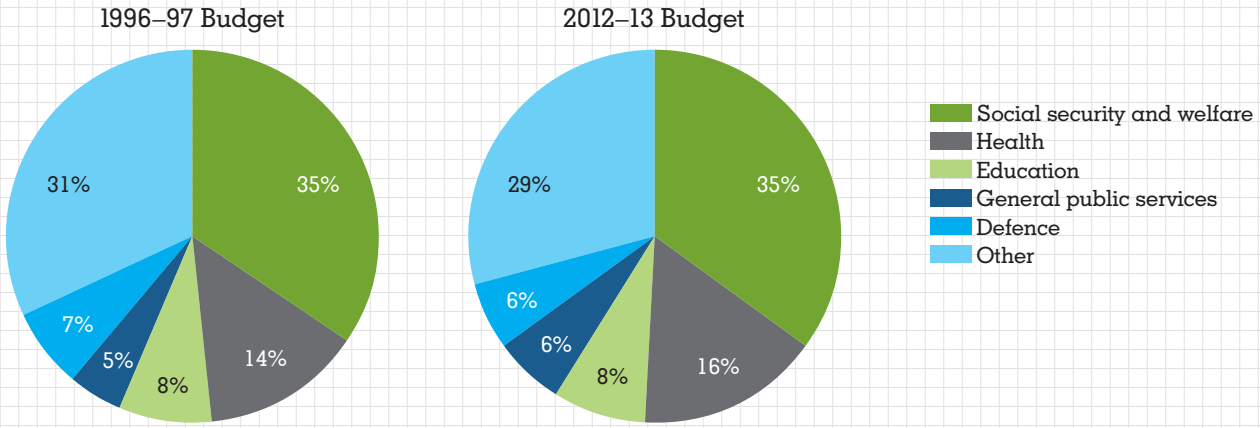
The paper provides further impetus to our call for the federal government to commit to an independent review of the size and scope of government and the long-term structure of the budget.

About this publication

The Business Council of Australia (BCA) brings together the chief executives of more than 100 of Australia's leading companies, whose vision is for Australia to be the best place in the world in which to live, learn, work and do business.

This paper, *Long-term Funding of Health and Ageing: The Rising Pressure on Commonwealth and State Budgets*, incorporates a report prepared for the BCA by Deloitte Access Economics titled 'An Intergovernmental Report for the States: Health and Aged Care Expenditure'.

Figure 1: Composition of expenditure over time



Source: Commonwealth of Australia, 1996–97 Commonwealth Budget, pp. 3–12 and Budget Paper No. 1, 2012–13, pp. 6–7.

The figure above shows a remarkable stability in other areas of expenditure, but health spending is the one area to change its share of expenditure in the decade and a half since the last review of Commonwealth finances in 1996, having risen from 14 to 16 per cent over the period. Expenditure associated with ageing is classified as social security and welfare expenditure; with the demographic shift to an older population, ageing is accounting for a larger share of this category.

The findings in 'An Intergenerational Report for the States' answer two main questions:

How is government expenditure on health and aged care expected to grow compared to total government expenditure?

Health and aged care is projected to become a bigger proportion of government expenditure in each of the jurisdictions over the next 40 years.

Table 1: Projected government expenditure on health and aged care as a proportion of total government expenditure of the jurisdiction

	Australian Government		State and territory governments	
	2009–10	2049–50	2009–10	2049–50
Health	12.5%	20.7%	25.2%	40.0%
Ageing	15.4%	25.1%	0.7%	1.0%
Total	27.9%	45.8%	25.9%	41.0%

Source: Deloitte Access Economics, 'An Intergovernmental Report for the States: Health and Aged Care Expenditure', report for the Business Council of Australia, January 2012.

The Australian Government has higher expenditure than the combined states and territories, reflecting its different funding responsibilities – particularly for ageing, where it funds age pensions and most of aged care.

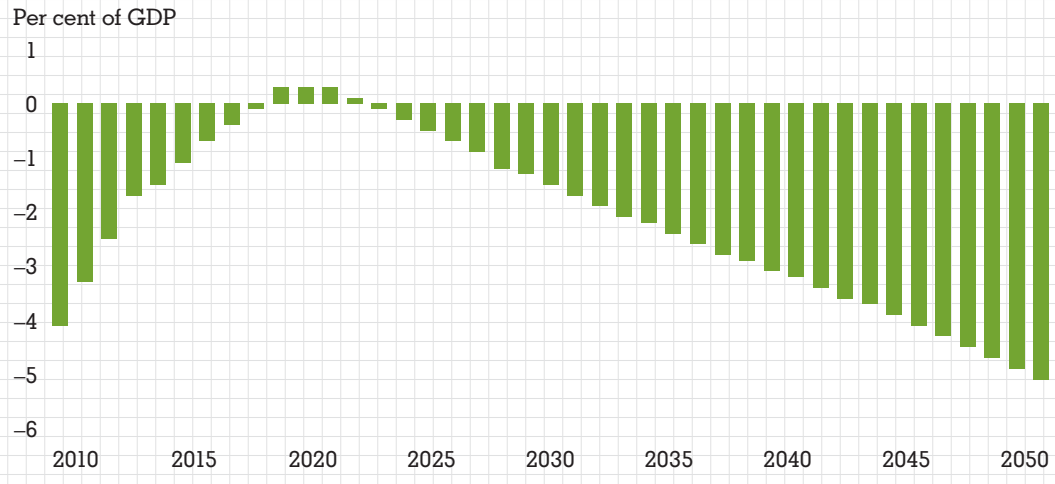
The states and territories show some modest variation between one another in their health and aged care expenditure, based on their different demographic profiles, how much they currently spend on areas that might shrink or grow as the population ages, and their current budget positions.

What does growing expenditure on health and aged care mean for government budgets?

Growth in expenditure on health and aged care that outstrips growth in GDP will lead to worsening budget positions for both the Australian Government and the states and territories.

With no change in policy over the next 40 years, expenditure growth would need to be funded by significant levels of debt, and the cost to budgets would grow exponentially. While this is an extreme scenario, it illustrates the impact of a 'do nothing' approach.

Figure 2: Primary fiscal balance: all governments



Source: Deloitte Access Economics, 'An Intergenerational Report for the States', report incorporated in the Business Council of Australia Submission to the 2011 Tax Forum, *Preparing for a Better Future: Progressing Comprehensive Tax Reform in Australia*, October 2011.

Implications of the findings and questions for government

Rapid growth in spending on health and aged care warrants a serious response by governments and the community to ensure not only that the level of the expenditure reflects the community's preferences, but also that we get the greatest value from this significant part of the economy.

Several important conclusions can be drawn from the Deloitte Access Economics report.

1. The trend of rising expenditure on health and aged care will not reverse

Strong projected growth in expenditure on health and aged care is occurring in all wealthy nations. As national incomes rise, countries spend more on health and aged care, both in absolute terms and also as a share of overall expenditure. While some dampening of expenditure growth is possible through improved efficiency, the general trend of rising proportion of overall government expenditure going to health and aged care attracts strong electoral support.

The question for government is how the strong projected expenditure growth might be dampened while delivering equivalent or better outcomes to individuals.

2. There is no major efficiency and effectiveness strategy in place or planned

The biggest impact of recent reforms is a reallocation of funding responsibilities from the states and territories to the Australian Government. The modelling assumes that the National Health Reform Agreement will lead to a modest increase in the contribution of health and aged care to total Australian Government expenditure that is essentially offset by a reduction in the state and territory contribution.[2] Deloitte Access Economics made this assumption based on its assessment of the likely impact of the reforms.

The modelling does not factor in any efficiencies that could arise from:

- more patient-oriented care, where funding focuses on patient rather than program or functional unit lines

- greater allocative efficiency, allowing more flexibility to reallocate funding between program and geographic boundaries to meet patient needs
- improved use of use of information technology to collect and analyse health and aged care data
- better use of competition, e.g. for public and private patients in the hospital sector.

A key challenge for government is to identify the changes in the division of expenditure responsibilities between Australia's governments that could lead to more efficient use of resources.

3. Private sources are contributing less to expenditure on health and aged care

Although nations and individuals choose to spend a greater proportion of income on health and aged care as they become richer, in Australia there has been a decline in the share of health and aged care expenditure[3] being covered by private sources[4] over the past few years, from 33 per cent in 2003–04 to 30 per cent in 2009–10.

A question for government and the community is the extent to which private funding sources (from individuals and through private health insurance) should contribute to funding the growth in expenditure on health and aged care.

4. States face a particular funding challenge for health and aged care

The funding challenge is greatest for the states. While the Australian Government is projected to face a bigger rise in the proportion of its GDP devoted to health and aged care than the states and territories, the problem that states face is a much more limited revenue base that is likely to further shrink over time.

The challenge for governments is to identify the revenue base or funding structure that could assure funding for the growth in government expenditures.

Next steps

The Business Council of Australia is calling on the Commonwealth Government to:

1. Undertake a whole-of-nation Intergenerational Report to confirm the economic and fiscal task ahead, including measuring the impact of already changing policy settings and circumstances on the long-term outlook.
2. Commission an independent review of the size, scope and efficiency of government. This would assist in determining which level of government is best placed to provide services, and an understanding of how those services can be more efficiently provided.
   - The terms of reference for this review should include a stocktake of current government programs, an analysis of the Commonwealth's balance sheet and the identification of areas of duplication and overlap in responsibilities between the Commonwealth, state and territory governments.
   - A review would enable governments to focus on what is being achieved in government programs against the assumptions made at the time they were funded. This is particularly important in the fastest-growing areas of expenditure like health and aged care. The focus needs to be on outputs rather than inputs.
   - It has now been over 16 years since the last such exercise was undertaken at the Commonwealth level. In that time the fundamental roles and responsibilities of the Commonwealth, state and territory governments have changed with each new reform progressed by the Council of Australian Governments, but the fiscal consequences of these changes are often not fully understood.
   - This task is particularly urgent because there are advantages in taking early preventative action to address the structural vulnerabilities in the budget, as early action provides greater time and flexibility in how we deal with the problems that are uncovered.
   - It is anticipated that the review would develop a program of detailed rolling audits to be undertaken in the areas of the largest and fastest-growing expenditures, like health and ageing.

Our health and aged care system and the services that it provides are too important to be left vulnerable to government inaction and ballooning debt, higher taxes or the sub-standard services that would follow.

NOTES

1. Deloitte Access Economics, 'An Intergenerational Report for the States', report incorporated in the Business Council of Australia Submission to the 2011 Tax Forum, *Preparing for a Better Future: Progressing Comprehensive Tax Reform in Australia*, October 2011.
2. An increase of 0.4 percentage points greater contribution by the Australian Government by 2049–50 as against a 0.6 percentage point reduction for the states and territories.
3. This covers expenditure on health and aged care goods, such as medications and health and aged care aids and appliances; health and aged care services, such as hospital, dental and medical services; public health and aged care activities and other activities that support health and aged care systems, such as research and administration.
4. Private sources means private health and aged care insurers, individuals and other non-government third parties such as workers compensation and compulsory third-party motor vehicle insurance payments.

Deloitte Access Economics

An IGR for the States: health and aged care expenditure **Final Report**

Business Council of Australia

23 January 2012

Deloitte.

Contents

Charts

Tables

Glossary of acronyms

ABF	activity based funding
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANHPA	Australian National Preventive Health Agency
COAG	Council of Australian Governments
DOHA	Department of Health and Ageing
ED	emergency department
GDP	Gross Domestic Product
GP	general practitioner
GSP	Gross State Product
HACC	Home and Community Care
IHPA	Independent Hospital Pricing Authority
NHCDC	National Hospital Cost Data Collection
NHA	National Healthcare Agreement
NHRA	National Health Reform Agreement
NP	National Partnership
NSW	New South Wales
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
QLD	Queensland
SA	South Australia
SPP	Specific Purpose Payment
S&T	states and territories
TAS	Tasmania
VIC	Victoria
WA	Western Australia

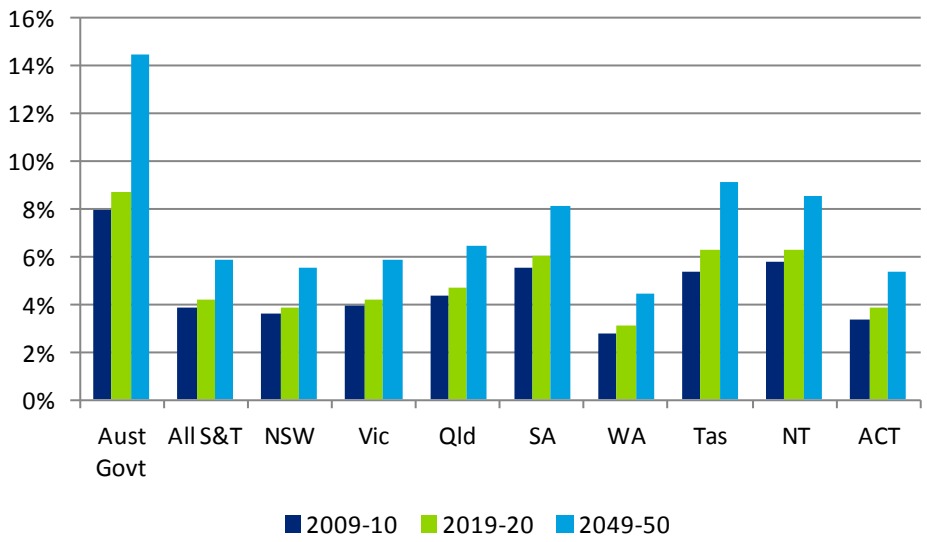
Executive summary

An IGR for the States (Deloitte Access Economics 2011) presents the outcomes of modelling Australian Government, combined states and individual state and territory revenues and expenditure to 2049-50. Rising expenditure on health and aged care services is indicated as a key driver of worsening primary balances (as a proportion of output) for each of the jurisdictions. The purpose of this report is to provide projections for health and aged care services, as a proportion of total government outlays, for each of the jurisdictions.

Each of the states and territories and the Australian Government are projected to spend an increasing proportion of Gross State Product (GSP) / Gross Domestic Product (GDP) on health and ageing in 2019-20 than in 2009-10, with the proportion increasing further by 2049-50 (Chart i).

The impact is greatest for the Australian Government (rising from 8.0% in 2009-10 to 14.5% in 2049-50), Tasmania (from 5.4% in 2009-10 to 9.1% in 2049-50), South Australia (SA, from 5.5% in 2009-10 to 8.1% in 2049-50) and the Northern Territory (NT, from 5.8% in 2009-10 to 8.5% in 2049-50). Western Australia's (WA) health and ageing expenditure as a proportion of GSP is relatively low and is projected to grow more slowly than in the other jurisdictions.

Chart i: Health and ageing expenditure projections by jurisdiction (% of GSP)



Source: Deloitte Access Economics 2011. S&T = states and territories.

Similarly, health and ageing expenditure is projected to rise as a proportion of total government expenditure for each of the jurisdictions over the period 2009-10 to 2049-50.

Projections for total government expenditure are presented excluding and including interest payments. With no change in policy, interest payments would grow exponentially over the period, as a result of raising debt, largely to fund higher health and ageing expenditure. However, assuming no policy change is probably unrealistic, as the debt burden increases to a point where states would find it difficult or impossible to raise such

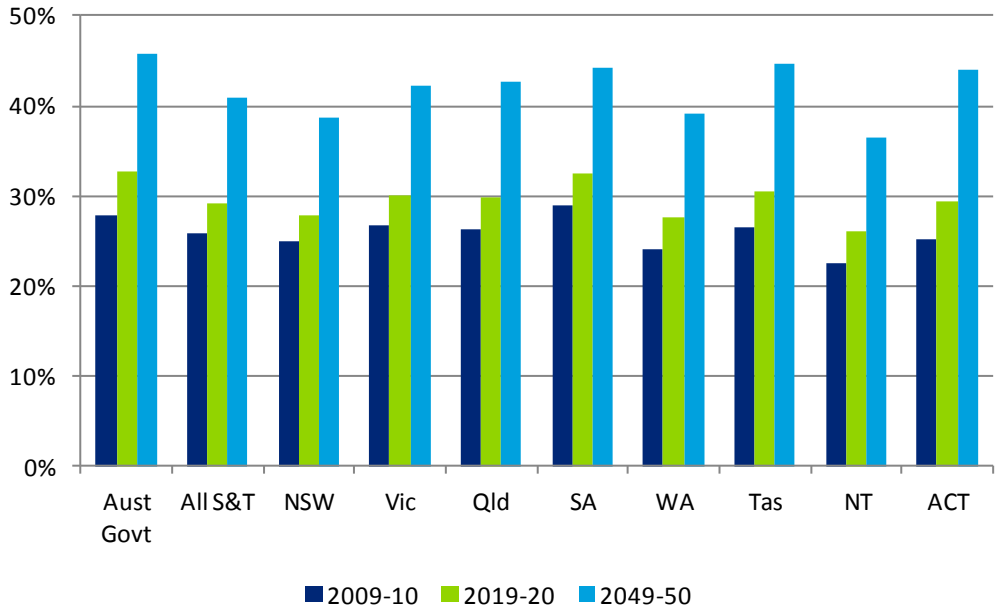
debt from financial market lenders. The alternative 'extreme' projections of total expenditure excluding interest payments are thus modelled as equivalent to a scenario where additional government expenditure in the future is funded through new taxation or other new revenue sources. In reality, it is likely that a combination of debt and taxation will be utilised.

The rise in expenditure on health and ageing as a proportion of total expenditure excluding interest payments (Chart ii), over the period 2009-10 to 2049-50 is more pronounced than when interest payments are included (Chart iii). This is because of the projected growth in interest payments over the period, since interest payments form part of the total and dwarf other expenditure. This impact is most pronounced in Queensland and Victoria, where health and ageing expenditure as a proportion of total expenditure actually falls (Chart iii).

Excluding interest payments from the total expenditure projections puts the focus on health and ageing rather than on other areas of government expenditure. Health and ageing expenditure increases in significance in each of the jurisdictions over the projection horizon, from 26% in 2009-10 to over 40% in 2049-50 (Chart ii).

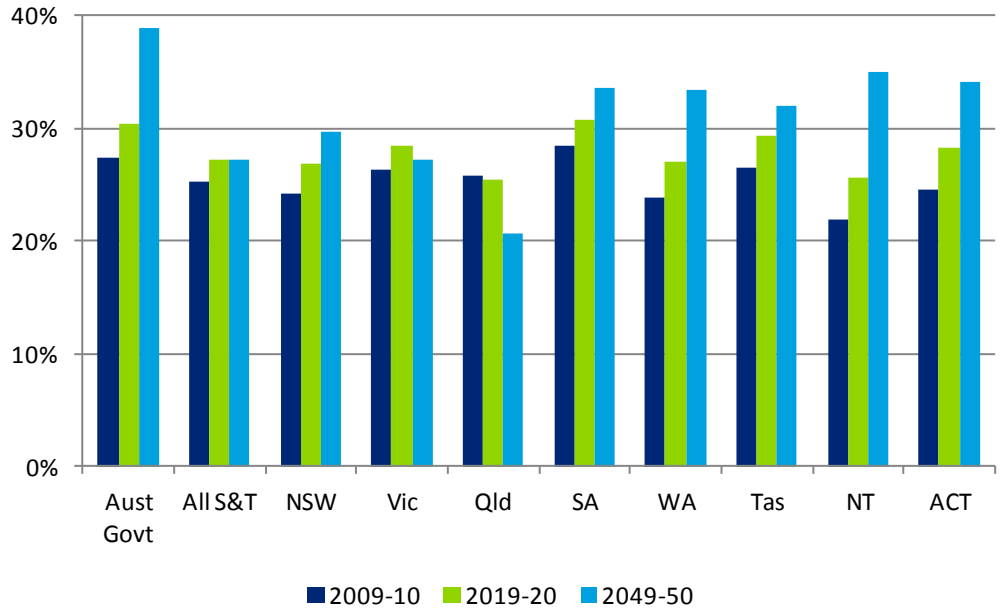
The Australian government has higher expenditure than the combined states and territories. This reflects its different funding responsibilities, in particular for ageing – including the aged pension and 98% of residential aged care funding.

Chart ii: Health and ageing expenditure projections by jurisdiction (% of total government expenditure excluding interest payments)



Source: Deloitte Access Economics 2011.

Chart iii: Health and ageing expenditure projections by jurisdiction (% of total government expenditure including interest payments)



Source: Deloitte Access Economics 2011.

Table i summarises the projections for total health expenditure as a proportion of total government expenditure. The impacts mirror those in Chart ii and Chart iii, reflecting that for the states and territories, the majority of health and ageing expenditure is on health. It is also clear that interest payments make up a greater proportion of total expenditure in the states and territories than in the Australian Government, particularly in Queensland and Victoria. In all of the states and territories, although not the Australian Government, these movements are driven by expenditure on acute care institutions (predominantly hospitals).

Table i: Health expenditure by jurisdiction (% of total government expenditure)

	Excluding interest			Including interest		
Jurisdiction	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government	12.5	13.6	20.7	12.3	12.6	17.6
All states and territories	25.2	28.4	40.0	24.7	26.5	26.7
NSW	24.2	27.1	37.8	23.5	26.1	29.0
Victoria	26.1	29.4	41.4	25.6	27.8	26.6
Queensland	25.5	29.0	41.5	25.0	24.6	20.1
SA	28.6	32.0	43.7	28.2	30.4	33.4
WA	23.5	27.0	38.3	23.3	26.3	32.8
Tasmania	25.7	29.7	43.4	25.6	28.5	31.2
NT	21.6	25.1	35.2	20.9	24.5	33.8
ACT	24.3	28.7	43.0	23.9	27.6	33.3

Source: Deloitte Access Economics 2011.

Table ii summarises projections for expenditure on ageing as a proportion of total expenditure in each of the jurisdictions. 'Ageing' and 'aged care' are equivalent for the

states and territories, but the 'ageing' figure for the Australian Government also includes expenditure on aged pensions, which makes up the majority of overall expenditure on ageing. At the Australian Government level, expenditure on ageing is projected to rise to 21.4% of total expenditure (including interest payments) from 2009-10 to 2049-50, more than six percentage points higher than in 2009-10. Excluding interest payments, ageing represents 25.1% of total expenditure. At the state and territory level, expenditure on ageing (predominantly community care) is less significant, typically representing less than 1% of total government expenditures over the period 2009-10 to 2049-50.

Table ii: Total ageing expenditure by jurisdiction (as a % of total government expenditure)

	Excluding interest			Including interest		
Jurisdiction	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government, all ageing expenditure	15.4	19.1	25.1	15.1	17.8	21.4
Australian Government, aged care	3.0	3.4	5.6	3.0	3.2	4.8
All states and territories	0.7	0.8	1.0	0.7	0.7	0.6
NSW	0.7	0.8	1.0	0.7	0.7	0.7
Victoria	0.6	0.7	0.9	0.6	0.7	0.6
Queensland	0.9	0.9	1.2	0.8	0.8	0.6
SA	0.3	0.3	0.3	0.3	0.3	0.3
WA	0.6	0.7	0.7	0.6	0.7	0.7
Tasmania	0.8	0.9	1.2	0.8	0.9	0.8
NT	1.0	1.1	1.3	0.9	1.0	1.3
ACT	0.7	0.8	1.1	0.7	0.8	0.8

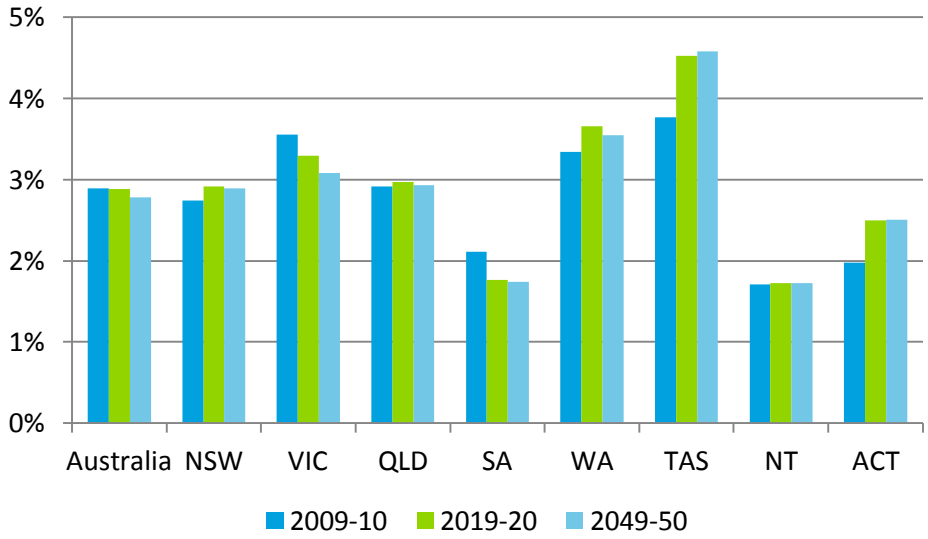
Source: Deloitte Access Economics 2011.

Projections of private expenditure

Chart iv shows the proportion of GDP/GSP that health contributes in 2009-10 and is projected to contribute in 2019-20 and 2049-50.

- Nationally, health is projected to stay at approximately 2.8 to 2.9% of GDP throughout the projection period. This to some extent reflects the growing contribution of government expenditures, as discussed in sections 3 and 4.
- NSW and Queensland hover around similar proportions over the projection years as Australia: NSW 2.7%-2.9%; Queensland 2.9%-3.0%.
- Victoria falls over the projection years, from 3.6% in 2009-10 to 3.1% by 2049-50.
- SA also falls, from 2.1% in 2009-10 to 1.7% by 2049-50.
- WA, Tasmania and the ACT rise over the projection years, Tasmania in particular, which reaches 4.5% by 2019-20, significantly above the national proportion. WA falls slightly and the ACT plateaus after an initial rise.
- The NT sits around a similar proportion as SA in later years – 1.7%.

Chart iv: Projected private health consumption as a proportion of GDP/GSP



Source: Deloitte Access Economics 2011.

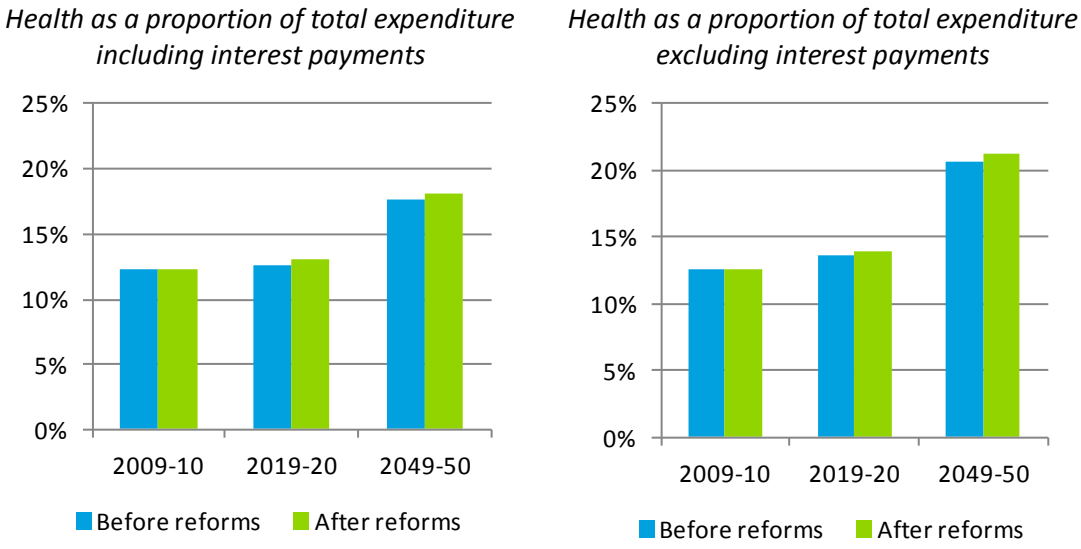
Impacts of national health reform

The overall impact on the Australian Government budget is shown in Chart v. Additional funding commitments for the Australian Government as part of the National Health Reform Agreement that have been modelled are listed below.

- The commitment to fund growth in respect of public hospitals to:
    - 50% of the 'efficient' price of public hospital services (through ABF);
    - 50% of recurrent expenditure on research & training (through block funding);
    - 50% of capital expenditure (through block funding); and
    - 50% of rural and remote public hospital funding (through block funding) (COAG 2011b).
- Additional funding commitments under the NP Agreement on Improving Public Hospital Services (COAG 2011c), totalling $3.4 billion over 2009-10 to 2016-17.

The projected impact means that health makes an approximate 0.4 percentage point greater contribution to total Australian Government expenditure (including interest, or 0.5 percentage points excluding interest) by 2049-50 than in the absence of the reforms.

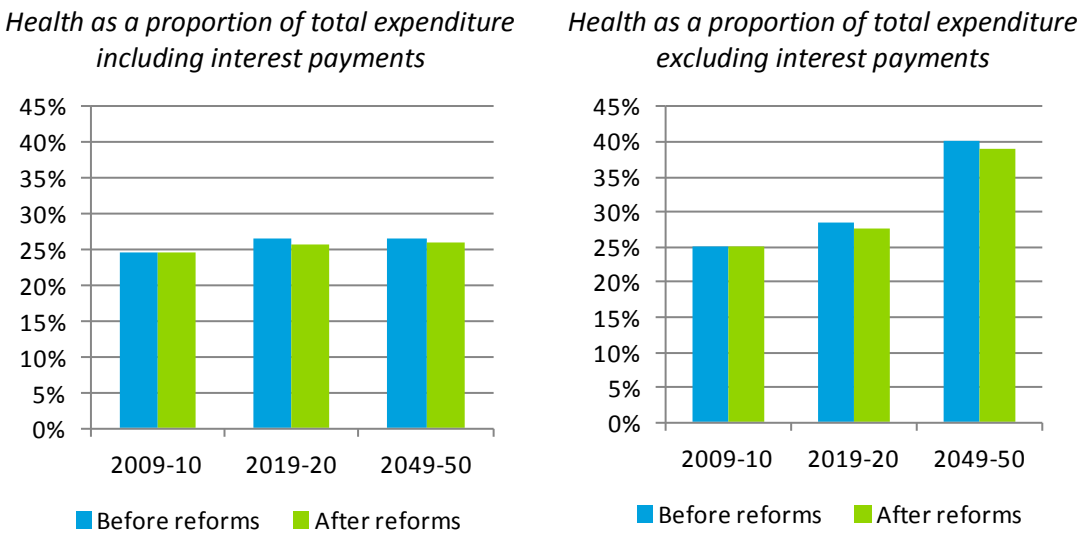
Chart v: Impact of reforms on Australian Government expenditure



Source: Deloitte Access Economics 2011.

The changes to funding commitments modelled for state and territory governments are essentially the reverse of those for the Australian Government. The proportion of combined state and territory government expenditure going to health is approximately 0.6 percentage points lower than in the absence of reforms by 2049-50 (including interest payments, or 1.0 percentage points excluding interest payments) (Chart vi).

Chart vi: Impact of reforms on combined state and territory government expenditure



Source: Deloitte Access Economics 2011.

The impacts of health reform on health expenditure as a proportion of total expenditure for state and territory governments are greatest in SA, Victoria and the ACT, although these impacts are all less than one percentage point (including interest payments).

The modelling is built on population projections and service usage among the population, based on demographic characteristics and historical costs to government for providing services. This approach factors in, to some degree, efficiency gains under the service delivery model that currently operates, based on governments' budget constraints and cost minimisation objectives. No further efficiency gains have been modelled as a result of the recent reforms to service funding and delivery, including establishment of the Independent Hospital Pricing Authority (IHPA), regionalisation of management of primary and acute care services through Medicare Locals and Local Hospital Networks, and preventative care initiatives. This is because, overall, these reforms are not expected to result in net changes that will reduce expenditure projections beyond current estimates, for the reasons outlined further below.

Where reforms have been associated with efficiencies, it is not yet clear whether: (i) this will eventuate; and (ii) the result will be lower costs to government. Some reforms may potentially increase costs if efficiencies do not offset the committed expenditure – for example:

- the transition costs and extra tier of administration from creating Medicare Locals and Local Hospital Networks;
- the operation and efficiency of outcomes from pursuing the objective of extending ABF and setting and monitoring efficient prices through the IHPA, given the limited ability of this mechanism to enforce through current COAG processes overall lower levels of funding, when block grants, program grants, cost relocation, transition costs and continuous quality improvement factors are also considered; and
- the potential for preventive health initiatives under the Australian National Preventive Health Agency (ANHPA) to make additional gains may be limited, given that many similar programs are entrenched (e.g. programs targeted at smoking reduction, dietary guidelines, physical activity and cancer screening), new programs are likely to be subject to diminishing returns, and expenditure projections do not take account of potentially worsening trends in many important risk factors (e.g. overweight/obesity, physical inactivity, inadequate fruit and vegetable consumption), particularly when demographic ageing is considered where these risk factors are age-related.

An additional scenario, which models the impact of substituting care for triage category 4 and 5 from an Emergency Department (ED) to a General Practitioner (GP) visit does not result in any material change to the proportion of total expenditure relating to health at either level of government (see Sections 7.1 and 7.3).

Overall, the National Health Reform Agreement is not projected to make a significant impact on the proportion of total government expenditure that goes to health, at either state/territory or Australian Government levels.

Deloitte Access Economics

1 Background and purpose

An IGR for the States (Deloitte Access Economics 2011) presented the outcomes of modelling Australian Government, combined states and individual state and territory revenues and expenditure to 2049-50. Rising expenditure on health and ageing services is indicated as a key driver of worsening primary balances (as a proportion of output) for each of these jurisdictions.

The purpose of this report is to provide the projections for health and ageing services, as a proportion of total government outlays, for the Australian Government each of the states and territories and the states and territories combined.

- Section 2 very briefly summarises the methodology underlying the modelling.
- Section 3 presents the findings for health expenditure.
- Section 4 presents the findings for expenditure on ageing. For the Australian Government this is predominantly aged pensions, but also residential aged care and community care. Ageing expenditure predominantly relates to community care for the States and Territories.
- Section 5 summarises the findings across both health and ageing.
- Section 6 presents the findings of the model regarding private expenditures on health and ageing.
- Section 7 provides projections of the impact of the national health reforms agreed in August 2011 on health expenditures as a percentage of total government outlays, for the states, the Australian Government and the States and Territories combined.

2 Methodology

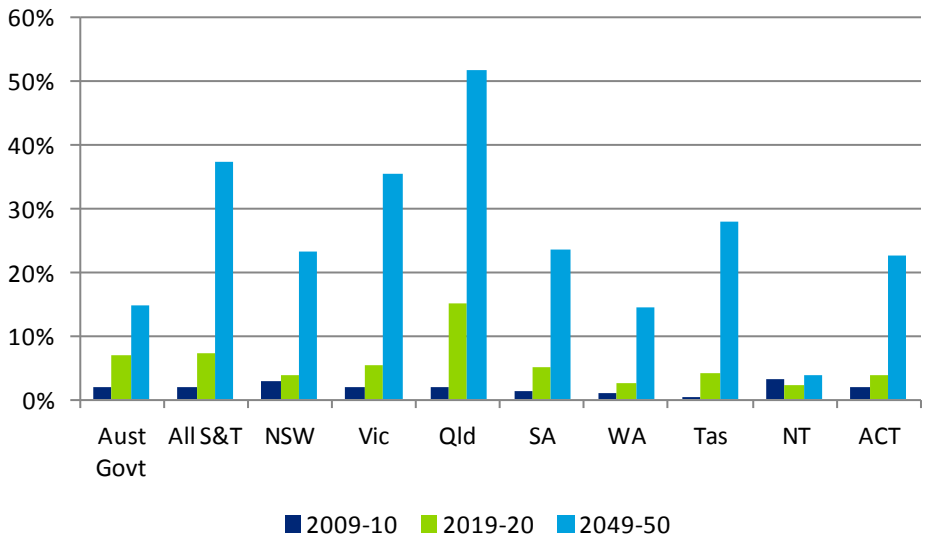
2.1 Health and ageing expenditure as a proportion of total expenditure

The modelling methodology was described in Deloitte Access Economics (2011) and expenditures are projected based on government policy prevailing in mid-2010.

Projections for total government expenditure are presented excluding and including interest payments. With no change in policy, interest payments would grow exponentially over the period, in part as a result of raising debt to fund higher health and ageing expenditure. However, assuming no policy change is probably unrealistic, as the debt burden increases to a point where states would find it difficult or impossible to raise such debt from financial market lenders. The alternative 'extreme' projections of total expenditure excluding interest payments are thus modelled as equivalent to a scenario where additional government expenditure in the future is funded through new taxation or other new revenue sources.

The impact is different in each of the jurisdictions, depending on the proportion of total expenditure made up by interest payments, as shown in Chart 2.1. It also increases in significance over the projection period. Queensland and Victoria in particular have high projected interest payments, relative to other jurisdictions. In reality, it is likely that a combination of debt, taxation and possibly expenditure reduction measures will be utilised and, thus, the true proportion will lie somewhere between the two projections.

Chart 2.1: Projected interest payments (% of total expenditure) by jurisdiction



Source: Deloitte Access Economics 2011.

Health expenditure figures are broken down into spending on acute care institutions, other health institutions, community health services, pharmaceuticals and other health. In some states and territories, expenditure on pharmaceuticals is included under acute care institutions, as the state/territory government does not separately report the figure for pharmaceuticals (which are partially funded by the state/territory government in the acute care setting). Australian Government expenditure on pharmaceuticals primarily relates to the Pharmaceutical Benefits Scheme (PBS). Ageing expenditure figures are broken down into aged care and the aged pension (the latter is only applicable to the Australian Government).

In order to separate aged care services (residential aged care and community care) from the overall projections for health services, the following assumptions are employed in this report:

- The Home and Community Care (HACC) program receives 40% of funding from the States and Territories (on average) and 60% from the Australian Government; and
- States and territories contribute 2% of total government expenditure on residential aged care (based on Department of Health and Ageing 2008).

2.2 Projections of private expenditure on health

The modelling from Deloitte Access Economics (2011) included a component of private expenditure on health care, based on demographics, service usage and co-contribution rules. The outcomes of this modelling are presented in section 6.

2.3 Impacts of National Health Reform

2.3.1 Summary of changes to health and ageing funding arrangements

The *National Health Reform Agreement* (NHRA) was signed by each of the Australian, state and territory governments on 2 August 2011, setting out the changes to the funding and service delivery arrangements for healthcare. The process began in 2009 with the Council of Australian Governments (COAG) agreement to reform financial relations between the Australian, state and territory governments. Under the reforms, healthcare is one of six areas governed by a national agreement, the *National Healthcare Agreement (NHA) 2011*, and supplemented by a number of *National Partnerships (NPs)* (eight were specified in the 2011-12 Budget, Australian Government 2011).

From 1 July 2012, the National Healthcare Specific Purpose Payment (SPP) will be replaced by funding as agreed under the NHA, the NHRA and the NPs. Transitional arrangements for the first two years will provide equivalent funding to that which would have been provided under the National Healthcare SPP. This will become "base funding" under the new agreements.

The Australian Government has committed to fund growth, in respect of public hospitals to:

- 50% of the 'efficient' price of public hospital services through activity based funding (ABF) – discussion follows;
- 50% of recurrent expenditure on research & training;
- 50% of capital expenditure; and
- 50% of rural and remote public hospital funding (COAG 2011b).

An ABF model will allocate funding to states and territories, according to the numbers and kinds of services public hospitals provide, relative to the base year. This will begin on 1 July 2012 for inpatient services and 1 July 2013 for outpatient services. Funding under ABF will be adjusted on the basis of growth in the 'efficient' price or volume from the previous year, as determined by the Independent Hospital Pricing Authority (IHPA). From 1 July 2014, the Australian Government will contribute 45% of 'efficient' growth funding, with the proportion rising to 50% from 2017-18.

For some specific areas, arrangements to provide block funding may be agreed through bilateral arrangements between the Australian Government and the State or Territory Government. The same arrangements as under ABF will apply to contributions to 'efficient' growth funding.

The Australian Government has also guaranteed payment of at least $16.4 billion between 2014-15 and 2019-20, to ensure that the states and territories are at least as well off as they would have been under the National Healthcare SPP (COAG 2011b). Any residual amount will be provided to health services with the intention of ameliorating growth in the demand for hospital services (Australian Government 2011).

2.3.2 Modelling the impact on the Australian, state and territory government expenditures

The high-level changes[1] relevant to Australian Government expenditure on health and ageing relate to:

- The commitment to fund growth in respect of public hospitals to:
  - 50% of the 'efficient' price of public hospital services (through ABF);
  - 50% of recurrent expenditure on research & training (through block funding);
  - 50% of capital expenditure (through block funding); and
  - 50% of rural and remote public hospital funding (through block funding) (COAG 2011b).
- Additional funding commitments under the NP Agreement on Improving Public Hospital Services (COAG 2011c), totalling $3.4 billion over 2009-10 to 2016-17;
- Division of responsibilities under the Home and Community Care (HACC) program – Australian Government takes on full funding and policy responsibility for aged care for people aged 65 and over and indigenous people aged 50 and over, states and territories are responsible for people aged under 65 and indigenous people aged under 50 (excludes Victoria and WA) (COAG 2011b);
- Devolving responsibility for operating hospitals to Local Hospital Networks and establishing Medicare Locals and aged care one stop shops.

The outcomes from modelling the impacts of national health reforms on the proportion of total government outlays spent on healthcare are given in section 7. The expected impacts by category of health and ageing expenditure as a result of national health reform are summarised in Table 2.1 and Table 2.2, under the same headings as the expenditures were modelled under. Each area is discussed in more detail in the remainder of this section.

Additional funding for public hospitals

Funding approximately half of the efficient growth in public hospital expenditure represents the most significant change in relation to Australian, state and territory government health expenditures. This will begin on 1 July 2014. Prior to that time, there is no imperative on the Australian government to make higher contributions than what would have been paid under the National Healthcare SPP. Guarantee amounts will be allocated between the states and territories on an equal per capita basis (COAG 2011b).

Improved efficiency in hospital funding, through the introduction of the IHPA and the ABF may also be expected to reduce expenditure. A 2009 Productivity Commission report found that the output (technical efficiencies) of individual hospitals in both the public and private sectors was, on average, approximately 20% below best practice (using data for 2006-07). Among large hospitals, the scope to improve efficiency was greater among public hospitals than private. However, no provision has been factored into the forward estimates for savings as a result of improved system efficiency, i.e. as a result of ABF. We have therefore not included any adjustments to the estimates to account for this.

[1] The modelling focuses on changes in funding responsibilities at each level of government, rather than individual additional service improvement commitments.

Division of responsibilities under the Home and Community Care (HACC) program

Excluding specific new measures, the division of responsibilities under the HACC program was presented in the 2011-12 Australian Government Budget as budget neutral for the Australian, state and territory governments. This is because funds are to be withdrawn from the National Healthcare SPP, although the mechanism to achieve this has not been finalised (Australian Government 2011).

No provision has been factored into the forward estimates for savings as a result of improved system efficiency, i.e. as a result of funding, policy and service delivery becoming the responsibility of one level of government. In the absence of any information to substantiate an efficiency gain (and the quantum of gain), no impact has been modelled regarding savings to government expenditure from this potential source.

Devolving responsibility for operating hospitals to Local Hospital Networks and establishing Medicare Locals and aged care one stop shops.

As for aged and community care, no provision has been factored into the forward estimates for savings as a result of potential improved system efficiency under these measures and there is no information to substantiate an efficiency gain (or the quantum of gain). It is possible that the additional tier of administration may increase costs (i.e. reduce efficiency) overall. Therefore no impact has been modelled regarding savings to government expenditure from this potential source.

Section 7 presents the outcomes of the modelled impacts.

Table 2.1: Impact of reforms on modelled Australian Government expenditure

Expenditure category	Description of impact of reforms	Financial impact
Health		
Acute care institutions	• Additional efficient growth funding from 2014-15 (45% of efficient funding growth, based on the ABF and determined by the IHPA, growing to 50% in 2017-18. • Additional funding committed to improve services through the National Partnership Agreement on Improving Public Hospital Services (notably targeting elective surgery waiting lists and emergency access)	• $19.8 billion in funding from 2014-15 to 2019-20. • Additional expenditure in public hospitals in respect of NPs: ◦ up to $800 million for elective surgery, including to meet the National Elective Surgery Target; ◦ up to $500 million to achieve a four hour National Emergency Access Target ; ◦ up to $250 million in emergency department capital; ◦ up to $1.6 billion for new subacute beds; and ◦ up to $200 million flexible funding pool for capital and recurrent projects across elective surgery, EDs and subacute care.
Other health institutions	No impact.	No financial impact.
Community health services	Introduction of Medicare Locals to coordinate local primary care needs.	No financial impact overall.
Pharmaceuticals	No impact[2].	No impact.
Other health	No impact.	No impact.
Ageing		
Aged care	Division of responsibilities under the HACC program – Australian Government responsible only for people aged 65 and over and indigenous people aged 50 and over (excludes Victoria and WA).	No financial impact overall.[3]
Aged pensions	No impact.	

Source: COAG 2011, COAG 2011b, COAG 2011c, PwC 2010, Department of Health and Ageing 2010.

[2] Savings from earlier PBS reforms are already accounted for in the official forward estimates.

[3] While there may be some people under 65 and Indigenous people under 50 previously funded who will not now be, these numbers are likely to be small and the exclusion of two states diminishes the impact further. Moreover, official forward estimates assume no impact (Australian Government 2011).

Table 2.2: Impact of reforms on modelled State and Territory Government expenditure

	Description of impact of reforms	Financial impact
Health		
Acute care institutions	Reduced commitment to rising costs (Australian Government contribution to efficient growth funding).	Reduced expenditure totalling $19.8 billion over 2014-15 to 2019-20.
Other health institutions	Support for Australian Government initiatives relating to GPs and primary health care.	No expected financial impact.
Community health services	No impact.	No financial impact.
Pharmaceutical	Any growth in usage or prices will be impacted upon by Australian Government commitment to fund additional costs – see above	Pharmaceutical expenditure in hospitals will come under the Australian Government's commitment to provide funding for growth – see above.
Ageing		
Aged care	Division of responsibilities under the HACC program – states and territories responsible only for people aged under 65 and indigenous people aged under 50 (excludes Victoria and WA).	No financial impact overall.[4]

Source: COAG 2011, COAG 2011b.

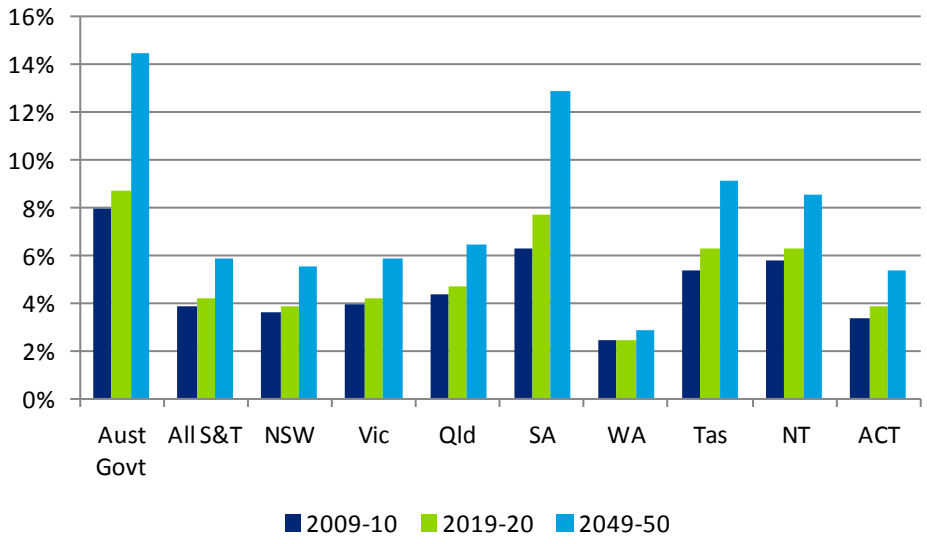
[4] See previous footnote.

3 Health expenditure as a proportion of gross production and total government outlays

3.1 Health expenditure as a proportion of gross production

Each of the States and Territories and the Australian Government are projected to spend an increasing proportion of Gross State Product (GSP) / Gross Domestic Product (GDP) on health and ageing in 2019-20 than in 2009-10, with the proportion increasing further by 2049-50 (Chart 3.1). The impact is greatest for the Australian Government (rising from 8.0% in 2009-10 to 14.5% in 2049-50), South Australia (SA, from 6.3% in 2009-10 to 12.9% in 2049-50), Tasmania (from 5.4% in 2009-10 to 9.1% in 2049-50) and the Northern Territory (NT, from 5.8% in 2009-10 to 8.5% in 2049-50). Western Australia's (WA) health and ageing expenditure as a proportion of GSP is relatively low and is projected to grow more slowly than in the other jurisdictions. The differences reflect different demographic ageing profiles and different contributions from other sectors of the economy (e.g. mining).

Chart 3.1: Health and ageing expenditure projections by jurisdiction (% of GSP)



Source: Deloitte Access Economics 2011.

3.2 Australian Government

Chart 3.2 shows projected health expenditure as a proportion of total Australian Government expenditure, split into acute care institutions, pharmaceuticals, community

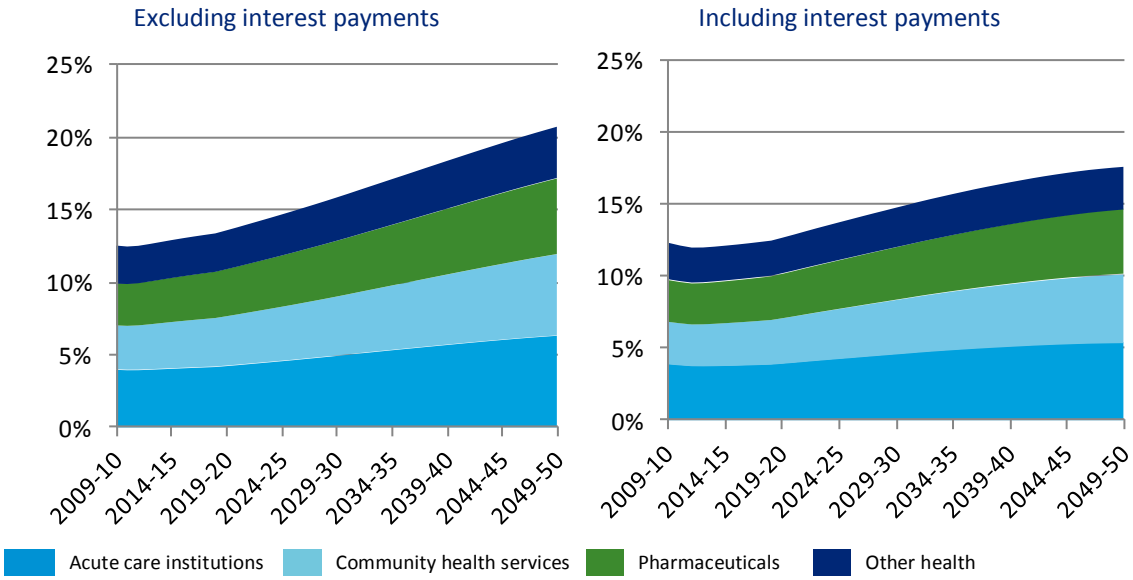
health services and other health. The growing proportion of total government outlays spent on health is evident from the chart on the left, which shows total expenditure excluding interest payments. The chart on the right includes interest payments in the total expenditure projections, which grow exponentially over the period, partly as a result of raising debt to fund higher health and ageing expenditure. To some extent, the impact of rising health expenditure is masked by interest payments in the second chart.

Of the health categories, acute care institutions (including hospitals) make up the largest share of total expenditure in 2009-10, but over the projection period, the gap narrows.

- Excluding interest payments, acute care institutions rise from 4.0% of total expenditure in 2009-10 to 4.2% by 2019-20, and 6.3% by 2049-50. Community health services rise from 3.0% in 2009-10 to 3.4% in 2019-20 and 5.6% by 2049-50. Pharmaceuticals also rise from 2.9% in 2009-10 to 3.3% in 2019-20 and 5.2% by 2049-50.
- Including interest payments, acute care institutions remain at 3.9% of total expenditure from 2009-10 to 2019-20, rising to 5.4% by 2049-50. Community health services rise from 3.0% in 2009-10 to 3.2% in 2019-20 and 4.8% by 2049-50. Pharmaceuticals also rise from 2.9% in 2009-10 to 3.3% in 2019-20 and 4.5% by 2049-50.

Based on these projections, health expenditure will grow in significance in terms of the Australian Government budget. Excluding interest payments, health grows from 12.5% of total expenditure in 2009-10 to more than 20% in 2049-50. Including interest payments, health represents 17.6% of total expenditure by 2049-50. Recall that the impact is most likely to fall somewhere between these two projections, based on additional expenditure being financed through a combination of taxation and debt.

Chart 3.2: Projected Australian Government health expenditure (% of total expenditure)



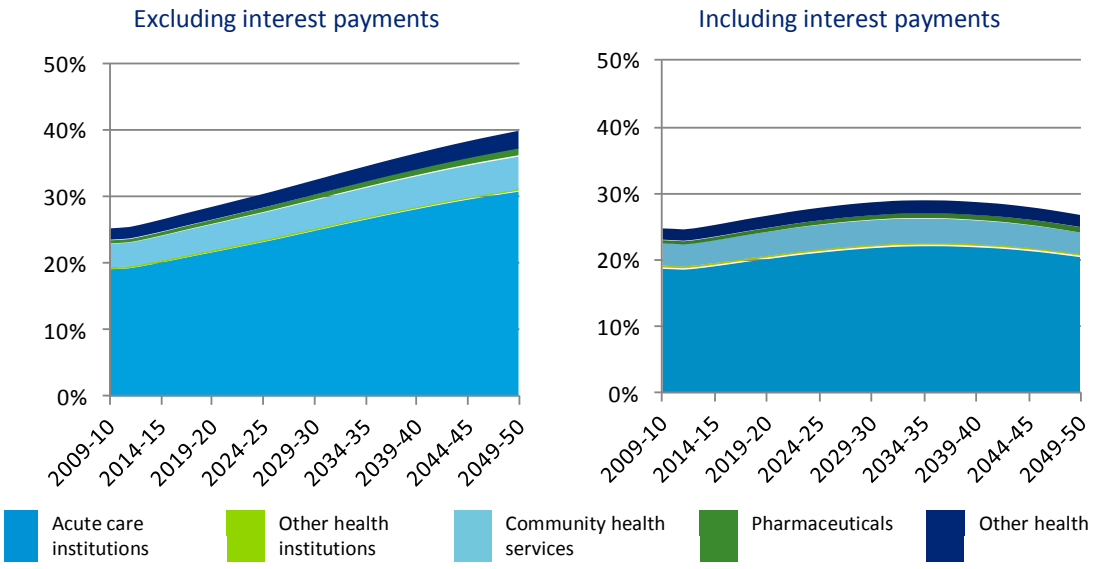
Source: Deloitte Access Economics 2011.

3.3 Combined states and territories

Chart 3.3 shows projected health expenditure as a proportion of total expenditure for all of the states and territory governments combined. Excluding interest rates (the chart on the left), the picture is similar to that for the Australian Government – i.e. health expenditure rises as a proportion of total expenditure from 2009-10 to 2049-50. However, in the chart on the right, the increasing significance of interest payments means that health expenditure makes up a lower proportion of total expenditure, actually declining after the peak in 2035-36. By 2049-50, health expenditure represents 40.0% of total expenditure excluding interest payments, but 26.7% when interest payments are included (versus approximately 25% in 2009-10.

For states and territories, the majority of health expenditure is attributable to acute care institutions (predominantly hospitals). These make up 19.1% of total expenditure excluding interest payments (out of 25.2% for all health) in 2009-10, rising to 30.8% (out of 40.0% for all health) in 2049-50. This category should be interpreted with caution, due to the difference in reporting pharmaceuticals expenditure between states and territories. Queensland, SA and Tasmania include pharmaceuticals in the acute care institutions figure, while the others do not. Summing the two categories gives a projection of 33.0% of total expenditure excluding interest in 2049-50 (from 19.5% in 2009-10).

Chart 3.3: Projected state and territory government health expenditure (% of total expenditure)



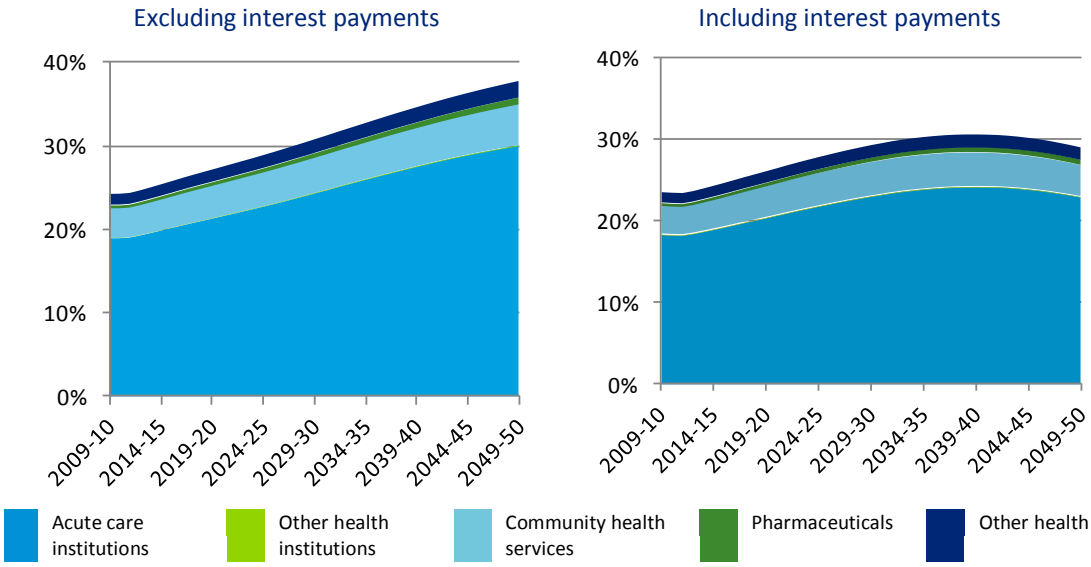
Source: Deloitte Access Economics 2011.

3.4 New South Wales

Chart 3.4 shows projected health expenditure as a proportion of total New South Wales (NSW) government expenditure. Health as a proportion of total government expenditure excluding interest payments grows by more than 13 percentage points from 2009-10 to 2049-50 (from 24.2% to 37.8%). The 2049-50 projection is slightly below that for the states and territories combined (40.0%). In NSW, as for the other states and territories, health

expenditure is driven by expenditure in acute care institutions. Community health services are more significant than for the states and territories combined (3.8% vs. 3.3%), but pharmaceuticals (0.6% vs. 0.8%) and other health (1.5% vs. 1.8 %) are similar. Including interest payments, the proportion peaks across 2037-38 to 2041-42, when health represents 30.6% of total expenditure, but falls to 29.0% in 2049-50.

Chart 3.4: Projected NSW government health expenditure (% of total expenditure)

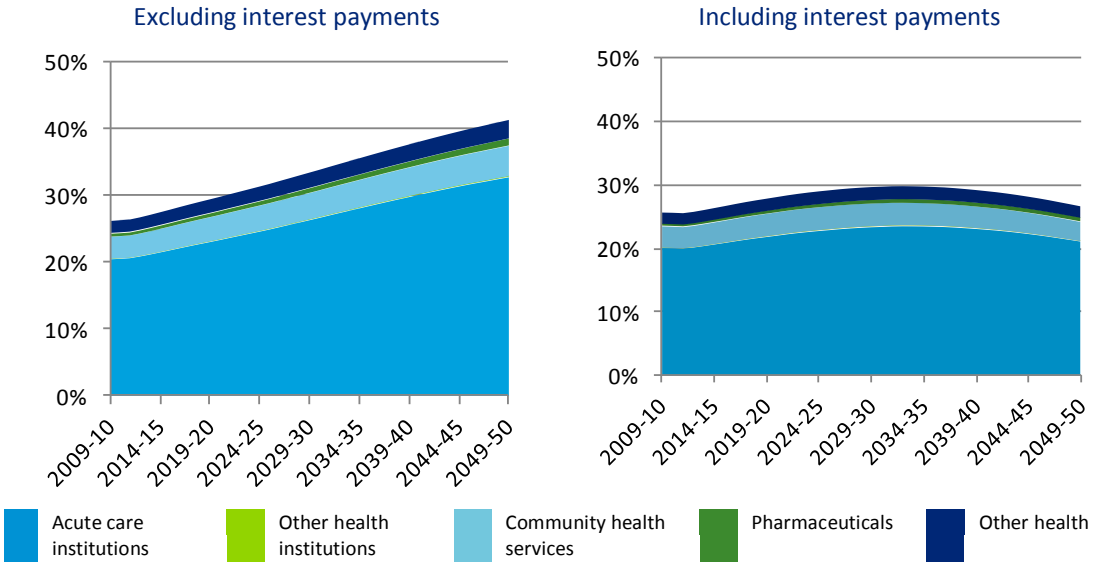


Source: Deloitte Access Economics 2011.

3.5 Victoria

In Victoria, health expenditure grows from 26.1% of total expenditure excluding interest payments in 2009-10 to 41.4% in 2049-50, slightly above that for the states and territories combined (40.0%) (Chart 3.5). Results are also similar to the states and territories combined when considered by category: acute care institutions 32.8% (vs. 30.8%); community health services 4.5% (vs. 5.0%); pharmaceuticals 1.0% (vs. 1.2%); and other health 1.8% (vs. 1.8%). Including interest payments, the peak in Victoria occurs in 2032-33, at 29.8%, after which the proportion falls to 26.6%.

Chart 3.5: Projected Victorian government health expenditure (% of total expenditure)



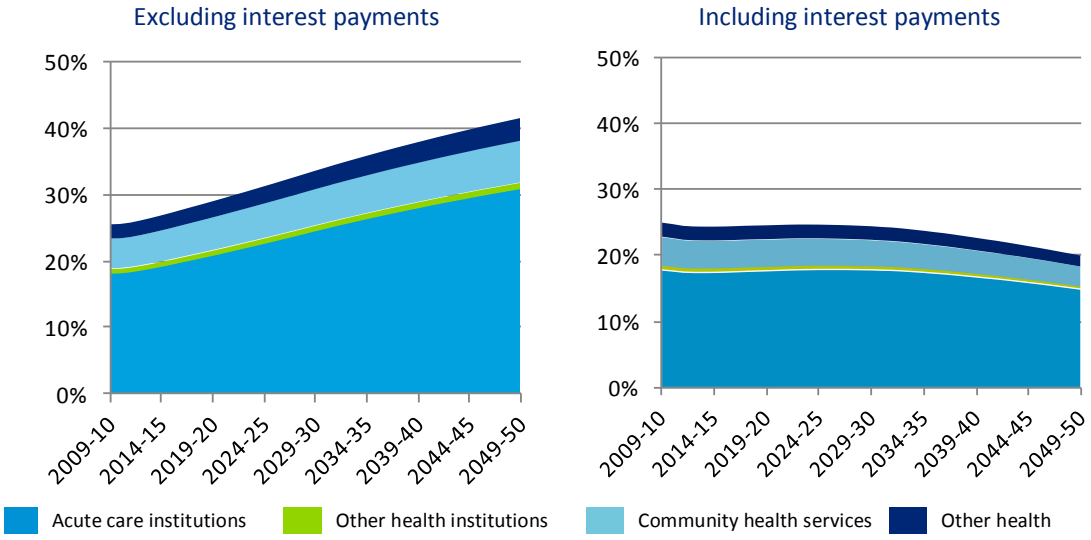
Source: Deloitte Access Economics 2011.

3.6 Queensland

In Queensland, health expenditure as a proportion of total expenditure excluding interest payments is also projected to grow similarly to the states and territories combined – to 41.5% in 2049-50 (vs. 40.0%) (Chart 3.6). Acute care institutions make up the same proportion of total expenditure excluding interest payments as for the states and territories combined (30.8%). However, as pharmaceuticals are not separately reported in SA, the appropriate comparison is with the sum of acute care institutions and pharmaceuticals, 33.0%. Community health services are more significant (6.3% vs. 5.0%) and other health is similar (1.7% vs. 1.8%) in Queensland.

Including interest payments, Queensland's result is different than for the other states and territories. Rather than a peak, the proportion declines throughout the period, and this accelerates toward 2049-50. This is a result of higher interest payments in Queensland than in the other states and territories. The overall proportion falls from 25.0% in 2009-10 to 24.6% in 2019-20 and 20.1% in 2049-50. Between 2009-10 and 2049-50, the proportion of total expenditure including interest payments attributable to acute care institutions is projected to fall from 17.8% to 14.9%.

Chart 3.6: Projected Queensland government health expenditure (% of total expenditure)

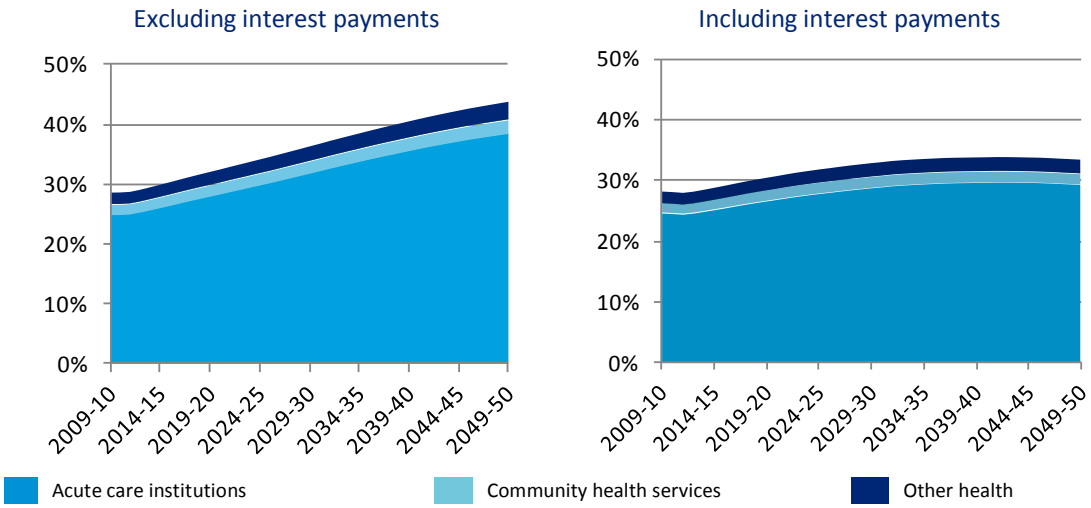


Source: Deloitte Access Economics 2011.

3.7 South Australia

South Australian government health expenditure is projected to remain below that for the states and territories combined, increasing from 28.6% of total expenditure excluding interest payments in 2009-10 to 43.7% in 2049-50, slightly above the combined state and territory figure (Chart 3.7). This is driven by acute care institutions, which are projected to represent 38.4% of total expenditure excluding interest payments in 2049-50. As pharmaceuticals are not separately reported in SA, the appropriate comparison with the combined states and territories is the sum of acute care institutions and pharmaceuticals, 33.0%. Community health services are less significant in SA (2.3% vs. 5.0%) and other health represents 2.2% in 2049-50 (vs. 1.2%). Including interest payments, health expenditure as a proportion of total expenditure peaks in 2041-42 at 33.8% before falling slightly to 33.4% by 2049-50.

Chart 3.7: Projected SA government health expenditure (% of total expenditure)



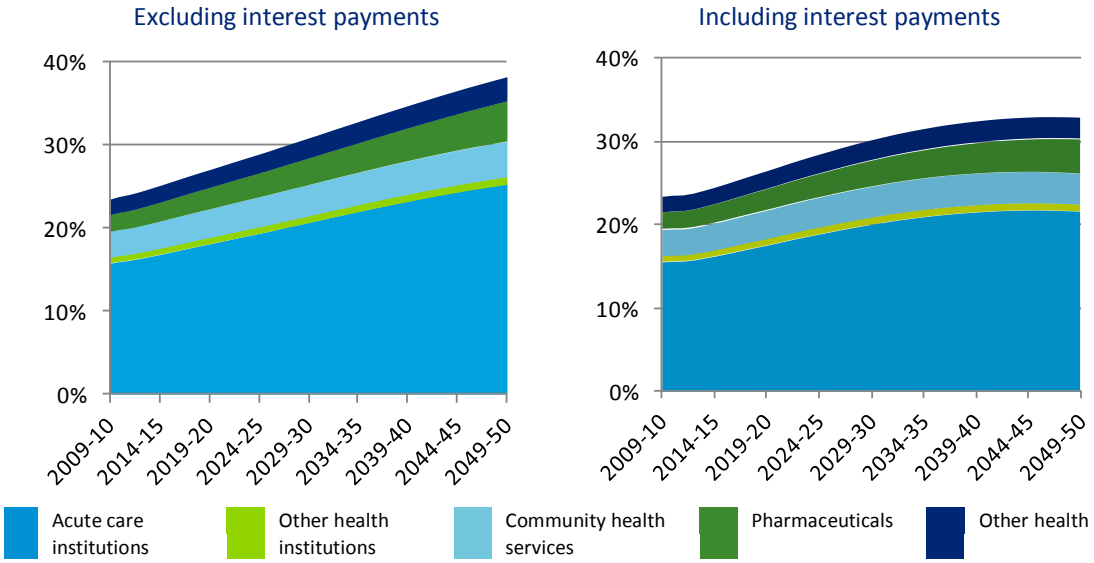
Source: Deloitte Access Economics 2011.

3.8 Western Australia

In Western Australia, the growth in health expenditure as a proportion of total expenditure excluding interest payments is lower in 2009-10 than in other states and territories (23.5% vs. 25.2%) and grows strongly at a similar rate, remaining slightly below the combined state and territory level in 2049-50 (38.3% vs. 40.0%) (Chart 3.8). When interest payments are included, health expenditure continues to grow as a proportion of total expenditure over the projection period, although slowing considerably over the last decade to reach 32.8% in 2049-50.

This growth is led by expenditure in acute care institutions. Although these make up a lower proportion of expenditure than in the states and territories combined (25.2% in 2049-50 vs. 30.8%), this may be accounted for by pharmaceutical expenditure, which is separately accounted for in WA (representing 4.8% of total expenditure excluding interest payments), but is included in the acute care institutions figure for some jurisdictions. There are also increasing shares of total expenditure attributable to community health services (from 3.1% in 2009-10 to 4.3% in 2049-50), pharmaceuticals (2.0% in 2009-10 to 4.1% in 2049-50) and other health (1.9% in 2009-10 to 2.9% in 2049-50).

Chart 3.8: Projected WA health expenditure (% of total government expenditure)

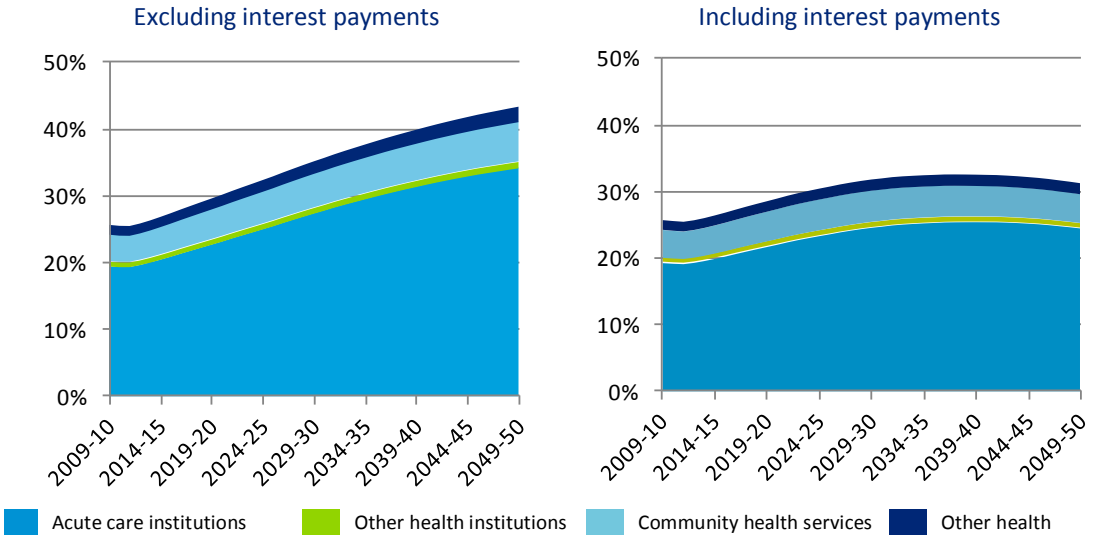


Source: Deloitte Access Economics 2011

3.9 Tasmania

Health expenditure represents a greater proportion of total government expenditure excluding interest in Tasmania than in other jurisdictions, rising from 25.7% in 2009-10 to 43.4% in 2049-50 (Chart 3.9). As in other states and territories, this is driven by expenditure in acute care institutions (34.1% of total expenditure excluding interest payments). This is slightly higher than the summed acute care institutions and pharmaceuticals figure for the states and territories combined (33.0%) (pharmaceuticals are not separately identified in the Tasmanian expenditure data). Including interest payments, the proportion of expenditure attributable to health peaks at 32.5% across 2035-36 to 2040-41, before falling to 31.2% in 2049-50.

Chart 3.9: Projected Tasmanian government health expenditure (% of total expenditure)

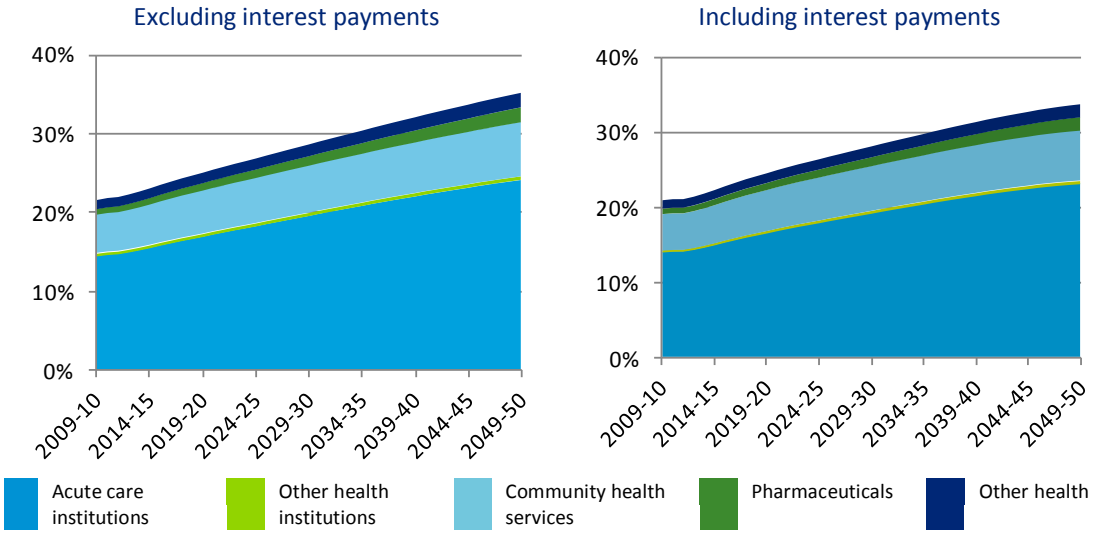


Source: Deloitte Access Economics 2011.

3.10 Northern Territory

For the Northern Territory, the proportion of total expenditure excluding interest payments attributable to health is the lowest of the jurisdictions in 2009-10. Although this is projected to rise to 35.2% by 2049-50 (Chart 3.10), it remains below the figure for combined states and territories (40.0%). As in other states and territories, expenditure is driven by acute care institutions (which represent 24.1% of total expenditure excluding interest in 2049-50). Community health services are also significant, rising from 5.0% in 2009-10 to 6.9% in 2049-50. Over the same period, pharmaceuticals grow from 0.7% to 1.9% and other health from 1.2% to 1.8%. When interest payments are included, the proportion of total expenditure attributable to health is projected to rise to 24.5% by 2019-20 and 33.8% by 2049-50.

Chart 3.10: Projected NT health expenditure (% of total government expenditure)

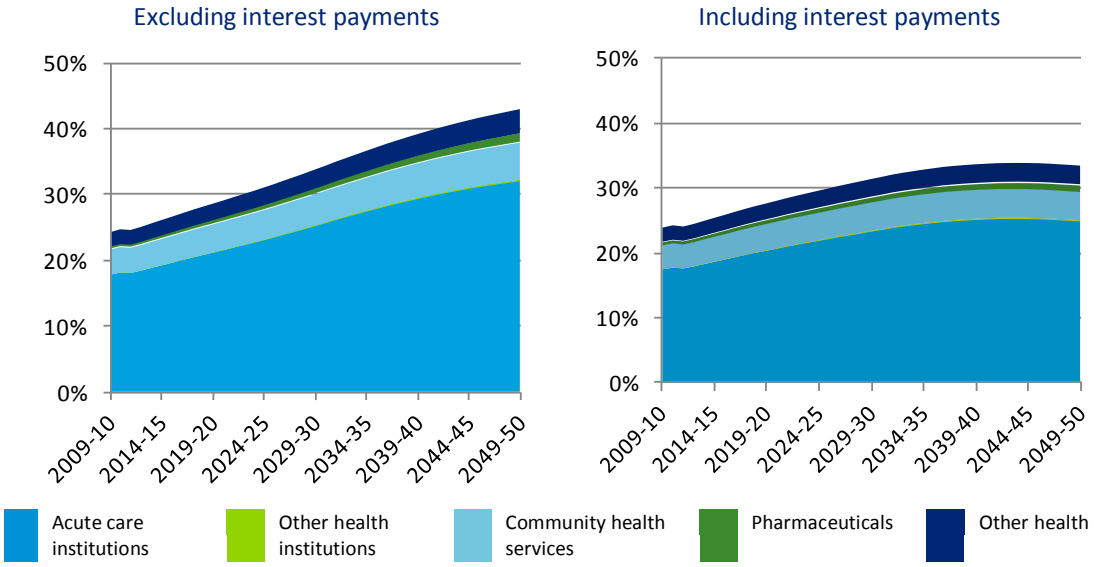


Source: Deloitte Access Economics 2011.

3.11 Australian Capital Territory

Similarly to Tasmania, estimated 2009-10 figures and projections to 2049-50 for the Australian Capital Territory (ACT) show a higher proportion of total expenditure excluding interest payments attributable to health (Chart 3.11) (rising from 24.3% in 2009-10 to 43.0% in 2049-50). As for the other states and territories, this is driven by acute care institutions. In 2009-10, this category represented 17.7% of total expenditure, rising to 32.1% in 2049-50. Community health services grew from 3.8% to 5.7% over the same period, pharmaceuticals from 0.5% to 1.3% and other health from 2.2% to 3.7%. When interest payments are included, health peaks as a proportion of total expenditure across 2041-42 to 2045-46, at 33.7% (rising from 23.9% in 2009-10), falling slightly to 33.3% by 2049-50.

Chart 3.11: Projected ACT government health expenditure (% of total expenditure)



Source: Deloitte Access Economics 2011.

3.12 Summary

Table 3.1 summarises the projections shown in the charts in this section, highlighting the differences between jurisdictions. Total health expenditure is projected to rise as a proportion of total expenditure excluding interest payments for all jurisdictions over the period 2009-10 to 2049-50 (left side of the table). Health is a more significant proportion of the government budgets for the states and territories than for the Australian Government (due to the additional funding responsibilities of the Australian Government). Nevertheless, the Australian Government is projected to see a similar proportionate rise in health expenditure as a proportion of total expenditure (excluding interest payments) to the states and territories, in the order of more than 50%. In all of the states and territories, although not the Australian Government, these movements are driven by expenditure in acute care institutions.

The impact of interest payments (on the right side of Table 3.1) is different between the jurisdictions. Health expenditure rises as a proportion of total expenditure including interest payments for each of the jurisdictions excluding Queensland, although NSW, Victoria, SA, Tasmania and the ACT see a peak during the 2030's and a subsequent decline during the final decade of the projection period. Projections for the Australian Government, WA and the NT continue to rise over the period.

Table 3.1: Expenditure on acute care institutions by jurisdiction (% of total government expenditure)

	Excluding interest payments			Including interest payments		
Jurisdiction	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government	4.0	4.2	6.3	3.9	3.9	5.4
Combined states and territories	19.1	21.6	30.8	18.7	20.2	20.5
NSW	18.9	21.2	29.9	18.3	20.4	23.0
Victoria	20.5	23.1	32.8	20.1	21.8	21.1
Queensland	18.2	20.8	30.8	17.8	17.7	14.9
SA	24.9	28.0	38.4	24.6	26.6	29.3
WA	15.7	18.0	25.2	15.5	17.5	21.6
Tasmania	19.4	22.6	34.1	19.3	21.7	24.5
NT	14.4	16.9	24.1	14.0	16.5	23.1
ACT	17.7	21.1	32.1	17.4	20.3	24.9

Source: Deloitte Access Economics 2011.

Table 3.2: Total health expenditure jurisdiction (% of total government expenditure)

	Excluding interest payments			Including interest payments		
Jurisdiction	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government	12.5	13.6	20.7	12.3	12.6	17.6
Combined states and territories	25.2	28.4	40.0	24.7	26.5	26.7
NSW	24.2	27.1	37.8	23.5	26.1	29.0
Victoria	26.1	29.4	41.4	25.6	27.8	26.6
Queensland	25.5	29.0	41.5	25.0	24.6	20.1
SA	28.6	32.0	43.7	28.2	30.4	33.4
WA	23.5	27.0	38.3	23.3	26.3	32.8
Tasmania	25.7	29.7	43.4	25.6	28.5	31.2
NT	21.6	25.1	35.2	20.9	24.5	33.8
ACT	24.3	28.7	43.0	23.9	27.6	33.3

Source: Deloitte Access Economics 2011.

4 Expenditure on ageing

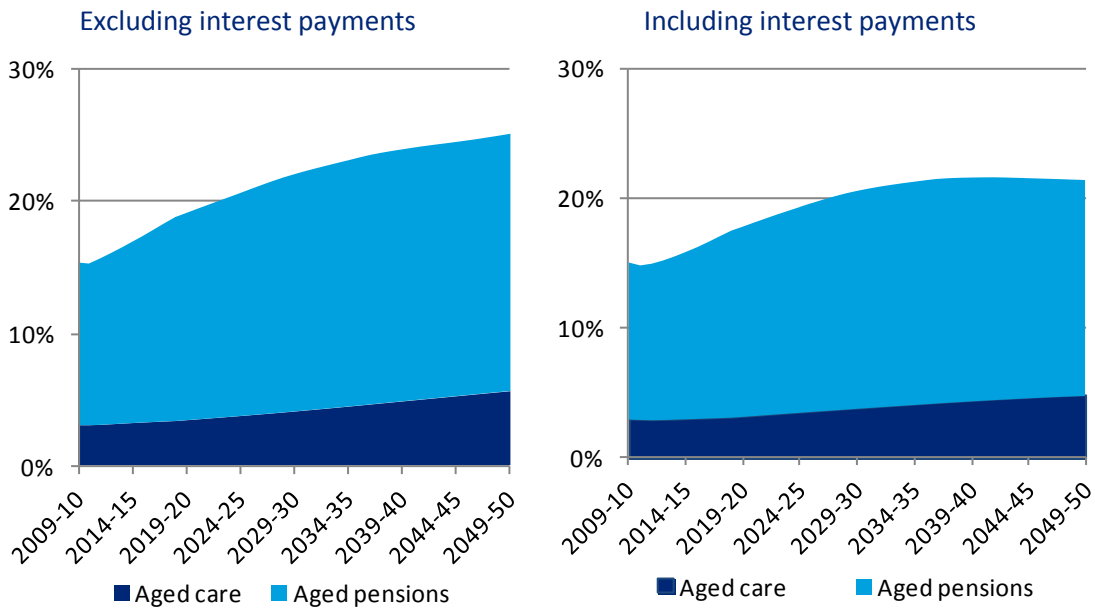
4.1 Australian Government

The Australian Government provides funding for:

- 100% of the aged pension;
- 98% of residential aged care; and
- 60% of home and community care under the HACC program.

Chart 4.1 shows the projected increasing share of total Australian Government expenditure attributable to aged care (residential aged care and community care) and aged pensions. In 2009-10, expenditure on aged care represents 3.0% of total expenditure excluding interest payments and aged pensions a further 12.3% (total 15.3%). By 2019-20, the proportions are projected to rise to 3.4% and 15.7%, respectively (total 19.1%), and increase further to 5.6% and 19.5% (total 25.1%) by 2049-50. When interest payments are included, expenditure on ageing rises as a proportion of total expenditure over 1009-10 to 2049-50, although reaching a plateau at approximately 21.5% after 2036-37.

Chart 4.1: Projected Australian Government expenditure on ageing (% of total expenditure)



Source: Deloitte Access Economics 2011.

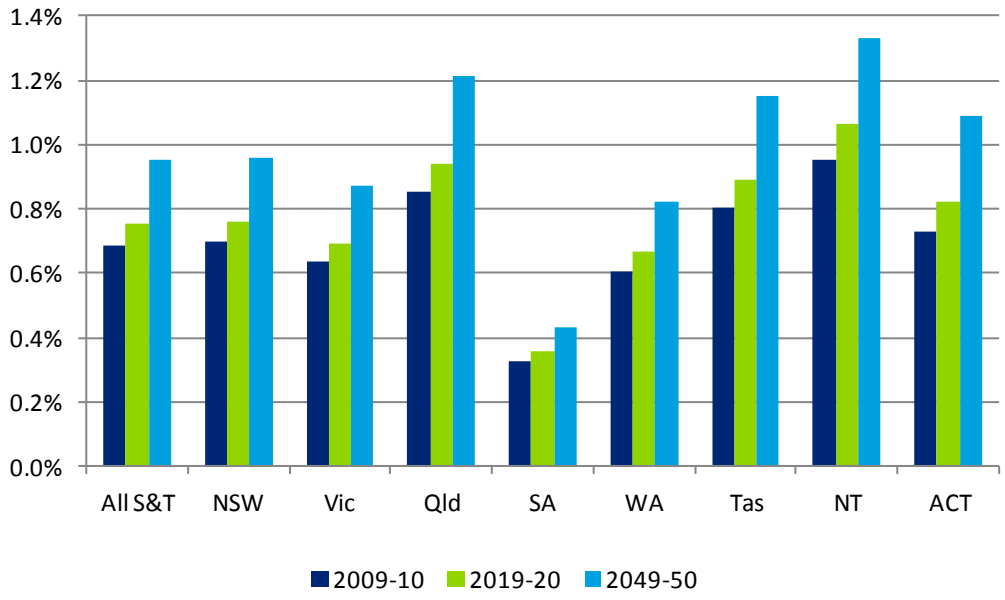
4.2 States and territories

States and Territories provide funding for:

- 2% of residential aged care; and
- 40% of home and community care under the HACC program.

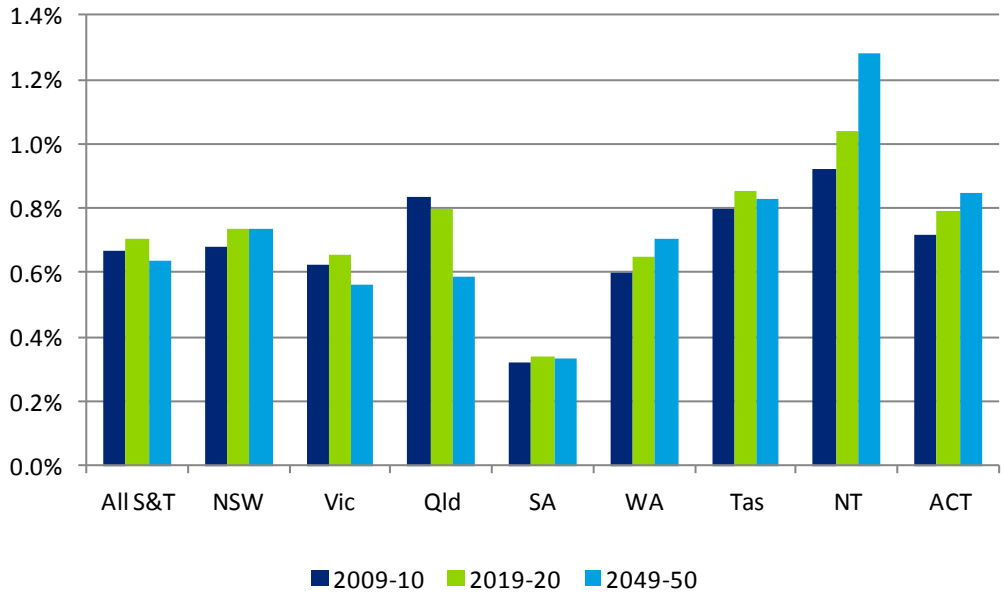
Chart 4.2 shows projected expenditure on aged care as a proportion of total expenditure for each of the states and territories, with comparisons in the years 2009-10, 2019-20 and 2049-50. Movements are relatively small (compared with the health expenditure movements discussed in section 3), with most hovering at between 0.5% and 1.0% of total expenditure.

Chart 4.2: Projected expenditure on ageing by jurisdiction (% of total state and territory government expenditure, excluding interest payments)



Source: Deloitte Access Economics 2011.

Chart 4.3: Projected expenditure on ageing by jurisdiction (% of total state and territory government expenditure, including interest payments)



Source: Deloitte Access Economics 2011.

4.3 Summary

In 2049-50, expenditure on ageing is projected to reach almost one quarter of total Australian Government expenditure, if interest is excluded.

Table 4.1 summarises projections for expenditure on ageing, and aged care, as a proportion of total expenditure in each of the jurisdictions. These figures are the same for the states and territories, but the figure for the Australian Government also includes expenditure on aged pensions, which makes up the majority of overall expenditure on ageing. At the Australian Government level, expenditure on ageing is projected to rise to 25.1% of total expenditure excluding interest payments and 21.4% including interest payments by 2049-50. At the state and territory level, expenditure on ageing is less significant, representing less than 1.5% of total government expenditure over the period 2009-10 to 2049-50.

Table 4.1: Projected expenditure on ageing by jurisdiction (% of total government expenditure)

	Excluding interest			Including interest		
Jurisdiction	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government, all ageing expenditure	15.4	19.1	25.1	15.1	17.8	21.4
Australian Government, aged care	3.0	3.4	5.6	3.0	3.2	4.8
All states and territories	0.7	0.8	1.0	0.7	0.7	0.6
NSW	0.7	0.8	1.0	0.7	0.7	0.7
Victoria	0.6	0.7	0.9	0.6	0.7	0.6
Queensland	0.9	0.9	1.2	0.8	0.8	0.6
SA	0.3	0.4	0.4	0.3	0.3	0.3
WA	0.6	0.7	0.8	0.6	0.7	0.7
Tasmania	0.8	0.9	1.2	0.8	0.9	0.8
NT	1.0	1.1	1.3	0.9	1.0	1.3
ACT	0.7	0.8	1.1	0.7	0.8	0.8

Source: Deloitte Access Economics 2011.

5 Summary

Health and ageing expenditure for each of the jurisdictions is projected to rise over the period 2009-10 to 2049-50 as:

a a proportion of total government expenditure, excluding interest; and

b a proportion of GSP / GDP.

Table 5.1 and Table 5.2 summarise the projections of total health expenditure, total ageing expenditure and combined health and ageing expenditure, as a proportion of total government expenditures for each of the jurisdictions discussed in this report. Breakdowns by category of expenditure are provided in Appendix A.

Table 5.1: Projected health and ageing expenditure by jurisdiction (% of total government expenditure excluding interest payments)

	Total health expenditure			Total ageing expenditure			Total health and ageing expenditure		
Jurisdiction	**2009-10**	**2049-50**	**2049-50**	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government	12.5	13.6	20.7	15.4	19.1	25.1	27.9	32.7	45.8
Combined states and territories	25.2	28.4	40.0	0.7	0.8	1.0	25.9	29.2	41.0
NSW	24.2	27.1	37.8	0.7	0.8	1.0	24.9	27.9	38.8
Victoria	26.1	29.4	41.4	0.6	0.7	0.9	26.8	30.1	42.2
Queensland	25.5	29.0	41.5	0.9	0.9	1.2	26.3	29.9	42.8
SA	28.6	32.0	43.7	0.3	0.4	0.4	28.9	32.4	44.2
WA	23.5	27.0	38.3	0.6	0.7	0.8	24.1	27.7	39.1
Tasmania	25.7	29.7	43.4	0.8	0.9	1.2	26.5	30.6	44.6
NT	21.6	25.1	35.2	1.0	1.1	1.3	22.6	26.1	36.5
ACT	24.3	28.7	43.0	0.7	0.8	1.1	25.1	29.5	44.1

Source: Deloitte Access Economics 2011.

Table 5.2: Projected health and ageing expenditure by jurisdiction (% of total government expenditure including interest payments)

	Total health expenditure			Total ageing expenditure			Total health and ageing expenditure		
Jurisdiction	**2009-10**	**2049-50**	**2049-50**	**2009-10**	**2019-20**	**2049-50**	**2009-10**	**2019-20**	**2049-50**
Australian Government	12.3	12.6	17.6	15.1	17.8	21.4	27.3	30.5	39.0
Combined states and territories	24.7	26.5	26.7	0.7	0.7	0.6	25.3	27.2	27.3
NSW	23.5	26.1	29.0	0.7	0.7	0.7	24.2	26.8	29.8
Victoria	25.6	27.8	26.6	0.6	0.7	0.6	26.3	28.5	27.2
Queensland	25.0	24.6	20.1	0.8	0.8	0.6	25.8	25.4	20.6
SA	28.2	30.4	33.4	0.3	0.3	0.3	28.5	30.8	33.7
WA	23.3	26.3	32.8	0.6	0.7	0.7	23.9	27.0	33.5
Tasmania	25.6	28.5	31.2	0.8	0.9	0.8	26.4	29.3	32.1
NT	20.9	24.5	33.8	0.9	1.0	1.3	21.8	25.6	35.1
ACT	23.9	27.6	33.3	0.7	0.8	0.8	24.6	28.4	34.2

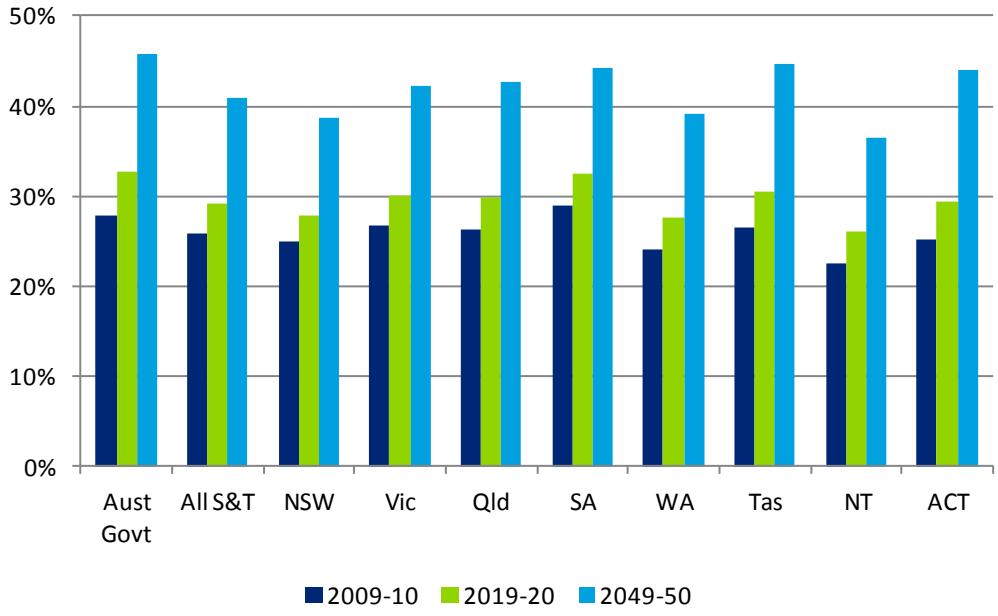
Source: Deloitte Access Economics 2011.

The rise in expenditure on health and ageing as a proportion of total expenditure excluding interest payments (Chart 5.1), over the period 2009-10 to 2049-50 is more pronounced than when interest payments are included (Chart 5.2). This is because interest payments are projected to grow exponentially over the period. This impact is most pronounced in Queensland and Victoria.

Excluding interest payments from the total expenditure projections puts the focus on health and ageing versus other areas of government expenditure. Health and ageing increases in significance in each of the jurisdictions over the projection period, with all showing more than 50% growth (average 61.8%) between 2009-10 and 2049-50 (Chart 5.1). Including high interest payments (relative to other jurisdictions), Queensland's health and ageing expenditure as a proportion of total expenditure actually falls (Chart 5.2).

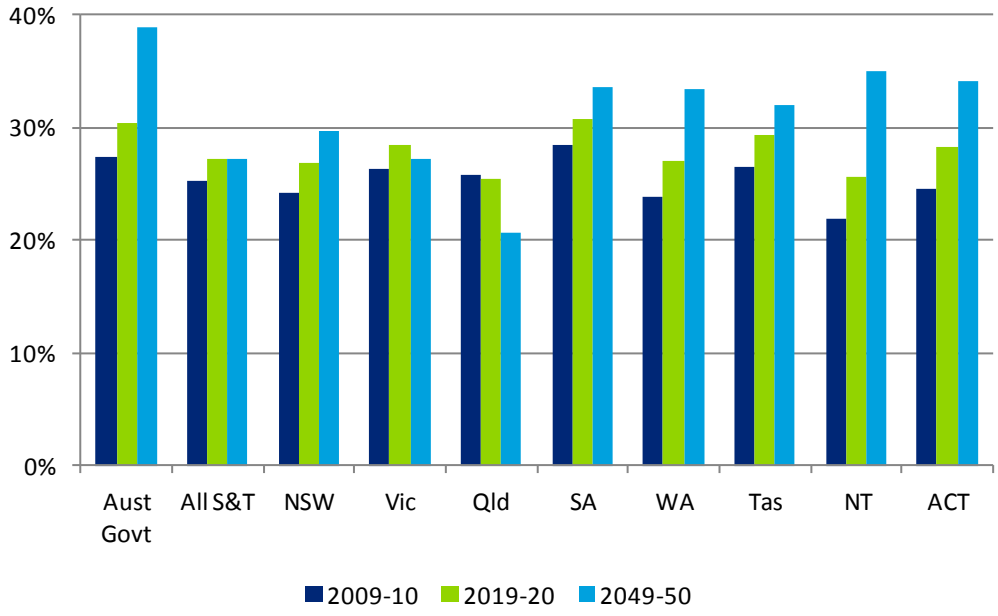
The Australian Government has higher expenditure than the combined states and territories. This reflects its different funding responsibilities, in particular for ageing – including the aged pension and 98% of residential aged care.

Chart 5.1: Health and ageing expenditure projections by jurisdiction (% of total government expenditure excluding interest payments)



Source: Deloitte Access Economics 2011.

Chart 5.2: Health and ageing expenditure projections by jurisdiction (% of total government expenditure including interest payments)



Source: Deloitte Access Economics 2011.

6 Projections of private expenditure

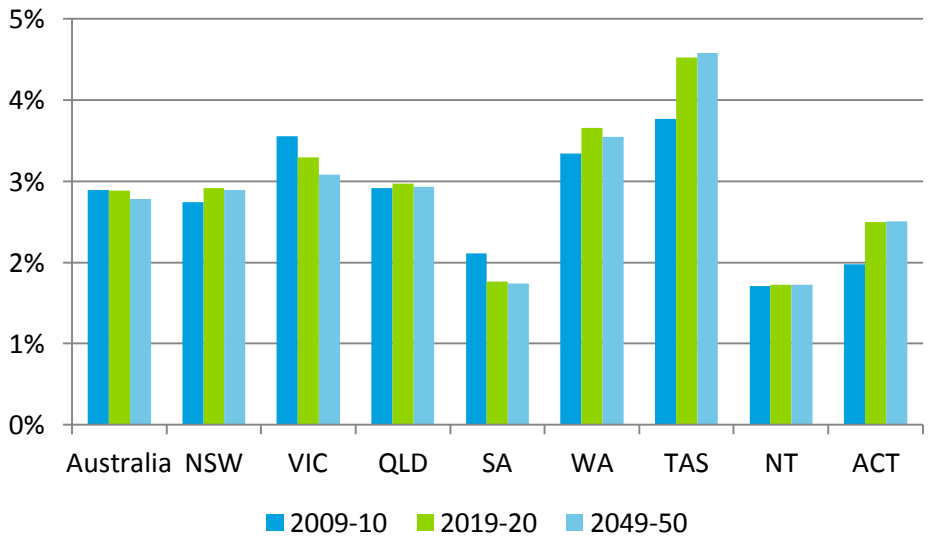
6.1 Projections from the model

Health consumption expenditure was modelled by Deloitte Access Economics (2011). This section presents the findings for health expenditure as a proportion of GDP for Australia and GSP at state and territory level. Projections are based on the continuation of current co-contributions from the private sector (which include predominantly private individuals and private health insurance).

Chart 6.1 shows the proportion of GDP/GSP that health contributes in 2009-10 and is projected to contribute in 2019-20 and 2049-50.

- Nationally, health is projected to stay at approximately 2.8 to 2.9% of GDP throughout the projection period. This to some extent reflects the growing contribution of government expenditures, as discussed in sections 3 and 4.
- NSW and Queensland hover around similar proportions over the projection years as Australia: NSW 2.7%-2.9%; Queensland 2.9%-3.0%.
- Victoria falls over the projection years, from 3.6% in 2009-10 to 3.1% by 2049-50.
- SA also falls, from 2.1% in 2009-10 to 1.7% by 2049-50.
- WA, Tasmania and the ACT rise over the projection years, Tasmania in particular, which reaches 4.5% by 2019-20, significantly above the national proportion. WA falls slightly and the ACT plateaus after an initial rise.
- The NT sits around a similar proportion as SA in later years – 1.7%.

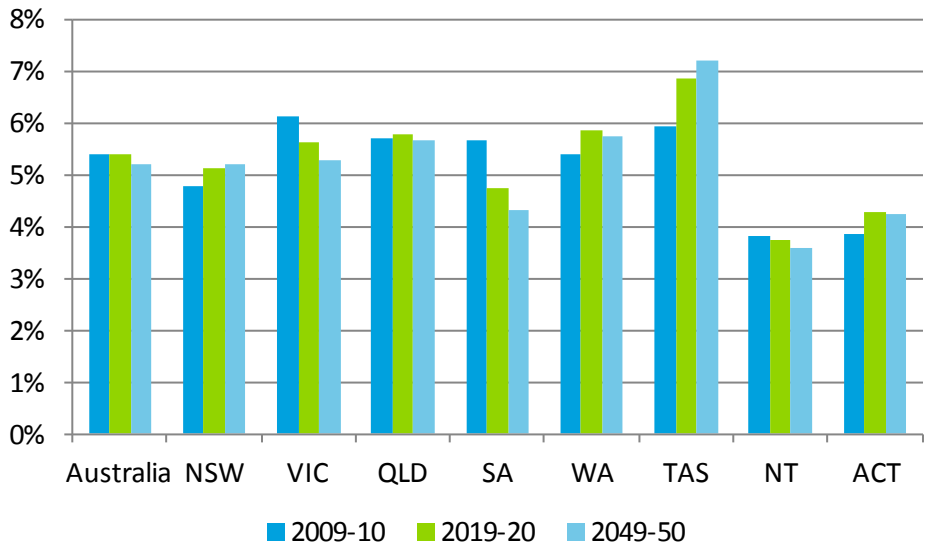
Chart 6.1: Projected private health consumption as a proportion of GDP/GSP



Source: Deloitte Access Economics 2011.

Chart 6.2 shows the proportions of total private consumption expenditure attributable to health in each of the jurisdictions (private consumption does not solely relate to households – the definition is similar to in the national accounts). Excluding the impacts of government expenditure, investments, imports and exports highlights the contribution of private health consumption to GDP/GSP (as shown in Chart 6.1). While some of the relationships are more pronounced in Chart 6.2 than in Chart 6.1 (excluding the ACT), the overall directions of the relationships are similar (i.e. increasing or decreasing). Overall for Australia, the proportion of private consumption expenditure attributable to health falls slightly from 5.4% in 2009-10 to 5.2% in 2049-50.

Chart 6.2: Health as a proportion of projected private consumption expenditure



Source: Deloitte Access Economics 2011.

6.2 Interpretation

The projections of private consumption and government expenditures on health should be considered together. Private expenditure projections have been made on the basis that current co-contribution rules for patients continue over the projection period. One consequence of this is for government expenditures to rise as a proportion of total outlays (when interest payments are not taken into account), as indicated in section 3 – and for strong growth in government expenditures relative to GDP/GSP.

The two scenarios presented in section 3, where additional government expenditures are funded through taxation or raising debt, only represent the government's options if co-contribution rules (from individuals and through private health insurance) remain unchanged. A third scenario might involve increasing participation of the private sector or private individuals in financing healthcare. As also discussed in section 3, a likely result may include a combination of all three scenarios. This would see private expenditures rise as a proportion of both private consumption expenditure and GDP/GSP.

7 Impacts of National Health Reform on government expenditures

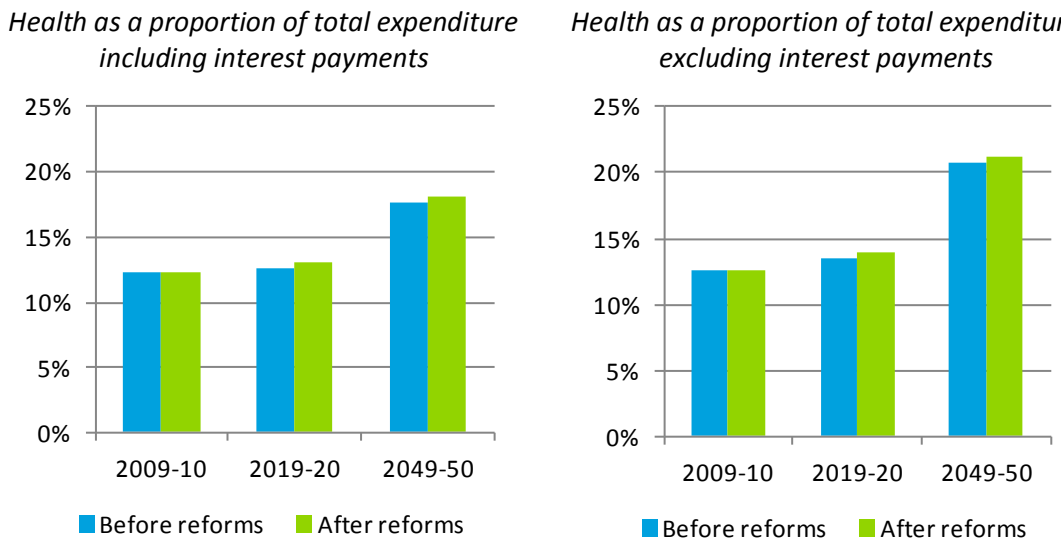
7.1 Impacts on the Australian Government

The overall impact on the Australian Government budget is shown in Chart 7.1. Additional funding commitments for the Australian Government as part of the National Health Reform Agreement that have been modelled are listed below (see methodology discussion in section 2.3).

- The commitment to fund growth in respect of public hospitals to:
  - 50% of the 'efficient' price of public hospital services (through ABF);
  - 50% of recurrent expenditure on research & training (through block funding);
  - 50% of capital expenditure (through block funding); and
  - 50% of rural and remote public hospital funding (through block funding) (COAG 2011b).
- Additional funding commitments under the NP Agreement on Improving Public Hospital Services (COAG 2011c), totalling $3.4 billion over 2009-10 to 2016-17.

The projected impact means that health makes an approximate 0.4 percentage point greater contribution to total Australian Government expenditure (including interest, or 0.5 percentage points excluding interest) by 2049-50 than in the absence of the reforms.

Chart 7.1: Impact of reforms on Australian Government expenditure



Source: Deloitte Access Economics 2011.

The modelling is built on population projections and service usage among the population, based on demographic characteristics and historical costs to government for providing

services. This approach factors in, to some degree, efficiency gains under the service delivery model that currently operates, based on governments' budget constraints and cost minimisation objectives. No further efficiency gains have been modelled as a result of the recent reforms to service funding and delivery, including establishment of the IHPA, regionalisation of management of primary and acute care services through Medicare Locals and Local Hospital Networks, and preventative care initiatives. This is because, overall, these reforms are not expected to result in net changes that will reduce expenditure projections beyond current estimates, for the reasons outlined further below.

Where reforms have been associated with efficiencies, it is not yet clear whether: (i) this will eventuate; and (ii) the result will be lower costs to government. Some reforms may potentially increase costs if efficiencies do not offset the committed expenditure – for example:

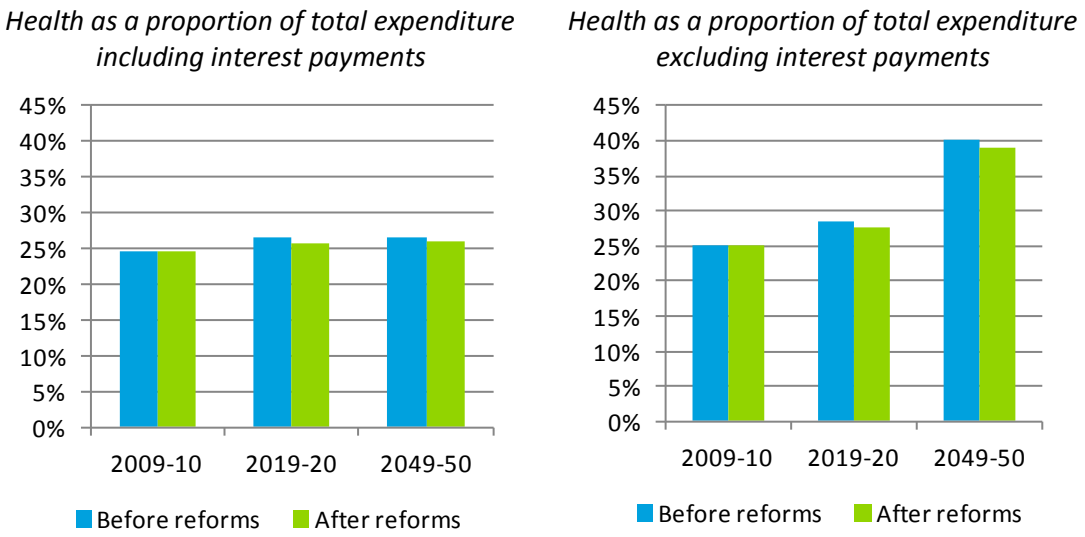
- the transition costs and extra tier of administration from creating Medicare Locals and Local Hospital Networks;
- the operation and efficiency of outcomes from pursuing the objective of extending ABF and setting and monitoring efficient prices through the IHPA, given the limited ability of this mechanism to enforce through current COAG processes overall lower levels of funding, when block grants, program grants, cost relocation, transition costs and continuous quality improvement factors are also considered; and
- the potential for preventive health initiatives under the Australian National Preventive Health Agency (ANHPA) to make additional gains may be limited, given that many similar programs are entrenched (e.g. programs targeted at smoking reduction, dietary guidelines, physical activity and cancer screening), new programs are likely to be subject to diminishing returns, and current expenditure projections do not currently take account of potentially worsening trends in many important risk factors (e.g. overweight/obesity, physical inactivity, inadequate fruit and vegetable consumption), particularly when demographic ageing is considered where these risk factors are age-related.

As a result of this uncertainty, additional efficiency gains were excluded from the modelling. The scenario presented in section 7.3 considers the impact of substituting episodes of non-urgent and semi-urgent Emergency Department (ED) care with General Practitioner (GP) visits, which might emerge over the forecast horizon if acute care providers attempt to realise efficiency gains in this manner.

7.2 Impacts on state and territory governments

The changes to funding commitments modelled for state and territory governments are essentially the reverse of those for the Australian Government. The proportion of combined state and territory government expenditure going to health is approximately 0.6 percentage points lower than in the absence of reforms by 2049-50 (including interest payments, or 1.0 percentage point excluding interest payments). This is shown in Chart 7.2.

Chart 7.2: Impact of reforms on combined state and territory government expenditure



Source: Deloitte Access Economics 2011.

7.3 Scenario – substitution of Emergency Department presentations for GP visits

The modelling presented in sections 7.1 and 7.2 is built on population projections and service usage among the population, based on demographic characteristics, with no impact assumed to have resulted from the reforms (see discussion in section 7.1). This section presents the findings from modelling an alternative scenario, to indicate the potential impact of providing more accessible and appropriate primary care, through the establishment of Medicare Locals and GP 'Super Clinics', and through intentional acute care provider efforts to realise efficiency gains in this manner.

Super Clinics are a recent policy initiative, which makes it difficult to assess whether any impact has been made on ED presentations. At the end of 2011, 20 Super Clinics were open, however the majority are less than two years old, with the first opening in September 2009 (DoHA 2011). Performance data are needed to be able to measure the impact of these services and therefore to be able to estimate the probable impact of extending similar services more widely. It is therefore important to note that the scenario presented in this section merely demonstrates *potential* impacts.

Super Clinics are intended to relieve some of the pressure from EDs, by providing an after hours alternative. Care would be available in a more appropriate and lower cost environment for patients who do not require acute care admission. The modelling assumes this to be all patients who are determined to be non-urgent or semi-urgent (triage

categories 4 and 5)[5], although in reality some category 4 and 5 patients may require acute care referral and admission.

Australian Institute of Health and Welfare (AIHW) data for triage category 4 and 5 presentations in major public hospitals was used to model potential cost savings. The assumed reduced cost to governments was based on substituting one episode of ED care for one GP visit (i.e. assuming these ED and GP episodes would not lead to the patient being admitted). ED care was estimated to cost approximately $349 per episode for non-admitted triage category 4 patients and $217 per episode for non-admitted triage 5 patients in 2008-09 (NHCDC, cited in SCRGSP 2011)[6]. Adjusted for health inflation of 3.2% per annum (AIHW 2010) gives costs of approximately $372 and $231 in 2011-12. The cost of a GP visit is $35.60, taken from the Medicare Benefits Schedule (DoHA 2011c). For each ED presentation, the saving is therefore estimated to be $336 for triage category 4 and $196 for triage category 5. The average saving per patient (weighted by numbers of triage 4 and 5 category patients in 2009-10) is estimated to be $308.

Savings are phased in over five years, with 100% of the assumed impact occurring from 2014-15. The full impact is approximately $600 million in annual savings to the Australian Government and $855 million in annual savings to the combined state and territory governments (2011-12 $).

The assumptions that: (i) one episode of ED care is substitutable for one GP visit; and (ii) all patients who are determined to be in triage categories 4 and 5 could be substituted, may substantially overestimate potential savings. There are therefore significant risks associated with achieving the modelled savings.

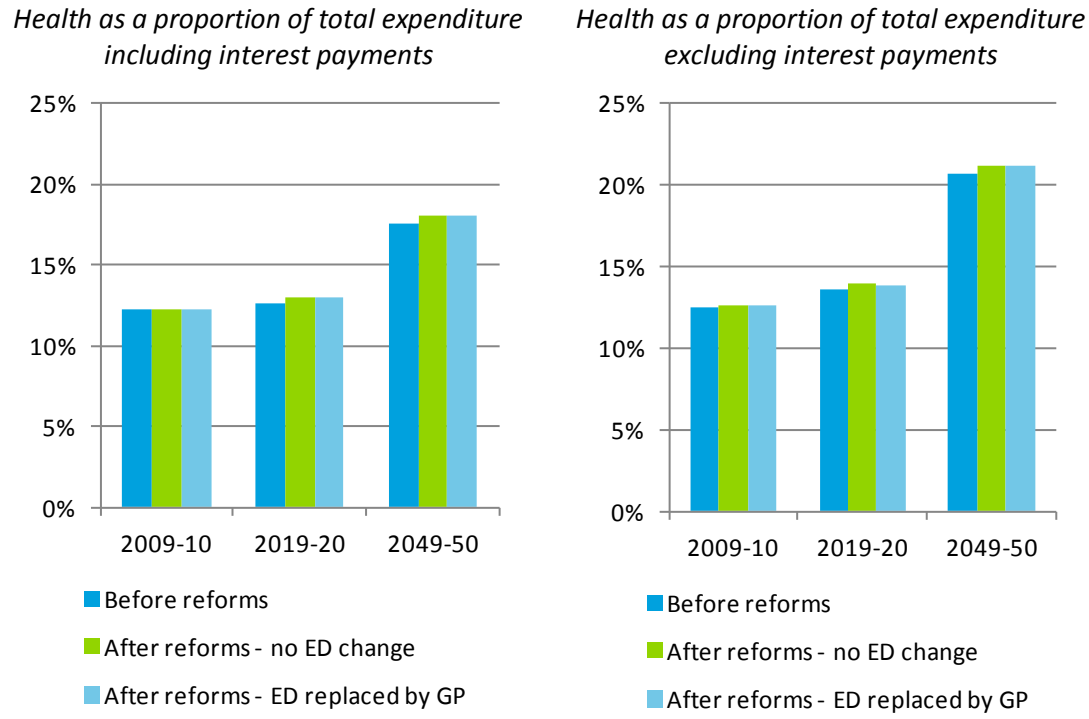
In any case, the savings estimated from the modelling are small relative to total expenditure. Chart 7.3 and Chart 7.4 show the impacts of the reforms described in sections 7.1 and 7.2 (shown in Chart 7.1 and Chart 7.2) and the additional impacts under the scenario where triage category 4 and 5 ED presentations are substituted for GP visits. In terms of overall expenditure, there is no material difference in the proportion of total government expenditure that relates to health under this scenario from that discussed in sections 7.1 and 7.2.

[5] When patients present to the ED of a hospital, triage nurses assess overall condition and assign patients to a triage category from the Australasian Triage Scale indicating how soon they should receive care. The five categories are:

- Category 1 - Resuscitation: immediate / immediately life-threatening;
- Category 2 - Emergency: within 10 minutes / imminently life-threatening;
- Category 3 - Urgent: within 30 minutes / potentially life-threatening;
- Category 4 - Semi-urgent: within 60 minutes / potentially serious; and
- Category 5 - Non-urgent: within 120 minutes / less urgent (AIHW 2010).

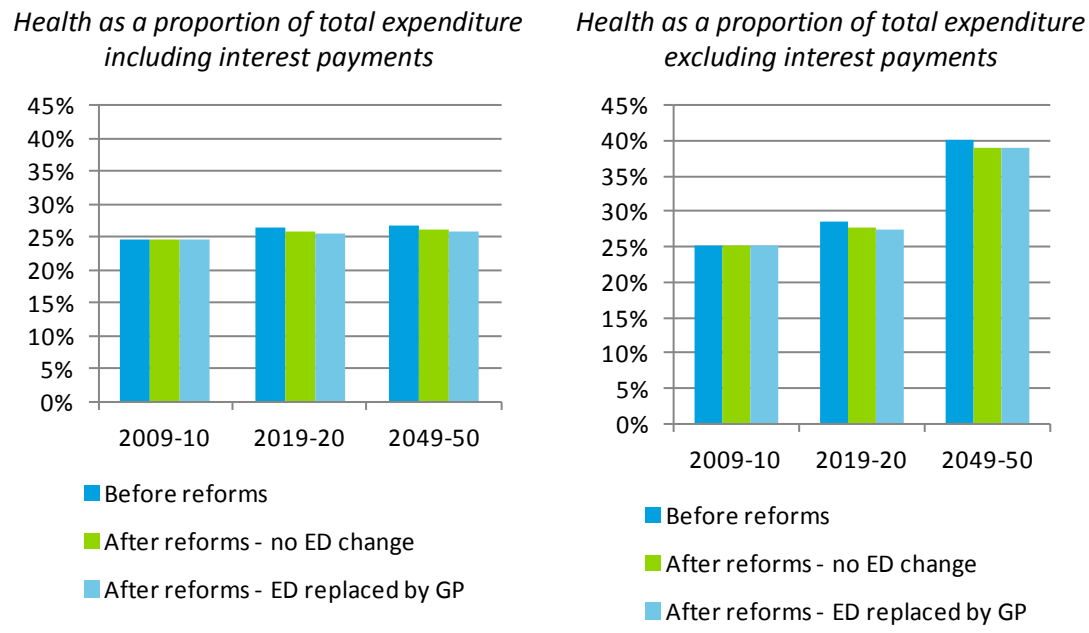
[6] NHCDC data are cited by the Productivity Commission as the source for its estimate of $217 in 2008-09 dollars for non-admitted triage 5 average cost per occasion of service in Table 10.14 of its Report on Government Services 2011 http://www.pc.gov.au/__data/assets/pdf_file/0016/105253/rogs-2011-volume2.pdf.

Chart 7.3: Impact of scenario on Australian Government expenditure



Source: Deloitte Access Economics 2011.

Chart 7.4: Impact of scenario on combined state and territory government expenditure



Source: Deloitte Access Economics 2011.

7.4 Summary

The impacts of health reform on health expenditure as a proportion of total expenditure for the Australian, state and territory governments are shown in Chart 7.5. The impacts are greatest in SA, Victoria and the ACT, although these impacts are all less than one percentage point (including interest payments). An additional scenario, which models the impact of substituting care for triage category 4 and 5 from an ED to a GP visit does not result in any material change to the proportion of total expenditure relating to health at either level of government.

Overall, the National Health Reform Agreement is not projected to make a significant impact on the proportion of total government expenditure that goes to health, at either state/territory or Australian Government levels.

Chart 7.5: Impact of reforms on health as a proportion of total expenditure (% points)

Source: Deloitte Access Economics 2011.

Appendix A: Data tables

Total expenditure excluding interest payments

Table A.1: Projected Australian Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	4.0	4.0	4.2	4.6	4.9	5.3	5.7	6.0	6.3
Other health institutions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community health services – health	3.0	3.2	3.4	3.7	4.1	4.5	4.9	5.2	5.6
Pharmaceutical	2.9	3.1	3.3	3.6	3.9	4.2	4.5	4.9	5.2
Other health	2.6	2.6	2.7	2.8	3.0	3.1	3.3	3.4	3.5
Total health	**12.5**	**12.9**	**13.6**	**14.7**	**15.8**	**17.1**	**18.3**	**19.6**	**20.7**
Community health services – aged care	3.0	3.2	3.4	3.7	4.1	4.5	4.9	5.2	5.6
Aged pensions	12.3	13.7	15.7	16.9	18.0	18.7	19.1	19.3	19.5
Total ageing	**15.4**	**16.9**	**19.1**	**20.6**	**22.1**	**23.1**	**23.9**	**24.5**	**25.1**
Total health and ageing	**27.9**	**29.8**	**32.7**	**35.3**	**37.9**	**40.2**	**42.3**	**44.1**	**45.8**

Table A.2: Projected combined state and territory governments health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	19.1	20.1	21.6	23.2	24.9	26.6	28.1	29.6	30.8
Other health institutions	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4
Community health services – health	3.6	3.7	3.9	4.1	4.3	4.5	4.6	4.8	5.0
Pharmaceutical	0.4	0.5	0.6	0.7	0.7	0.8	0.9	1.0	1.2
Other health	1.7	1.8	1.9	2.1	2.2	2.3	2.5	2.6	2.7
Total health	**25.2**	**26.5**	**28.4**	**30.4**	**32.5**	**34.6**	**36.6**	**38.4**	**40.0**
Community health services – aged care	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0
Total ageing	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.9**	**0.9**	**0.9**	**1.0**
Total health and ageing	**25.9**	**27.2**	**29.2**	**31.2**	**33.3**	**35.5**	**37.5**	**39.4**	**41.0**

Table A.3: Projected NSW Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	18.9	19.8	21.2	22.6	24.2	25.8	27.4	28.8	29.9
Other health institutions	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Community health services – health	3.6	3.8	4.0	4.2	4.3	4.5	4.7	4.8	5.0
Pharmaceutical	0.3	0.4	0.4	0.5	0.5	0.6	0.7	0.7	0.8
Other health	1.3	1.4	1.5	1.5	1.6	1.7	1.8	1.9	2.0
Total health	**24.2**	**25.3**	**27.1**	**28.9**	**30.8**	**32.7**	**34.6**	**36.4**	**37.8**
Community health services – aged care	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0
Total ageing	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.9**	**0.9**	**0.9**	**1.0**
Total health and ageing	**24.9**	**26.0**	**27.9**	**29.7**	**31.6**	**33.6**	**35.5**	**37.3**	**38.8**

Table A.4: Projected Victorian Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	20.5	21.5	23.1	24.6	26.4	28.1	29.8	31.4	32.8
Other health institutions	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Community health services – health	3.3	3.4	3.6	3.8	3.9	4.1	4.3	4.4	4.5
Pharmaceutical	0.4	0.5	0.5	0.6	0.7	0.7	0.8	0.9	1.0
Other health	1.8	1.9	2.0	2.1	2.3	2.4	2.6	2.7	2.8
Total health	**26.1**	**27.4**	**29.4**	**31.3**	**33.4**	**35.6**	**37.7**	**39.6**	**41.4**
Community health services – aged care	0.6	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.9
Total ageing	**0.6**	**0.7**	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.8**	**0.9**
Total health and ageing	**26.8**	**28.1**	**30.1**	**32.0**	**34.2**	**36.4**	**38.5**	**40.5**	**42.2**

Table A.5: Projected Queensland Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	18.2	19.2	20.8	22.6	24.5	26.3	28.0	29.5	30.8
Other health institutions	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	0.9
Community health services – health	4.5	4.6	4.9	5.2	5.4	5.7	5.9	6.1	6.3
Pharmaceutical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other health	2.1	2.3	2.4	2.6	2.8	3.0	3.1	3.3	3.4
Total health	**25.5**	**26.8**	**29.0**	**31.2**	**33.6**	**35.8**	**37.9**	**39.8**	**41.5**
Community health services – aged care	0.9	0.9	0.9	1.0	1.0	1.1	1.1	1.2	1.2
Total ageing	**0.9**	**0.9**	**0.9**	**1.0**	**1.0**	**1.1**	**1.1**	**1.2**	**1.2**
Total health and ageing	**26.3**	**27.7**	**29.9**	**32.2**	**34.6**	**36.9**	**39.0**	**41.0**	**42.8**

Table A.6: Projected SA Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	24.9	26.1	28.0	29.8	31.8	33.8	35.6	37.2	38.4
Other health institutions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community health services – health	1.7	1.8	1.8	1.9	2.0	2.1	2.1	2.2	2.3
Pharmaceutical	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other health	1.9	2.0	2.1	2.3	2.4	2.5	2.7	2.8	2.9
Total health	**28.6**	**29.9**	**32.0**	**34.1**	**36.3**	**38.5**	**40.5**	**42.3**	**43.7**
Community health services – aged care	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Total ageing	**0.3**	**0.3**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**
Total health and ageing	**28.9**	**30.2**	**32.4**	**34.5**	**36.7**	**38.9**	**40.9**	**42.7**	**44.2**

Table A.7: Projected WA Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	15.7	16.7	18.0	19.2	20.6	21.9	23.1	24.3	25.2
Other health institutions	0.8	0.8	0.8	0.9	0.9	0.9	0.9	1.0	1.0
Community health services – health	3.1	3.3	3.5	3.6	3.8	3.9	4.1	4.2	4.3
Pharmaceutical	2.0	2.3	2.6	2.9	3.2	3.5	3.9	4.4	4.8
Other health	1.9	2.0	2.2	2.3	2.4	2.6	2.7	2.8	2.9
Total health	**23.5**	**25.1**	**27.0**	**28.9**	**30.9**	**32.8**	**34.8**	**36.6**	**38.3**
Community health services – aged care	0.6	0.6	0.7	0.7	0.7	0.8	0.8	0.8	0.8
Total ageing	**0.6**	**0.6**	**0.7**	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.8**
Total health and ageing	**24.1**	**25.7**	**27.7**	**29.6**	**31.6**	**33.6**	**35.5**	**37.4**	**39.1**

Table A.8: Projected Tasmanian Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	19.4	20.4	22.6	24.9	27.3	29.5	31.3	32.9	34.1
Other health institutions	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	1.0
Community health services – health	4.2	4.3	4.6	4.9	5.2	5.4	5.6	5.8	6.0
Pharmaceutical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other health	1.5	1.5	1.7	1.8	1.9	2.0	2.1	2.2	2.3
Total health	**25.7**	**26.9**	**29.7**	**32.4**	**35.2**	**37.8**	**40.0**	**41.9**	**43.4**
Community health services – aged care	0.8	0.8	0.9	0.9	1.0	1.0	1.1	1.1	1.2
Total ageing	**0.8**	**0.8**	**0.9**	**0.9**	**1.0**	**1.0**	**1.1**	**1.1**	**1.2**
Total health and ageing	**26.5**	**27.8**	**30.6**	**33.4**	**36.2**	**38.8**	**41.0**	**43.0**	**44.6**

Table A.9: Projected NT Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	14.4	15.5	16.9	18.2	19.5	20.8	22.0	23.1	24.1
Other health institutions	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Community health services – health	5.0	5.2	5.6	5.8	6.0	6.3	6.5	6.7	6.9
Pharmaceutical	0.7	0.8	1.0	1.1	1.2	1.4	1.5	1.7	1.9
Other health	1.2	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.8
Total health	**21.6**	**23.1**	**25.1**	**26.9**	**28.6**	**30.4**	**32.1**	**33.7**	**35.2**
Community health services – aged care	1.0	1.0	1.1	1.1	1.2	1.2	1.2	1.3	1.3
Total ageing	**1.0**	**1.0**	**1.1**	**1.1**	**1.2**	**1.2**	**1.2**	**1.3**	**1.3**
Total health and ageing	**22.6**	**24.1**	**26.1**	**28.0**	**29.8**	**31.6**	**33.3**	**34.9**	**36.5**

Table A.10: Projected ACT Government health and ageing expenditure (% of total government expenditure excluding interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	17.7	19.1	21.1	23.0	25.2	27.4	29.4	30.9	32.1
Other health institutions	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Community health services – health	3.8	4.0	4.3	4.5	4.8	5.0	5.3	5.5	5.7
Pharmaceutical	0.5	0.5	0.6	0.7	0.8	0.9	1.0	1.1	1.3
Other health	2.2	2.3	2.5	2.7	2.9	3.1	3.3	3.5	3.7
Total health	**24.3**	**26.2**	**28.7**	**31.1**	**33.8**	**36.7**	**39.2**	**41.3**	**43.0**
Community health services – aged care	0.7	0.8	0.8	0.9	0.9	1.0	1.0	1.1	1.1
Total ageing	**0.7**	**0.8**	**0.8**	**0.9**	**0.9**	**1.0**	**1.0**	**1.1**	**1.1**
Total health and ageing	**25.1**	**26.9**	**29.5**	**32.0**	**34.8**	**37.6**	**40.2**	**42.4**	**44.1**

Total expenditure including interest payments

Table A.11: Projected Australian Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	3.9	3.8	3.9	4.3	4.6	4.9	5.1	5.3	5.4
Other health institutions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community health services – health	3.0	3.0	3.2	3.5	3.8	4.1	4.4	4.6	4.8
Pharmaceutical	2.9	2.9	3.0	3.3	3.6	3.9	4.1	4.3	4.5
Other health	2.6	2.4	2.5	2.6	2.8	2.9	3.0	3.0	3.0
Total health	**12.3**	**12.1**	**12.6**	**13.7**	**14.8**	**15.7**	**16.5**	**17.2**	**17.6**
Community health services – aged care	3.0	3.0	3.2	3.5	3.8	4.1	4.4	4.6	4.8

Aged pensions	12.1	12.9	14.6	15.8	16.8	17.2	17.2	16.9	16.6
Total ageing	**15.1**	**15.9**	**17.8**	**19.3**	**20.6**	**21.3**	**21.6**	**21.5**	**21.4**
Total health and ageing	**27.3**	**28.0**	**30.5**	**33.1**	**35.3**	**37.0**	**38.1**	**38.7**	**39.0**

Table A.12: Projected combined state and territory governments health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	18.7	19.1	20.2	21.2	21.8	22.1	22.0	21.4	20.5
Other health institutions	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Community health services – health	3.5	3.5	3.7	3.7	3.8	3.7	3.6	3.5	3.3
Pharmaceutical	0.4	0.5	0.5	0.6	0.7	0.7	0.7	0.8	0.8
Other health	1.7	1.7	1.8	1.9	1.9	1.9	1.9	1.9	1.8
Total health	**24.7**	**25.2**	**26.5**	**27.7**	**28.5**	**28.8**	**28.6**	**27.9**	**26.7**
Community health services – aged care	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.6
Total ageing	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.6**
Total health and ageing	**25.3**	**25.8**	**27.2**	**28.4**	**29.3**	**29.6**	**29.3**	**28.5**	**27.3**

Table A.13: Projected NSW Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	18.3	19.0	20.4	21.8	23.0	23.9	24.2	23.9	23.0
Other health institutions	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Community health services – health	3.5	3.6	3.8	4.0	4.1	4.2	4.1	4.0	3.8
Pharmaceutical	0.3	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6
Other health	1.3	1.3	1.4	1.5	1.6	1.6	1.6	1.6	1.5
Total health	**23.5**	**24.3**	**26.1**	**27.8**	**29.3**	**30.3**	**30.6**	**30.2**	**29.0**
Community health services – aged care	0.7	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.7
Total ageing	**0.7**	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.7**
Total health and ageing	**24.2**	**25.0**	**26.8**	**28.6**	**30.1**	**31.1**	**31.4**	**31.0**	**29.8**

Table A.14: Projected Victorian Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	20.1	20.7	21.8	22.8	23.4	23.5	23.1	22.3	21.1
Other health institutions	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Community health services – health	3.2	3.3	3.4	3.5	3.5	3.4	3.3	3.1	2.9
Pharmaceutical	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	0.7
Other health	1.8	1.8	1.9	2.0	2.0	2.0	2.0	1.9	1.8
Total health	**25.6**	**26.3**	**27.8**	**28.9**	**29.6**	**29.7**	**29.2**	**28.1**	**26.6**
Community health services – aged care	0.6	0.6	0.7	0.7	0.7	0.7	0.6	0.6	0.6
Total ageing	**0.6**	**0.6**	**0.7**	**0.7**	**0.7**	**0.7**	**0.6**	**0.6**	**0.6**
Total health and ageing	**26.3**	**27.0**	**28.5**	**29.6**	**30.3**	**30.3**	**29.8**	**28.7**	**27.2**

Table A.15: Projected Queensland Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	17.8	17.5	17.7	17.9	17.8	17.5	16.8	15.9	14.9
Other health institutions	0.7	0.7	0.6	0.6	0.6	0.6	0.5	0.5	0.5
Community health services – health	4.4	4.2	4.2	4.1	4.0	3.8	3.5	3.3	3.1
Pharmaceutical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other health	2.1	2.1	2.1	2.1	2.0	2.0	1.9	1.8	1.7
Total health	**25.0**	**24.4**	**24.6**	**24.7**	**24.4**	**23.8**	**22.7**	**21.5**	**20.1**
Community health services – aged care	0.8	0.8	0.8	0.8	0.8	0.7	0.7	0.6	0.6
Total ageing	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**0.7**	**0.7**	**0.6**	**0.6**
Total health and ageing	**25.8**	**25.2**	**25.4**	**25.5**	**25.2**	**24.5**	**23.4**	**22.1**	**20.6**

Table A.16: Projected SA Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	24.6	25.1	26.6	27.8	28.7	29.4	29.6	29.6	29.3
Other health institutions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community health services – health	1.7	1.7	1.8	1.8	1.8	1.8	1.8	1.8	1.7
Pharmaceutical	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other health	1.9	1.9	2.0	2.1	2.2	2.2	2.2	2.2	2.2
Total health	**28.2**	**28.8**	**30.4**	**31.8**	**32.8**	**33.5**	**33.7**	**33.7**	**33.4**
Community health services – aged care	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Total ageing	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**	**0.3**
Total health and ageing	**28.5**	**29.1**	**30.8**	**32.1**	**33.1**	**33.8**	**34.1**	**34.0**	**33.7**

Table A.17: Projected WA Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	15.5	16.2	17.5	18.8	20.0	20.9	21.5	21.7	21.6
Other health institutions	0.8	0.8	0.8	0.8	0.9	0.9	0.9	0.9	0.8
Community health services – health	3.1	3.2	3.4	3.6	3.7	3.7	3.8	3.7	3.7
Pharmaceutical	2.0	2.2	2.5	2.8	3.1	3.4	3.7	3.9	4.1
Other health	1.9	2.0	2.1	2.2	2.4	2.4	2.5	2.5	2.5
Total health	**23.3**	**24.3**	**26.3**	**28.3**	**30.0**	**31.4**	**32.3**	**32.8**	**32.8**
Community health services – aged care	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Total ageing	**0.6**	**0.6**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**	**0.7**
Total health and ageing	**23.9**	**24.9**	**27.0**	**29.0**	**30.7**	**32.1**	**33.0**	**33.5**	**33.5**

Table A.18: Projected Tasmanian Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	19.3	19.9	21.7	23.4	24.6	25.3	25.5	25.3	24.5
Other health institutions	0.7	0.7	0.7	0.8	0.8	0.8	0.7	0.7	0.7
Community health services – health	4.2	4.2	4.4	4.6	4.7	4.7	4.6	4.5	4.3
Pharmaceutical	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other health	1.5	1.5	1.6	1.6	1.7	1.7	1.7	1.7	1.7
Total health	**25.6**	**26.3**	**28.5**	**30.4**	**31.8**	**32.4**	**32.5**	**32.1**	**31.2**
Community health services – aged care	0.8	0.8	0.9	0.9	0.9	0.9	0.9	0.9	0.8
Total ageing	**0.8**	**0.8**	**0.9**	**0.9**	**0.9**	**0.9**	**0.9**	**0.9**	**0.8**
Total health and ageing	**26.4**	**27.2**	**29.3**	**31.3**	**32.7**	**33.3**	**33.4**	**33.0**	**32.1**

Table A.19: Projected NT Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	14.0	14.9	16.5	17.9	19.2	20.4	21.5	22.5	23.1
Other health institutions	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Community health services – health	4.8	5.0	5.4	5.7	5.9	6.1	6.4	6.5	6.7
Pharmaceutical	0.7	0.8	0.9	1.1	1.2	1.3	1.5	1.6	1.8
Other health	1.1	1.2	1.3	1.4	1.5	1.6	1.6	1.7	1.8
Total health	**20.9**	**22.3**	**24.5**	**26.4**	**28.1**	**29.8**	**31.4**	**32.8**	**33.8**
Community health services – aged care	0.9	1.0	1.0	1.1	1.1	1.2	1.2	1.3	1.3
Total ageing	**0.9**	**1.0**	**1.0**	**1.1**	**1.1**	**1.2**	**1.2**	**1.3**	**1.3**
Total health and ageing	**21.8**	**23.3**	**25.6**	**27.5**	**29.3**	**31.0**	**32.6**	**34.0**	**35.1**

Table A.20: Projected ACT Government health and ageing expenditure (% of total government expenditure including interest payments)

Expenditure category	2009-10	2014-15	2019-20	2024-25	2029-30	2034-35	2039-40	2044-45	2049-50
Acute care institutions	17.4	18.5	20.3	21.8	23.3	24.5	25.1	25.2	24.9
Other health institutions	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Community health services – health	3.7	3.9	4.1	4.3	4.4	4.5	4.5	4.5	4.4
Pharmaceutical	0.5	0.5	0.6	0.7	0.7	0.8	0.9	0.9	1.0
Other health	2.1	2.3	2.4	2.6	2.7	2.8	2.8	2.9	2.8
Total health	**23.9**	**25.4**	**27.6**	**29.5**	**31.3**	**32.7**	**33.5**	**33.7**	**33.3**
Community health services – aged care	0.7	0.7	0.8	0.8	0.8	0.9	0.9	0.9	0.8
Total ageing	**0.7**	**0.7**	**0.8**	**0.8**	**0.8**	**0.9**	**0.9**	**0.9**	**0.8**
Total health and ageing	**24.6**	**26.1**	**28.4**	**30.3**	**32.1**	**33.6**	**34.4**	**34.6**	**34.2**

References

Australian Government 2011, 2010b, *Budget measures: budget paper no. 3: 2011–12*, Commonwealth of Australia, Canberra, http://www.budget.gov.au/2011-12/content/bp3/html/index.htm, accessed 21 November 2011.

- 2010, *A National Health and Hospitals Network for Australia's Future – Delivering the Reforms*, http://www.yourhealth.gov.au/internet/yourHealth/publishing.nsf/Content/DeliveringTheReforms/$FILE/DeliveringTheReforms.pdf, accessed 17 November 2011.

- 2010b, *Budget measures: budget paper no. 3: 2010–11*, Commonwealth of Australia, Canberra, http://www.budget.gov.au/2010-11/content/bp3/html/index.htm, accessed 21 November 2011.

Australian Institute of Health and Welfare (AIHW) 2011, 'Health expenditure Australia 2009-10', *Health and welfare expenditure series*, no. 46, cat. no. HWE 55, Canberra.

- 2010, 'Australia's Health 2010'*, Australia's health*, no. 12. cat. no. AUS 122. Canberra.

- 2009, *Estimating the impact of selected National Health and Hospitals Reform Commission (NHHRC) reforms on health care expenditure, 2003 to 2033,* cat. no. HWE 45, Canberra, AIHW, http://www.aihw.gov.au/publication-detail/?id=6442468271, accessed 13 November 2011.

Council of Australian Governments (COAG) 2011, *National Healthcare Agreement 2011*, Intergovernmental agreement on federal financial relations, http://www.coag.gov.au/docs/national_healthcare_agreement_2011.pdf, accessed 13 November 2011.

- 2011b, *National Health Reform Agreement*, http://www.coag.gov.au/docs/national_health_reform_agreement.pdf, accessed 13 November 2011.

- 2011c, *The National Health Reform Agreement - National Partnership Agreement On Improving Public Hospital Services*, Intergovernmental agreement on federal financial relations, http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/National_health_reform/national_partnership.pdf, accessed 13 November 2011.

- 2011d, *National Partnership Agreement on Health Services*, Intergovernmental agreement on federal financial relations, http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/health_services/national_partnership.pdf, accessed 13 November 2011.

Department of Health and Ageing (DoHA) 2011, *GP super clinics latest news*, http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinics-latestnews, accessed 19 January 2012.

- 2011b, *Data Collections: National Hospital Cost Data Collection (NHCDC)*, http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-about_NHCDC, accessed 19 January 2012.

- 2011c, 'Search the MBS', *MBS Online*, http://www9.health.gov.au/mbs/search.cfm, accessed 19 January 2012.

Gillard, J (Prime Minister) and Roxon, N (Minister for Health and Ageing) 2011, 'National health reform finalised', Joint media release, Parliament House, Canberra, 2 August, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr142.htm, accessed 17 November 2011.

Deloitte Access Economics 2011, 'An IGR for the States', in Business Council of Australia, *Preparing for a better future*, submission to the 2011 Tax Forum, http://www.bca.com.au/DisplayFile.aspx?FileID=765, accessed 26 October 2011.

Department of Health and Ageing 2008, 'How aged care services in Australia are paid for', *Ageing and aged care in Australia*, http://www.health.gov.au/internet/main/publishing.nsf/Content/BFE46F21A3241ECBCA2574BE001A6E06/$File/Ageing_and_Aged_Care.pdf, accessed 26 October 2011.

Price Waterhouse Coopers 2010, *The impacts of pharmaceutical benefits scheme* reform, Report for the Department of Health and Ageing, February 2010, http://www.health.gov.au/internet/main/publishing.nsf/Content/pbs-reform-report, accessed 21 November 2011.

SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Report on Government Services 2011*, Productivity Commission, Canberra.

Limitation of our work

General use restriction

This report is prepared solely for the use of the Business Council of Australia. This report is not intended to and should not be used or relied upon by anyone else and we accept no duty of care to any other person or entity. The report has been prepared for the purpose outlined in our engagement letter. You should not refer to or use our name or the advice for any other purpose.

Contact us

Deloitte Access Economics
ACN: 49 633 116

Level 1
9 Sydney Avenue
Barton ACT 2600
PO Box 6334
Kingston ACT 2604 Australia

Tel: +61 2 6175 2000
Fax: +61 2 6175 2001

www.deloitte.com/au/economics

Deloitte Access Economics is Australia's pre-eminent economics advisory practice and a member of Deloitte's global economics group. The Directors and staff of Access Economics joined Deloitte in early 2011.

About Deloitte

Deloitte provides audit, tax, consulting, and financial advisory services to public and private clients spanning multiple industries. With a globally connected network of member firms in more than 150 countries, Deloitte brings world-class capabilities and deep local expertise to help clients succeed wherever they operate. Deloitte's approximately 170,000 professionals are committed to becoming the standard of excellence.

About Deloitte Australia

In Australia, the member firm is the Australian partnership of Deloitte Touche Tohmatsu. As one of Australia's leading professional services firms. Deloitte Touche Tohmatsu and its affiliates provide audit, tax, consulting, and financial advisory services through approximately 5,400 people across the country. Focused on the creation of value and growth, and known as an employer of choice for innovative human resources programs, we are dedicated to helping our clients and our people excel. For more information, please visit our web site at www.deloitte.com.au.

BUSINESS COUNCIL OF AUSTRALIA
42/120 COLLINS STREET MELBOURNE 3000
T 03 8664 2664 | F 03 8664 2666
www.bca.com.au

 ISBN 978 1 922058 18 8
Business Council of Australia ABN 75 008 483 216