



DEPARTMENT OF TREASURY

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Dear Mr Spasojevic

ACT SUBMISSION ON SOCIO-DEMOGRAPHIC COMPOSITION

Thank you for the opportunity to provide a submission to the Commonwealth Grants Commission's Staff Discussion Paper CGC 2006/01 '*Socio-Demographic Composition*'.

The attached submission outlines the ACT's views on matters raised by the Commission regarding the assessment of socio-demographic composition (SDC).

This submission has not been provided until now because of the overlap with the disaggregation expenses Discussion Paper.

In a number of circumstances, the approaches suggested by Commission staff for assessing SDC disabilities have only recently been clarified at the disaggregation conference. For example, the extent to which broad indicators would be used and the degree of disaggregation and assessment of detailed disabilities. This has necessitated revisions to the ACT's initial draft SDC submission.

If you have any questions regarding the attached response, please contact Mr Andrew Philip, Manager, Commonwealth-State Finances Unit (phone 6207 0018).

Yours sincerely

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AUSTRALIAN CAPITAL TERRITORY

SUBMISSION TO THE COMMONWEALTH GRANTS COMMISSION'S STAFF DISCUSSION PAPER:

2006/01: *SOCIO-DEMOGRAPHIC COMPOSITION*

September 2006



Introduction

The socio-demographic composition (SDC) assessments currently rely on too much judgement; are often based on unreliable data (particularly cost weight data); are overly complex; and it is not clear that they accurately capture disabilities reflective of individual State circumstances.

Given that the SDC assessments redistribute over \$2 billion per annum, SDC disabilities must be rigorously and reliably based. The reliance of large components of SDC assessments on patchy, non-verifiable data should be addressed. In this context, the statement that *“improving the quality of the cost data used in SDC assessments will be an important aspect of the work to be undertaken”* is supported.

Consistent with the 2010 Review Terms of Reference (ToR) and the assessment guidelines, SDC impacts should only be assessed once four key hurdles are met, namely:

- satisfactory evidence is available to demonstrate that certain population groups impact on the use of, or cost of, providing services;
- data are fit-for-purpose and the use and cost weights can be estimated reliably;
- the Commission has confidence in the results; and
- the impact is material (as defined by the materiality thresholds; or
- a strong conceptual case exists and it is reasonable for judgement to be used.

The 2010 Review ToR and strengthened assessment guidelines imply the need for better data, and consequently, reduced levels of judgement. While there is a strong preference for assessments to be based on robust data, it is reasonable for judgement to be used where a strong conceptual case exists and it is required to achieve equalisation. In these instances, the assessment guidelines stipulate the need for conservative assessments to be made.

Tremendous potential exists for using a broad measure with adjustments for certain SDC characteristics. This is particularly the case if average policy is specified in simpler terms - based on the highest common State policy. This would reduce the number of SDC disabilities required and increase simplification.

Further, the adoption of ‘simpler average policy’ is also consistent with the top-down approach to disaggregation and reflects the new emphases of the 2010 Review.

Broader and simpler measures of SDC

General Comments

In the context of fewer, more aggregated categories, the view that a major component of the work will involve how best to identify and measure cost and demand drivers is supported.

Well designed SDC assessments, in combination with broader indicators, should obviate a number of data concerns (removing the need for use and cost weights in numerous cases), reduce the complexity of assessments, and minimise the need for broad judgement.

Single broad measure

In the past, numerous disabilities have been assessed to account for just about every possible non-policy influence, reflecting in part a bottom-up approach. This led to overly complex assessments where disabilities were assessed to the minutiae.

In the context of the top-down approach being adopted, tremendous potential exists for using broad measures, with adjustments if valid, to capture specific SDC characteristics.

Specifying ‘average policy’ in simpler terms, that is, interpreting States’ policies at the highest common level would allow broader measures to be used effectively. This approach would effect the extent to which non-policy influences need to be reflected in the assessments. Using broad measures that capture use may also obviate the need to adjust for many perceived policy influences and different use rates of services by SDC groups. Adjusting for additional SDC related costs, where valid, could therefore be the major assessment focus.

In terms of the operational environment, States have limited capacity to make significant service delivery changes, either because of fiscal constraints (inability to meet unmet demand), the structures that have evolved since Federation, or because they are already providing services to an acceptable level and within parameters laid down by the Australian Government (legislative arrangements and Commonwealth-State agreements encompassing policy provision and objectives).

In return for additional funding to the States, the Australian Government has implemented policy change aimed primarily at increasing national consistency in standards across Australia and access to services. Adopting a ‘simpler average policy’ approach makes sense given that States’ face similar structural circumstances and generally respond to these in similar ways.

To illustrate the rationale for ‘simpler average policy’, and appropriate broad measures, examples are provided for the schools education and inpatients services assessments as they represented nearly 50 per cent of States’ net expenditures in the 2006 Update (2004-05 year). They are also interesting examples as the circumstances surrounding the supply of schools education and inpatient services are very different.

Schools Education

The supply of student places is driven by the demand for services, that is, the number of enrolments of school age children. This is because States are required by legislation to provide school services to **all** students of school age.

In the 1993 Review the Commission decided that the ToR required it to focus on transactions of governments (including private services partly funded by government), not those of the wider ‘community’. This led to the adoption of the ‘narrow view’ of fiscal equalisation.

For schools education, this view implied that a State would be entitled to a larger per capita share of GST funding if its community demanded relatively more publicly funded services. This ‘narrow view’ led to the majority interpretation that actual enrolments in the government and non-government sectors should be the basis for assessing needs.

A ‘simpler average policy’ approach also implies that disabilities would be largely assessed based on, for example, actual enrolments, with adjustments for particular SDC groups if valid.

Changes to school policy occurring over time, and since the 2004 Review, suggest that the use of actual enrolments is not only practical in terms of reducing complexity and ensuring more reliable assessments, but also credible because it more simply reflects what States actually do.

Actual enrolments are suitable given increased commonality in State school policy, including: encouraging higher retention and participation; moves towards a nationally consistent starting age; the adoption of lower school class sizes for the early years of schooling; increased commonality in leaving age; and other changes (see ACT's Disaggregation Expenses Submission for further information).

There is clear evidence that the Commonwealth is a major driver of school standards which has resulted in the States providing very similar schooling arrangements, for example, universal structures, courses and assessment arrangements.

Any policy differences are relatively small. For example, the view that age of commencement materially affects States' service delivery costs is weak and problematic. No convincing causal relationships have been established and there is little qualitative or quantitative evidence available to suggest that it has material impacts between the States on the cost of providing education services. Certainly, in the context of ongoing reform and implementation of consistent standards and service provision arrangements, it would appear that the actual impact of policy differences is much less than what is currently assessed.

Similarly, the case for adjusting for post-compulsory participation is weak. Much of the qualitative and quantitative evidence available indicates that differences between States are not policy driven. For example, the following factors have a statistically significant relationship with post-compulsory school participation:

- parents' occupation and educational background (socio-economic status) – white collar, university education positively impacts on post-compulsory school participation;
- occupational and industry structure – a market with a greater proportion of higher skilled occupations (positive impact) provides incentive to remain in full time education and achieve tertiary qualifications;
- metropolitan (positive impact) and non-metropolitan (negative impact) location;
- non English speaking background (positive impact); and
- the proportion of the population that is Indigenous (higher proportions have a negative impact).

The ACT's relatively high post-compulsory school participation is predominantly explained by all of these factors.

In summary, there are strong grounds for using enrolments as the broad indicator for schools education, particularly given the:

- convergence in State policy over time and the rationale, therefore, of adopting a 'simpler policy approach'; and
- use of this measure in the past, consistent with the 'narrow view' of fiscal equalisation.

Inpatient (and health) Services

Mortality rates

Using mortality rates as a single broad measure for inpatient services is likely to be more robust than the current method as it would be based on reliable data and it overcomes problems of trying to determine reliable use and cost weights for a range of population sub-groups.

However, despite these benefits, mortality rates are too broad to capture States' relative SDC demand and cost disabilities as they have very little to do with the use of inpatient services.

Simpler average policy approach

The inpatient services assessment focuses on population characteristics that are considered to result in above average demand and cost. This approach is amiss as it implies that various SDC groups demand different levels of service, and that the government responds to provide more services (commensurate with demand) to these groups.

In reality, the current interpretation of average policy is incorrect, as is the way disabilities are measured, because:

- State policy is to ration the supply of inpatient services given funding constraints (evidenced by, for example, large surgery waiting lists); and
- State's inpatient services expenditures are driven by the whole of the population and illness, and not specific SDC groups per se.

To the extent that some SDC groups may demand and receive more hospital services per capita, this is accommodated by providing less services per capita to other population cohorts. For example, both WA and the NT provide above national average hospital separations per capita for their Indigenous population, however, provide a below average rate of separations per capita for their non-Indigenous population.¹

The case of emergency departments (ED) is a stark example in this regard, and probably provides the most clear example that a States' population as a whole, rather than specific SDC groups, drives the use of services.

By their nature ED services must be continuously available and capable of responding to emergencies for the population served as a whole, and not specific SDC groups. For example, the range of ED services are provided irrespective of income, Indigeneity, age, gender, or CALD background. Even in a State with a relatively older age cohort, such as SA, which faces proportionately a greater level of use by older citizens relative to other States, the full range of medical equipment and ED services are required to deal with illnesses unrelated to old age. That is, State policy is to provide ED services to the whole population.

Additionally, medical staff are largely trained to deal with illnesses that affect the population as a whole. Only at the margin are officers appointed to deal with specific SDC groups, such as translators for some Indigenous persons (such costs may not be material).

¹ Based on AIHW 2004-05 public hospital separations data (*Australian hospital statistics 2004-05*, Table 8.7, page 172), WA and the NT have 0.571 and 0.864 Indigenous separations per capita respectively compared to the Australian average of 0.451 in 2004-05, yet for non-Indigenous, WA and the NT have 0.179 and 0.178 non-Indigenous separations per capita respectively compared to the Australian average of 0.203 in 2004-05.

A recent study of WA hospital use highlights that illness drives costs, not SDC groups:

*“These results demonstrate vertical equity within WA’s hospital system, where people with the greatest disease burden receive the most care. This finding is consistent with Canadian research.”*²

An assessment premised on above average costs being driven by SDC disabilities is inconsistent with what States do given restrictions applied to the supply of services and the need to service the whole population.

Even for what is generally considered to be one of the more costly SDC groups, Indigeneity, services are rationed. The Department of Health and Aged Care’s Occasional Paper noted:

*“Indigenous Australians are under represented in the medical workforce and under serviced by that work force.”*³

In these circumstances, a ‘simpler average policy’ approach would be to assess States’ disabilities using broader indicators that largely focus on whole of population effects, rather than SDC groups.

The other alternative is to use a target population and adjust for the material drivers of differences in cost – old age and perhaps Indigeneity.

Reviewing the major non-policy influenced demand and cost drivers – low income

The design of assessments and the applicability of using broader indicators will largely be driven by decisions regarding major demand and cost disabilities considered to influence service delivery.

In the 2004 Review, low income was a key disability assessed for health services as, at the time, it was considered to be an influence that led to greater use and cost of inpatient (and other health) services. The ACT disputed this, and thus welcomes the results of Commission staff’s recent internal analysis which indicates that low income is not a major cost driver for inpatient services: *“...income is not as important a driver of differences between States in demand for health services”*.⁴

Independent findings suggest that poor health literacy, rather than SDC characteristics, is the most applicable measure of health use and cost. According to the American Medical Association, poor health literacy is:

*“...a stronger predictor of a person’s health than age, income, employment status, education level, and race.”*⁵

The case for including a range of SDC disabilities within the health assessments, in particular low income, should be rigorously tested. Given that low income is not necessarily associated with higher health spending, nor necessarily results in poorer health outcomes, it is not a significant driver of use and cost. If only major disabilities are to be included in the

² Medical Journal of Australia, *High-cost users of hospital beds in Western Australia: a population-based record linkage study*, 2006. See: http://www.mja.com.au/public/issues/184_08_170406/cal10930_fm.html#0_i1092550

³ Commonwealth Department of Health and Aged Care *The Australian Medical Workforce* Occasional papers: August 2001 pg 43.

⁴ Disaggregating Expenses, Staff Discussion Paper 2006/06, p 25.

⁵ Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *JAMA*, Feb 10, 1999.

assessments, low income effects may not be material, and might already be captured through other measures such as above average use and cost of old age or Indigenous persons.

Additionally, there is a need to ensure that inpatient services disabilities are not policy induced due to the inadequate provision of primary and preventative health measures.

According to the Australian Chronic Disease Prevention Alliance, up to 30 per cent of illnesses, and thus associated costs, are preventable:

*“Up to one third of all health problems are attributable to known and preventable risk factors such as smoking, physical inactivity, obesity, poor nutrition and high blood pressure.”*⁶

One example where State health prevention could have a significant impact is in regard to the propensity of the Indigenous population to smoke. While 20 per cent of the total Australian adult population smokes, half of the Indigenous population consume tobacco and in some regions of Australia, up to 83 per cent of Indigenous men and up to 73 per cent of Indigenous women use tobacco.⁷

It is well established that cigarette smoking not only causes many diseases, it impedes treatment. The Royal Australasian College of Physicians (RACP) states that:

*“Smokers use inpatient hospital services more than people who have never smoked and are also more likely than non-smokers to use services such as emergency and outpatient departments. Wounds heal less quickly and smokers are more likely to be admitted to intensive care after surgical procedures.”*⁸

In the context of smoking related hospital illnesses, these could be reduced significantly if health prevention strategies were targeted more effectively. The RACP notes that Indigenous persons are particularly affected by smoking as they may lack knowledge about the more specific harmful effects of cigarette smoking.⁹

With the rapid ageing of the population, health costs are expected to increase significantly. However, costs can be reduced by early intervention, educative and preventative strategies. According to a WA inpatient services study, the most effective means for reducing expenses for high-cost users is:

*“An integrated package of preventive health strategies appears to offer the most hope for curbing high hospital costs.”*¹⁰

The WA study also notes that:

“Our finding that many high-cost users were hospitalised for chronic conditions (such as end-stage renal disease, angina, congestive heart failure and cancer) that

⁶ The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease, Australian Chronic Disease Prevention Alliance, January 2004. See: http://www.heartfoundation.com.au/downloads/ACDPA_brochure_oct04.pdf#search=%22health%20prevention%20strategies%20reducing%20costs%22

⁷ The Royal Australasian College of Physicians, Health & Social Policy, *Tobacco Policy: Using Evidence for Better Outcome*. See: <http://www.racp.edu.au/hpu/policy/tobacco/intro1.htm>

⁸ Ibid.

⁹ Ibid.

¹⁰ Medical Journal of Australia, *High-cost users of hospital beds in Western Australia: a population-based record linkage study*, 2006. See: http://www.mja.com.au/public/issues/184_08_170406/cal10930_fm.html#0_i1092550

have identifiable and modifiable risk factors highlights the potential preventability of some hospital use.”¹¹

Governments are undertaking a range of initiatives to improve health literacy, such as public health promotion campaigns, primary health initiatives and school education programs. This makes sense given that physical inactivity, low levels of fruit & vegetable consumption, and the impact of obesity have a major impact on the burden of chronic disease facing Australians.¹²

However, according to the Report on Public Health expenditure, the amount spent on selected health promotion (a key component of health literacy) and research differs substantially between the States as seen in the following table.

A revised assessment approach for health services should ensure that States’ relative disabilities are not overestimated given that governments influence, and have a role in, promoting health literacy and introducing preventative measures to reduce costs.

TOTAL GOVERNMENT EXPENDITURES PER PERSON ON SELECTED PUBLIC HEALTH ACTIVITIES, CURRENT PRICES, BY STATE 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Selected Health promotion									
Average per person (\$)	7.83	15.14	8.54	11.7	10.64	15.43	14.15	16.38	10.74
Per Person Index ^(a)	72.9	141.0	79.6	109.0	99.1	143.7	131.8	152.5	100.0
Public Health Research									
Average per person (\$)	3.84	5.90	3.20	5.53	6.10	4.91	4.96	9.54	4.67
Per Person Index ^(a)	82.3	126.5	68.6	118.5	130.6	105.1	106.3	204.3	100.0

^(a) The ‘per person’ index for each category is referenced to the national per person expenditure = 100.0.

Source: Table 1.8, National Public Health Expenditure Report 2001–02 to 2003–04, AIHW.

Proxy measures

There is merit in examining proxy measures as a way of reducing data problems and simplifying the assessments. This approach could be an alternative to using broader measures where they do not capture SDC disabilities to an acceptable degree of accuracy.

To determine pertinent proxy measures, a thorough investigation of the material demand and cost drivers is required.

While comfortable with the use of regression analysis to test the validity and the weight of proxy measures, a range of studies and data collections should be available to guide the development of proxy measures.

¹¹ Ibid.

¹² The Economic Case for Physical Activity and Nutrition in the Prevention of Chronic Disease, Australian Chronic Disease Prevention Alliance, January 2004. See: http://www.heartfoundation.com.au/downloads/ACDPA_brochure_oct04.pdf#search=%22health%20prevention%20strategies%20reducing%20costs%22

The Discussion Paper states that the use of proxy measures would mean that GST redistributions could not be attributed to particular characteristics. This view is not shared as the redistributions would be reflective of those population sub-groups that are recognised in the assessments. For example, if old age and Indigeneity are used as the major drivers of health costs, any redistribution based on these measures must, ipso facto, relate to them.

Improving the 2004 Review approach

General Comments

If the broader approaches are found unsuitable for achieving HFE, the simplification of the current measurement framework is supported subject to overcoming immaterial and small adjustments and extensive judgement or the use of unreliable data.

Refining the current approach has the potential to achieve HFE while significantly reducing the extent of disaggregation. The major drawback appears to be that use and costs weights are required under this approach, a number of which are unreliable and in our view fail to meet the data reliability requirements.

Large cross-tabulations

Do we need cross-tabulations?

The joint factor approach and the use of cross-tabulated data are supported as it reduces double counting by recognising the interdependence of SDC characteristics and interactions.

The use of separate factors is problematic as it requires, amongst other things, judgments about the relative importance of each factor and how they might be combined.

The impact on GST shares highlighted in Table 4 of the Discussion Paper reinforces the concern that using separate factors can produce spurious results as the interaction between population characteristics are not accurately captured.

Reducing the number of population characteristics

Comments on proposed guidelines for including population characteristics and how can the number of population characteristics be reduced?

Including SDC characteristics is supported when:

- a conceptual case exists that the characteristic impacts on the use and/or cost of services;
- the impact on State needs of the characteristic can be reliably measured; and
- the total impact of the characteristics in the assessments is material.

While supportive of the suggested approach of minimising the number of SDC splits, research will be required to determine which SDC characteristics are material.

Reliability of use of cost weights

Comments on the importance of reliable data, how should the quality of State data be improved and what areas of State activity should there be a focus on improving?

Given the relative importance of cost weights in driving the relativities, and consistent with one of the major aims of the 2010 Review, it is critical that the data used to determine SDC disabilities are reliable, fit-for-purpose and independently verifiable.

As State data are often of poor quality or not comparable, the onus for improving these data rests with the States, particularly those advocating the various SDC factors. If deficiencies continue to exist with the data, and a detailed, disaggregated assessment is required to achieve HFE, the SDC impacts should either be discounted or not assessed.

In this context, jurisdictions need to develop whole of government strategies for improving the scope and quality of data. The ACT Treasury has undertaken steps requiring agencies to outline strategies for improving data. In some cases this has led to Cabinet requiring agencies to undertake comprehensive data collections and collect more reliable data.

In terms of targeting SDC data for improvement, the focus should be on areas where the redistributive impacts are relatively high; quantitative data are lacking; and where judgement based decisions (particularly cost weights) are undertaken.

Defining the disabilities

Indigenous SDC factors

Do we need to investigate the possible varying cost impacts of Indigenous persons living in different settings and levels of assimilation / integration?

There are a number of ongoing concerns with the assessment of Indigenous SDC factors, including that they are based on insufficient data, lack transparency and rely too heavily on broad judgement. Concerns are heightened when consideration is given to the extent of the redistribution of funding that occurs due to these factors.

Investigations into whether Indigenous persons are well assimilated into various communities will be subjective and will complicate the process. The Indigenous Inquiry has already reviewed, at a detailed level, a range of Indigenous costs and the impact of differing groups of the Indigenous population. If such a specific inquiry was unable to progress the suggested areas of research, it is doubtful that they could be progressed during the 2010 Review.

As a consequence of the difficulties already inherent with many Indigenous disabilities, it is important that focus is placed on improving the current weights. States that benefit from these factors face the prospect that many of them would be eliminated given their unreliability.

Socio-economic status

Current socio-economic status (SES) measures and adjustments for family size & cost of living could be improved / considered. We would need to consider whether the extra complexity of doing so is justified. Is that a level of complexity to which we should not go?

It is only equitable, and consistent with HFE, that all disabilities that are conceptually sound and have a material impact on States' service provision costs should be reflected in the assessments. As such, for example, the consideration of Indigeneity should not be at the expense of low income (with appropriate adjustments).

Appropriate low-income thresholds for families and individuals should be firstly determined and then adjusted to reflect higher costs of living and family size.

There is a body of evidence that reinforces the view that these adjustment should be made:

- the appropriateness of the low-income thresholds used for families and individuals is investigated each Review, and should again be undertaken for the 2010 Review;
- the merits of using the new ABS measure of household-equivalised income to adjust for the differences in family size were referred to in the 2004 Review Report;¹³
- the Commission accepted the conceptual case for the adjustment to the income threshold for differences between States in the cost of living;¹⁴ and
- Professor Pincus noted that varying State price levels and costs-of-living should be reflected in the development and application of a poverty line.

The Henderson Poverty Line (HPL) adjustments for low-income thresholds are material. As such, it is important that they:

- are up-to-date (reflect the latest financial circumstances of individuals and families);
- are reliable and accurate; and
- align with what the Australian Government is using to determine welfare assistance.

The use of the HPL to capture low-income persons has led to inflated estimates of the number of people in poverty over time. According to the ABS the 'original OECD' and Henderson equivalence scales are no longer in common use. The 'modified OECD' equivalence scale is now more widely accepted.

The Department of Family and Community Services also notes that the HPL has generally fallen into disuse among researchers.

The Commission has defined the poverty line as \$31,200 for families and \$20,800 for individuals. NATSEM's half mean poverty line (including housing costs) for 1999 suggests the poverty line is \$21,132 pa for families (\$406.38 per week) and \$11,698 pa for individuals (\$224.97 per week). The March 2002 HPL (including housing costs), as updated by MIAESR, is defined as \$28,666 pa (\$551.27 per week) for families and \$15,262 pa (\$293.5 per week) for individuals.

The Simplified Henderson Equivalence Scale (SHES) does not vary with age or gender, however, most social researchers agree that the variation of costs for children of different ages is an important factor in determining household disposable income. As this is the case, NATSEM has modified the SHES to take into account the age of children for their own research.

The HPL is updated using the ABS's Survey of Income and Housing Costs (SIHC), which is based on self-reporting by respondents. The general consensus is that individuals tend to underestimate their incomes and fail to take into account non-cash benefits, such as government services, eg Medicare and public education, which are considered to be of greatest benefit to lower income units. Further the SIHC has a fairly small sample size and is subject to sampling error, particularly in more recent years.

¹³ Commonwealth Grants Commission *Report on State Revenue Sharing Relativities 2004 Review*, Page 71.

¹⁴ Ibid.

The Commission's defined poverty lines produce inflated poverty lines and are out of step with current practice and various poverty line calculations. As such the low-income population used in a range of assessments (particularly the health and welfare categories) is considered to result in a significant overestimation of 'low-income earners' and those in 'poverty'.

High economic growth resulting in strong wage increases, coupled with changes to the Family Tax Benefits system, have also resulted in significant changes to income levels. These impacts have consequences for the current low income calculations and adjustments.

The more conventional approach is to assume half the median income, as suggested by NATSEM, as this softens outlier effects, which can significantly skew the data set. A more appropriate alternative for the Commission to use, therefore, is the half mean income.

Accurately measuring low income thresholds and adjusting for cost of living and household-equivalised income is important if HFE is to be achieved.

Persons from non-English speaking background

Is it reasonable to treat persons from a NESB as one homogenous group? Or are there many groups with different impacts, which can be reliably measured and are material?

There is concern with how SDC non-English speaking background (NESB) use and cost weights are determined. Patchy information and data are generally relied upon, and judgment is used to determine the Culturally and Linguistically Diverse (CALD) use and cost weights. In numerous cases sufficient evidence does not appear to exist to substantiate the current NESB factors within the assessments, let alone there being other reliable data available to further refine these factors.

States that benefit from the assessment of NESB factors should concentrate on substantiating the current use and costs weights, as without further evidence, many of them are unreliable and are at risk of being eliminated.

Materiality

A population characteristic might not be disaggregated unless it has a material impact. Should another threshold be introduced for this purpose? Or can we use the \$10 per capita threshold or the \$3 per capita threshold? How do we use the proposed materiality thresholds in developing SDC assessments? How should these thresholds fit together?

Given the new approach to use broader indicators wherever possible, it appears that the \$10 per capita threshold will be extensively used, and the \$3 per capita threshold infrequently used. As such, at first blush, these two thresholds would appear to have the ability to work well together. Adding an additional threshold will add to complexity and confusion, and is not supported unless there is clear evidence that it is required and will improve the proposed processes.

However, the issue that requires clarification is how the \$10 and \$3 per capita thresholds will be applied in practice. For example, the number of diplomatic children aged 15 and above attending government secondary schools may be by itself 'trivial', but in reality, the adjustment is required in order to ensure that the relevant population is accurately assessed, and enrolments meet the \$10 per capita threshold.

As such, depending upon the order or way in which this matter is approached, an adjustment might be included or excluded. Using the above example, the 'combined view' would be that an adjustment for diplomatic children is required to ensure that enrolments are accurate, or a 'split view' would be that an adjustment for diplomatic children by itself is trivial.