

# 1 Background

This publication reports on health expenditure in Australia, by area of expenditure and source of funds for the period 1995–96 to 2005–06. Expenditure is analysed in terms of who provides the funding for health care and what types of services attract that funding.

## **Box 1: Defining health expenditure and health funding**

### **Health expenditure**

*Health expenditure is reported in terms of who incurs the expenditure, rather than who ultimately provides the funding for that expenditure. In the case of public hospital care, for example, all expenditures (that is, expenditure on accommodation, medical and surgical supplies, drugs, salaries of doctors and nurses, etc.) are incurred by the states and territories, but a considerable proportion of those expenditures is funded by transfers from the Australian Government.*

### **Health funding**

*Health funding is reported in terms of who provides the funds that are used to pay for health expenditure. In the case of public hospitals, for example, the Australian Government funded 41.4% in 2005–06 and the states and territories funded 50.6%, together providing over 90% of the funding; these funds are derived ultimately from taxation and other sources of government revenue. Some other funding comes through private health insurers and from individuals who choose to be treated as private patients and pay their hospital fees out-of-pocket.*

The bulk of funding for health expenditure is provided by the Australian Government and the state and territory governments. Therefore, as well as consideration of the whole period from 1995–96 to 2005–06, analyses of trends in expenditure have been linked to the periods covered by the major health care funding agreements between these two levels of government. These are:

- from 1 July 1993 to 30 June 1998
- from 1 July 1998 to 30 June 2003
- from 1 July 2003 to 30 June 2008.

Australia is compared with other member countries of the Organisation for Economic Co-operation and Development (OECD) as well as other countries in the Asia-Pacific region.

The tables and figures in this publication detail expenditure in terms of current and constant prices. Constant price expenditure adjusts for the effects of inflation using either the annually re-weighted chain price indexes produced by the Australian Bureau of Statistics (ABS) or either ABS or the Australian Institute of Health and Welfare (AIHW) implicit price deflators (IPDs). Because the reference year for both the chain price indexes and the IPDs is 2004–05, the constant price estimates indicate what expenditure would have been had 2004–05 prices applied in all years.

### **Box 2: Constant price and current price expenditures**

*Wherever expenditures in 'constant prices' are shown, 'current prices' have been adjusted to reflect the prices of the reference year, 2004–05. The aim is to remove the effects of inflation. Hence expenditures in different years can be compared on an equal dollar-for-dollar basis, as measures of changes in the volume of health goods and services. The constant price method is used because it is not possible to derive estimates of volume by directly adding, say, the number of surgical operations to the number of pharmaceutical prescriptions.*

*Constant price estimates for expenditure aggregates have been derived using either the annually re-weighted chain price indexes produced by the ABS or AIHW/ABS IPDs.*

*The term 'current prices' refers to expenditures reported for a particular year, unadjusted for inflation. So changes in current price expenditures reflect changes in both price and volume.*

Throughout this publication there are references to the general rate of inflation. These refer to changes in economy-wide prices, not just consumer prices. The general rate of inflation is calculated by the ABS using the IPD for gross domestic product (GDP).

Expenditure estimates for 1998–99 to 2004–05 that have been revised since the publication of *Health expenditure Australia 2004–05* (AIHW 2006a) are detailed in Section 7.5.

## **High-level residential aged care**

The high-level care portion of residential aged care facility expenditure was included in previous editions of *Health expenditure Australia*. However, all expenditure related to these facilities has now been reclassified as welfare services expenditure (see Chapter 6 for further information). Hence, total expenditure data in this report are not comparable with previous editions of *Health expenditure Australia*. The reclassification of this residential aged care expenditure has reduced the health expenditure to GDP ratio in 2005–06 by 0.6% percentage points (i.e. the health to GDP ratio would have been 9.6% without the reclassification) (Table 64). The welfare services expenditure to GDP ratio would have increased accordingly (AIHW in press).

## **1.1 The structure of the health sector and its flow of funds**

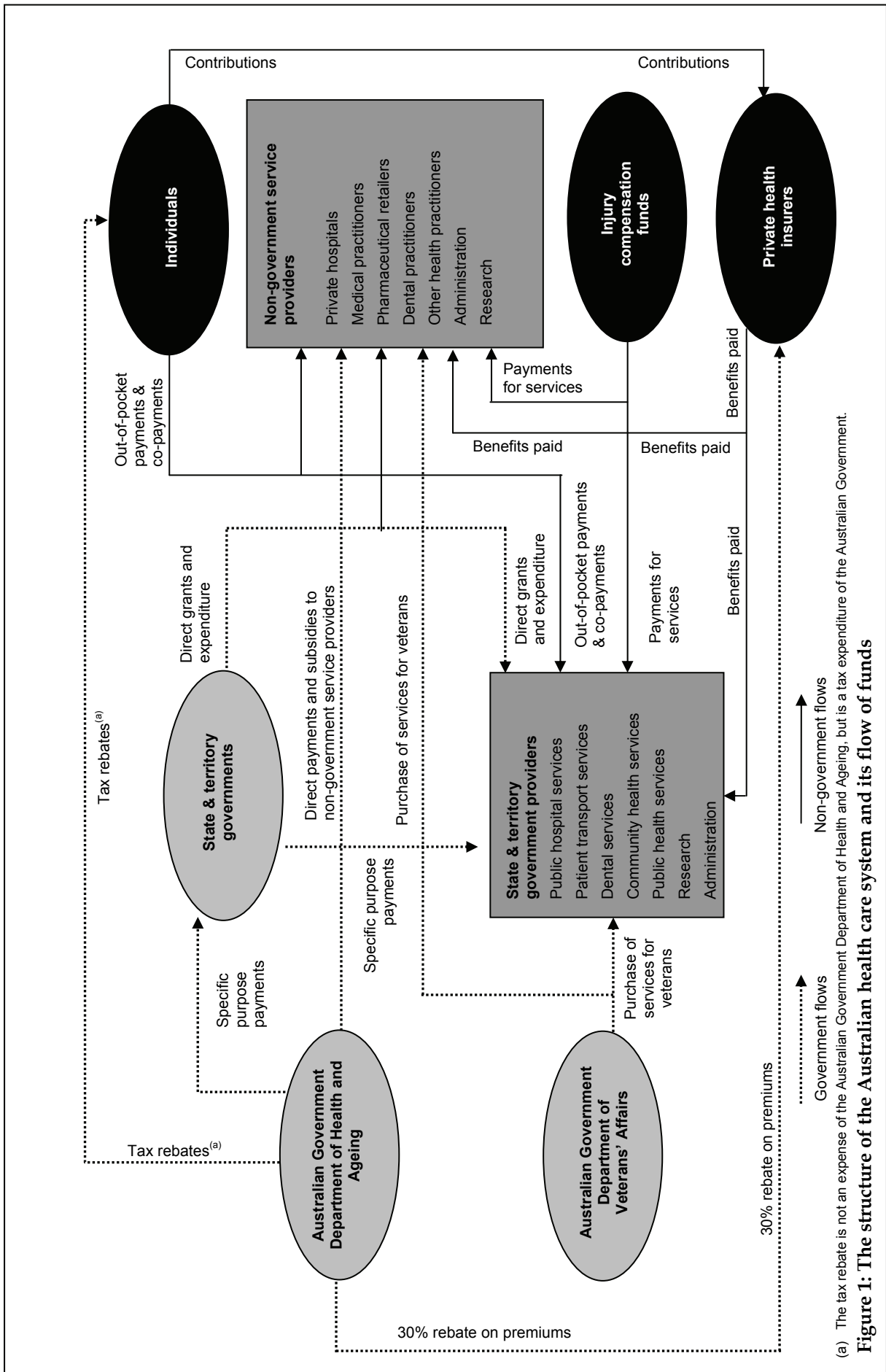
The flow of money around the Australian health care system is complex and is determined by the institutional frameworks in place, both government and non-government. Australia is a federation, governed by a national government (the Australian or Commonwealth Government) and eight state and territory governments. Both these levels of government play important roles in the provision and funding of health care. In some jurisdictions, local governments also play a role. All of these levels of government collectively are called the government sector. What remains is the non-government sector, which in the case of funding for health care comprises individuals, private health insurers and other non-government funding sources (principally workers' compensation and compulsory motor vehicle third-party insurers, but also includes funding for research from non-government sources and miscellaneous non-patient revenue received by hospitals). Figure 1 shows the major

flows of funding between the government and non-government sectors and the providers of health goods and services.

Most non-hospital health care in Australia is delivered by non-government providers, among them private medical and dental practitioners, other health practitioners (such as physiotherapists, acupuncturists and podiatrists) and pharmaceutical retailers. Delivery of health care can occur in a diverse range of settings – hospitals, rehabilitation centres, community health centres, health clinics, ambulatory care services, the private consulting rooms of health practitioners, patients' homes or workplaces, and so on.

In summary, the following are the main features of Australia's health system (see Figure 1):

- Universal access to benefits for privately provided medical services under Medicare, which are funded by the Australian Government, with co-payments by users when the services are not bulk-billed.
- Eligibility for public hospital services, free at the point of service, funded jointly by the states and territories and the Australian Government.
- Private hospital activity largely funded by private health insurance, which in turn is subsidised by the Australian Government through the 30% rebates on members' contributions to private health insurance.
- The Australian Government, through its Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS), subsidises a wide range of pharmaceuticals outside public hospitals, and also funds a wide range of services for eligible veterans.
- The Australian Government provides most of the funding for health research.
- State and territory health authorities are primarily responsible for the operations of the public hospital networks, mental health programs, the transport of patients, community health services, and public health services such as health promotion and illness prevention.
- Individuals primarily spend money on medications, private hospitals, medical, dental, other health practitioner services and aids and appliances.



(a) The tax rebate is not an expense of the Australian Government Department of Health and Ageing, but is a tax expenditure of the Australian Government.

**Figure 1: The structure of the Australian health care system and its flow of funds**

## 1.2 Revisions to ABS estimates

Revisions to ABS estimates of GDP and capital expenditure have affected the estimates in this publication, as in previous issues.

GDP estimates for this publication are sourced from the ABS (ABS 2007a). The current price GDP estimates in that ABS publication are slightly higher for all years, except for 2003–04 and 2004–05, compared to those published in *Health expenditure Australia 2004–05* (AIHW 2006a).

ABS estimates of capital expenditure have also been revised for most years, since *Health expenditure Australia 2004–05* (AIHW 2006a).

## 1.3 Changes to AIHW estimates

In this report there are a number of areas of health expenditure for which there were substantial changes in the methodology used to calculate estimates of expenditure. The results of these methodological changes are summarised below and are explained in detail in Chapters 6 and 7.

The work of the Health Expenditure Advisory Committee (HEAC) (see Chapter 7) will, over time, further enhance the quality and comparability of health expenditure data reported in the *Health expenditure Australia* publications.

### High-level residential aged care

In previous editions of *Health expenditure Australia*, high-level residential aged care was classified as part of health expenditure. In this report and for all subsequent reports this expenditure has been reclassified as welfare expenditure and is reported in the AIHW's *Welfare expenditure Australia* report series. The reclassification of high-level residential aged care from health to welfare services expenditure has reduced the health to GDP ratio and the estimates of Australian Government expenditure on health. The health to GDP ratio is 9.0% in 2005–06 and would have been 9.6% if high-level residential aged care expenditure was still reported under health expenditure. See Chapter 6 for further details.

### Public hospitals and public hospital services

There is a break in series due to differences in definitions of public hospital and public hospital services between 2002–03 and 2003–04. Prior to 2003–04, the AIHW Public Hospitals Establishments collection data were used to derive *public hospital* expenditure estimates for each state and territory. This expenditure reflects the level of expenditure on goods and services provided in hospitals. In contrast, *public hospital services* estimates, provided directly from the state and territory health authorities, are used for 2003–04 onwards and reflect the level of expenditure on goods and services provided in hospitals but *exclude* where possible any community health services, dental services, patient transport services, public health and health research expenditure undertaken by public hospitals. These expenditures are included under their respective categories in the health expenditure matrix. Due to this change in data source for public hospitals, there is a resulting break in time series between 2002–03 and

2003–04 for patient transport services, community health, public health and dental services as well. For example, patient transport expenditure that prior to 2003–04 was captured as part of public hospitals expenditure, would now be captured as part of patient transport services expenditure (see Box 3 in Chapter 4 for further details).

## **Private hospitals**

The ABS Private Hospital Survey series (ABS, cat. no. 4390.0) is the source of data on total spending on private hospitals in this report. In previous editions of *Health expenditure Australia* the total amount reported for private hospitals by the Institute and the ABS differed slightly due to methodological differences.

## **Individual out-of-pocket expenditure for dental services, other health practitioner services, aids and appliances, all other medications and patient transport services**

A change in the methods used to estimate individual out-of-pocket expenditure for dental services, other health practitioner services and aids and appliances for 2002–03 onwards has resulted in substantial revisions to these numbers in this report. The previous methods had relied on high level ABS data which proved to be unreliable and was subject to substantial revision over time. The new methods mostly rely on detailed private health insurance data. As a result of this change in methods there were large upward revisions to individual expenditure on ‘other health practitioner services’ for 2002–03, 2003–04 and 2004–05 of \$486 million (65.4%), \$347 million (34.4%) and \$362 million (31.6%) respectively. In contrast, this change in methodology has generally resulted in large downward revisions to individual out-of-pocket expenditure on aids and appliances. In 2003–04 this decrease was \$533 million (22.9%) while for 2004–05 it was \$1.1 billion (35.4%). This change in methodology did not have a substantial impact on individual out-of-pocket expenditure for dental services.

Revisions to individual out-of-pocket expenditure on ‘all other medications’ for 2001–02 onwards meant there was a decrease of \$562 million (15.2%) for individual out-of-pocket spending on ‘all other medications’ for 2002–03, an increase of \$24 million (0.7%) for 2003–04 and an increase of \$309 million (8.7%) for 2004–05.

In addition, for 1997–98 onwards, there was a change in the method used to calculate individual out-of-pocket expenditure on patient transport services by relying on data from the Productivity Commission’s Report on Government Services (ROGS). This change in method has resulted in downward revisions to individual out-of-pocket expenditure on patient transport services of \$171 million (43.4%) in 2002–03, \$212 million (54.2%) in 2003–04 and \$258 million (57.7%) in 2004–05.

The overall impact on individual out-of-pocket expenditure due to the changes in methodology for dental services, other health practitioner services, aids and appliances, all other medications and patient transport services was a decrease of \$1.4 billion (10.5%) in 2002–03, a decrease of \$1.9 billion (12.7%) in 2003–04 and a decrease of \$2.5 billion (15.3%) in 2004–05, compared to what was published in *Health expenditure Australia 2004–05* (AIHW 2006a).

## **State and territory funding of health expenditure**

The Institute received revised data from the Northern Territory health authority that has resulted in a downward revision to Northern Territory funding of recurrent health expenditure of \$18 million for 2002–03, an upward revision of \$112 million for 2003–04 and an upward revision of \$37 million for 2004–05.

Domiciliary care services expenditure is classified as welfare services expenditure not health expenditure. This has been the case for over 10 years. However some States had been reporting domiciliary care services expenditure as part of community health services expenditure. This misreporting has been corrected by moving this expenditure to welfare services where it can be identified, from 2003–04 onwards. This has resulted in quite large downward revisions for community health services of \$494 million and \$584 million for 2003–04 and 2004–05 respectively.

## **Premium rebates claimed through the taxation system**

In *Health expenditure Australia 2004–05*, premium rebates claimed through the taxation system for 2004–05 were reported to be \$314 million based on advice from the Australian Tax Office. This preliminary estimate has been revised by the Australian Tax Office down to \$155 million.