

7 Technical notes

7.1 General

Health expenditure is reported domestically using the Australian National Health Accounts (NHA) framework. This framework, which has operated since the early 1960s, is based on a national health expenditure matrix showing areas of expenditure by sources of funding.

Since 1998, the AIHW, which has responsibility for developing estimates of national health expenditure, has collated and stored its health expenditure data in a way that enables it to simultaneously report national health expenditure according to the national framework and according to the OECD's System of Health Accounts (OECD 2000).

Health Expenditure Advisory Committee (HEAC)

In 2003, the AIHW established the HEAC, comprising data users and providers, to provide advice on health expenditure reporting in Australia. The committee, which meets twice a year, consists of representatives of Australian government agencies – DoHA, ABS, DVA, Commonwealth Grants Commission, Medicare Australia and the Private Health Insurance Administration Council (PHIAC) – and each state and territory health department. This committee has now expanded to include a representative from the Ministry of Health New Zealand, and a health economist. The terms of reference for this committee are to provide advice to the AIHW on:

- data sources, analysis and presentation of its estimates of health expenditure in Australia
- integration of the AIHW's health expenditure collections with all other Australian sub-national and national collections, and with international frameworks and collections of health expenditure statistics
- longer term directions related to the reporting of expenditure on health, both within Australia and to international bodies such as the OECD and WHO.

Government Health Expenditure National Minimum Data Set (GHE NMDS)

Under the auspices of the HEAC, the AIHW has begun developing a national minimum dataset (NMDS) for government funded health expenditure (GHE) which will enhance the current reporting of health expenditure data.

An NMDS is a mandated national data collection for all states and territories. It is dependent upon national agreement to collect and supply uniform core data towards a national collection. The most important aspect of an NMDS is the agreement between all relevant parties. An NMDS agreement includes data standards specified using data elements, as well as the scope for the application of those data elements (AIHW 2007c).

Current approach

Expenditure and funding data for health goods and services are published annually in the *Health expenditure Australia* reports. These data are obtained from a wide variety of sources in the public and private sectors. The state and territory health authorities currently supply

their data to the AIHW. The current data collection instrument contains a mix of provider (e.g. public hospitals) and function categories (e.g. mental health services).

Proposed approach for NMDS

Policy areas increasingly want health expenditure information that they can use to identify the cost of specific programs, such as immunisation programs or mental health programs, as well as how much was spent by providers such as hospitals.

The proposed approach comprises data provided under the GHE NMDS which will include government expenditure data from the public, private and community sector health systems, including expenditure on health services such as hospitals and residential care services, patient transport, medical, other health practitioners, dental, community and public health services, and research and administration costs and expenditure provided for health goods such as pharmaceuticals and aids and appliances. It will also include information on the source of public and private revenue. These data will be supplied to the AIHW by existing data providers.

There will be four categories to capture expenditure and revenue:

- provider/organisation
- program/function
- source of public and private revenue
- economic type framework.

The first three of these categories use classifications which correspond to those used by the OECD in its System of Health Accounts. The Economic type framework classification is an ABS classification. Some additional classification sources have also been used:

- ABS Australian and New Zealand Standard Industry Classification
- ABS Government Purpose Classification
- Australian Accounting Standards Board 1049 and 118
- existing National Health Data Dictionary items.

Provision of data under the GHE NMDS is expected to begin from the collection period 1 July 2008 to 30 June 2009.

7.2 Definition of health expenditure

‘Health expenditure’ is the sum of expenditure on health goods and services which are used up within a year and health-related investment which has a longer life.

Expenditure on health goods and services used up within a year includes expenditure on health goods (medications, aids and appliances), health services (clinical interventions); and other health services such as expenditure on public health, research and administration. These expenditures are collectively termed recurrent expenditure. Depreciation (or capital consumption) is part of recurrent expenditure but in these accounts only non-government capital consumption is incorporated in recurrent expenditure. Government capital consumption is reported separately.

Health-related investment is referred to as gross fixed capital formation or capital expenditure. In this publication the term 'capital expenditure' is used.

The AIHW's definition of health expenditure closely follows the definitions and concepts provided by the OECD's SHA (OECD 2000) framework. It excludes:

- expenditure that may have a 'health' outcome but that is incurred outside the health sector (such as expenditure on building safer transport systems, removing lead from petrol, and educating health practitioners)
- expenditure on personal activities not directly related to maintaining or improving personal health
- expenditure that does not have health as the main area of expected benefit.

Some of the expenditure from non-government health organisations, such as the National Heart Foundation and Diabetes Australia is not included in these accounts. In particular, as data are not available, most of the non-research expenditure funded by donations to these organisations is not included.

Total health expenditure reported for Australia (both domestically and internationally) is slightly underestimated in that it excludes health expenditure on health services provided by the Australian Defence Force, some school health expenditure and some health expenditure incurred by corrective services institutions in the various states and territories.

It is arguable that there is some over-estimation of health expenditure in the dental area. Expenditure on orthodontics is included in dental expenditure, but the principal purpose of most of this expenditure is cosmetic and health is only a secondary purpose. Thus it probably should not be part of health expenditure. On the other hand, expenditure on toothbrushes and toothpaste is not currently included in health expenditure but it could be argued that the primary purpose of this expenditure is health with the secondary purpose being personal care/hygiene.

Difficulties in separating expenditures incurred by local governments on particular health functions from those of state and territory governments mean that these funding sources are often combined. However, the ABS data indicate that the contribution of local governments is relatively small.

Table 65: Areas of health expenditure used in this report

Term	Definition
Public hospital	Includes public psychiatric and non-psychiatric hospitals. A public hospital is a health care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, operated by, or on behalf of state and territory governments and authorised to provide treatment and/or care to patients. Such hospitals are recognised under the AHCA's and they include some hospitals, such as some denominational hospitals which are privately owned.
Public hospital services	Services provided to a patient who is treated by a public hospital (as defined above), but excludes , where possible, dental services, community health services, patient transport services, public health and health research undertaken by the hospital. Can include services provided off the hospital site such as hospital in the home dialysis or other services.
Private hospital	A private hospital is a health care facility, established under Commonwealth, state or territory legislation as a hospital or free-standing day procedure unit and authorised to provide treatment and/or care to patients. A private hospital is not defined by whether it is privately owned but by whether it is <u>not</u> a public hospital (as defined above). Private hospital expenditure includes expenditures incurred for public patients being treated in a private hospital under contract.
Patient transport services	Expenditure by organisations primarily engaged in providing transportation of patients by ground or air, along with health (or medical) care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. Includes public ambulance services or flying doctor services such as Royal Flying Doctor Service and Care Flight. Also includes patient transport programs such as patient transport vouchers or support programs to assist isolated patients with travel to obtain specialised health care. <i>(Note: Previously called 'Ambulance and other'.</i> For 2003–04 onwards, this category may include patient transport expenses that are included in the operating costs of public hospitals.
Medical services	Comprises medical services funded by the Medicare Benefits Scheme, compulsory Motor Vehicle Third Party Insurance, Workers Compensation Insurance, Health Services Australia and from patient out-of-pocket payments. Includes services listed in the Medical Benefits Schedule (MBS) that are provided by registered medical practitioners. Most medical services in Australia are provided on a fee-for-service basis and attract benefits from the Australian Government under Medicare. Also includes medical services provided to private admitted patients in hospitals, non-MBS medical services such as the provision of vaccines for overseas travel, as well as some expenditure that is not based on a fee-for-service (i.e. alternative funding arrangements). Excludes medical services provided to public admitted patients in public hospitals and medical services provided to public patients at outpatient clinics in public hospitals.
Other health practitioners	Services provided by health practitioners (other than doctors and dentists). These include chiropractors, optometrists, physiotherapists, speech therapists, audiologists, dietitians, podiatrists, homeopaths, naturopaths, practitioners of Chinese medicine and other forms of traditional medicine, etc.
Medications	Comprises benefit-paid pharmaceuticals and other medications.
Benefit-paid pharmaceuticals	Pharmaceuticals in the PBS and the RPBS (see Glossary) for which the Australian Government paid a benefit.
Other medications	Pharmaceuticals for which no PBS or RPBS benefit was paid and other medications. Includes: <ul style="list-style-type: none"> • pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned • pharmaceuticals dispensed through private prescriptions that do not fulfil the criteria for payment of benefit under the PBS or RPBS • over-the-counter medicines including pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band-aids and condoms.

(continued)

Table 65 (continued): Areas of health expenditure used in this report

Term	Definition
Aids and appliances	<p>Durable medical goods dispensed to ambulatory patients that are used more than once, for therapeutic purposes, such as glasses, hearing aids, wheelchairs and orthopaedic appliances and prosthetics that are not implanted surgically but are external to the user of the appliance.</p> <p>Excludes prostheses fitted as part of admitted patient care in a hospital.</p>
Community health	<p>Non-residential health services offered by establishments to patients/clients, in an integrated and coordinated manner in a community setting, or the coordination of health services elsewhere in the community.</p> <p>Includes:</p> <ul style="list-style-type: none"> • well baby clinics • health services provided to particular groups such as Aboriginal and Torres Strait Islander people, women, youth and migrants, as well as family planning services, alcohol and drug treatment services, etc. • specialised mental health programs for patients with mental illness that are delivered in a community setting.
Public health	<p>Services provided and/or funded by governments that are aimed at protecting and promoting the health of the whole population or specified population subgroups and/or preventing illness or injury in the whole population or specified population subgroups.</p> <p>Public health services do not include treatment services.</p>
Dental services	<p>A range of services provided by registered dental practitioners.</p> <p>Includes oral and maxillofacial surgery items; orthodontic, pedodontic and periodontic services; cleft lip and palate services; dental assessment and treatment; and dental items listed in the MBS.</p>
State and territory dental services	<p>School dental programs, community dental services and hospital dental programs funded by state and territory health authorities.</p>
Health administration	<p>Activities related to the formulation and administration of government and non-government policy in health and in the setting and enforcement of standards for health personnel and for hospitals, clinics, etc.</p> <p>Includes the regulation and licensing of providers of health services.</p> <p>Where possible administrative costs related to the delivery of particular health goods and services are added to the direct expenditure on those goods and services.</p>
Health research	<p>Research undertaken at tertiary institutions, in private non-profit organisations and in government facilities that has a health socioeconomic objective.</p> <p>Excludes commercially oriented research carried out or funded by private business, the costs of which are assumed to be included in the prices charged for the goods and services (e.g. medications that have been developed and/or supported by research activities).</p>
Capital expenditure	<p>Expenditure on fixed assets (e.g. new buildings and equipment with a useful life of more than a year).</p>
Capital consumption	<p>Capital consumption is otherwise known as depreciation and represents the amount of fixed capital used up each year.</p>
Non-specific tax expenditure	<p>The only tax expenditure currently included here is the medical expenses tax rebate. This becomes available to individuals to claim through the taxation system if they have out-of-pocket medical expenses over a specified limit in an income year. For the 2005–06 income year, the tax rebate was 20 cents for each \$1 by which a taxpayer's net medical expenses exceeded \$1,500 (the threshold).</p> <p>The Australian Treasury estimates other tax expenditure in the health area, such as the cost of exempting low income earners from the Medicare levy. These tax expenditures are not included in the Australian NHA framework.</p>

7.3 Data and methods used to produce estimates

General

The total expenditure and revenue data used to generate the tables are, to the greatest extent possible, produced on an accrual basis; that is, expenditures reported for each area relate to expenses incurred in the year in which they are reported. This is not, however, achievable in all cases. For example, where the data on which the estimates are based are provided by a funding source, such as the private health insurance funds, they sometimes relate to the date of processing claims. These do not necessarily coincide with the date on which the related service was provided. As a further consequence, the contribution of that funding source may be understated in one year and overstated in another.

A very small part of public hospital expenditure is funded by private practitioner facility fees. This revenue is in turn partly funded by the Medicare Benefits Scheme and that money is reported separately in the medical services row of the health expenditure matrix.

Therefore there is a partial double count of the public hospital expenditure funded from private practitioner facility fees and medical services.

The AIHW gathers information on which to base its estimates of health expenditure from a wide range of sources. The ABS, the Department of Health and Ageing, and state and territory health authorities provided most of the basic data used in this publication. Other major data sources are the DVA, the PHIAC, Comcare, and the major workers' compensation and compulsory third-party motor vehicle insurers in each state and territory.

State and territory expenditure tables

The state and territory tables are intended to give some indication of differences in the overall levels of expenditure on health in the states and territories; they do not necessarily reflect levels of activity by state and territory governments. For example, service providers located in the different states and territories pursue a variety of funding arrangements involving inputs from both government and non-government sources. As a result, one state or territory may have a mix of services and facilities that is quite different from that in another state. The estimates will enable a state or territory government to monitor the impact of policies on overall expenditure on health goods and services provided within its borders.

It should be noted that estimates of funding by state and local government in respect of a particular state/territory table are derived by deducting from gross health expenditure estimates, any Australian Government grants and other revenue received by the state and territory health authorities. This funding relates to all funding by state/territory and local governments on services provided in the state or territory concerned. Some of the services concerned may actually be the subject of cross-border reimbursement arrangements between the states and territories.

Where funding data are provided only on a national basis, as is the case for some Australian Government programs, the AIHW calculates allocations for those expenditures by state and territory.

State government contracting of private hospital services

At present the matrices for each state and territory prior to 2002–03 indicate that state and territory governments provided no funding for services provided by private hospitals. This is incorrect, because there are at least two situations in which they do provide funding for services provided by private hospitals, namely where:

- (a) a state or territory government or an area health service has contracts with private hospitals to provide services to public patients
- (b) a public hospital purchases services from a private hospital in respect of some of its public patients.

The AIHW has begun to collect the first of these data flows from 2002–03 and they are included in both the national and the state and territory matrices from that year.

The second of these flows would currently be included in total expenditure, but they would be counted as funding for services provided by public hospitals (so long as the related purchases are being included in the reported expenses of the purchasing hospitals in the public hospital establishments data).

Allocation of expenditure by the Australian Government to states and territories

The bulk of the expenditures by the Australian Government can readily be allocated on a state and territory basis. These include:

- specific purpose payments (SPPs) to the states and territories for health purposes
- Medicare benefits payments
- pharmaceutical benefit payments
- Department of Veterans' Affairs expenditure.

Data on other health funding by the Australian Government are generally not available on a state and territory basis. In those cases, indicators are used to derive state and territory estimates. For example, non-Medicare payments to medical service providers aimed at enhancing or modifying medical practice are allocated according to the proportion of vocationally registered general practitioners in each state or territory.

Expenditure by state, territory and local governments

The ABS produces annual estimates of public finance, which contribute information used in the AIHW National Health Accounts. These include expenses and revenues for all levels of government.

Until 1996–97, public finance data were reported on a cash basis. From 1997–98, reporting has been on an accrual basis for most jurisdictions. Where states or territories have not reported on an accrual basis, their cash accounts have been modified by the ABS to conform to accrual definitions. State and territory data included in the ABS's public finance database are provided by each of the state and territory treasuries. The GPC developed by the ABS is used to allocate expenses and revenues by function.

There have always been difficulties in accurately allocating government expenditures in the public finance database according to purpose (function). This is particularly the case at the lower levels of disaggregation.

Since the move to accrual-based accounting, the emphasis of the ABS and the Treasury departments has been on ensuring that transaction-type classifications of expenditure are correct (that is, ensuring that expenses and revenues are correctly classified in the state and territory accounts). To date, less attention has been given to the verification of expenditure in the public finance database according to function. As a consequence, only the ABS's estimates of total health expenditure by state and local governments are used in this publication as a guide to the overall movements in state and local government recurrent funding for health from one year to the next.

The ABS provided research expenditure data from its Research and Experimental Development Survey series (ABS 2004a, 2004b, 2004c, 2004d, 2005a, 2006). Some of the state allocations in the supplied 2004–05 data were derived by the ABS.

Break in series for selected areas of expenditure between 2002–03 to 2003–04

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 (PHE) collection data were used to derive public hospital expenditure estimates for each state and territory. The PHE data comprises expenditure on goods and services provided in hospitals, including expenditure on the components of community and public health services, dental and patient transport services and health research that are provided in public hospitals. This expenditure is referred to as 'public hospital' expenditure.

In contrast, 'public hospital services' estimates, provided directly from the state and territory health authorities, are reported for 2003–04 onwards and reflect the level of expenditure on goods and services provided in hospitals, however, these estimates *exclude*, where possible, any community and public health services, dental and patient transport services and health research expenditure undertaken in public hospitals. These expenditures are included under their respective categories in the health expenditure matrix. For example, patient transport services expenditure that prior to 2003–04 was captured as part of public hospital expenditure, would now be captured as part of patient transport services expenditure.

The AIHW PHE collection was the source of data for state and territory expenditure on public hospitals reported in Tables 33 to 37 and Figure 13.

State and territory funding for public hospitals was derived by subtracting Australian Government grants and any other public hospital revenue from the PHE data.

Community and public health services and dental and patient transport services

Due to the above-mentioned change in definitions for public hospitals and public hospital services, there is a resulting break in time series between 2002–03 and 2003–04 for community and public health services and for dental and patient transport services.

In addition, for community health services, an indeterminate amount of domiciliary care expenditure was included in the community health services data prior to 2003–04. Domiciliary care, which includes home and community care (HACC) funding, is considered

to be more a welfare service than a health service and for this report has been excluded where possible from the community health services estimates.

Although valid comparisons across the discontinuity can be made for total health expenditure, caution should be exercised when comparing data across the decade for these four areas of expenditure.

Funding by the non-government sector

Funding by the non-government sector is shown in the various state matrices in three broad 'source of funds' categories:

- health insurance funds
- individuals
- other non-government sources.

Health insurance funds

Funding by health insurance funds on health goods and services within a state or territory is assumed to be equal to the level of benefits paid by health insurance funds that operate from that state or territory. In the case of New South Wales and the Australian Capital Territory, the NSW funds cover ACT residents. Therefore private health insurance benefits cannot easily be split between NSW and the ACT. Data from *Australian Hospital Statistics* is used to separate private health insurance benefits for hospitals between the ACT and NSW, but for non-hospital benefits, the benefits for both NSW and ACT are included in the NSW tables B1 to B3 and no benefits are included in the ACT tables B19 to B21.

Private health insurance rebates

In all years from 1997-98, funding by health insurance funds has been reduced by the extent of the Australian Government subsidy through the Private Health Insurance Incentives Scheme (up until the end of 1998) and the 30% rebate on private health insurance contributions (since 1999).

Individuals

Estimates of expenditure by individuals on:

- dental services
- other health practitioners
- aids and appliances

for 2002-03 onwards mostly rely on detailed private health insurance data from PHIAC. The previous methods relied on high-level ABS data which proved to be unreliable and were subject to substantial revisions over time. The new methodology uses the growth in the cost of services combined with the change in proportion of the population who have ancillary cover from year to year to project forward the individual out-of-pocket expenditure for these categories. Funding of these services by private health insurance funds and injury

compensation insurers are deducted from these estimates to arrive at the estimates of individuals' out-of-pocket funding.

Estimates of expenditure by individuals on patient transport services are based on data from the Productivity Commission's Report on Government Services (SCRCSSP 1999 and 2003, SCRGSP 2007) from 1997-98 onwards. Prior to 1997-98, estimates were derived from PHIAC data.

Other non-government sources

Workers compensation and third party motor vehicle insurance payments comprise the majority of expenditure for this category. The Institute obtains these data from the respective injury compensation insurers in each state and territory.

Change in methodology for deflators

There are nine types of deflators (see Appendix D for more information) used in this report (Table 66). Most deflators are very specific to the type of expenditure they are applied to. For example, all hospitals use the government final consumption expenditure (GFCE) hospitals and nursing homes deflator.

There are four new deflators used in this report, which replace deflators used in *Health expenditure Australia 2004-05* (AIHW 2006a). See next page (Table 66) for further details.

Table 66: Area of health expenditure by type of deflator applied

Area of expenditure	Deflator applied
Public hospitals ^(a) / Public hospital services ^(a)	GFCE hospitals and nursing homes
Private hospitals	GFCE hospitals and nursing homes
Patient transport services	GFCE hospitals and nursing homes
Medical services	Medicare medical services fees charged
Dental services	Dental services ^(b)
Other health practitioners	Other health practitioners ^(b)
Community health and other	Professional health workers wage rate index ^(b)
Public health	GFCE hospitals and nursing homes
Benefit-paid pharmaceuticals	PBS pharmaceuticals
All other medications	HFCE on chemist goods
Aids and appliances	Aids and appliances ^(b)
Administration	Professional health workers wage rate index
Research	Professional health workers wage rate index
Capital expenditure	Gross fixed capital formation
Capital consumption	Gross fixed capital formation
Non-specific tax expenditure	Professional health workers wage rate index

(a) See Box 3 for details on the distinction between public hospitals and public hospital services.

(b) These deflators are new in this report and have replaced those used in *Health expenditure Australia 2004–05* (AIHW 2006a).

Blank cells in expenditure tables

The national and the state and territory tables in Appendixes A and B have some cells for which there is no expenditure recorded. The reasons for this are many, but the main ones are:

- (i) There are assumed to be no funding flows because they do not exist in the institutional framework for health care funding.
- (ii) The total funding is so small that it rounds to less than \$500,000.
- (iii) A flow of funds exists but it cannot be estimated from available data sources.
- (iv) Some cells relate to 'catch-all' categories and the data and metadata are of such high quality as to enable all expenditure to be allocated to specified areas. This, in turn, means that there is no residual to be allocated to the 'catch-all' categories.

As to (i), for example, there are no funding flows by the state, territory and local government for medical services and benefit-paid pharmaceuticals because these are funded by the Australian Government, individuals and private health insurance funds through Medicare and the PBS.

An example of (iii) is state and local government funding for private hospitals. There are known to be funding flows in this area because state and territory governments are known to contract with private hospitals to provide some hospital services to public patients. Data have been inserted in the matrices from 2002–03 onwards, but not for earlier years.

As to (iv), in some years some small miscellaneous expenditures by the Australian Government have been allocated to the category 'Other non-institutional n.e.c.'. These could not, at that time, be allocated to the specific health expenditure areas in the matrix. In other years, better quality of description may have allowed those types of expenditures to be more

precisely allocated. The expenditure category remains in order to show what total health expenditure is over a long time period.

Population

The per person estimates of expenditure are calculated using estimates of annual mean resident population, which are based on quarterly estimated resident population data from the ABS (ABS 2007b). See Appendix G for further details.

7.4 Revisions of definitions and estimates

Definitions

Patient transport services

In earlier health expenditure publications, the term 'ambulance and other' was used instead of 'patient transport services'. These terms are identical in definition. See Table 65 for further information on what comprises patient transport services.

Public and community health

In earlier health expenditure publications, public health expenditure was included with community health expenditure because of the difficulty in obtaining reliable data about these two categories of expenditure. These data were sourced from the ABS GFS and from the states and territories themselves.

Separate and timely data on public health expenditure data, based on nine core public health expenditure activities, have now become available from the AIHW's Public Health Expenditure Project. This project, which forms an integral part of the development of public health information under the former National Public Health Partnership, is funded by the DoHA. It aims to develop reliable and timely estimates of public health investment in Australia, both in the public sector and in the non-government sector.

The data for 1999-00 to 2004-05 have been published in the AIHW's *National public health expenditure* reports (AIHW 2002, 2004, 2007b). Data for 2005-06 will be released later in 2007. The estimates of public health expenditure in this report are based on the data in the National Public Health Expenditure Project. Note that, at present, public health expenditure data are collected only for key health departments and agencies of the Australian Government and states and territories and includes depreciation.

Other medications

Expenditure on other medications includes expenditure on over-the-counter medicines, complementary medicines, over-the-counter medical non-durables, as well as prescribed medications for which no benefits are paid under the PBS or RPBS, including PBS or RPBS items which have a price less than or equal to the co-payment (see Table 65 for further details).

Over-the-counter medications and medical non-durables

Over-the-counter medicines and medical non-durable goods are all therapeutic goods of a type that are sold at pharmacies or supermarkets and are used to treat or cure a condition. These include pharmacy-only medicines. Examples of over-the-counter medicines are analgesics, antacids and cough medicines. Examples of over-the-counter medical non-durable goods include non-prescription therapeutic goods that tend to be single-use items, such as bandages, elastic stockings, incontinence articles, condoms and other mechanical contraceptive devices. Goods that are for personal use such as tanning lotion are not considered to be therapeutic, whereas after-sun lotion to treat sunburn would be within the scope of health expenditure.

The AIHW has obtained over-the-counter data for 2001–02 to 2004–05 from *Retail pharmacy* (Flanagan 2002a, 2004a, 2005a) and *Retail world* (Flanagan 2002b, 2003, 2004b, 2005b), having previously obtained it from *Pharmacy 2000* (Feros 1998, 1999, 2000, 2001). Over-the-counter supermarket and pharmacy data for 2005–06 were obtained from Retail World (Flanagan 2006) and Synovate AZTEC (unpublished data) respectively.

The change in data source has enabled a more comprehensive breakdown of each category of products sold at pharmacies and supermarkets. For example, the estimates are now able to include the therapeutic proportion of the total sales of mouthwash sold at supermarkets. No data are yet available for health goods sold through retail outlets such as convenience stores and health food stores but such expenditure constitutes a small part of total over-the-counter sales of pharmaceuticals and medical non-durables.

Non-benefit prescriptions

Non-benefit prescription expenditure was derived from total prescription volume and the average price of private and under co-payment scripts. These data were provided by DoHA and the Pharmacy Guild of Australia's pharmacy survey.

Revision of estimates

Some components of total health expenditure have been revised since the publication of *Health expenditure Australia 2004–05* (AIHW 2006a).

High-level residential aged care

In earlier editions of *Health expenditure Australia* reports, high-level residential aged care was classified as part of health expenditure. For this report and in all subsequent reports this expenditure is now classified as welfare expenditure and reported as part of the *Welfare expenditure Australia* report series. The reclassification of high-level aged residential care from health to welfare expenditure has affected the health to GDP ratio. See Executive Summary and Chapter 6 for further details.

Private hospitals

The ABS Private Hospital Series (ABS, Cat. no. 4390.0) is the source for total spending on private hospitals in this report. In previous reports, the ABS Private Hospital survey was the source of the majority but not all funding on private hospitals. There were downward revisions of total spending on private hospitals of \$195 million for 2002–03, \$524 million for 2003–04 and \$587 million for 2004–05 from previously published estimates.

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 methodology used to calculate individual out-of-pocket expenditure for dental services, other health practitioner services and aids and appliances for 2002–03 onwards and patient transport services for 1997–98 onwards has resulted in substantial revisions to all of these areas of health spending in this report. In earlier editions of *Health expenditure Australia*, ABS HFCE estimates were used to calculate individual out-of-pocket expenditure for these categories.

In this report for 2002–03 onwards, individual out-of-pocket expenditure on dental services, other health practitioners and aids and appliances were calculated from PHIAC data. This change in methodology has resulted in a \$486 million increase in individual expenditure on other health practitioner services in 2002–03 compared to a \$347 million increase for 2003–04 and a \$362 million increase for 2004–05. 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 while in 2004–05 it was \$1.1 billion. The change in methodology did not have a substantial impact on individual out-of-pocket-expenditure for dental services.

Revisions to non-benefit scripts expenditure for 2001–02 onwards for this report have had an impact on individual spending estimates for all other medications. For 2002–03 there was a decrease of \$562 million, while in 2004–05 there was an increase of \$309 million for individual spending on all other medications.

For 1997–98 onwards, Productivity Commission rather than PHIAC data were used to calculate individual out-of-pocket expenditure on patient transport services. This change in methodology has caused a downward revision to individual spending estimates for each year. For 2002–03 to 2004–05, \$171 million, \$212 million and \$258 million respectively, were the downward revisions for individual spending on patient transport services.

Revisions to state and territory estimates of health expenditure

The Institute received revised data from the Northern Territory health authority that has resulted in revisions to Northern Territory funding of recurrent health expenditure for 2002–03 to 2004–05. There was a downwards revision 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.

State government funding and individual out-of-pocket funding for public hospital services has been revised for New South Wales and Victoria to ensure that the public hospital services expenditure and revenue data included in this report for 2003–04 onwards was based on data received from the state and territory health authorities. For New South Wales this resulted in an increase in state government funding and a decrease in out-of-pocket funding of public hospital services for 2003–04 and 2004–05. For Victoria this resulted in a decrease for both state government funding and out-of-pocket funding of public hospital services in 2003–04 and 2004–05. Prior to 2003–04, the AIHW Public Hospitals Establishments collection was the main source for public hospitals expenditure data.

Domiciliary care services expenditure that was previously reported as part of community health services expenditure by the state and territory health authorities has been removed where possible from 2003–04 data onwards. Domiciliary care has more of a welfare than a health purpose and consequently will be reported as part of the *Welfare expenditure Australia*

report series. As a result of this reclassification, there are quite large downward revisions for community health services funding by state and territories for 2003–04 onwards in this report. In 2004–05, the decrease was \$428 million while in 2003–04 it was \$471 million.

Premium rebates claimed through the taxation system

In *Health expenditure Australia 2004–05* (AIHW 2006a), premium rebates for 2004–05 that were claimed through the taxation system were reported to be \$314 million. This preliminary estimate has been revised down to \$155 million in this report. The large difference in the amount was due to moving from a cash accounting to an accrual accounting basis. The preliminary estimate for 2004–05 contained the amount for both cash and accrual as this was the year the change occurred. This meant there was effectively a double count of the expense amount in 2004–05 from bringing forward the accrual amount.

Summary of revisions to expenditure estimates following the release of *Health expenditure Australia 2004–05*

These were the revisions to total health expenditure from 1998–99 onwards (Table 67).

Table 67: Comparison of previously published estimates of total health expenditure, current prices, 1998–99 to 2004–05, with current estimates (\$ million)

Year	Previous estimate	Revised estimate	Change
1998–99	51,419	48,502	–2,917
1999–00	54,916	52,442	–2,474
2000–01	61,618	58,287	–3,331
2001–02	67,132	63,448	–3,684
2002–03	73,108	68,932	–4,176
2003–04	79,114	73,945	–5,169
2004–05	87,296	81,125	–6,171

Source: AIHW health expenditure database.

Revision of 1998–99 estimates

Overall, the estimates of health expenditure for 1998–99 were reduced by \$2,917 million. Reclassification of high-level residential aged care to welfare removed \$3,706 million.

There was an upwards revision of \$507 million to capital expenditure and an upwards revision of \$355 million to community health.

Revision of 1999–00 estimates

Overall, the estimates of health expenditure for 1999–00 were reduced by \$2,474 million. Reclassification of high-level residential aged care to welfare removed \$3,737 million.

The major areas of revision were:

- capital expenditure (up \$841 million)
- community health (up \$446 million)
- other health practitioners (up \$87 million)
- administration (down \$44 million).

Revision of 2000–01 estimates

Overall, the estimates of health expenditure for 2000–01 were reduced by \$3,331 million. Reclassification of high-level residential aged care to welfare removed \$3,890 million.

The major areas of revision were:

- capital expenditure (up \$827 million)
- private hospitals (down \$108 million)
- patient transport services (down \$98 million)
- administration (down \$58 million).

Revision of 2001–02 estimates

Overall, the estimates of health expenditure for 2001–02 were reduced by \$3,684 million. Reclassification of high-level residential aged care to welfare removed \$4,140 million.

The major areas of revision were:

- capital expenditure (up \$531 million)
- other health practitioners (up \$264 million)
- aids and appliances (up \$172 million)
- patient transport services (down \$137 million)
- dental services (down \$131 million)
- all other medications (down \$88 million)
- private hospitals (down \$87 million).

Revision of 2002–03 estimates

Overall, the estimates of health expenditure for 2002–03 were reduced by \$4,176 million. Reclassification of high-level residential aged care to welfare removed \$4,548 million.

The major areas of revision were:

- capital expenditure (up \$914 million)
- all other medications (down \$563 million)
- other health practitioners (up \$485 million)
- private hospitals (down \$195 million)
- patient transport services (down \$168 million)
- dental services (down \$143 million)
- aids and appliances (up \$116 million).

Revision of 2003–04 estimates

Overall, the estimates of health expenditure for 2003–04 were reduced by \$5,169 million. Reclassification of high-level residential aged care to welfare removed \$5,072 million.

The major areas of revision were:

- capital expenditure (up \$897 million)
- aids and appliances (down \$532 million)

- private hospitals (down \$524 million)
- community health and other (down \$494 million)
- other health practitioners (up \$344 million).

Revision of 2004–05 estimates

Overall, the estimates of health expenditure for 2004–05 were reduced by \$6,171 million. Reclassification of high-level residential aged care to welfare removed \$5,586 million.

The major areas of revision were:

- aids and appliances (down \$1,012 million)
- capital expenditure (up \$838 million)
- private hospitals (down \$587 million)
- community health and other (down \$584 million)
- other health practitioners (up \$344 million)
- all other medications (up \$307 million).