6 Technical notes

6.1 General

Health expenditure is reported domestically using the NHA framework. This framework, which was used experimentally since the early 1960s and was formally adopted by the Institute in 1985 as its national reporting framework, 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 and reporting on 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 both the national framework and the OECD's SHA (OECD 2000).

Health Expenditure Advisory Committee (HEAC)

In 2003, the Institute established the HEAC, comprising data users and providers, to give advice and feedback on its 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. It also includes a representative from the Ministry of Health New Zealand, and an academic 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 Institute has developed a national minimum data set (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.

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 using a data collection instrument which contains a mix of provider categories (for example, public hospitals) and function categories (for example, mental health services).

New approach

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

The new approach, outlined below, relies on data provided under the GHE NMDS, which will include government expenditure and funding data for the public, private and community sector health systems. This will identify expenditure on health services, such as hospital, patient transport, medical, other health practitioners, dental, community and public health services; expenditure on activities that support health care systems, such as research and administration; and expenditure on health goods, such as medications and aids and appliances. It will also include the various forms of public and private revenue that are used to fund these expenditures. These data will be supplied to the AIHW by existing data providers.

There will be three categories to capture expenditure and revenue:

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

It is anticipated that data providers will also include information on the nature of the economic transaction involved, such as whether it relates to taxation revenue, sales of goods and services, property income, current or capital transfers.

These categories use classifications that correspond to those used by the OECD in its System of Health Accounts. Information provided on the type of economic transaction will be based on the ABS Economic type framework classification. Some additional classifications have been used in the development of the GHE NMDS. These include:

- 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 will commence for the collection period 1 July 2008 to 30 June 2009.

6.2 Definition of health expenditure

Health expenditure is defined as:

> *the sum of expenditure on health goods and services which are used up within a year and health-related investment*

(See Glossary for detailed descriptions of health expenditure components).

Expenditure on health is traditionally analysed in terms of recurrent expenditure and capital expenditure. Recurrent expenditure can generally be thought of as goods and services consumed within a year. It includes expenditure on health goods, such as medications and health aids and appliances; health services, such as hospital, dental and medical services;

public health activities and other activities that support health systems, such as research and administration. Capital consumption (depreciation) is also included as part of recurrent expenditure.

Health-related investment is referred to as gross fixed capital formation (as defined in the ABS government finance statistics) 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 by 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 overestimation of health expenditure in the dental area. Expenditure on orthodontics is included in dental expenditure, but the principal purpose of some of this expenditure is cosmetic and health is 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 generally combined. In the ABS public finance data the contribution of local governments to health expenditure appears to be relatively small. However, examination of this local government data indicates that their quality is also quite poor.

6.3 Data and methods used to produce estimates

General

The total expenditure and revenue data used to generate the tables are mainly administrative by-product. To the greatest extent possible, they are produced on an accrual basis; that is, expenditures and funding reported for each area relate to expenses and revenues incurred in the year in which they are reported. This is not always achievable. For example, the data from private health insurance funds are sometimes provided on the basis of the date on which the claims for benefit are processed. These are not necessarily the same as the date on which the services were provided.

There was a small part of public hospital expenditure that was funded by facility fees and charged to private medical practitioners. This is not traditionally identified in the hospital statistics as a separate form of revenue. This facility fees revenue would have been partly funded by claims on Medicare and the benefits paid and hence would be included in the medical services row of our health expenditure matrix. Therefore there is a partial double-count of the public hospital expenditure funded from private practitioner facility fees and medical services in our hospitals and medical services rows of our health expenditure matrix. It is anticipated that with the introduction of the GHE NMDS in 2008–09, the AIHW will be able to remove most of this double count.

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 within 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 another. The estimates enable state and territory governments to monitor the impact of their policy initiatives on overall expenditures on health goods and services provided within its borders.

It should be noted that estimates of funding by state/territory governments 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 funding by any state/territory government on services provided in the state or territory concerned. For example, some services in the particular state/territory may relate to residents of another state or territory and vice versa. Such transactions may eventually be the subject of cross-border reimbursement arrangements between the states and territories concerned. However, such cross-border adjustments are not made in these estimates. In the most recent *Australian hospital statistics 2007–08* report (AIHW 2009a), a table was included that showed a notional

estimate of cross-border flows (based on Diagnosis Related Groups) between jurisdictions, for public patients, by state and territory of usual residence (see Table 7.10, p. 170 in that report).

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

The annual matrices for states and territories for years before 2002–03 indicate that state and territory governments provided no funding for services provided by private hospitals. There were, however, at least two situations where the states and territories provided funding to private hospitals. These were where:

(a) state or territory governments or Area Health Services had contracts with private hospitals to provide services to public patients

(b) individual public hospitals purchased services from private hospitals in respect of their public patients.

The AIHW began collecting and reporting these types of data from 2002–03 onwards and they have been included in both the national and the state and territory matrices from that year.

Allocation of Australian Government expenditures by 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 GPs in each state or territory.

Expenditure by state and territory governments

The majority of health expenditure data for state and territory governments is sourced from each of the state and territory health authorities. These data are now all supplied on an accruals basis. Prior to 2007–08, South Australia was only able to supply their data on a cash basis.

Data on research, capital expenditure and capital consumption are generally sourced from the ABS. Research expenditure data comes from the Research and Experimental

Development Survey series (ABS 2008a, 2008b, 2008c, 2008d) which is generally only available every second year. Projections are made by the AIHW every second year, for example, 2005–06 and 2007–08. The data for government capital consumption and capital expenditure is sourced from ABS's GFS.

Break in series for selected areas of expenditure from 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's public hospitals establishments (PHE) collection data were used to derive public hospital expenditure estimates for each state and territory. The PHE data comprises operating expenses incurred by public hospitals (such as wages and salaries, food, repairs and maintenance, and so forth) in providing a range of services—including community and public health services, dental and patient transport services and health research—that are provided by public hospitals. This is referred to as 'public hospital' expenditure.

Estimates of expenditure on 'public hospital services' have been provided directly by the state and territory health authorities from 2003–04 onwards. These reflect only that part of public hospitals' expenses that are used in providing 'hospital services'. That is, they *exclude* expenses incurred in providing community and public health services, dental and patient transport services and health research undertaken by public hospitals. These excluded expenses are shown under their respective categories in the health expenditure matrix. For example, expenditure on patient transport services that was incurred by public hospitals prior to 2003–04 was reported as a part of public hospital expenditure. From 2003–04, it was captured as part of expenditure on patient transport services.

As part of the 2003–04 revisions, most states and territories also allocated their central office expenses to functional areas. Previously, those expenses had been subsumed into the 'administration' expenditure category. As a result, although the public hospital services category after 2003–04 excludes the expenditures mentioned above, that does not mean that expenditure on public hospital services is necessarily lower than would have been the case had these changes not taken place. If the central office expenses that have been allocated to 'public hospital services' are greater in total than the excluded expenditures, expenditure on public hospital services would increase.

The AIHW PHE collection was the source of data for state and territory expenditure on public hospitals reported in tables 4.3 to 4.7 and figures 4.3 and 4.4.

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 funding, is considered to be

funding for welfare services rather than health services and has, since 2003–04, been excluded from the community health services expenditure 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 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 for health goods and services by health insurance funds within a state or territory is assumed to be equal to the level of benefits paid by health insurance funds with patients who reside in that state or territory. For 2001–02 onwards, in the case of New South Wales and the Australian Capital Territory, the benefits paid by health insurance funds for New South Wales and Australian Capital Territory residents, that were previously all reported under New South Wales, have now been disaggregated. The disaggregation was based on the number of separations for patients who reside in either the New South Wales or the Australian Capital Territory whose funding source was Private Health Insurance. Data from the Australian Hospital Statistics publication series and the ABS Private Health Establishments Collection were used to separate private health insurance benefits for public and private hospitals for patients residing in the Australian Capital Territory and New South Wales. The non-hospital benefits for New South Wales and the Australian Capital Territory are included in tables B1 to B3 and B19 to B21 respectively.

Private health insurance premium rebates

In all years from 1997–98, funding of health goods and services through health insurance funds has been divided into two categories:

- funding by private health insurance
- funding by the Australian Government.

This reflects the effect of two forms of indirect Australian Government subsidy of private health insurance—the means-tested Private Health Insurance Incentives Scheme (up until the end of 1998) and the non-means-tested 30–40% rebate on private health insurance premiums (from 1 January 1999). Refer to Box 3.1 for further details.

Although the rebate related to the premiums payable by health insurance members, they are regarded as being an indirect subsidy by the Australian Government of the types of activities funded through private health insurance funds. These include both health and non-health activities. The non-health activities include the accumulation of reserves (which is regarded as an 'insurance-type' activity).

The subsidy by the Australian Government is assumed to be spread across all these activities in proportion to the levels of expense and variations in reserves. But only the portions of the subsidy allocation that relate to health activities are included in the estimates of funding by the Australian Government.

Individuals

Estimates of expenditure by individuals on:

- dental services
- other health practitioners
- aids and appliances

from 2002–03 mostly rely on detailed private health insurance data from the PHIAC. The methods in respect of years before 2002–03 relied on highly aggregated ABS data, which proved to be unreliable and were subject to substantial revisions over time. The current methodology uses growth in the cost of services combined with changes in the 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, 2003; SCRGSP 2007, 2008, 2009).

Estimates of expenditure by individuals on over-the-counter pharmaceuticals in this report are sourced from Feros 1998, 1999, 2000, 2001; Flanagan 2002a, 2002b, 2003, 2004a, 2004b, 2005a, 2005b, 2006, 2007 and 2008 and Synovate AZTEC.

Other non-government sources

Workers compensation and compulsory 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.

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. There are many reasons for this, 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 nil or so small that it rounds to zero —designated as '—'.

(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 recurrent health expenditure 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.

6.4 Changes in data sources and methodologies used in this report

Capital consumption

In previous *Health expenditure Australia* reports, private capital consumption was included as part of recurrent expenditure, while government capital consumption was reported as part of total health expenditure but not part of recurrent health expenditure. In *Health expenditure Australia 2007–08*, government capital consumption has been included as part of recurrent health expenditures for all years. The reasons for incorporating both government and non-government capital consumption as part of recurrent expenditure are;

- government and private capital consumption are treated consistently
- international reporting includes depreciation as part of recurrent expenditures.

Private hospitals

Until 2006–07, the ABS *Private Hospital Series* (ABS, Cat. No. 4390.0) was the source of total spending on private hospitals in *Health expenditure Australia* reports. For 2007–08, the ABS Private Hospital survey was not done so an alternative methodology needed to be used to derive total private hospital expenditure. The methodology used is best illustrated by the following equation:

Total expenditure = number of separations x cost per separation

The number of private hospital separations for 2007–08 was taken from the AIHW National Hospital Morbidity Database and the cost per separation for 2007–08 was derived by applying the average annual growth rate in cost per separation for 2004–05 to 2006–07 to the cost per separation for 2006–07.

Over-the-counter medications sold in pharmacies

Over-the-counter medicines sold at pharmacies for 2001–02 to 2004–05 were sourced from *Retail pharmacy* (Flanagan 2002a, 2004a, 2005a), having previously been sourced from

Pharmacy 2000 (Feros 1998, 1999, 2000, 2001). Over-the-counter pharmacy data for 2005–06 to 2007–08 were sourced from Synovate AZTEC to enable a more comprehensive breakdown of each category of products sold at pharmacies.

Care needs to be taken when comparing data for 2006–07 and 2007–08 with earlier years as some changes were made to the sample size, projection methods and category definitions by Synovate AZTEC. The 2006–07 and 2007–08 data were prepared using consistent methodology.

Public health

Separate and timely data on public health expenditure, based on nine core public health expenditure activities, are available from the AIHW's Public Health Expenditure Project.

The data for 1999–00 to 2007–08 have been published in the AIHW's *National public health expenditure* reports (AIHW 2002, 2004, 2006, 2007b, 2008b) and *Public health expenditure in Australia* reports (2008c, 2009b (in press)). The data collected for these reports are only for key health departments and agencies of the Australian Government and states and territories.

The scope of public health services expenditure in this report has been expanded to include for 1999–00 to 2007–08, departmental costs for the following DoHA regulators: Therapeutic Goods Administration, Office of Gene Technology Regulator and the National Industrial Chemicals Notification and Assessment Scheme. These departmental costs are not included in the *National public health expenditure* or *Public health expenditure in Australia* reports as the data are not within scope for these reports. These costs are included as part of other private expenditure on public health services for years 1999–00 to 2007–08 inclusive, in this report as well as in the online health expenditure data cubes.

6.5 Revision of estimates

Some components of total health expenditure for earlier years have been revised since the publication of *Health expenditure Australia 2006–07* (AIHW 2008a). A summary of the revisions is shown in Table 6.1.

Table 6.1: Comparison of previously published estimates of total health expenditure, current prices, 1998–99 to 2006–07, with current estimates ($ million)

Year	*Health expenditure Australia 2006–07* estimate	Revised estimate	Change
1998–99	48,446	48,428	–18
1999–00	52,541	52,570	29
2000–01	58,415	58,269	–146
2001–02	63,562	63,099	–463
2002–03	69,164	68,798	–366
2003–04	73,633	73,509	–124
2004–05	80,892	81,060	168
2005–06	86,753	86,685	–69
2006–07	94,003	94,938	936

Note: Components may not add to totals due to rounding.

Source: AIHW health expenditure database.

The areas of expenditure that had major revisions are discussed below.

Capital consumption

The reallocation of government capital consumption to areas of recurrent health expenditure for all years has resulted in large increases to many areas of expenditure, but particularly to public hospital services.

Capital expenditure

The ABS provides the Institute with government finance statistics that enable the Institute to calculate gross fixed capital formation which represents capital expenditure in *Health expenditure Australia* reports. There were revisions to capital expenditure estimates for financial years 2000–01 to 2006–07 inclusive. These revisions varied between a downwards revision of $223 million in 2000–01 and an upwards revision of $200 million in 2006–07.

Public health

As noted above, the scope of public health services expenditure for *Health expenditure Australia* reports was expanded to include departmental costs for the following DoHA regulators: Therapeutic Goods Administration, Office of Gene Technology Regulator and the National Industrial Chemicals Notification and Assessment Scheme. The inclusion of these costs increased total public health expenditure for the years 1999–00 to 2006–07. The increases were $18 million in 1999–00, with the amount increasing progressively over the next 8 years to be $97 million in 2006–07. There were also some minor revisions to other government public health expenditure for some years.

Public hospitals and public hospital services

The large increase in expenditure, for all years, on public hospital services was mostly due to the inclusion of government capital consumption costs that could be attributed to public hospital services. Capital consumption costs for state and territory governments attributed to public hospital services are over 80% of the total for most states and territories.

Research

Research expenditure data comes from the ABS Research and Experimental Development Survey series. Revisions to past years data have been incorporated into the latest editions of this series. The updated data have been incorporated into our health expenditure database. The largest revision was an upwards revision of $88 million in 2003–04. The complete Research and Experimental Development Survey series is only available every second year. Projections are made by the AIHW for every second year, for example, 2005–06 and 2007–08. Revisions were required for these alternate years whenever data for a preceding or ensuing year were revised.

Community health and other

The large increase in expenditure on community health and other was mostly due to the inclusion of government capital consumption costs that could be attributed to this category. Capital consumption costs for state and territory governments that can be attributed to community health and other were as high as 18% of total capital consumption for some states and territories.

Aids and appliances

Out-of-pocket expenditure for individuals has been revised down for 2001–02 and 2002–03 to remove benefits paid out by private health insurers on aids and appliances.

All other medications

The Institute received revised estimates of over-the-counter medications for 2006–07 from Synovate AZTEC. Care needs to be taken when comparing data for 2006–07 and 2007–08 with earlier years as some changes were made to the sample size, projection methods and category definitions by Synovate AZTEC. The 2006–07 and 2007–08 data were prepared using consistent methodology.

Medical services

The upwards revision of $64 million for 2006–07 was mainly due to the exclusion of two Australian Government programs from the *Health expenditure Australia 2006–07* report. The cost of these two programs was $58 million.

Revisions by year

Major revisions for each of the years 1998–99 to 2006–07 are detailed below.

The majority of the revisions to recurrent health expenditure for 1998–99 to 2006–07 were caused by the reallocation of government capital consumption from its own category across to other areas of expenditure.

Revision of 1998–99 estimates

Overall, the estimates of total health expenditure for 1998–99 were revised down by $18 million.

- capital consumption ($884 million reallocated to areas of recurrent health expenditure)
- public hospitals (up $687 million)
- community health and other (up $104 million).

Revision of 1999–00 estimates

Overall, the estimates of total health expenditure for 1999–00 were revised up by $29 million.

- capital consumption ($942 million reallocated to areas of recurrent health expenditure)
- public hospitals (up $709 million)
- community health and other (up $111 million)
- research (up $57 million)
- patient transport (up $45 million)
- public health (up $18 million).

Revision of 2000–01 estimates

Overall, the estimates of total health expenditure for 2000–01 were revised down by $146 million.

- capital consumption ($984 million reallocated to areas of recurrent health expenditure)

- public hospitals (up $737 million)
- capital expenditure (down $223 million)
- community health and other (up $117 million)
- patient transport (up $51 million)
- public health (up $48 million)
- research (up $45 million).

Revision of 2001–02 estimates

Overall, the estimates of total health expenditure for 2001–02 were revised down by $463 million.

- capital consumption ($1,029 million reallocated to areas of recurrent health expenditure)
- public hospitals (up $737 million)
- aids and appliances (down $329 million)
- community health and other (up $117 million).

Revision of 2002–03 estimates

Overall, the estimates of total health expenditure for 2002–03 were revised down by $366 million.

- capital consumption ($1,073 million reallocated to areas of recurrent health expenditure)
- public hospitals (up $762 million)
- aids and appliances (down $341 million)
- community health and other (up $119 million).

Revision of 2003–04 estimates

Overall, the estimates of total health expenditure for 2003–04 were revised down by $124 million.

- capital consumption ($1,160 million reallocated to areas of recurrent health expenditure)
- public hospital services (up $806 million)
- community health and other (up $127 million)
- research (up $88 million)
- public health (up $80 million).

Revision of 2004–05 estimates

Overall, the estimates of total health expenditure for 2004–05 were revised up by $168 million.

- capital consumption ($1,260 million reallocated to areas of recurrent health expenditure)
- public hospital services (up $1,180 million—due mostly to increases in state and territory government funding but also due to non-capital consumption related increases in funding by DVA and individuals in that year)
- community health and other (up $136 million)
- public health (up $92 million).

Revision of 2005–06 estimates

Overall, the estimates of total health expenditure for 2005–06 were revised down by $69 million.

- capital consumption ($1,321 million reallocated to areas of recurrent health expenditure)
- public hospital services (up $988 million)
- community health and other (up $142 million)
- capital expenditure (down $109 million)
- public health (up $90 million)
- research (up $49 million).

Revision of 2006–07 estimates

Overall, the estimates of total health expenditure for 2006–07 were revised up by $936 million.

- capital consumption ($1,430 million reallocated to areas of recurrent health expenditure)
- public hospital services (up $1,052 million—due mostly to increases in state and territory government funding but also due to non-capital consumption related increases in funding by individuals in that year)
- all other medications (up $653 million)
- capital expenditure (up $200 million)
- community health and other (up $155 million)
- public health (up $97 million)
- research (up $66 million)
- medical services (up $64 million).