# 6 Technical notes

## 6.1 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 the OECD's System of Health Accounts (SHA).

### 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, Health Insurance Commission and the Private Health Insurance Advisory Council (PHIAC)—and each state and territory health department. 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 AIHW's health expenditure collections with all other Australian subnational 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.

## 6.2 Definition of health expenditure

The term 'health expenditure' refers to expenditure on health goods and services, health-related services and health-related investment. Health goods and services expenditure includes expenditure on health goods (pharmaceuticals, aids and appliances) and health services (clinical interventions); and health-related services including expenditure on public health, research and administration. These expenditures are collectively termed recurrent expenditure. Health-related investment is often referred to as capital formation or capital expenditure.

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 professionals)
- 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 national benefit
- expenditure on capital transfers by government to underwrite medical indemnity insurance or premiums paid by individuals for private health insurance cover. Such expenditure, while having a health-related purpose, is regarded as expenditure on insurance rather than expenditure on a health good or service. Such funds become health expenditure to the extent that they are drawn upon when they are used to purchase health goods and services.

Total health and health-related expenditure reported for Australia (both domestically and internationally) is slightly underestimated in that it excludes health expenditure by the Australian Defence Force, some school health expenditure and some expenditure incurred by corrective services institutions in the various states and territories. Difficulties in separating expenditures incurred by local governments on particular health functions from those of state and territory governments means that these funding sources are often combined. However, the ABS data indicate that the contribution of local governments would be quite small.

**Table 43: Areas of health expenditure used in this report**

| Term | Definition |
|---|---|
| Public (non-psychiatric) hospitals | Hospitals operated by, or on behalf of, state and territory governments that provide a range of general hospital services. Such hospitals are recognised under the AHCAs. |
| Private hospitals | Privately owned and operated institutions that provide a range of general hospital services. In health expenditure publications the term includes private free-standing day hospital facilities. |
| Public (psychiatric) hospitals | Hospitals operated by, or on behalf of, state and territory governments that provide treatment and care specifically to patients with psychiatric disorders. |
| High-level residential care | Care provided to residents in residential care facilities who have been classified as having a need for and are receiving a very high level of care (i.e. patients classified in RCS categories 1–4). |
| Residential care facilities | Establishments that provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile in-patients. They must be approved by DoHA and licensed by a state or territory government. |
| Ambulance services | Public or registered non-profit organisations which provide patient transport (or ambulance) services associated with out-patient or residential episodes to and from health care facilities.<br><br>Excludes patient transport expenses that are included in the operating costs of public hospitals. |
| Medical services | Services listed in the Medical Benefits Schedule that are provided by registered medical practitioners.<br><br>Most medical services in Australia are provided on a fee-for-service basis and attract benefits from the Australian Government under Medicare.<br><br>Expenditure on medical services includes services provided to private in-patients in hospitals as well as some expenditure that is not based on fee-for-service (i.e. alternative funding arrangements).<br><br>Excludes expenditure on medical services provided to public patients in public hospitals and medical services provided at out-patient clinics in public hospitals. |
| Other professional services | Services provided by registered 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. |
| Benefit-paid pharmaceuticals | Pharmaceuticals in the PBS and the RPBS (see Glossary) for which the Australian Government paid a benefit. |
| Other pharmaceuticals | Pharmaceuticals for which no PBS or RPBS benefit was paid.<br><br>Includes:<br><br>• 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<br><br>• medicines dispensed through private prescriptions for items not listed in the PBS or RPBS<br><br>• over-the-counter medicines such as aspirin, cough and cold medicines, vitamins and minerals, some herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band aids and condoms. |

*(continued)*

**Table 43 (continued): Areas of health expenditure used in this report**

| Term | Definition |
| --- | --- |
| Aids and appliances | Durable medical goods dispensed to out-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.<br>Excludes prostheses fitted as part of in-patient care in a hospital. |
| Community health | Non-residential health services offered by public or registered non-profit establishments to patients/clients, in an integrated and coordinated manner in a community setting, or the coordination of health services elsewhere in the community.<br>Includes:<br>• domiciliary nursing service<br>• well baby clinics<br>• health services provided to particular groups such as Aboriginal and Torres Strait Islander people, as well as family planning services, alcohol and drug rehabilitation, etc.<br>• specialised mental health programs for patients with mental illness that are delivered in a community setting. |
| Public health | 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, injury and disability, in the whole population or specified population subgroups. |
| Dental services | A range of services provided by registered dental practitioners.<br>Includes maxiofacial surgery items listed in the Medical Benefits Schedule. |
| Health administration | Activities related to the formulation and administration of government and non-government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc.<br>Includes the regulation and licensing of providers of health services. |
| Health research | Research undertaken at tertiary institutions, in private non-profit organisations and in government facilities that has a health socioeconomic objective.<br>Excludes commercially oriented research carried out or commissioned by private business, the costs of which are assumed to have been included in the prices charged for the goods and services (e.g. pharmaceuticals that have been developed and/or supported by research activities). |
| Capital expenditure | Expenditure on large-scale fixed assets (e.g. new buildings and equipment with a useful life extending over a number of years). |

# 6.3 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 often 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.

The AIHW gathers information on which to base its estimates of health expenditure from a wide range of sources. The ABS, the DoHA, 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 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 concerned.

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.

## Expenditure by the Australian Government

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

- SPPs to the states and territories for public hospitals
- other SPPs to the states and territories for health
- high-level residential care subsidies
- Medicare benefits payments

- pharmaceutical benefit payments.

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. Expenditures on public health that are not part of SPPs to the states and territories have been allocated according to the allocation of public health SPPs.

## Expenditure by state, territory and local governments

The ABS produces annual estimates of public finance, which form part of the NHA. 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. Government Purpose Classifications (GPCs) developed by the ABS are used to allocate expenses and revenues by function.

There have always been difficulties associated with the way the government expenditures in the public finance database have been allocated 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 according to function. As a consequence, the ABS's estimates of total expenditure only 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 AIHW relies on data from state and territory health authorities for its estimates of state and local government expenditure and funding for:

- public hospitals
- high-level residential care
- dental services.

These have proved consistent over time, whereas there has been a lack of consistency in the ABS public finance data for these types of services.

On the other hand, in most years the ABS public finance database estimates have been used for state, territory and local government expenditure on:

- administration
- ambulance services.

The ABS Research and Experimental Development Survey series has provided information about research. Estimates of state and territory expenditure on community and public health

services are then derived by subtraction. Thus, this is a residual category and has been somewhat volatile.

In 1998–99 and 2001–02, as part of the process for collection of data for studies into expenditure on health goods and services for Aboriginal and Torres Strait Islander peoples, each of the states and territories provided detailed estimates of expenditure for programs for which they had primary responsibility. That information has been extensively checked and verified with the provider agencies. Because of the rigorous processes gone through in verifying the accuracy of the data, the AIHW has, wherever possible, incorporated them in the state/territory estimates of health expenditure for those years.

It should also be noted that the estimates of expenditure on public hospitals in this publication reflect the level of expenditure on goods and services provided in hospitals, including community health services that are operated by public hospitals. The estimates of community health services exclude expenditure on community health services that is already included in the gross operating expenditures of public hospitals. This complicates state-by-state comparisons as far as those services are concerned, because the proportion of community health services delivered by hospitals (and included in the hospital operating costs) varies from state to state.

## Expenditure 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.

Funding by health insurance funds on health goods and services within a state or territory is assumed to be equal to the level of expenditure by health insurance funds that operate from that state or territory. In the case of New South Wales and the Australian Capital Territory, it is assumed that their combined total expenditure is equal to the total funding by health insurance funds registered in New South Wales. This is then split between New South Wales and the Australian Capital Territory according to the relative numbers of available private hospital beds in the two jurisdictions. In all years from 1997–98, funding by health insurance funds has been reduced by the extent of the Australian Government subsidy through the PHIIS and the 30% rebate on private health insurance contributions.

Estimates of expenditure by individuals on:

- patient transport (ambulance services)
- dental services
- other professional services
- non-benefit pharmaceuticals
- aids and appliances

are based on ABS estimates of HFCE. Funding of these services by private health insurance funds are deducted from HFCE estimates to arrive at the estimates of individuals' out-of-pocket funding.

### Blank cells in expenditure matrices

The national and the state and territory matrices in Appendixes A and B have some cells for which there is no expenditure recorded. The reasons for this are manifold, 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 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 governments' 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. Some data has been inserted in the 2002–03 matrices. The AIHW is negotiating with state and territory health departments to obtain data that would support estimates of their funding of private hospitals 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 (nec)'. 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 that data over long time series.

### Population

The per capita estimates of expenditure are calculated using estimates of annual mean resident population, which are calculated using quarterly population estimates from the ABS.

## 6.4 International comparisons

The countries chosen for international comparisons are, like Australia, members of the OECD. The OECD averages in this publication are averages (means) of member countries for which data are available for all the years presented. The periods covered by the OECD data for a particular year may differ from one country to another (see Box 2 for examples).

**Box 2: Periods equating to OECD year 2003**

| Country | Financial year |
| --- | --- |
| *Australia* | *1 July 2003 to 30 June 2004* |
| *Canada* | *1 April 2003 to 31 March 2004* |
| *France* | *1 January 2003 to 31 December 2003* |
| *Germany* | *1 January 2003 to 31 December 2003* |
| *Japan* | *1 April 2003 to 31 March 2004* |
| *Netherlands* | *1 January 2003 to 31 December 2003* |
| *New Zealand* | *1 July 2003 to 30 June 2004* |
| *Sweden* | *1 January 2003 to 31 December 2003* |
| *United Kingdom* | *1 April 2003 to 31 March 2004* |
| *United States* | *1 October 2002 to 30 September 2003* |

## 6.5 Preliminary estimates

Estimates throughout this report are derived from the AIHW's health expenditure database. This contains comprehensive estimates for all areas of expenditure and all sources of funds for years up to and including 2002–03. It also contains estimates in respect of some areas of expenditure and some sources of funds for 2003–04.

In order to provide an indication of the likely level of expenditure for the latest year possible, the AIHW has devised methods for developing preliminary estimates that can substitute for these missing data for 2003–04. The shaded cells in (Table A4) indicate that all or part of the data that are used in the estimates for these cells are based on very preliminary data and are likely to be changed when more precise data become available. Unshaded cells, on the other hand, are fully based on data from the health expenditure database and are unlikely to be changed substantially. Of course, estimates for all areas and sources of funding for all years are subject to revision if better data become available. Some estimates contained in this publication differ from those previously published by the AIHW, because of this type of ongoing revision. These are discussed in detail in the Revisions section below.

# 6.6 Revisions of definitions and estimates

## Definitions

### High-level residential care

'High-level residential care' refers to services of a type that would have been provided to patients in institutions that were formerly classified as nursing homes.

Facilities that were formerly classified as nursing homes are now incorporated into the class of facility known as 'residential care facilities'. Aged persons' hostels are also included in this class of facilities, as are aged persons' complexes.

Residents in such facilities are classified according to the level of care that they need and receive, and there are eight such care-level categories. For the purpose of maintaining consistency with international reporting, residents who are classified into the four highest categories are included as receiving 'health care' and the associated expenditure is included in this publication as high-level residential care.

All residents whose care needs do not come within the four highest levels of care are regarded as receiving welfare services, and none of the expenditure related to that care is classified as health services expenditure. In Australia this distinction is made to conform with the OECD requirement that expenditure on residential care relates to aged people and people with a disability who require nursing care. This is different in intensity of care from, say, limited medical assistance (such as the supervision of compliance with medication in hostel-type care) which is expenditure associated with welfare services rather than health expenditure.

### Public and community health

In this publication there is now a separate category for public health expenditure. In previous 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 that was sourced from the public finance statistics of the ABS and from the states and territories themselves.

However, 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 in the development of public health information under the National Public Health Partnership, is funded by 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, 2000–01 and 2001–02 have been published in the AIHW's *National Public Health Expenditure Reports*. Data for 2001–02, 2002–03 and 2003–04 will be released late in 2005. 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 (it excludes smaller amounts of expenditure on public health undertaken by the non-government sector and those not funded through government programs).

### Other pharmaceuticals

Expenditure on all other pharmaceutical items includes expenditure on over-the-counter medicines, other therapeutic medical non-durables, as well as prescribed medications for which no benefits are paid under the PBS, including PBS items less than or equal to the co-payment.

The over-the-counter medicines are all therapeutic goods of a type that are sold at pharmacies, supermarkets and convenience stores and are used to treat or cure a condition. Examples of over-the-counter therapeutic goods are analgesics, antacids and cough medicines. 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 scope of health expenditure.

The AIHW has obtained over-the-counter data for 2001–02 and 2002–03 from *Retail World* (Flanagan 2002b and 2003) and *Retail Pharmacy* (Flanagan 2002a and 2004), having previously obtained it from *Pharmacy 2000* (Feros 1998 to 2001). This 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 but such expenditure constitutes a very small part of total over-the-counter sales of pharmaceuticals and medical non-durables.

### Non-specific tax expenditure

These are a form of tax expenditure known as the medical expenses tax offset. 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 2003–04 income year, the tax offset was 20 cents for each $1 by which a taxpayer's net medical expenses exceeded $1,500 (the threshold).

Net medical expenses are the medical expenses that have been paid less any refunds that have been received, or could be received, from Medicare or a private health fund. The medical expenses tax offset covers a wide range of health expenditures, not just expenses associated with doctors as its name might suggest. It is named 'non-specific tax expenditure' in this publication to reflect the fact that it cannot be specifically allocated to the various areas of expenditure.

## Revision of estimates

Some estimates of recurrent health expenditure have been revised since the publication of *Health Expenditure Australia 2002–03*. These revisions relate to all years after 1996–97 (Table 44).

The large downward revision of estimated expenditure for 1998–99 has meant that growth in expenditure between 1997–98 and 1998–99 in nominal and real terms is now lower than previously reported. Similarly, the large upward revision of estimated expenditure for 2001–02 has meant that growth in expenditure between 2000–01 and 2001–02 is now higher than previously reported.

**Table 44: Comparison of previously published estimates of total health expenditure, current prices, 1997–98 to 2001–02, with current estimates ($ million)**

| Year | Previous estimate | Revised estimate | Change |
|---|---|---|---|
| 1997–98 | 48,274 | 48,288 | 14 |
| 1998–99 | 51,726 | 51,440 | –286 |
| 1999–00 | 55,427 | 55,255 | –172 |
| 2000–01 | 61,660 | 61,635 | –25 |
| 2001–02 | 66,541 | 66,769 | 228 |

*Source:* AIHW health expenditure database.

## Revision of 1997–98 estimates

Overall, the estimates of health expenditure for 1997–98 were revised up by $14 million. The major area of revision was for state and local government funding of high-level residential care ($13 million), which was due to a change in the reported estimates for South Australian state government funding of nursing homes.

## Revision of 1998–99 estimates

Overall, the estimates of health expenditure for 1998–99 were revised down by $286 million. The major areas of revision were:

(i) individuals' funding of ambulance and other (nec) ($119 million)

(ii) individuals' funding of other professional services (–$235 million)

(iii) individuals' funding of aids and appliances ($186 million)

(iv) state and local government funding of capital outlays (–$344 million).

Revision items, (i), (ii) and (iii), were due to changes in the methodology surrounding the treatment of private health insurance benefits paid for contractual ancillary services. Revision item (iv) was due to a revision of ABS estimates for state and local government funding of capital outlays.

## Revision of 1999–00 estimates

Overall, the estimates of health expenditure for 1999–00 were revised down by $172 million. The major areas of revision were:

(i) Australian Government funding of high-level residential care (–$167 million)

(ii) individuals' funding of medical services (–$110 million)

(iii) Australian Government funding of other professional services (–$142 million)

(iv) individuals' funding of other professional services (–$262 million)

(v) Australian Government funding of aids and appliances ($146 million)

(vi) individuals' funding of aids and appliances ($210 million)

(vii) state and local government funding of public health ($120 million).

Revision items (ii), (iv) and (vi) were due to changes in the methodology surrounding the treatment of private health insurance benefits paid for contractual ancillary services. Item (v)

arose from two things, firstly from the change described above, but also from an adjustment that was made to rectify an error in the processing of some Australian Government funding data that was previously captured as part of other professional services where it should have been part of aids and appliances. Item (iii) was to rectify the same processing error detailed above. Item (i) was due to a revision of some Australian Government funding data for high-level residential care while item (vii) arose from the availability of additional core public health expenditure data not previously captured and some revisions to state public health expenditure data.

### Revision of 2000–01 estimates

Overall, the estimates of health expenditure for 2000–01 were revised down by $25 million.

The major areas of revision were:

(i) Australian Government funding of high-level residential care (–$216 million)

(ii) state and local government funding of ambulance and other (nec) (–$131 million)

(iii) individuals' funding of other professional services (–$336 million)

(iv) state and local government funding of community health and other ($542 million)

(v) state and local government funding of public health ($121 million)

(vi) state and local government funding of capital outlays (–$89 million).

Revision item (iii) was due to two things, firstly to changes in the methodology surrounding the treatment of private health insurance benefits paid for contractual ancillary services and secondly to a downward revision of ABS HFCE estimates for other health professionals in 2000–01. Item (ii) was due to some states revising their state ambulance expenditure data. Items (i) and (vi) were revisions made to Australian Government funding of high-level residential care data and changes in ABS estimates for state and local government funding of capital outlays respectively. Item (iv) was due to the removal of adjustments made to comply with ABS government finance statistics growth rates. Item (v) arose from the availability of additional core public health expenditure data not previously captured and some revisions to state public health expenditure data.

### Revision of 2001–02 estimates

Overall, the estimates of health expenditure for 2001–02 were revised up by $228 million.

The major areas of revision were:

(i) state and local government funding of public (non-psychiatric) hospitals ($445 million)

(ii) Australian Government funding of high-level residential care (–$253 million)

(iii) state and local government funding of high-level residential care (–$202 million)

(iv) individuals' funding of ambulance and other (nec) ($90 million)

(v) individuals' funding of other professional services ($179 million)

(vi) individuals' funding of all other pharmaceuticals ($64 million)

(vii) individuals' funding of aids and appliances (–$198 million)

(viii) state and local government funding of community health and other ($119 million)

(ix) state and local government funding of dental services ($60 million)

(x) state and local government funding of capital outlays (–$88 million).

Revision items (iv) and (vi) were due to changes in the methodology surrounding the treatment of private health insurance benefits paid for contractual ancillary services. Item (vi) was also due to a downward revision of HFCE for aids and appliances in 2001–02, which had an inverse impact on the HFCE for pharmaceuticals. Items (v) and (vii) arose from two things, firstly from changes to the treatment of contractual ancillary services described above and secondly, revisions were made to Victorian third-party insurance expenditure data. An upward revision of ABS HFCE for other health professionals and a downward revision of the HFCE for aids and appliances in 2001–02 also contributed to the upward revision of item (v) and a downward revision of item (vii). Items (ii) and (iii) were due to revisions made to Australian Government and state and local government funding of high-level residential care data respectively. Item (viii) was due to the removal of adjustments made to comply with ABS government finance statistics growth rates as well as from changes to South Australia, Tasmania and Queensland state community health data. Item (ix) was due to revisions for South Australia, Queensland, Tasmania and Western Australia state dental expenditure data while item (x) was due to changes in ABS estimates for state and local government funding of capital outlays. Item (i) was due to the removal of adjustments made to the 2001–02 Australian Hospital Statistics data to comply with data reported in *Expenditures on health for Aboriginal and Torres Strait Islander Peoples 2001–02*. These adjustments were not part of the methodology used in early data collections and the adjustments distorted the time series data for public (non-psychiatric) hospital expenditure. The revision was also due to an adjustment of South Australia's state public non-psychiatric hospital expenditure as well as a reallocation of $11 million of public non-psychiatric hospital expenditure from being state and local government funded to private sector funded.