1 History of health and welfare services expenditure data development in Australia

Analysis of Australian health expenditure has come a long way from that which existed in 1970 to its present form. The development of the analysis of Australian welfare services expenditure, however, is more recent—it had its debut in 1995.

Health expenditure data development

Broad estimates of government and private expenditure on health have been compiled by the ABS in constructing the Australian National Accounts for many years. This enabled some estimation to be made of total expenditure by broad type of health care.

The preparation of more detailed estimates, by service type and source of funds has been undertaken by a number of different players at different times since the beginning of the 1970s. These include:

- Dr John Deeble (covering the period 1960–61 to 1966–67);
- Commonwealth Department of Health (from 1969–70 to 1980–81); and
- AIHW (covering the period 1981–82 to date).

Early development of the Australian health expenditure matrix

The first detailed breakdown of Australian health expenditure by service type and source of funds was undertaken by Dr John Deeble (Deeble 1970). He developed estimates of current and capital account expenditure on health for 1960–61, 1963–64 and 1966–67, together with estimates of output and unit costs for some major groups of health services. He used a sources of funds/type of service matrix approach in the presentation of his estimates.

Deeble's work, which was specifically targeted at Australia's health funding arrangements, complemented that being undertaken at the time by the World Health Organization (Abel-Smith 1969) for the presentation of internationally comparable estimates of national expenditure on health services.

Two major sources identified by Deeble in his work are no longer identified in estimates of expenditure by source of funds. These are:

- voluntary insurance; and
- charitables.

Voluntary insurance included commercial insurance companies as well as non-profit organisations, which were registered under the *National Health Act 1953* for the payment of Commonwealth benefits. The expenditure recorded against the voluntary insurance source was the contributions income paid by members of voluntary insurance organisations for particular types of inclusions in their health cover.

Funds raised by charitable bodies and miscellaneous sources covered all the receipts from non-government sources that were not related to the provision of particular health services or did not entitle the payer to specific benefits. Included also were proceeds from public appeals, social and charitable functions, and research grants from governments or private foundations overseas.

Commonwealth Department of Health

Deeble's matrix was adopted by the Commonwealth Department of Health (DOH) in its triennial estimates of health expenditure for Australia, which covered the period from 1969–70 to 1974–75.

Some of the private funding sources adopted by the DOH differed from Deeble's. For example, voluntary insurance identified the surpluses of the voluntary health insurance funds. Patient fees (called 'Recipients' in Deeble's work) included direct payment by patients and payments through workers' compensation and compulsory motor vehicle third party insurance schemes. 'Other' included donations, funds raised by charitable bodies and miscellaneous sources. The estimates produced by DOH were well in excess of the ABS estimates of expenditure on health. Expenditures on teaching and research were not included in the DOH matrix.

The Department of Health published time-series data for 1960–61, 1963–64, 1966–67 and 1969–70 for three broad areas of expenditure: 'Institutional care', 'Other medical care', and 'Public health services'. These were followed up with more detailed data for the same periods by Deeble in a project commissioned by the Hospitals and Health Services Commission (Deeble & Scott 1978). Deeble's analysis was of recurrent expenditure by area of expenditure but not dissected by source of funds.

In 1978 the Commonwealth, in a joint management review project funded by the Commonwealth Department of Health, the Public Service Board and the ABS, developed a method aimed at reconciling the output from the three major sources of data—ABS National Accounts, Deeble's estimates and the DOH data. The result was an annual analysis of the total costs of health care in Australia for 1974–75 to 1976–77 (Commonwealth of Australia 1978). The matrix produced by this project was broadly similar to its predecessors. A new feature was a reconciliation between the funds paid directly by individuals for health services and total expenditure by individuals on health care. This adjustment was, in effect, the surplus or deficit of individuals' contributions to private health insurance over total payments by the funds for health services in a year. This was important in enabling comparison between the matrix and the estimates of private consumption expenditure on health in the ABS National Accounts.

The joint management review recommended that the matrix of health care expenditure, as used in the national health accounts study, be adopted and maintained by the Commonwealth Department of Health. Consequently, a time-series covering 1974–75 to 1977–78 was published (Commonwealth Department of Health 1980). The major change from the preceding matrix presentations was that funding by health insurance funds now included only benefit payments from the funds for health services incurred by contributor units, plus the management expenses. This replaced contributions paid to the funds. The rationale for this was that expenditure on health for any one year should match, as closely as possible, the health services rendered in that year.

Recurrent expenditure was subsequently classified into five broad areas:

- institutional
- non-institutional
- preventive services
- administration
- research.

The former 'Public health services' category was split into a new category, 'Preventive services', and a sub-category of 'Non-institutional—Community health'. Preventive services included activities such as the encephalitis program, general quarantine, health education, drug education, and tuberculosis control. Community health services was made up of expenditure on community health, domiciliary nursing care benefit, home nursing subsidy and maternal and child care.

The compilation of health expenditure statistics was the responsibility of the Central Statistical Unit and the Health Expenditure and Financing Section of the Commonwealth Department of Health until 1985, when it was transferred to the incipient Australian Institute of Health.

Australian Institute of Health and Welfare

In the Australian Institute of Health's first publication, which covered the period 1979–80 to 1981–82 (Australian Institute of Health (AIH) 1986), the category title of 'Preventive services' was changed to 'Health promotion and illness prevention'. A second publication, covering 1970–71 to 1984–85, was published in 1988. The Institute also published its first health expenditure estimates in 1986.

In 1992, the responsibilities of the Institute were expanded to include research into welfare services and housing assistance. Its name was changed to the Australian Institute of Health and Welfare and it continued publication of the health expenditure estimates, the latest of which was published in September 2001 (Australian Institute of Health and Welfare (AIHW) 2002a).

While the annual matrices since 1974–75 have maintained their structure, there have been considerable changes in the data sources used. The first series of major changes followed the introduction of Medibank in 1975.

Medibank provided 'free' access to standard ward hospital care for all Australians and this was to be funded through cost-sharing agreements between the Commonwealth and each state in respect of the state's public hospitals. Under those agreements, the states provided cost and utilisation data to the Commonwealth for hospitals recognised for cost-sharing purposes. These data became an important source in developing estimates of expenditure on public hospitals.

Because of changes to the public hospital funding arrangements during the 1980s, the cost-sharing data became redundant so that a new source of hospital cost data was needed. From the latter half of the 1980s states and territories have provided hospital expenditure and revenue data directly to the AIHW for inclusion in its annual Australian Hospital Statistics series. This now provides the major source of estimates of gross expenditure on public hospitals.

Another major change followed the introduction of Medicare in 1984. Since then sophisticated payment and monitoring systems have operated in respect of medical services and these have provided the basic data used in estimating expenditure on medical services. Those systems continue to be used in estimating the relative shares of funding for medical services borne by the Commonwealth and other funding sources and in the shares of some expenditure on dental services and other professional services (optimetrical services).

Recent developments

State and territory estimates of health expenditure

From 1996–97 estimates of expenditure on health have been compiled on a state/territory basis. This involves the allocation of some types of national expenditures by state/territory using allocation factors derived from other, related data.

Adoption of the OECD's System of Health Accounts

A most important initiative has been the adoption by the AIHW of the classifications developed by the Organisation for Economic Cooperation and Development (OECD) for:

- health care activities (HC classification);
- providers (HP classification); and
- funders (HF classification).

These form part of the OECD's System of Health Accounts that was developed by the Directorate for Education, Employment, Labour and Social Affairs of the OECD and is outlined in a 2000 publication, *A System of Health Accounts*, that was prepared by Manfred Huber, an administrator with the Directorate. All Australian estimates of expenditure since 1998–99 have been coded to the OECD classifications.

Private health insurance subsidies and rebates

In 1997 the Commonwealth enacted the *Private Health Insurance Subsidy Act 1997*. This initially provided for an income-tested subsidy, known as the private health insurance incentive subsidy (PHIIS), to low-to-middle income earners with private health insurance cover. The legislation was later changed to provide a rebate of 30% to all Australians who had private health insurance cover.

Members of private health insurance funds pay contributions (premiums) to the funds in exchange for private health insurance cover. The primary purpose of those contributions is to enable the funds to pay benefits in respect of health expenditures incurred by the members. Therefore, the benefits and related administrative expenses that are paid out of the funds, using the contributions and other earnings of the funds (such as interest, dividends and rent received), are regarded as private health insurance funding of health expenditure.

Some adjustments are made by the funds to provide for outstanding claims at the end of each accounting period and to maintain a minimum level of reserves for prudential reasons. These adjustments are not regarded as health expenditure.

By paying its PHIIS and 30% rebate to the contributors, the Commonwealth Government effectively subsidises the activities that are financed by the private health insurance funds. This includes both the health activities (that is, benefits and management expenses) and the non-health activities expenditures (that is, adjustments to provisions and reserves).

Consequently, the AIHW regards the PHIIS and the 30% rebate as Commonwealth funding. It apportions that Commonwealth funding across the expenditure categories (private hospitals, medical services, etc.) in line with the levels of expenditure by the funds on those categories. For example, because just over half the expenditure of private health insurance funds is on benefits to private hospitals, just over half of the Commonwealth's expenditure on PHIIS and the 30% rebate is allocated to private hospital expenditure. Of course, only that part of the Commonwealth's expenditure that is related to health activities is included in the estimates of health expenditure.

The Commonwealth expenditure on PHIIS and the 30% rebate is then offset against the gross expenditure by private health insurance funds.

Welfare services expenditure data development

The AIHW undertook a comprehensive review of existing data sources for expenditure on welfare services in Australia in 1994 (AIHW: Pinyopusarerk & Gibson 1994). The first estimates of welfare services expenditure followed in 1995. Its analysis covered the period from 1987–88 to 1992–93. Data were for the public sector only, broken down into three areas of expenditure:

- family and child welfare services;

- aged and disabled welfare services;
- other welfare services.

The scope of the initial analysis was limited to expenditure by governments on welfare services. Therefore, spending on income support—for example, the old age pension, disability pension, sole parent pension, and housing and rental assistance—was not included.

Other areas of government expenditure with 'welfare services' flavour were also excluded from the estimates of expenditure on welfare services. These included nursing homes (later high-level residential aged care) and pre-schools. The former, following OECD definitions, are considered to be predominantly 'health' in nature. The latter are considered to have an 'education' purpose.

Subsequent issues of the welfare services expenditure bulletins expanded the data elements to include information on expenditure by the private sector—non-government community services organisations, clients and households (Australian Institute of Health and Welfare (AIHW) 1996).

From 1997–98, expenditure on services for older people was able to be split from services for people with disabilities. This was made possible when the Commonwealth Grants Commission developed separate assessment categories for concession items.

There has been a break in the series due to the change in government accounting systems in most jurisdictions from cash to accrual in 1998–99. The data for years before 1998–99 are not comparable to those from 1998–99 onward. There were also problems with data reliability because only some jurisdictions changed to the accrual system.

Regrettably, there is no OECD framework specifically covering welfare services expenditure. However there is a broader OECD framework for social expenditures, which covers areas such as employment, health, housing, social security and welfare. AIHW is moving to base its estimates on this framework in future years.