

# Health expenditure database 2011-12

## Identifying and definitional attributes

Metadata item type:	Quality Statement
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## Data quality

### Quality statement summary:

### Summary of key issues

- The Australian Institute of Health and Welfare (AIHW) compiles its health expenditure database from a wide range of government and non-government sources. The data are mainly administrative in nature though some survey information is included. Since 2008–09, the main source of government expenditure data has been the Government Health Expenditure national minimum data set (GHE NMDS). The GHE NMDS was developed with the advice of the Health Expenditure Advisory Committee (HEAC) and is mandatory to report against for all state and territory governments.
- Total health expenditure excludes some sources of expenditure, including Australian Defence Force expenditure, some local government expenditure and some non-government organisation expenditure.
- The state and territory estimates 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 actual levels of activity by state and territory governments.
- The data, to the greatest extent possible, are produced on an accrual basis.
- Estimates in [Health expenditure Australia 2011-12](#) are not comparable with the data published in issues prior to 2005–06 because of the reclassification of expenditure on high-level residential aged care from 'health services' to 'welfare services'.

### Description

The AIHW annually compiles the AIHW health expenditure database that comprises a wide range of information about health expenditure in Australia. Data from the database is reported 15 months after the end of the financial year. Each release provides a 10 year time series from the reference year. In [Health expenditure Australia 2011-12](#), data is provided for 2011–12 with estimates back to 2001–02.

Health expenditure is defined as expenditure on health goods and services and health-related investment. The definition closely follows the definitions and concepts provided by the Organisation for Economic Co-operation and Development's (OECD) System of Health Accounts (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.

The Australian Bureau of Statistics (ABS), Treasury, Department of Health and

Ageing (DoHA) and state and territory health authorities provide most of the basic data used in the health expenditure database. Other major data sources are the Department of Veterans' Affairs (DVA), the Private Health Insurance Administration Council (PHIAC), Comcare, and the major workers compensation and compulsory third-party motor vehicle insurers in each state and territory.

Expenditure on health is compiled in terms of recurrent expenditure and capital expenditure. Recurrent expenditure can 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 context the term 'capital expenditure' is used.

Information provided on the type of economic transaction is based on the ABS economic type framework classification. For [Health expenditure Australia 2011-12](#), the data have been reconciled with established reporting structures to ensure the robustness of the estimates provided under this new reporting framework. In future years, this data will increasingly be used to present health expenditure estimates in new ways, such as identifying the various forms of public and private revenue that are used to fund the various health services.

**Institutional environment:** The AIHW is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health and Ageing portfolio.

The Institute aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance to the *Privacy Act 1988*, ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <http://www.aihw.gov.au/>

Australia's expenditure reporting format has not changed markedly since the AIHW's first national health expenditure report in 1985. The format that the AIHW has used for reporting expenditure on health since 1985 is based on the World Health Organization's (WHO) reporting structure, which the WHO adopted during the 1970s. The WHO structure is generally referred to as the National Health Accounts (NHA) and it shows areas of expenditure by sources of funding. The Australian version is the Australian National Health Accounts.

The consistency in reporting format allows the impact of changes in the way health care is delivered and financed to be monitored over time.

Since 1998, the AIHW 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 SHA (OECD 2000). Since 2007, the OECD has been revising its SHA manual to; further improve the comparability of health expenditure data across countries; provide better information to assess the performance of health systems; and provide better information on the role of the health sector within the national economy.

In October 2011, a new edition, building on the original manual was released (OECD, WHO, Eurostat 2011). The AIHW is working towards reporting its health expenditure to the OECD in accordance with the new guidelines.

In 2004, the AIHW established the Health Expenditure Advisory Committee (HEAC), comprising data users and providers, to give advice and feedback on its health expenditure reporting. The committee meets twice a year and consists of representatives from DoHA, Treasury, ABS, DVA, Commonwealth Grants Commission, Medicare Australia, the PHIAC and each state and territory health department. It also includes an academic health economist.

**Timeliness:** [Health expenditure Australia 2011-12](#) includes data for the 2011–12 financial year, as well as data back to 2001–02.

The AIHW health expenditure database cannot be compiled for a given year until each jurisdiction is able to supply data for that year. Ability for timely reporting is dependent on whether all jurisdictions meet the deadline for data supply and any delay to data supply past the deadline has an impact on the release date. The 2011–12 financial year data was supplied by all jurisdictions by 18 June 2013.

The NHA are generally released 15 months after the end of the reference year, as part of the Health expenditure Australia series of publications.

There have been some revisions to previously published estimates of health expenditure, due to receipt of additional or revised data or changes in methodology. Comparisons over time should therefore be based on the estimates provided in the most recent publication, or from the online data cubes, rather than by reference to earlier editions.

**Accessibility:** Reports are published and are available on the AIHW website where they can be downloaded without charge. <http://www.aihw.gov.au/expenditure-publications/>

Data are also available through data cubes. <http://www.aihw.gov.au/expenditure-data/#Public>

General enquiries about AIHW publications can be made to the Media and Strategic Engagement Unit on (02) 6244 1025 or via email to [info@aihw.gov.au](mailto:info@aihw.gov.au). Specific enquires about health expenditure data can be made to the Expenditure and Workforce Unit.

**Interpretability:** The primary purpose of AIHW's health expenditure database is to enable reporting of estimates of national health expenditure. Because definitions closely follow those used by the OECD, the database can be used to report internationally.

State and territory estimates are also provided, however, as the methodology used in the report is primarily for national reporting, there may be some differences in figures reported by individual jurisdictions.

Similarly, there may be differences with other reporting of expenditure such as that in AIHW's National Public Hospitals Establishments Database (see 'Chapter 5 Technical notes' in [Health expenditure Australia 2011-12](#) for more details).

Also see Chapter 5 for detailed descriptions of concepts, data sources and estimation methods and the Glossary for the terms used. Further information on the GHE NMDS can also be found on the AIHW's METeOR system.

**Relevance:** The AIHW health expenditure database is highly relevant for monitoring trends in health expenditure, including international comparisons. The data are used for many purposes by policy-makers, researchers, government and non-government organisations and the public.

Comparisons with GDP enable consideration of the role of the health sector and per person expenditure provides an indication of changes in expenditure with respect to the population.

The relative contribution of the Australian Government and state and territory governments is highly relevant to health policy and administration. Similarly, expenditure by the non-government sector including the out-of-pocket expenses of individuals are also relevant to a range of health policy issues such as those related to access and the provision of services.

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.

**Accuracy:**

The AIHW health expenditure database is generally considered to provide accurate estimates of total and component health expenditure in Australia. The introduction of the GHE NMDS in 2008–09 allows additional scrutiny and improvement of the expenditure and revenue data, and mitigates the chances of double-counting.

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.

Some of the expenditure by non-government health organisations, such as the National Heart Foundation and Diabetes Australia, is not included. In particular, most of the non-research expenditure funded by donations to these organisations is not included, as data are not available. The estimates do not include indirect expenditure such as the cost of lost wages for people accessing health services.

The state and territory estimates 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 with 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.

There is a partial double-count of the public hospital expenditure funded from private practitioner facility fees and medical services in the hospitals and medical services rows of tables. A small part of public hospital expenditure funded by facility fees and charged to private medical practitioners is not traditionally identified in 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, hence would be included in the medical services estimates.

From 2003–04, estimates of individuals' 'out-of-pocket' expenditure on dental services, other health practitioners and aids and appliances, mostly relied on detailed private health insurance data from the Private Health Insurance Administration Council (PHIAC). The methods before 2003–04 relied on highly aggregated ABS data. Current methods are based on growth in the cost of services, combined with changes in the proportion of the population who have ancillary health insurance cover; see 'Chapter 5 Technical notes' of [Health expenditure Australia 2011-12](#) for further details.

AIHW does not separately collect health expenditure information from local government authorities. In the ABS Government Finance Statistics (GFS) data, the contribution of local governments to health expenditure is included but appears to be relatively small. If local government authorities received funding for health care from the Australian Government or state and territory governments, this expenditure would be included in that jurisdiction's expenditure.

The data, to the greatest extent possible, are produced on an accrual basis; that is, expenditure 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.

## Coherence:

Comparisons over time should be based on the estimates in [Health expenditure Australia 2011-12](#), or from the online data cubes, rather than by reference to earlier editions. Previously published estimates are periodically revised due to receipt of additional or revised data or changes in methodology.

Since 2008–09, data presented in this series have been collected through the GHE NMDS. The data collection process requires state and territory data providers to allocate expenditure against a different range of categories from those used for previous collections. These data have been mapped back to the expenditure categories from previous Health expenditure Australia publications to ensure consistency and comparability in these statistics over time.

It is possible that the revised data collection process has led to the identification of previously unreported health expenditure, or to disaggregations of existing items that allow them to be more precisely allocated to health expenditure categories. All measures have been taken to ensure that, particularly at the higher level, statistics are consistent with previous years. There is a possibility that, in some of the more disaggregated state expenditure tables, these changes to the data collection and analysis process have driven the variations, rather than actual changes in health expenditure.

There are breaks in the series due to differences in definitions of public hospitals and public hospital services between 2002–03 and 2003–04. 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. 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. See 'Chapter 5 Technical notes' of [Health expenditure Australia 2011-12](#) for further details of these breaks in series.

Estimates in this report are not comparable with the data published in issues prior to 2005–06 because of the reclassification of expenditure on high-level residential aged care from 'health services' to 'welfare services'.

Australia was one of the first countries to adopt a new international standard, the System of National Accounts 2008. The new system increased the scope of production activities included in the measurement of GDP. The changes increased the size of Australia's GDP, which had the effect of reducing Australia's health to GDP ratio, particularly in comparison with other countries that have not yet adopted the new standard. More information about the new system can be found at <http://www.abs.gov.au/ausstats/abs@.nsf/mf/5310.0.55.002>. Revisions to ABS estimates of GDP using the new system affected the estimates in Health expenditure Australia from 2008–09.

GDP estimates for this publication are sourced from the ABS (ABS 2013). The ABS made revisions to their GDP estimates, which incorporated more up-to-date data and concurrent seasonal adjustments. The revisions have been applied retrospectively, so health expenditure to GDP ratios for all years back to 2001–02 in [Health expenditure Australia 2011-12](#) are not consistent with those shown in previous Health expenditure Australia reports.

The substantial variation in inflation in recent years has been specifically confirmed with the ABS and is held to be accurate.

## Source and reference attributes

### Reference documents:

ABS 2013. Australian national accounts: national income, expenditure and product, March 2013. Cat. no. 5206.0. Canberra: ABS

OECD (Organisation for Economic Co-operation and Development) 2000. A system of health accounts, version 1.0. Paris: OECD.

OECD, Eurostat, WHO 2011. A system of health accounts 2011 edition. Paris: OECD.

## Relational attributes

**Related metadata references:**

Supersedes [Health expenditure database 2010-11](#)

- [AIHW Data Quality Statements](#), Superseded 25/09/2013

Has been superseded by [Health expenditure database 2012-13](#)

- [AIHW Data Quality Statements](#), Superseded 24/09/2015

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