Health expenditure database 2018–19; Quality Statement

Exported from METEOR (AIHW's Metadata Online Registry)

Health expenditure database 2018–19; Quality Statement

Identifying and definitional attributes

Metadata item type: Data Quality Statement

METEOR identifier: 735937

Registration status: AIHW Data Quality Statements, Superseded 26/11/2021

Data quality

Data quality statement summary:

Summary of key issues

- Total health expenditure, as reported from the Australian Institute of Health and Welfare (AIHW) Health Expenditure Database, excludes some types of health-related expenditure, including health-related Australian Defence Force expenditure, some local government expenditure and some non-government organisation expenditure, such as that by the National Heart Foundation and Diabetes Australia.
- Throughout the years, there have been changes in the cost centres data provided by the Australian Government Department of Health. This may lead to changes in the classification of areas of expenditure for some items, including some changes between unreferred medical services and community health services in 2018–19.
- The price deflator for the MBS medical services fees charged was reviewed and updated for this year's report. This change was back cast to 1985–86.
- The final Australian Bureau of Statistics (ABS) Private Hospital Establishment Collection (PHEC) was conducted for the 2016–17 reporting period. Data from this collection contributed to estimates of both individual and other private expenditure. The expenditure estimates for 2017–18 have been modelled using historical PHEC data. From 2018–19, the Private Hospital Data Bureau (PHDB) is used to estimate the patient revenue component of private hospitals. The other revenue component is continued to be modelled on historical data. Therefore, the private hospital expenditure in 2018–19 might not be directly comparable with previously published data.
- Data for over-the-counter sales of health-related products by individuals at supermarkets and retail pharmacies for the period 2016–17 to 2018–19 are sourced from Information Resources Incorporated (IRI 2018a, b; 2019a, b; 2020a, b), which might have different scopes compared to the years prior to 2016–17. Therefore cautions need to be exercised in relevant comparisons.
- Due to data unavailability, individuals' expenditure on private scripts in 2018–19 is modelled on historical data.
- In 2017, the Australian Government funded the Tasmanian Government for operating the Mersey Community Hospital. The payment was made as a single lump sum payment but funds are being accrued over a 10-year period. Australian Government expenditure for Mersey Community Hospital from 2007–08 has not been offset from Tasmanian government's expenditure.
- The ABS implemented a new classification system for the reporting of government finance statistics, which was implemented for the 2017–18 period. Estimates from 2017–18 onwards are not directly comparable with previously published data.

Institutional environment:

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

The AIHW 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 variety of topics and issues, including health and welfare expenditure, hospitals, disease and injury, mental health, ageing, homelessness, disability and child protection.

The AIHW also plays a role in developing and maintaining national metadata standards. This work helps improve the quality and consistency of national health and welfare

statistics. The AIHW works closely with governments and non-government organisations to achieve greater adherence to those 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 data sets based on data from each jurisdiction, analyse the data sets, and disseminate information and statistics.

Compliance with the provisions of both the Australian Institute of Health and Welfare Act and the Privacy Act 1988 (Cwlth) ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions to preserve privacy and confidentiality.

For further information, see www.aihw.gov.au.

The AIHW's reporting on health expenditure includes ANHA, which are distinct from but related to the Australian National Accounts produced by the Australian Bureau of Statistics (ABS) and the System of Health Accounts reported by the OECD.

The AIHW compiles its Health Expenditure Database from a wide variety of government and non-government data sources. Since 2008–09, the main source of state and territory government expenditure data has been the Government Health Expenditure National Minimum Data Set (GHE NMDS), which consists of data provided by the states and territories to the AIHW. Information about Australian Government expenditure is also sourced from the ABS, Australian Prudential Regulation Authority, Australian Taxation Office, Comcare, Department of Health, Department of Veterans' Affairs and Treasury.

Timeliness:

This release of Health expenditure Australia 2018–19, includes data for the 2018–19 financial year, as well as data back to 2008–09.

The AIHW Health Expenditure Database cannot be compiled for a given year until all providers have supplied data for that year. Timely reporting depends on whether all providers meet the deadline for data supply. Any delay to data supply past the deadline may impact on the release date.

The data are generally released about 15 months after the end of the reference year, as part of the annual Health expenditure Australia series of publications. Due to the Covid-19 disruptions to data supply, Health expenditure Australia 2018–19 is published later than this normal timeline.

There have been some revisions to previously published estimates of health expenditure, due to receipt of extra or revised data or changes in method. As a result, comparisons over time should be based on the estimates provided in the most recent publication, or from the data visualisation tool available here, rather than by reference to earlier editions.

Accessibility:

Reports based on the database are published and are available on the AIHW website where they can be downloaded here.

Additional tables that support the analysis presented in *Health expenditure Australia 2018–19* are available in Excel format and can be downloaded here.

Data are also available through a data visualisation tool.

General enquiries about AIHW publications can be made to the Strategic Communications and Stakeholder Engagement Unit on (02) 6244 1000 or via email to info@aihw.gov.au.

Specific enquiries about health expenditure data can be made to the Economics, Expenditure and Medicare Unit via email to info@aihw.gov.au.

Interpretability:

See Chapter 5 of the *Health expenditure Australia 2018–19* report for detailed descriptions of concepts, definitions, data sources and estimation methods, and see the Glossary for the terms used. Information is also available on the AIHW's Metadata Online Registry (METeOR) system.

Further information on the GHE NMDS can also be found here.

Relevance:

Scope and coverage

Total health expenditure reported for Australia (both domestically and internationally) is known to be an underestimate—it excludes some types of health-related expenditure, including that of the Australian Defence Force and some local government expenditure. Some of the expenditure by non-government health organisations—such as the National Heart Foundation and Diabetes Australia—is also 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 AIHW's Health Expenditure Database is highly relevant for monitoring trends in health expenditure, including international comparisons. Policymakers, researchers, government and non-government organisations, and the public use these data for many purposes.

Comparisons with gross domestic product (GDP) enable consideration of the size of the health sector relative to the broader economy, and per person expenditure provides an indication of changes in expenditure in relation to the population.

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

The estimates enable state and territory governments to monitor the impact of their policy initiatives on their overall expenditure on health goods and services.

The AIHW does not separately collect health expenditure information from local government authorities.

Reference period

The most recent reference period of these data is the 2018−19 financial year.

Geographic detail

Data are presented at the national and state and territory levels.

Statistical standards

The data are analysed and categorised in terms of the AIHW's classification of area of expenditure and source of funds as well as the OECD's System of Health Accounts.

Accuracy:

Potential sources of error

In some cases, public hospitals receive fees from medical practitioners in return for the right to practice privately

within the hospital. The medical practitioner may then receive payment from the Medicare Benefits Schedule (MBS), individuals and/or private health insurance funds for these services. The expenditure from these sources is captured in the expenditure data, but the fees received by the hospital are not always captured as revenue in the hospitals data. This can effectively lead to a double counting of expenditure on the same service. For example, it may appear as though the hospital paid for a portion of the service as well as the MBS.

The AIHW does not separately collect health expenditure information from local government authorities. If a local government authority received funding for health care from the Australian Government or state and territory government, it appears as expenditure by that respective body.

The data, to the greatest extent possible, 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 when the claims for benefit are processed, which is not necessarily the same as the date when the services were provided.

Data validation

Data provided by state and territory health agencies are validated by the agency to ensure they have been collected accurately. State and territory health agencies are also provided with an opportunity to review the final data for their jurisdiction before public release.

Coherence:

The ANHA aims to support a long-term, whole-of-system understanding of health spending nationally and over time. This system is unique in Australia and it varies from other health system reporting in scope, degree of stability over time and classification systems used. Other systems tend to focus on specific funding programs, jurisdictions or time periods.

The long-term holistic approach requires developing methods to appropriately allocate spending figures from multiple and often overlapping data sources. These sources change over time to the relatively stable ‘area’ and ‘source’ categories used in the ANHA. In doing so, care is taken to avoid the risk of misallocation, unnecessary breaks in the time series, missed data and double counting.

The methods used in the ANHA are overseen by the Health Expenditure Advisory Committee (HEAC). The HEAC includes subject matter experts and representatives from the Australian Government and all state and territory

governments. The AIHW has worked with the HEAC over many years to develop approaches to maximise the completeness and accuracy of the estimates over time and minimise the risk of double counting. For example, when estimating total spending on hospital services in a year, the funds the Australian Government gives to states and territories is subtracted from the hospital spending reported by the states and territories to derive the amount that the states and territories spent from their own resources.

This holistic approach, unique classification system and methods developed mean the figures reported here often vary from other data sources, particularly where other reporting tends to focus on specific funding programs, institutions, funders or purposes. For example, program-specific reporting such as for the Medicare Benefits Scheme, government budget papers or health department annual reports vary from the figures here due to differing classifications, scopes and methods used to account for double counting.

As part of ongoing data quality improvement activities, the AIHW, through the HEAC, works with the ABS, the Australian Government, state and territory governments, the NHFB, the OECD and other data suppliers to ensure the estimates presented in the ANHA are as complete and accurate as possible and reflect changes in health system financing over time. Chapter 5 provides more information about the methods and data sources used to develop the ANHA.

Examples of other health expenditure reporting include:

- Australian Bureau of Statistics (ABS) uses the System of National Accounts to report Australia's National Accounts (ABS 2016). This economy-wide classification system is broader than just the health sector and uses different data sources and estimation methods to the ANHA to ensure consistency across the economy. The AIHW is working with the ABS to better align the estimates wherever possible and over the course of 2020, the AIHW has conducted an external review of the ANHA approaches, including variances with the national accounts. Further on this will be released as part of a separate technical report but preliminary findings suggest that the processes and quality assurance mechanisms employed by both agencies are consistent and reflect best practice in national statistics. Despite this, variances are unavoidable due to the different scope and classifications systems used. For example, where spending through health insurance is considered part of the health system under the ANHA, it is considered part of the insurance sector in the System of National Accounts. Another reason for variation comes from the ABS use of the Government Finance Statistics (GFS) as a source for government spending, which varies from the source used by the AIHW, which has been tailored specifically for the ANHA. While the basis for both systems is the general ledger transactions that are recorded by the various government agencies, including Departments of Health, the two vary for a number of reasons, including:

– The GFS approach is a 'purpose' classification, which means that the basis for classifying expenditures is the purpose for which the expenditure relates, rather than the nature of the product or service purchased. This means, for example, that remote housing constructed for the purpose of housing medical staff would be treated as health spending in the GFS but not in the ANHA.

– The health classification in the GFS potentially includes activities that are outside of the scope of the ANHA (e.g. nursing and convalescent home services) and may exclude activities that are within the scope of the ANHA.

- All governments within Australia produce financial reports, including annual reports, budget papers and specific program data. While these generally use the same source data as are provided to the AIHW (audited financial statements and 'general ledgers'), variations in scope can occur between what might, for example, be in a report covering spending across a health and human services portfolio and what is needed for the ANHA. Classifying the data to fit the ANHA classification system can require adjusting specific items to avoid duplication, or drawing on other data sources, such as hospital activity data, to 'fit' the spending into ANHA categories. For example, staff engaged by a specific health service might technically be considered departmental staff in some states and territories. In these cases, spending can essentially be captured twice in the annual report but this duplication is eliminated for reporting to the AIHW. The states and territories conduct this work each year as part of the Government Health Expenditure National Minimum Data Set (GHE NMDS) collation. The AIHW continually reviews this with the states and territories bilaterally and through HEAC to maximise consistency over time and between jurisdictions. The results, however, inevitably vary to some degree from what is publicly reported.

- The Administrator of the National Health Funding Pool, supported by the National Health Funding Body (NHFB) publishes data on funding and payments through the National Health Funding Pool (NHFP) that was established under the National Health Reform Agreement (NHRA) (Box 5.1 has more details). These data form an important component of the spending outlined in this report, particularly with public hospital spending. However, not all public hospital spending outlined in this report is administered through the NHFP, so additional information sources are drawn on to capture the full scope of public hospital spending. From the perspective of the Australian Government, this includes spending such as by the Department of Veterans' Affairs (DVA), the Highly Specialised Drugs program, the Department of Health's own programs, including blood and organ programs, all of which operate outside of the NHFP. From the perspective of the states and territories, their funding contributions through the NHFP do not match their figures provided through the GHE NMDS for a variety of reasons, including:

– additional ‘top-up’ funding provided to hospitals outside the NHFP where the cost of providing services exceeds the National Efficient Price under NHRA funding mechanisms and/or the particular services are outside the scope of NHRA arrangements;

– locally sourced revenue and associated spending may not be administered through the NHFP. Where hospitals have local revenue sources (for example, private patients, accommodation charges, sub-rent revenue and car parking fees) and this is used to fund hospital services, this funding may not be administered through the NHFP but is captured in the ANHA;

– funding related to centrally managed programs such as pathology and diagnostics services, where the provider for multiple hospitals might be contracted directly by the state/territory’s health department (outside the NHFP), rather than these services being sourced by individual hospitals;

– non-hospital services funded through the NHFP. In some jurisdictions, services such as community care and public health may be funded by contributions administered through the NHFP. This spending is reported and treated separately under the ANHA; and differences between cash and accrual accounting cycles, which mean timing of cash payments, expenses and reporting can vary.

- The Independent Hospital Pricing Authority (IHPA) collects, validates and reports public hospital costing data under the National Hospital Cost Data Collection (NHCDC) to determine the National Efficient Price and National Efficient Cost for the purpose of Activity Based Funding (ABF) and Block Funding under the NHRA. These data have different scopes and standards compared with the ANHA. The IHPA does not report public hospital spending in the aggregate level. More about the IHPA and NHCDC can be found at https://www.ihpa.gov.au/.
- Each year the AIHW provides a derivation of the ANHA to the Organisation for Economic Co-operation and Development and the World Health Organization in accordance with the classification used for international reporting, known as the System of Health Accounts. Despite being derived from the same source data, differing classification systems can result in variations in figures for particular components of the health system.

Estimates are not comparable with the data published in reports issued before 2005–06 due to the reclassification of expenditure on high-level residential aged care from ‘health services’ to ‘welfare services’.

Since 2008–09, some of the data presented in the *Health expenditure Australia* series of publications 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 reports to ensure consistency and comparability in these statistics over time.

Throughout the years, there have been changes in the cost centres data provided by the Australian Department of Health which might lead to changes in the classification of areas of expenditure for some items, including some changes between unreferred medical services and community health services in 2018–19.

The price deflator for the MBS medical services fees charged was reviewed and updated for this year’s report. This change was back cast to 1985–86.

The final ABS PHEC was conducted for the 2016–17 reporting period. Data from this collection contributed to estimates of both individual and other private expenditure. The expenditure estimates for 2017–18 have been modelled using historical PHEC data. From 2018–19, the PHDB

(Department of Health 2020) is used to estimate the patient revenue component of private hospitals. The other revenue component is continued to be modelled on historical data. Therefore, the private hospital expenditure in 2018–19 might not be directly comparable with previously published data.

Data for over-the-counter sales of health-related products by individuals at

supermarkets and retail pharmacies for the period 2016–17 to 2018–19 are sourced from Information Resources Incorporated (IRI 2018a, b; 2019a, b; 2020a, b), which might have different scope compared to the years prior to 2016–17.

Due to data unavailability, individuals' expenditure on private scripts in 2018–19 is modelled on historical data.

In 2017, the Australian Government funded the Tasmanian Government for operating the Mersey Community Hospital. The payment was made as a single lump sum payment but funds will be accrued over a 10-year period. Australian Government expenditure for Mersey Community Hospital from 2007–08 has not been offset from Tasmanian government's expenditure.

The ABS implemented a new classification system for the reporting of government finance statistics, which was implemented for the 2017–18 period. Estimates from 2017–18 onwards are not directly comparable with previously published data.

Source and reference attributes

Reference documents:

AIHW 2020. *Health expenditure Australia 2018–19*. Health and welfare expenditure series no. 65. Cat. no. HWE 77. Canberra: AIHW.

IRI (Information Resources Incorporated) 2018a. National Australia Grocery 2016–17. Unpublished data. Melbourne: IRI.

IRI 2018b. National Australia Pharmacy 2016–17. Unpublished data. Melbourne: IRI.

IRI 2019a. National Australia Grocery 2017–18. Unpublished data. Melbourne: IRI.

IRI 2019b. National Australia Pharmacy 2017–18. Unpublished data. Melbourne: IRI.

IRI 2020a. National Australia Grocery 2018–19. Unpublished data. Melbourne: IRI.

IRI 2020b. National Australia Pharmacy 2018–19. Unpublished data. Melbourne: IRI.

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

Relational attributes

Related metadata references:

Supersedes Health expenditure database 2017–18; Quality Statement
AIHW Data Quality Statements, Superseded 27/10/2020

Has been superseded by Health expenditure database 2019–20; Quality Statement
AIHW Data Quality Statements, Superseded 04/11/2022