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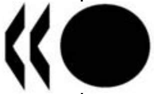

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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

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Working Party on Social Policy. Health Policy Statistics.

SUMMARY RECORD OF THE MEETING OF EXPERTS IN NATIONAL HEALTH ACCOUNTS

Held on 27-28 October 2003

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SUMMARY RECORD OF THE MEETING OF EXPERTS IN NATIONAL HEALTH ACCOUNTS 27-28 OCTOBER 2003

1. The main objectives of the meeting were to contribute to the development of a framework for the regular, comparative presentation and interpretation of the results from SHA-based health accounts, and to improve the availability and comparability of health expenditure in *OECD Health Data*.

2. Among the participants were 55 experts from 26 countries, as well as representatives from the European Commission, Eurostat, the WHO, the World Bank and other organisations involved in SHA-related international activities.

ITEM 1: OPENING REMARKS

3. Mr Peter Scherer opened the meeting and welcomed the delegates. Mr Dan Waldo was then elected to chair the meeting.

ITEM 2: ADOPTION OF THE AGENDA

4. The draft agenda was adopted.

ITEM 3: APPROVAL OF THE SUMMARY RECORD

5. The summary record of the last meeting was duly approved.

ITEM 4: MAJOR TASKS FOR IMPROVING THE AVAILABILITY AND COMPARABILITY OF HEALTH EXPENDITURE IN *OECD HEALTH DATA 2004*

6. The Secretariat presented an overview of the progress of harmonising health expenditure data reporting to *OECD Health Data* with the *System of Health Accounts – International Classification for Health Accounts* SHA-ICHA). Currently 12 countries report health expenditure data to *OECD Health Data* based on the SHA (Australia, Canada, Denmark, France, Germany, Hungary, Japan, Korea, Netherlands, Switzerland, United Kingdom and the United States). A further 12 countries have either partially harmonised data; undertaken pilot studies of SHA or have started implementation but with no results presently available. The remaining 6 countries have either not started or have no plans to start SHA implementation (Austria, Greece, Iceland, Italy, New Zealand and Portugal).

7. The second part focused on the current state of data availability in *OECD Health Data* in particular with regards to core and priority variables. It was stressed that a breakthrough in data availability and comparability was still required in a number of countries and for certain variables. In addition delegates were asked to comment on the proposal to merge the overlapping networks of health accounts experts and health expenditure data correspondents.

8. A round table discussion followed the presentation with each country informing the meeting of the current state of harmonisation, particular problems and any future plans. Some of this discussion focused on the differences between national reporting and reporting to the OECD. While some delegates

stressed that national and OECD figures should be the same (e.g., Mexico), others did not see a problem with reporting one figure for national purposes and another, according to the OECD definition, for international comparative purposes (e.g., Germany). The other common issues raised around the table related to the treatment of long-term care and healthcare/social-care boundary issues, and also the split of Inpatient/Outpatient data. A number of countries also raised concerns about the ongoing status of their projects regarding the uncertainty of allocated resources and question marks over the institutionalisation.

9. The participants agreed to the proposals for improving comparability and availability of health expenditure data [DELSA/ELSA/WP1/HS(2003)4], including a minimum sub-set of the core variables that should be reported by member countries for *OECD Health Data 2004.* Also, the meeting supported the idea of enhancing the scope of responsibility of the NHA experts group and renaming it "Network of health accounts experts and correspondents for health expenditure data".

ITEM 5: INFORMATION ON INTERNATIONAL ACTIVITIES IN HEALTH ACCOUNTING SINCE THE LAST EXPERTS' MEETING

10. The following progress reports were presented on international activities connected to health accounting:

Overview of current EU sponsored SHA related projects (by Mr. Gunter Brückner, Eurostat)

11. Mr Gunter Brückner (Eurostat) ran through the results and conclusions to date on 9 EU-funded projects related to SHA framework, as well as some other policy related projects and activities. Mr Ole Henriksen (European Commission, DG-SANCO) provided further information of the forthcoming Working Party "Health Systems" (November 21, 2003), and ran through the proposed agenda.

Presentation of the WHO/World Bank/USAID on the publication "Guide to producing national health accounts with special applications to low-income and middle-income countries"

12. An overview of the *Guide to producing national health accounts* was given reporting on some of the history, the reasons behind the guide and the first results from the roll-out of the guide. The delegate from Mexico confirmed that they had been using the guide since June and had found it useful in training purposes and in preparing state accounts. The United Kingdom reported on their own work in producing an EU-based compilers guide which was faced with similar questions as the WHO/World Bank/USAID guide but was geared towards a different audience. It was hoped that a working draft would be available at the end of the October.

Presentations by representatives of regional NHA networks on recent developments in their regions

13. Mr Ravindra Rannan-Eliya (IPS) presented a report on the status of SHA implementation in the Asia-Pacific region, detailing that besides the OECD member countries in the region, five other countries (China, Sri Lanka, Samoa, Taiwan, Thailand) had institutionalised SHA accounts and a further 5 countries (Bangladesh, Hong Kong SAR, Malaysia, Mongolia, Nepal) would have SHA based accounts available within 12 months.

14. Ms. Akiko Maeda (World Bank) reported on the National Health Accounts Network for Commonwealth of Independent States running through some of the history and challenges on SHA implementation in the CIS as well as the forthcoming NHA Workshop (December 2003) and other activities in the region.

Information about the 3rd Global Symposium on National Health Accounts, San Francisco, June 13-14, 2003

15. Following an oral report on the symposium by Ms Tania Dmytraczenko (PHRplus), Ms Eva Orosz from the Secretariat presented some of the lessons learnt from the symposium, regarding cooperation with the WHO/World Bank and Eurostat in the implementation of SHA by non-OECD members and any future revisions of the SHA manual.

16. A discussion followed about the need for and timing of any revisions to the SHA manual, with Eurostat reminding the meeting that there was an agreement that no revisions should be made prior to 2005. The Secretariat emphasised that experiences gained from implementation (e.g., concerning data availability and differences in the interpretation of some elements of the functional classification, etc.) show a need for providing addendums to the SHA Manual with more guidance on some critical issues such as estimating expenditure on long-term care.

ITEM 6: ESTIMATING EXPENDITURE ON LONG-TERM CARE

17. The Secretariat presented a report on the progress of estimating expenditure on long-term care as part of the data work on the *Core study on long-term care* under the OECD Health Project. A review of the definitions of long-term care expenditure in the *International Classification for Health Accounts* (ICHA) published in the OECD manual *A System of Health Accounts* (SHA manual) was presented with a proposal for more refined and detailed definitions and guidance on how to derive estimates for this expenditure category. These definitions have initially been used for the *Core study* but might after a round of discussions with health accountants be used as a framework for improved estimates for regular data reporting, as a complement to the SHA manual.

18. In the ensuing discussion a number of delegates congratulated the work done, and at the same time expressed the opinion that the use of "activities of daily living" (ADLs) and "independent activities of daily living" (IADLs) was problematic due to the lack of international comparability and the conceptual issues attached to its use, such as the meaning of "substantial" and "limited" (e.g., Australia, the United Kingdom, Canada, Korea). It was felt that the adoption of ICF (International Classification of Functional Disability and Health), already underway in a number of countries, would provide a better basis for boundary issues of health care. In dealing with the boundary issues between health and social care both Eurostat and the World Bank felt the need to work together with those working on the social protection side would help. In response to the debate, the Secretariat acknowledged that many definitional issues still remained and agreed to consider the use of the ICF in the classifications of long-term care.

ITEM 7: CURRENT REVISION ROUND OF THE ISIC

19. As an introduction to the topic, Mr Huber emphasised the importance of harmonisation between the health-related components of international classifications and the International Classifications for Health Accounts.

20. An oral presentation was made by the Secretariat (Isaac Lagnado, Statistic Directorate) regarding the 2007 revision of the ISIC (International Standard Industry Classification) and the CPC (Central Product Classification). Whereas the last revision in 2002 was only minor the next revision is likely to see major changes and it should be seen as an opportunity to make amendments regarding the treatment of health services in these classifications. The proposal put forward on the advice of the Secretariat is to make human health a 2 digit division rather than the present 3 digit class. The consultation rounds will take place in 2004 and 2005 and delegates were asked to submit any comments to the Secretariat by end November regarding the initial proposal submitted.

ITEM 8: BASIC CONCEPTS FOR PRICE AND OUTPUT MEASUREMENT IN HEALTH

21. As an introduction to the topic, Mr Huber emphasised that achieving an improvement in health-related price indices in the *OECD Health Data* is high on the Secretariat's agenda for the coming years.

22. A presentation by Ms BRATHAUG (Norway) described the basic concepts for price and output measurement of health services in line with the work that has been carried out in Eurostat in the area of National Accounts. The same ideas and concepts should be used when establishing constant price estimates within the System of Health Accounts. After explaining the basic concepts of price and volume measures, the presentation focused on methods for estimating non-market health outputs at constant prices.

23. The United Kingdom delegate stated that a great deal of importance was being placed on such work in the United Kingdom to analyse whether the increase in expenditure was being matched by the output in different areas.

ITEM 9: KEY RESULTS OF RECENT SHA IMPLEMENTATIONS

24. Country presentations from the Czech Republic, the Slovak Republic, Sweden, Turkey and the United Kingdom focused on the first results obtained and the experiences of countries who had implemented SHA since the previous experts' meeting.

Country case: Czech Republic

25. The work undertaken by the Institute of Health Information and Statistics has included the translation of the SHA manual and the mapping of ICHA to national classifications; monitoring of data sources and the identification of new sources; and the collection and monitoring of new data. The next step is to publish the preliminary results which should be available by the end 2003.

Country case: Slovak Republic

26. The steps and the status of SHA implementation in the Slovak Republic were presented by the Institute of Health Information and Statistics. The major tasks have been to map the SHA methodology to Slovak classifications, the collection and classification of data and identification of steps ahead in developing NHA. SHA tables were presented for 1999-2001. The departures at present include – among others - no data available for private insurance enterprises (HF.2.2); the inability to separate ambulatory care in hospital settings; and the inability to report home care and long-term care.

Country case: Sweden

27. A main conclusion of the Swedish report was that classifying Swedish health care expenditure according to ICHA-HC has been possible. The predominant part of the ICHA-HC functions has been interpreted without any problems under the Swedish circumstances. Where the interpretation between ICHA-HC and the organisation of the Swedish health care differ, then the departures are well documented. Among the major challenges the following were mentioned. Privately produced and financed health care is a rather new phenomenon in Sweden, and data on a detailed level is very scarce and difficult to obtain. The estimation of long-time nursing care provided by the municipalities is based on the labour input by health care personnel. This method needs further consideration.

Country case: Turkey

28. The results of a World Bank study in 2002-3 to produce NHA in Turkey were presented. The Turkish health accounts - while designed for the special circumstances of the Turkish health system - are

compatible with the SHA. They will considerably improve data reporting to the *OECD Health Data*. The data sources identified and the preliminary results of the study were presented. The main challenges now are the institutionalisation of Turkish NHA and the reliable and stable data collection systems put in place[1].

Country case: United Kingdom

29. The presentation on the status of the United Kingdom health accounts showed the steps to date, the current issues and the future work program. The area of private financing remains the most problematic. To date the project has consumed around 3 person years of work. The next steps will be to investigate further into sources and methods to identify further primary data sources ("bottom-up"); produce estimates on a calendar year basis; and finally provide time series for policy analysis.

30. In the discussion, some countries expressed their need for support from international organisations including the OECD to sustain or start activities in SHA-based health accounting. In response, it was emphasised that the OECD is ready to provide non-financial (technical and "political") support.

ITEM 10: A FRAMEWORK FOR COMPARATIVE ANALYSIS OF SHA-BASED NATIONAL HEALTH ACCOUNTS

31. The Secretariat presented an interim report on the development of a Working Paper for Comparative Analysis of SHA-based National Health Accounts. The aim of the paper is to provide a framework for regular, comparative presentation and interpretation of the results from SHA-based health accounts. The project also contributes to further development and harmonisation of national practices in health accounting. At the present time, 12 countries are participating in the project: Australia, Canada, Denmark, Germany, Hungary, Japan, Korea, Mexico, Netherlands, Poland, Spain, and Switzerland.

32. The meeting confirmed that the materials of the SHA WP prepared so far (detailed plan and tables of the comparative chapter and the draft country chapters) are appropriate and meet the goal of developing a framework for regular publication of the results from SHA-based health accounts.

33. In the ensuing discussion there was general agreement on the overall structure and the choice of tables. In terms of the country chapters it was felt that there should be some harmonisation of the text length, without sacrificing the methodological information available. Regarding the departures from SHA the opinion was offered that extensive notes would need to accompany the tables and perhaps particular design features could help in the final paper. The timetable for those contributory countries (and any newcomers) was reiterated by the Secretariat. For those countries, such as the United Kingdom, unable to meet this deadline to join the project, it was agreed that their results will be mentioned in the introductory chapter.

34. The delegate from the World Bank expressed their interest in the project and stated that a similar exercise could take place for non-OECD countries and looked forward both to the results of the Working Paper and future co-operation with the OECD.

[1] Note: On 29 October, the Health Data Team had a meeting with the Turkish NHA experts to discuss the major issues in improving co-operation between the Secretariat and Turkey in health data reporting.

ITEMS 11 and 12: DISCUSSION OF COUNTRY CHAPTERS OF THE WORKING PAPER ON "SHA-BASED NATIONAL HEALTH ACCOUNTS IN OECD COUNTRIES"

35. The purpose of this agenda item was to discuss the first draft of the country chapters of the SHA Working Paper and give advice to their completion. Among the key issues the following were presented:

Country case: Germany

36. The total health expenditure reported nationally differs from the SHA-based German health accounts by including education and training as well as R&D in the former. The German SHA value is slightly underestimated by not including expenditure on military and prison health, or expenditure on health care administration by the central and local government (HC.7xHF.1.1). The health accounts do not work on a mode of production basis, hence day care services and out-patient services provided by hospitals are included in expenditure on inpatient care; (so data on in-patient services refer to services provided by hospitals); as well as home care services refer only to long-term nursing care.

37. There was a discussion following the presentation regarding the treatment of insurance for government employees in the SHA, which currently is treated as private social insurance (government as an employer).

Country case: Canada

38. Canadian Institute for Health Information (CIHI) carried out a major study mapping the Canadian Health Accounts (CHA) to SHA-based health accounts at the level of elementary data. The effect of SHA implementation resulted in a reduction of 3% in Total Health Expenditure from the Canadian Health Accounts due to boundary differences between the Canadian Accounts and the SHA. The public sector financing agent categories between the two classifications corresponds well; however, for the private sector, there is direct correspondence only for out-of-pocket expenditure. The mapping to ICHA-HP (provider classification of the SHA) raised an important methodological issue concerning the classification of payments to private practice physicians for their services provided in hospitals.

Country case: Denmark

39. The pilot implementation of SHA for the Danish Health Accounts for 1999 showed the main departures from the SHA to be: some health expenditures for day-care is included under inpatient care expenditure; some expenditures for home care for Long-term care is included under LTC inpatient care expenditure; some expenditure for rehabilitation and diagnostic imaging is included under services of curative care (HC.1); part of accommodation in residential care facilities for the elderly is included under LTC inpatient, which as a result over estimate the expenditures.

Country case: Hungary

40. Hungarian Health Accounts are now available for four years (1998-2001). The implementation of SHA based accounts resulted in substantial revisions to previous estimates. The presentation focused on the current sources and the development of the Private Health Provider Questionnaire (PHPQ) that would be implemented in 2004, in order to provide an alternative and more accurate source of private expenditure estimations.

Country case: Japan

41. If calculations are based on the SHA classifications, the total expenditure on health in Japan 2000 is about 700 billions of Yen (22%) higher than the value based on the National Medical Care Expenditure.

The scope of National Medical Expenditure (NME) is narrower than the definition of SHA: it includes only expenditures covered by public health insurance benefits and expenditures on things for which public funding is provided. The long-term care insurance system, introduced in Japan in 2000, gives the impression of a reduction in NME since the LTC expenditure is shifted to LTC insurance. However, this part of LTC is included in SHA based National health accounts. The trend of personal expenditure by SHA therefore shows a rising trend from 1995.

42. An important departure from the SHA is that estimates of private households' expenditure do not include medical treatment at one's own expense and special medical care coverage such as private room charges in hospital.

Country case: Korea

43. With the new accounts by the OECD SHA, it is now possible to better compare total health expenditure of Korea with other OECD countries and GDP share of total health expenditure in the *OECD Health Data* is currently the most frequently quoted figure on health expenditure in Korea. Interim health accounts for 1998-2001 have been constructed, including classification by providers and when completed would be submitted for *OECD Health Data 2004*.

44. The results show that public funding share has been increasing over time, but is still one of the lowest among OECD countries. Korea also has an unusual mix of health expenditure by mode of production, compared with other OECD countries with very low in-patient share (23.4%), considerably high out-patient share (41.2%) and high drug share (20.3%) of total health expenditure in 2001.

Country case: Mexico

45. The first NHA analysis in Mexico by FUNSALUD covered the period 1992 to 1998. The evidence provided was used in prospective policy formulation and for the National Health Program 2001 – 2006. In departures from the SHA definition of Total Health Expenditure, Health related functions are included as part of the total health expenditure. Another departure is that stewardship as a separate function distinct from administration. Availability of data limits the full implementation of the functional classification of the ICHA-SHA at this moment.

46. The following discussion focused on the treatment of stewardship as to whether it should be treated as a separate function or whether it falls between public health activity and administration.

Country case: Spain

47. The main issues in reporting Spanish Health Care Expenditure according to the SHA framework have been the mapping from previous classifications and the introduction of private expenditure. The main departures are: Health care provided in nursing and residential premises for elderly and disable people is not included. (It only includes the long-term care provided by hospitals with this specific purpose.); occupational health care is not included; private investment in medical facilities only includes hospital capital expenditure; prevention and public health expenditure includes only public expenditure. It was emphasized that improvements in the health reporting systems will be necessary due to the devolvement of health systems to the Autonomous Communities in 2002.

Country case: Poland

48. Work on the pilot project of health accounts for Poland was carried out in the period from November 2001 to March 2002. The project was financed with resources from the World Bank loan. 1999 was used as a base year and the results showed a difference of 7.7% between pre-SHA and pilot SHA

calculation of total health expenditure. It was also felt the real rate of private health care financing in Poland would be even greater than estimated. Further efforts were needed on standardisation of some health expenditure categories as well as redesigning the way of reporting data between providers, financing agents, and certain data collection institutions. As a burning issue, the uncertainty of institutionalization of producing SHA-based health accounts was mentioned.

Country case: Switzerland

49. OECD methodology for health accounting was adopted in 2000 and the time series has been revisited to provide SHA-based health accounts from 1995. A few departures however exist from the OECD methodology: the treatment and desegregation of current and investment expenditure at all levels of providers and functions; the over-estimation of expenditure on long-term care in relation to other OECD countries. A discussion followed regarding the estimation of LTC and the special features of the Swiss insurance system with the consensus being that further clarification was needed in these increasingly complex areas.

ITEM 13: CONCLUSIONS AND DISCUSSIONS OF THE NEXT STEPS

50. The Secretariat thanked all delegates for the work and the progress made since the last meeting.

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