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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE

Health Accounts Experts

PROPOSAL FOR 2009 JOINT OECD, EUROSTAT AND WHO HEALTH ACCOUNTS DATA COLLECTION

10TH MEETING OF HEALTH ACCOUNTS EXPERTS AND CORRESPONDENTS FOR HEALTH EXPENDITURE DATA

To be held at the OECD Conference Centre
8-9 October, 2008, starting at 9.30am on the first day

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NOTE BY THE SECRETARIAT

1. In response to the growing demands for international comparable information on health spending, the OECD, in co-operation with the Eurostat Task Force CARE members and experts in the field of health accounting, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. By 2005, many OECD countries and European Union Member States had at least started a pilot implementation of the SHA framework. OECD, Eurostat and WHO had been increasingly co-operating in health accounting activities. These antecedents provided a solid ground to launch a joint data collection in December 2005. The International Health Accounts Team (IHAT), consisting of experts working in the area of health accounting at the three organisations, was established in order to manage the joint data collection.

2. This report presents the IHAT proposals for the 2009 Joint Health Accounts Questionnaire (JHAQ), being the fourth such data collection. The main contents of this proposal are based on the discussion by IHAT at ITS meeting in Paris on 25-27 August 2008.

3. The remainder of this paper contains the proposed version of the practical working arrangements, the draft data questionnaire and methodological information questionnaire for the 2009 Joint OECD, Eurostat and WHO health accounts (SHA) collection. As for the previous year, it has been an overriding aim in the interests of consistency to keep changes from the 2008 questionnaire to a minimum. Delegates should also note that these documents are presented for comments and will be finalised during the 4th quarter 2008. The final documents of the questionnaire will take into consideration feedback received during the meeting, and the ongoing discussions between the international organisations.

4. Besides this report, an additional agenda paper of the 10th Meeting of Health Accounts Experts [DELSA/HEA/HA(2008)1] presents a preliminary evaluation of responses to the 2008 JHAQ.

5. The Secretariat invites participating experts to:

- COMMENT on the practical working arrangements and scope of SHA data collection under the co-operation between OECD, Eurostat and WHO*;*

- REPORT on their plans for, and any difficulties envisaged in, providing data in accordance with the scope of the questionnaire and within the proposed timeframe.

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1. PROPOSAL FOR 2009 JOINT OECD, EUROSTAT AND WHO HEALTH ACCOUNTS DATA COLLECTION

Background

6. Since the publication of the OECD manual "A System of Health Accounts" in 2000, the basic methodological framework has become widely accepted and has been adopted in a large and growing number of OECD and non-OECD countries as the standard accounting framework for statistics on health expenditure and financing.

7. The SHA Manual served as a basis for the *Guide to producing national health accounts with special applications for lower and middle-income countries* ("Producer Guide") published by the WHO, World Bank and USAID in 2003. Many WHO Member States implemented national health accounts according to the Producer Guide, and many others are initiating the process.

8. OECD, Eurostat and WHO have a responsibility, based on their respective mandates to regularly collect and publish health expenditure data of their member countries and further develop the underlying methodologies. With the stated aims of reducing the burden of data collection for the national authorities, increasing the use of international standards and thereby harmonising national health accounting practices, the three organisations established a framework for a joint health accounts data collection to cover OECD countries and EU member and candidate and acceding countries in 2005.

9. The International Health Accounts Team (IHAT) consisting of experts responsible for health accounts work at OECD, Eurostat and WHO, was established and drew up the *Practical working arrangements for cooperation between OECD, Eurostat and WHO* and the tables and methodological documentation for the first Joint SHA Questionnaire. These documents were revised for subsequent collections based on feedback and experience from the annual exercise and have been further reviewed by IHAT for the proposed 2009 data collection exercise.

10. The first joint questionnaire was sent to the countries concerned in December 2005. It is proposed that the agreed 2009 Joint Questionnaire is sent to participating countries in December 2008.

Main changes to the 2009 Joint Questionnaire:

11. In the interests of consistency and in order to keep the data reporting burden to a minimum, the International Health Accounts Team proposes no changes to the contents of the data questionnaire and only the following minimal changes to the Methodological questionnaires and documentation:

- The Methodological Information questionnaire will include an additional worksheet aimed at improving source and methodological information related to the Financing Sources (FS) dimension.

- Some refinement has been made to the Explanatory notes regarding Financing Sources (FS).

- A brief note has been included in the Explanatory notes in order to clarify the reporting of HC.R.1 – Capital formation of health care provider institutions.

Harmonisation with *OECD Health Data 2009*

12. Following the practice of previous years, the collection of health expenditure data via the Joint Questionnaire will be co-ordinated with the updating of the Health Expenditure and Financing sections of *OECD Health Data 2009*. In this respect, it is important to reconcile the conflicting aims of including timely health expenditure data in *OECD Health Data* and avoiding the repetition of the process of data validation. The timing of the release date of *OECD Health Data 2009* will take these points into consideration. It is also important to note that next year will also see the release of the next edition of *Health at a Glance 2009 - OECD Indicators* which will take data from the July release of *OECD Health Data 2009.*

13. The following schedule is proposed.

- For those countries able to submit the Joint Questionnaire by the deadline of 31 March 2009, it is envisaged that the data will be validated and incorporated into *OECD Health Data 2009*. Therefore there is no requirement to complete the Health Expenditure and Financing worksheet (*CountryCode*56.xls) of the *OECD Health Data* questionnaire for the years 2003-07.

- Countries expecting to complete the Joint Questionnaire after this deadline will be asked to provide preliminary data of at least the major aggregates of total, public and private expenditure up to 2007 by mid May. These data will be reported in the *OECD Health Data 2009* July release, and the final validated SHA data incorporated into the internet update. Note that the data series will be marked as non-validated in *OECD Health Data*.

- Only those countries not expected to be able to submit the Joint Questionnaire should complete the Health Expenditure and Financing sections (*CountryCode*56.xls) according to the published *OECD Health Data* timetable.

Co-ordination with WHO data collection

14. The data validated through the Joint OECD, Eurostat and WHO Questionnaire will also be used to update the WHO-NHA database. The World Health Statistics Annex tables will report validated data available in March 2009. The World Health Statistics is released early May. The validated figures after that date and longer data series will be available via the WHO/NHA web database updates. In agreement with the Executive Board resolution, all data to be published in the World Health Statistics will be presented to the national Ministries of Health before publication.

Documents of the 2009 questionnaire

15. Annexes contain the draft documents listed below, with the exception of the Data Tables. For practical reasons, this is replaced by a description of the "Tables used in the 2009 Joint OECD - Eurostat – WHO SHA Questionnaire" on page 12. The draft Excel file itself will be made available at the following URL address:

http://www.oecd.org/document/30/0,2340,en_2649_34629_35378512_1_1_1_1,00.html

16. The 2009 Joint OECD, Eurostat and WHO health accounts (SHA) questionnaire, to be sent out in December 2008, will consist of the following elements:

i. Practical working arrangements for the 2009 Joint OECD, Eurostat and WHO health accounts (SHA) data collection

ii. Structure of the classifications and tables presented in the Joint Questionnaire based on the OECD manual, A System of Health Accounts (SHA)

iii. 2009 Joint OECD, Eurostat and WHO SHA Data tables (in Excel) (not included)

iv. Additional descriptions and definitions used in the Joint Questionnaire

v. Méthodologique Information questionnaire (in Excel)

ANNEX 1. PRACTICAL WORKING ARRANGEMENTS FOR THE 2009 JOINT OECD, EUROSTAT AND WHO HEALTH ACCOUNTS (SHA) DATA COLLECTION

17. This section aims to inform member countries about the practical working arrangements for the 2009 Joint SHA (System of Health Accounts) data collection by two international organisations (OECD and WHO) and one supranational organisation (the European Commission, of which Eurostat is the responsible authority regarding community statistics).

18. The most immediate goal of the collaboration between OECD, Eurostat and WHO is to reduce the burden of data collection for the national authorities responsible for the provision of statistical information to the international organisations. This joint effort also increases the use of international standards and definitions.

19. In response to the growing demands for international comparable information on health spending, the OECD, in co-operation with the Eurostat Task Force CARE members and experts in the field of health accounting, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. *A System of Health Accounts* (SHA) proposes an integrated system of comprehensive and internationally comparable accounts and provides a uniform framework of basic accounting rules and a set of standard tables for reporting health expenditure data.

20. The implementation of SHA requires political commitment, clear institutional responsibility, and co-operation at the national level between institutions with relevant data sources. Nearly all EU Member States (MS) and OECD countries have, by now, at least started a pilot implementation of the SHA framework. Many WHO Member States have also implemented a health accounting standard (many of them following the Producer Guide to producing national health accounts with special applications for lower and middle-income countries), and many others are initiating the process. OECD, Eurostat and WHO will continue to support the SHA implementation by providing training and advice.

21. Through common efforts of SHA implementation, in 2005 the three organisations agreed to intensify their collaborative actions through a joint data collection. Letters were sent to the heads of the relevant national organisations (statistical offices and/or health ministries), emphasising the importance of SHA implementation and the joint SHA data collection. Furthermore, the relevant national organisations were asked to ensure that a single person be nominated as a focal point for the joint Health Accounts data collection.

22. The inaugural 2006 joint questionnaire was sent to the countries concerned in December 2005: 23 countries (18 OECD countries and 5 non-OECD EU Member States) returned the first Questionnaire. For the 2008 edition of the Joint Questionnaire, the number of responses increased to 30 countries.

Scope and approach to the 2009 data collection

23. The joint 2009 SHA questionnaire consists of three elements: 1) a set of SHA tables requesting data for revisions and new data for the period 2003-2007[1]; 2) a methodological questionnaire (questions and tables requesting metadata); and 3) explanatory notes/guidelines (including the description of the practical arrangements of the Joint data collection).

24. The joint 2009 collection will continue to collect preliminary aggregate estimates for total health expenditure; in this case for 2008. A table requesting this information by financing agent/scheme is included within the data questionnaire.

25. The 2009 questionnaire is based on currently used classifications[2] and it is envisaged that the questionnaire will continue to be based on this version for at least the next few years with any changes kept to a minimum.

26. In order to provide longer time series for analysis, it would be desirable to collect SHA Tables for preceding years (that is, from 2000 onwards) at some future date. The feasibility of collecting data by disease category and by age and sex will also be examined for possible inclusion in future data collections.

Data validation process

27. Since 2006, the International Health Accounts Team, set up by OECD, WHO and Eurostat, has continued to develop a methodology and a co-ordinated way of correspondence with national focal points in order to check the data submissions of the participating countries. Data validation will be carried out in a similar way for the 2009 data collection.

28. The aim is to finalise the data validation process within two months after data submission. To meet such a target requires a suitable commitment of resources from both the three organisations and the national reporting authorities.

29. In order to have internationally comparable data at a sufficiently disaggregated level, the implementation of the functional classification (ICHA-HC) is a necessary precondition. As a minimum requirement, Member States are invited to provide the three core tables (HCxHP, HCxHF and HPxHF) with sufficiently disaggregated data, together with the methodological information for the Joint Questionnaire data collection. Where appropriate, national health accountants are invited to discuss possible approaches with the International Health Accounts Team, in order to complement the partial deliveries and complete the basic submission.

Distribution of the data

30. The subsequent use and distribution of the data will be done independently by the three organisations, in accordance with the existing regulations and practices of OECD, WHO and Eurostat.

[1] For those countries that have previously provided SHA Tables for 2003-2006 as part of previous joint collections, the final validated tables will be sent with the 2009 questionnaire allowing the country to include any revisions to the data.

[2] Sources: *A System of Health Accounts* (SHA) and *Guide to producing national health accounts with special applications for lower and middle-income countries.*

Summary of the proposed process

31. The member countries of the EU, WHO and OECD will be involved in the 2009 joint OECD, Eurostat, and WHO SHA data collection.

1. The joint questionnaire will be sent to countries concerned by 15 December, 2008. Eurostat will be responsible for distributing the questionnaire to the EU27 and Accession Countries/Candidate Countries (AC/CC), and the OECD will distribute the questionnaire to the 10 OECD members which are neither members nor candidates of the EU. The questionnaire will be accompanied by a joint e-mail from the International Health Accounts Team to the designated focal point.

2. The deadline for return of the completed questionnaire is: 31 March, 2009

3. The joint questionnaire consists of three elements: SHA tables; Methodological questionnaire (questions and tables requesting metadata), and Explanatory notes / guidelines. (The guidelines include the description of the practical working arrangements of the Joint data collection.) In addition, the above elements will be made available, via the Internet[3], together with further explanatory notes where appropriate.

4. The questionnaire requests data for 2003 to 2007 and preliminary aggregates for 2008.

5. Format for data collection: Excel tables.

6. Experts serving as SHA focal points are invited to send the completed questionnaires by the same e-mail to the three organisations.

7. Countries are requested to address any questions to the IHAT. Generally, it is preferable that all correspondence concerning the SHA data collection should be addressed to all three organisations. In addition, countries might be sent questions only by one of the international organisations but with the other organisations on copy. Countries are requested to return the answer to all three organisations.

8. When validated by all three international organisations, countries will be informed about verification of the data by the organisation that sent the questionnaire to them.

9. Correspondents are kindly asked to provide their feedback about the applied process of the Joint data collection and proposals for modifications when needed.

3 www.oecd.org/health/sha/jointquestionnaire

ANNEX 2. STRUCTURE OF THE CLASSIFICATIONS AND TABLES PRESENTED IN THE JOINT QUESTIONNAIRE BASED ON THE OECD MANUAL *A SYSTEM OF HEALTH ACCOUNTS* (SHA)

32. SHA is a tri-axial system in which the financing, provision and consumption dimensions are covered by the ICHA (International Classification for Health Accounts): HC health care functions, HP health care providers, and HF health care financing agents / schemes

33. These are inter-linked and dependent of each other. Due to its three-dimensional complexity, tables on two pairs of axes are typically used. This means expenditure data are organised according to the following tables: Providers (HP) by Financing (HF); Functions (HC) by Providers (HP), and Functions (HC) by Financing (HF).

34. The tables in the Joint Questionnaire are based on the original set of classifications of the SHA manual. To make the picture of the classifications on health care more complete, HC.R (health care related) activities are added to the functions. In addition, a table showing the financing sources of the categories of financing schemes/agents (HFxFS), and a table displaying the human resources component of resource costs (RCxHP) are included in the requested set of tables.

35. The 2009 Joint Questionnaire continues to include a table requesting preliminary estimates of the main aggregates (by financing agent/scheme ICHA-HF) for 2008. Partial completion can focus on providing preliminary estimates of general government (HF.1) expenditure.

36. The tables in the Joint Questionnaire include a number of items in addition to the original ICHA classifications (see Annex 1). For the functional classification, an additional line is included specifying HC. 9: not elsewhere classified or not specified by kind.

37. The categories HC.9, HF.0 and HP.0: not elsewhere classified or not specified by kind, should be regarded as a “last resort”. Countries should make every possible effort to allocate all expenditure across the other categories of the ICHA classification. However, for use in those cases where it is absolutely necessary, HC.9 has been added. When using it, the respondent should supply a detailed explanation as to why an expenditure item cannot be allocated, and the potential content. It is important that expenditure allocated to the “not specified by kind” categories remain small as a percentage of total spending in order to allow for meaningful international comparisons of the other expenditure categories. The international organisations will work with the countries concerned to discuss strategies on how to avoid the use of this category in the SHA tables and to find ways of distributing the remaining expenditure according to the categories of the ICHA classification.

38. For the tables in the Joint Questionnaire containing the functional classification (i.e. HCxHP and HCxHF tables) the expenditure of health care (and health-care related) providers for activities outside the health care branch are included – HC.R for health-related functions and M.1(HC) for non-health/health-related goods and services.

39. Total expenditure (comprising mainly in-patient and out-patient care outlays) on the items of pharmaceuticals (M.2(HC))and ancillary services (M.3(HC)) are included. Policies related to

pharmaceuticals, in particular, require a comprehensive measurement of the expenditure thereon. These memorandum items therefore provide information on the total consumption of these items.

40. In the HCxHP table, expenditures by providers of health care related goods and services (excluding providers of gross capital formation) are included under M.1(HP).

41. In the Joint Questionnaire the HPxHF and HCxHP tables a distinction on expenditure by sector (government – private) is included to provide information on the importance of the private sector in the totality of the expenditure by providers and by functions.

42. In addition to health care functions included in total current health expenditure (HC.1 to HC.7), the ICHA-HC includes health-related functions (HC.R.1 to HC.R.7). All of these functions are important for health and social policies in a wider sense. HC.R.1: Capital formation of health care provider institutions is included in total health expenditure, except in the cross-classifications. In order to report total long-term care expenditure, including health and social components, two new items were developed under HC.R.6, namely HC.R.6.1: Long-term social care (other than HC.3) and HC.R.6.9: All other HC.R.6 expenditure

43. Basically, the classifications presented in the *SHA* manual [www.oecd.org/dataoecd/49/51/21160591.pdf] are to be followed. The *Guide to producing national health accounts with special applications for low-income and middle income countries* (WHO-WB-USAID, 2003) [http://www.who.int/nha/docs/en/ available in English, French, Russian Spanish and other languages] and the *Guidelines* produced under a EUROSTAT project [http://forum.europa.eu.int/Public/irc/dsis/caretf/library?l=/feedback/projectsreports/guidelines_project/sha_guidelinespdf/] provide useful advice to populate the tables. Additional definitions and descriptions are provided in the next section of these Explanatory Notes. Further information resources are also made available at: www.oecd.org/health/sha/jointquestionnaire

44. Those responsible for the completion of the Joint Questionnaire are invited to send any questions and comments arising during the preparation of the tables. Due to the different way countries produce their SHA tables, advice can be most appropriately given on a country-by-country basis.

45. To achieve the best result possible it is necessary to collect the information on expenditure at all possible levels of aggregation. Ideally, tables at two-digit or three-digit level of aggregation are desirable. For some countries, data at a detailed level are not accessible or conflict with data confidentiality. Adding information on expenditure from the three-digit level to the two-digit level or to the one-digit level is only possible in countries that have all the information available at the lowest level of aggregation. For other countries, tables on expenditure at higher (two-digit or one-digit) level would suit their purposes better.

ANNEX 3. TABLES IN THE 2009 JOINT OECD - EUROSTAT – WHO SHA QUESTIONNAIRE

46. For each year requested (2003-2007), there is a single data questionnaire file consisting of a front page information sheet with the following seven tables:

- Preliminary major aggregates of health expenditure for 2008[4] by Financing agent/scheme
- Health Expenditure on Functions of Health Care by Financing agents/schemes (HCxHF)
- Health Expenditure on Functions of Health Care by Health Care Providers (HCxHP)
- Current Health Expenditure on Health Care Providers by Financing agents/schemes (HPxHF)
- Health Expenditure from Financing sources to Financing agents/schemes (HFxFS)
- Health Expenditure on Human resources by Health Care Provider (RCxHP)

47. In the interest of providing consistency and reducing the burden on national authorities, proposed changes to the 2009 Joint OECD, Eurostat and WHO Health Accounts (SHA) Questionnaire have been kept to a minimum. The provisional 2009 data questionnaire file, containing the full listing of the classifications, is available at the following web address:

http://www.oecd.org/document/30/0,2340,en_2649_34629_35378512_1_1_1_1,00.html

[4] For those countries only able to supply detailed SHA tables for 2005, they would be expected to complete estimations for the major aggregates for 2006.

ANNEX 4. ADDITIONAL DESCRIPTIONS AND DEFINITIONS USED IN THE JOINT QUESTIONNAIRE

48. This note includes supplementary descriptions, notably for those expenditure categories that are not included in the published versions of the ICHA.

Addendum items to the Functional (HC) classification:

HC.R.6.1 Long-term social care (other than HC.3) or LTSC

49. This item comprises services of home help and residential care services: care assistance which are predominantly aimed at providing help with instrumental activities of daily living (IADL) restrictions to persons with functional limitations and a limited ability to perform these tasks on their own without substantial assistance, including supporting residential services (in assisted living facilities and the like).Home help or, more generally, help with IADLs (such as help with activities of home making, meals etc., transport and social activities) may be provided and remunerated as integrated services with long-term nursing and personal care services. In these cases, an effort should be made to estimate expenditure on these items separately. When disaggregation of these spending items is not possible, experts should decide – based on the dominant character of the particular programs – whether these cases are reported under HC.3.3 or HC.R.6.1. When it is not possible to judge the dominant character of the programs concerned, it is proposed to report this expenditure under HC.R.6.1. However, when a country has already established a practice of reporting this expenditure under HC.3.3, it is proposed not to change this practice until the envisaged revision of the ICHA-HC. (This should be clearly indicated in the methodological information provided.).

50. *Includes***:** subsidies to residential services (including costs of accommodation) in assisted living arrangements and other kinds of protected housing for persons with functional limitations (including residential services to people with mental retardation, mental illness or substance abuse problems and homes for the physically and mentally handicapped); services of housekeeping, social services of day care such as social activities for dependent persons; transport to and from day-care facilities or similar social services for persons with functional limitations.

51. *Excludes***:** all services which are predominantly related to providing assistance with activities of daily living (ADL) included in the function HC.3: Long-term health (nursing) care (LTHC). Also excludes: Services of surveillance of persons with mental deficits such as dementia patients; medical and services of assessment, case management and co-ordination between health and long-term care services (included under HC.3). Also excludes: meals on wheels. The reason for excluding meals on wheels is more practical than theoretical: difficulties in separation of spending on meals on wheels for persons with functional limitations from spending on meals on wheels due to other reasons.

52. *Excludes***:** services that aim predominantly to combat social isolation rather than protecting persons with functional limitations (body/mental functioning)**.** This is the case in particular for services and/or living arrangements where eligibility criteria explicitly require recipients to be without health impairing chronic conditions which would require substantial help with IADL or ADL restrictions. Expenditure on these services should be excluded even from HC.R.6.

53. **Note**: the full 'Guidelines for estimating long-term care expenditure' (based on guidelines of the 2006 Joint Questionnaire) are available at the following website address: www.oecd.org/health/sha/jointquestionnaire

HC.R.6.9 All other services classified under HC.R.6 activities

54. This item comprises all other social services provided for people with disease and impairment, not included in HC.R.6.1. For example**:** special schooling for the handicapped, sheltered employment and vocational rehabilitation.

M.1(HC) Other (non-health care/health-related) goods and services

55. Providers of health care can and do produce goods and services that cannot be classified as health care goods and services nor health-related goods and services. These services may also comprise all financial transactions of activities not related to the provision of health care services or goods (as well as the aforementioned social services) of health care providers. These financial transactions are not related to patients or treatment. Examples are the provision of a hostel for nurses employed in the hospital, child care facilities for employees, and the operation of a book and flower shop.

M.2(HC) Total pharmaceuticals and other medical non-durables (including in-patient and other modes of provision)

56. This entry is designed to provide information on the total consumption of pharmaceuticals. The ICHA HP.4 and HC.5 entries are limited to prescribed and non prescribed medicines purchased in retail outlets, although other channels, such as hospitals, may amount for 20%-40% of this level. The national accounts "intermediate consumption" of hospitals and other entities should be made visible.

57. The content is as indicated in the SHA manual (see pages 119-121) regardless of their distribution channel and their financing path (meaning all out-patient plus in-patient use). Additional examples:

1. *Includes*: traditional herbs and therapeutic nutrients

2. *Excludes*: products for veterinary uses, personal hygiene and toiletry.

58. Data sources: Information sources that are readily accessible comprise regulatory agencies, industry intelligence, hospital records and a range of business and household surveys.

Specific compilations and analysis:

1 In most European and OECD countries a governmental entity deals with pharmaceutical regulation, price control and mark-ups, subsidies and procurement, financing channels and quantities traded. Such entities can provide additional guidance on data coverage on therapeutic classes and on nature generic/branded).

2 Industry records (manufacturers, wholesalers, retailers), some produced on *ad hoc* basis and for selected years, detail the use of the various distributional channels. In some parts of the world, industry intelligence firms can provide access to part of their data,

3 National accounts reports display data on manufacture, import and exports pharmaceuticals and on value added in manufacturing and in retailing. Supply and use tables include the "intermediate consumption" of pharmaceuticals by various health care entities.

Administrative records (in support of specific compilations):

4 Business surveys and economic censuses display the output of retail sale enterprises, and hospital and other health providers' intermediate consumption. Household expenditure surveys using COICOP contain a specific entry on pharmaceuticals. Tax records display components on value added;

5 Executed budgets and internal records of public and large private health care providers and health insurance entities. Budgets display a specific entry on pharmaceuticals.

Complementary data:

6 Procurement for selected medicines and vaccines (a useful source when external grants are involved),

7 Records of medicine imports, exports and re-exports,

8 Traditional, alternative and complementary medicines for which records are not systematic[5].

9 Changes in inventories reported by retailers and hospital establishments,

59. Additional notes on estimation procedures: The use of data reported by national entities dealing with pharmaceutical spending is the easiest and most direct way to obtain the data for total pharmaceutical delivery and the government share of financing, including hospitals. This applies also to the measurement of National Accounts data.

60. A second best approach is the use of comprehensive reports by industry. Triangulation with other available data is always suggested as a quality check.

61. For the compilation exercise, data from business surveys, economic censuses and household surveys are the primary source to consult. The total output of retail sale enterprises may be used when keys allow for the allocation between pharmaceuticals and medical non durable goods.

62. When a nation-wide total figure is available (through national accounts or national pharmaceutical entities), the amount spent through retail sale can be deducted to obtain an estimate of the other components or "consumers", such as hospitals. The use of the traditional equation "national production + imports - exports" requires knowledge of mark-ups and of national production data. Pharmaceutical pricing differs across the various distribution channels. Final prices are desirable. When not available, wholesale prices or ex-factory prices should be collected and adjusted with appropriate retail mark-ups.

63. Ideally, hospital spending on pharmaceuticals should be adjusted to include overhead costs and own production in addition to acquisition costs.

64. Other adjustments should include an appropriate estimation of subsidies and indirect taxes in procurement. Household surveys frequently include an underestimation which requires adjustments to

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5 A WHO project has measured the expenditure on these products and services including the European Region (for details see the Italian WHO European collaborative centre http://www.who.int/whocc/Detail.aspx?cc_ref=ITA-73&cc_ref=ita-73&. http://www.who.int/mediacentre/factsheets/fs134/en/. http://www.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=614.

generate, for instance, the national accounts data. Metadata documenting the overheads and other determinants of pharmaceutical prices should be provided.

65. Further resources:

10 The WHO-WB-USAID guide, Producing national health accounts in page 92 offers an explanation and additionally an example is offered on pp 237 and 238. http://www.who.int/nha/docs/English_PG.pdf.

11 Information on prices, procurement and the whole programme at WHO is available at: http://www.who.int/medicines_technologies/en/. Specific information for European countries is available at www.euro.who.int/pharmaceuticals/.

M.3 (HC.3) Total ancillary services

66. Resource allocation policy requires more detail on total expenditure on ancillary services. The current ICHA-HC is limited to the measurement of the final consumption of ancillary services (laboratory, imaging, transportation and all other services) in out-patient care solely. However, in-patient care involves similar expenditures that are presently not identified nor always specifically recognised in decision-making. This entry accounts for all ancillary services.

67. Ancillary services are complementary to the provision of core curative, rehabilitative and preventive services. They constitute a component of the whole treatment but as related and dependent on the core services. Their demand is directly associated to health care. They are, nonetheless, technologically and instrumentally independent. Ancillary services comprise a large and heterogeneous array of medical and paramedical, invasive and non-invasive techniques, mainly of a diagnostic and monitoring nature as well as transportation.

68. The measurement of **total** expenditure across the various distributional channels is dependent on the available data. The easier method is the cost approach of the intermediate consumption records. These services may be provided by the same personnel performing the core treatment.

Includes: laboratory diagnosis, imaging and patient transport and emergency rescue, regardless of the provision channel. Laboratory test performed are those described in the ICD-9-CM code 90, general microscopic examination, and code 91, specialized microscopic examination. Imaging includes simple and more complex imaging diagnosis in ICD-9-CM codes as 87 and 88. ISIC Rev. 4 classes 86.90 and the equivalent component in class 86.10.

Excludes: the core treatment performed by paramedical or medical personnel.

Addendum items to the Provider (HP) classification:

M.1(HP) Providers of health care related goods and services (excluding providers of investment goods)

69. According to the SHA manual, health care related activities (excluding investments) comprise education and training of health care personnel (HC.R.2), research and development in health (HC.R.3), food, hygiene and drinking water control (HC.R.4), environmental health (HC.R.5) as well as administration and provision of social services in kind to assist living with disease and impairment (HC.R.6) and administration and provision of health related cash-benefits (HC.R.7).

70. In the provider classification, as originally presented in the manual, no mention is made of actors in the economy that provide these goods and services. This lack of information on providers in the area of

health care related goods and services creates an inconsistency between the various axes of the system. The boundary of the functions of health care (including the health care related functions) deviates from the boundary set by the by the provider classification and by the classification of financing agents.

71. To achieve greater consistency in the tables in the Joint Questionnaire it has been decided to create a separate category in the provider classification, the providers of health care related goods and services (not being providers of investments goods).

72. In the functional classification the health care related goods and services are not an integral part of the classification of health care functions (the health care related goods and services are not included in health care expenditure), in the provider classification these providers of health care related goods are also excluded from health care expenditure.

Gross Capital Formation

73. Gross capital formation in SHA is measured by the total value of the health providers' acquisitions, less disposals, of products that are used in production for more than one year. With a few exceptions, those products are likely to be produced outside the health sector.

74. In the JHAQ, Gross capital formation reported in table HCxHP shows the acquisitions, less disposals, made by providers included in items HP.1 to HP.3, HP.5 and HP.6. Gross capital formation is also reported in HCxHF, where the total value is broken-down by financing agents/schemes.[6]

Financing Sources

75. The aim of including the Financing Sources classification in the Joint Questionnaire is to distinguish between who pays for health, and who is funding health. Since the unit paying for health is not necessarily the original source, and only provides information on how funding is organized, not where it comes from, an additional classification is needed. While all sources originate from households, corporations, or foreign entities, we need an approximate source for the health system which provides useful information about who is funding health, regardless of third party payer arrangements.

a) the "financing agents" are the entities managing the funds (keeping funds, pooling them and purchasing services)

b) the "financing sources" are the entities providing the funds (through health and non-earmarked taxes, contributions to insurance, premiums paid, transfer payments, and discretionary allocation).

76. Financing sources are currently defined as the institutional units (including households as a generic group) whose resources are channelled to the health system, mobilised and managed by financing agents. The resource measurement through the "source" classification yields a measurement of the health financing burden among the main actors in the economy: governments, non-profit institutions, corporations and households, excluding the intermediation by third-party-payment arrangements.

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6 Please refer to SNA93 for solutions to practical problems in accounting Gross capital formation (i.e. improvements to existing assets; Costs incurred on acquisition and disposal of assets; Time of recording; ownership of assets; Valuation; Small tools; etc).

77. With the introduction of a distinct origin and mobilisation roles, the rest of the world funding is normally a financing source entry (SHA paragraph 6.24). The relevant paragraph specifically mentions the role of source, linked to the government and NPISH as financing agents.

78. Note: An actor of the health care system can perform several roles and serve as both a financing source and financing agent. The same actor can also own health units and consume medical goods and services.

79. Two examples follow:

(i) households in the role of financing sources, may provide funds to health insurance as well as purchasing services directly. Additional resources channelled to health are linked to the tax payments made by households, though not necessarily earmarked. Through the financing agents approach, the various actors are re-classified to reflect the purchase responsibility, specifically through third parties: in the case of households, the role of governments, social security and private insurance will be highlighted, netting household out-of-pocket payments. Some of the out-of-pocket payments are reclassified, as net reimbursements. In this case, the role of households measured as financing agents will be exclusively covering the direct payments and the various other contributions will be reflected according to the entity which manages those funds. However, when households are the financing source, the total set of contributions into the system will be accounted for, regardless of household decisions to make use of the system or not.

(ii) The Ministry of Finance acts as financing source when transferring resources from the general budget to territorial governmental units that serve as financing agents. Territorial governments raising taxes and channelling funds to their health budgets are playing a double role of both financing sources and agents.

80. Some of the **policy uses** of this classification include the contribution to the analysis of funding schemes of the insurance schemes, the reliance on external funds, and the role of reimbursements and donations. With additional information this can contribute to a more elaborated analysis, such as the equity measurement, when the contribution and the value of benefits received are compared. As in other cases, the expected analysis of the data should guide the minimum level of detail to obtain in the tables.

81. The main categories of Financing Sources are:

- FS.1 General government units
  - FS.1.1: Territorial government
  - FS.1.2: All other public units
- FS.2 Private sector
- FS.2.1, FS.2.3: Corporations (quasi-corporations) and Non-profit institutions serving households (NPISHs)
- FS.2.2: Households
- FS.3: Rest of the world

FS.1 Financing sources provided by General government units

82. Resources from the following institutional units of general government, made in the interest of providing resources for health financing schemes, including transfers to households, should be taken into account:

- All units of central, state and local governments
- Non-market non-profit institutions (NPIs) that are controlled and mainly financed by government units
- Unincorporated enterprises owned by government units that are not quasi-corporations remain integral parts of those units and, therefore, must be included in the general government sector.

83. Notes:

- Social security funds and related schemes are not a financing source as they obtain their funding from employers, employees and government transfers, which are then the sources. Social security is a financing agent because through legislation (expanded to voluntary coverage schemes) they mobilize resources from the various contributors. They can purchase services and transfer resources to other entities remaining in their role of financing agents, as well as by intermediating to mobilize specific health care resources to be channelled towards other institutions. Social security funds and related schemes may nonetheless have assets funding part of the health system, to be included under FS.1.2
- FS.1 does not include public corporations, even when all the equity of such corporations is owned by governments units. It also does not include quasi-corporations that are owned and controlled by government units. For more detail, see: SNA93, E. The general government sector and its sub-sectors (4.104. to 4.113).
- Government's external revenues earmarked for health (e.g. World Bank loans for health projects, aid by international organisations, etc.) should be accounted for under sources as FS.3 Rest-of-the-world funds.
- All other governmental units sources (FS.1.2) include certain funds of public providers of health care: revenue generated from non-health activities used for patient care.

FS.2.1 and FS.2.3 Financing sources provided by corporations and non-profit institutions

84. The following types of outlays by corporations and NPISHs made to health financing schemes should be taken into account:

- Employers' social insurance contributions
- Employers' resources channelled towards further occupational health care (the corporations serve as financing source and financing agent at the same time)
- Insurance fees (or related subsidies) paid by employers (corporations and NPISHs)

- Special revenue of private health care providers (revenues other than received for providing health services), when utilised for activities related to health care provision. For example, revenue from private capital market interest payments on their assets.

- Revenue of private insurance companies from private capital market interest payments on their assets, when utilised for activities related to provision of health insurance.

- Donations to NGOs.

85. Notes

1 Non-profit institutions can serve as financing source for social security or private insurance paying insurance contribution or insurance fee as employer; and also can act as both financing source and financing scheme at the same time when they manage health schemes.

2 Non-profit institutions, such as foundations mobilising funds for health care can play the dual role of financing source and financing agents.

3 Non-profit institutions providing assistance to households for buying certain health services (for example abroad) are considered as financing agents, even when households pays the money directly to the provider of services. For these non-profit institutions, households, government and foundations mentioned before may serve as financing source.

4 Non-profit institutions providing services free of charge are also considered serving as financing agent. For these non-profit institutions, households, government and foundations mentioned before may serve as financing source.

5 A special entry is the revenue of private health care providers (e.g., private hospitals) and private insurance companies from private capital market interest payments and other income on their assets. Health care providers may use this revenue for health service provision. In this case, the provider plays the roles of financing source and of financing agent (for their own primary activity as provider of health services). Similarly, private insurance corporations may use this type of revenues for activities related to provision of health insurance. In this case, they play the role of financing source and of financing agent for their own activity as provider of health insurance. These receipts have to be included as expenditure for health care when they are used for services; however, when they are not used for health services, they should be recorded under M.1 (HC).

FS.2.2 Financing sources provided by households

86. The following types of money-flows by households should be taken into account:

- Employees /household social insurance contributions

- Insurance premium paid by households

- Donations by households to non-profit organisations

- Household out-of-pocket payments (cost-sharing, direct disbursements)

87. *Note*: **Households' out-of-pocket payments as a "financing scheme" has only one source: household funds**. It means that when payment is first carried out by households and then reimbursed by an

insurance scheme or a non-profit institutions, the insurance scheme or a non-profit institutions are regarded as the financing scheme.

FS.3 Financing sources provided by rest-of-the-world (External funds)

88. Revenue from non-resident institutions, earmarked for the financing of health schemes such as

- International and supranational agencies
- Bilateral funds and technical assistance
- Foreign financial intermediaries (insurance, NGOs, charities and foundations)
- Household remittances.

With the introduction of a distinct origin and mobilisation roles, the rest of the world funding is a financing source entry (SHA paragraph 6.24). The relevant paragraph specifically mentions the role of source, linked to the government and NPISH as financing agents.

A special situation can arise with some entities, which are primarily funded from external funds. If they have a centre of interest and are located within the territory of a country, and conduct significant transactions in a continuous or permanent way, then they are considered resident entities (SNA93 paragraph 4.15). These entities act within the regulatory framework of their country of residence and are classified either as governmental or NPISH financing agents (SNA93 paragraph 4.16).

89. *Note*: Often data on Financing Sources can be obtained from the financing agents' records of financial inflows. In the case of health insurance, benefits are usually funded through a defined by law share of employer-employee and governmental transfer.

RESOURCE COSTS

RC.1.1 Human resources

90. This category measures the remuneration of all persons employed by health providers linked to the provision of HC.1 to HC.7 services only, regardless of profession, specialisation, or kind of employment. Note that services contracted by providers, e.g. for private physicians or agency nurses providing services in hospitals, are to be considered as purchases and should not be reported under this item. Furthermore, where medical professionals receive both a salaried and self-employed income, care should be taken to account for these separately in order to avoid double counting. This category should only cover HP.1 to HP.7 at the first digit level as it is accepted that it would be impossible to cover for HP.9.

91. **Compensation of employees** is defined as the total remuneration, in cash or in kind, payable by an enterprise to an employee in return for work performed by the latter during the accounting period. Compensation of employees should be recorded on an accrual basis i.e., it is measured by the value of the remuneration in cash or in kind which an employee becomes entitled to receive from an employer in respect of work done during the relevant period, irrespective of whether it is paid in advance or in arrears. (SNA93 paragraphs 7.21-7.23, 7.31-7.47).

92. Compensation of employees consists of wages and salaries on the one side and employers' social contributions on the other. Wages and salaries of employees include remuneration in-cash and in-kind for health activities, payable at regular intervals, and includes piecework, overtime, night work, weekend or

other anti-social hours, allowances for working away from home, on disagreeable or hazardous circumstances, as well as allowances linked to housing, travel or sickness benefits, ad hoc bonuses, commissions, gratuities, and in kind provision of goods and services required to carry out their work, as meals and drinks, uniforms, transportation. Wages and salaries include the values of any social contributions, income taxes, etc., payable by the employee even if they are paid directly by the employer on behalf of the employee. The definition is compatible with the Eurostat Concepts and Definitions: (http://circa.europa.eu/irc/dsis/coded/info/data/coded/en/gl006997.htm).

93. Employers' social contributions consist of the employers' payments to obtain social benefits for their employees. These may be either actual or imputed. Note that compensation of employees does not include any taxes payable by the employee on the wage and salary bill, such as a payroll tax. (SNA93 paragraphs 7.43-7.47)

94. **Self-employed income** refers to the income of sole owners or to the joint owners of unincorporated enterprises in which they work. This category should exclude unincorporated enterprises classified as quasi-corporations. The corresponding item reported in SNA93 of 'Mixed income' is the surplus or deficit accruing from production by unincorporated enterprises owned by households; it implicitly contains an element of remuneration for work done by the owner, or other members of the household, that cannot be separately identified from the return to the owner as entrepreneur but it excludes the operating surplus coming from owner-occupied dwellings (SNA93 paragraphs 7.80-7.86). The acquisition of supplies and overhead expenses as well as estimated consumption of fixed capital are excluded. Therefore, in the case of self-employed physicians and specialists, remuneration should be the gross income with practice expenses deducted. Such expenses cover the costs of materials, employees' wages and social contributions as well as general overhead costs and expenditures.

95. *Note*: The implementation of ISIC Rev. 4 (and related classifications) is expected to provide an improved source of national data at a disaggregated industry level in closer accordance to the ICHA-HP classification. Additional sources can include economic censuses and salary surveys, disaggregating at industry or branch level. For the public sector, including health insurance providers, information can be gained from general government payroll records, disaggregated by functions, and from budgetary information from institutions.

PRIVATE, PUBLIC AND GOVERNMENT SECTORS DEMARCATION[7]

96. Drawing a distinct demarcation line between public and private sector enhances the value of information on the efficiency of resources that are used and controlled by government on one side and of private entrepreneurs on the other side. In practice however, due to the complexity of the countries' regulations and the organisational structure of economic environment, data compilers often face problems when the decision on classifying a resident entity into public or private sector has to be made.

97. The assumption is that SHA has to be methodologically compatible with SNA as far as possible. This should guarantee, in the end, compatibility with other economic and social statistics like NACE or ESSPROS. Furthermore, one of the core SHA dimensions - the financing agent dimension – is based on institutional units grouped according the SNA institutional sector[8]. Bearing in mind the various starting

7 The text heavily based on: SNA93; ESA95, Handbook on Non-Profit Institutions in the System of National Accounts, materials from Eurostat training course on Government Finance.

8 Appropriate delineation of government units from the other public units should give the SHA data compilers the possibility of tracing back the results of data compilation by confronting them with amount attributed to category of General Government (HF1) in the financing agent dimension of SHA. However due to different

points for SHA data compilation, it is important to identify private units against public ones in the wider context of SNA institutional sectors.

98. Consequently, for SHA data compilation it is recommended to follow the SNA/ESA principles both: for separation of private providers (of health care goods and services) from the **public** ones and for delineation of **government** from the other **public** units

99. Entities which are institutional units can be classified as public or private units on the basis of whether they are owned or controlled by private or public units. The ***notion of control*** is the central issue for classification of the unit into ***public*** or ***private*** sectors.

100. According to ESA95, control is defined as the "ability to determine general (corporate) policy or programme of the entity". It can be executed via different means, among others, by appointing appropriate directors, managers or by owning a certain type or certain number of the shares.

101. Public producers can be found either in the corporation sector – if these are market entities – or in the general government sector – if these are non-market entities.[9] In contrast, private producers can be found in all SNA sectors, except the sector general government. The distinction between market and non-market producers depends on whether or not prices charged are economically significant.

102. Economically significant prices are defined as "prices that have a significant influence on the amounts that producers are willing to supply and on the amounts purchase wish to buy". The ***notion of economically significant prices*** is therefore the central issue for providing the correct delineation of ***government*** from the other ***public*** units.

103. In general it is said that:

- General government is the group of public sector non-market entities.
- Public corporations are public sector (because controlled by government) market entities.

104. For a non-profit institution (NPI) to be considered in the general government sector it must be both controlled and mainly financed by the general government; otherwise it is treated as non-profit institution serving households and therefore a private non-market unit.

A more detailed note on delineation of providers is now available on the Joint Questionnaire website (www.oecd.org/health/sha/jointquestionnaire).

PUBLIC HEALTH AND PREVENTION

105. This note aims at complementing and clarifying modalities to implement ICHA-HC.6: Prevention and public health services, contained in the SHA manual, pages 121-123, and in Guidelines for SHA in EU , pages 104-124.

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borderline of health sector in SHA and such system like COFOG or ESPROSS some additional adjustment might be necessary.

9 The sectorisation of non-profit institution (NPIs) constitutes a particular case. For NPI to be considered as general government sector it must be both controlled and mainly financed by the general government. However, if the government payments are due to purchase of the services or due to subsidy on products (similarly like for some other market producers) then the unit is classified in the sector NPI, either public or private depending on the degree of government control over it.

106. Public health activities are defined as those involving health promotion (facilitating change in behaviour and lifestyles), prevention (dealing with specific risks and effects on health), protection (dealing with people's education, personal skill development, identification of and intervention on reducing spread and impact of diseases and dysfunctions), and incentivating healthy policies (orienting the volume, the affordability of health services and consumption of specific services by targeted population groups).

- Health promotion relates to activities designed to reduce risk exposure and their consequences and to enhance the health status of the total population or sizeable population groups.
- Prevention relates to averting health risks at the level of individuals or cushioning their effect, also to the early detection of serious risks for the health of population segments (before clinical conditions are perceived or epidemiological warnings emerge).
- Community services deal with a systematic monitoring of population health and of quasi-collective interventions designed to enhance the health stock of population segments. These programmes are not necessarily publicly delivered services; e.g. programme control activities include vaccination, health promotion - education through NGOs and/or through community volunteers.

107. Public health activities may relate to curative as well as to preventive approach involving one or more characteristics:

- programmes towards "high risk anticipation", disease/disability "prevention" and similar purposes
- programmes targeting specific population segments and/or specific risks and/or mobilising specific technologies to combat diseases spreading across sizeable population segments. Some of these might entail a high subsidy for the procurement of goods, e.g. mass vaccination, the free distribution of condoms, a subsidised supply of prostheses - therapeutic appliances or prevention devises such as treated mosquito nets in malaria prone countries to vulnerable groups
- programmes that entail sizeable economies of scale over the delivery of services at the patient discretion or whose take-up rate might otherwise be uneven
- programmes with a high equity content and a strong effectiveness purpose, geared mainly towards vulnerable groups or that are universal so that to ensure very high take-up rates by vulnerable groups
- programmes accessible to a greater share of the population than would be consumed under prevailing primary income distribution and/or eligibility criteria, i.e. public goods.

108. Data sources for prevention and public health:

Administrative records: e.g. executed budgets by Territorial authorities (MoH and other ministries, such as education for school health services, prison authorities, etc); Health insurance (public schemes); Public corporations (e.g. parastatals); Extra budgetary entities (e.g. universities); NGOs and NIPSHs; Financial corporations (e.g. private health insurance); Non financial corporations (e.g. private enterprises, private financers and providers); Trade and professional entities; Special reports and other metadata; Trade; NGOs; Research and investigations (e.g. academic, audit, parliamentary)

109. Estimation approaches:

- Compilation from earmarked funding pools (by programmes).

- Ad hoc distributions prepared from value, volume and price (or cost) compilations
- Factor inputs: HRH (health human resources) special equipment, others
- Selected supplies such as vaccines, ARV (antiretroviral), others.

Separating personal and collective services and institutional arrangements

110. The current trend is towards an integrated response by service providers, in which the individual and personal delivery occurs as the main or partial component of other provision. Public health services are thus mainly embedded in in-patient, out patient, rehabilitative and long term care activities but also in educational, cultural, recreative programmes. Current measurement involves a different treatment for resources consumed through personal and collective services: as stated on page 122 of the manual,

"Prevention is, in many instances, a reason for encounter in primary care and not a separate procedure. This means that the same procedure (for example, many diagnostic procedures) can be either performed as preventive measures for screening purposes or as diagnostic procedures in the case of an acute health problem. The criterion for including the services under this item is whether prevention is provided as a social programme (public or private, including occupational health) or is requested on the patient's own initiative." (personal preventive activities)

111. Collective services are provided to the community as a whole, delivered simultaneously to every member of the community or to particular sections of the community, such as those in a particular region or locality. Their use is usually passive and does not require the explicit agreement or active participation of all individuals concerned. The provision of such services to an individual does not diminish the amount available to others in the same community or section of the community, i.e. there is no rivalry in acquisition.

112. As usage cannot be charged individually, they are mostly financed out of taxation or other governmental revenue; philanthropy finances part of them. As part of the institutional arrangements of personal and collective services classified under preventive and public health, programme components such as planning, monitoring and evaluation are included.

Separating public health from administrative services

113. Administrative services are directed at improving the use of resources in the health system under an institutional scope (see SHA pages 123-124). Public health is programme focused, of which a segment involves the control and management of the resources. Administration services differ from preventive and public health.

- Administrative services involve planning, monitoring and evaluation as well as regulation linked to the internal processes to run the health system and each of its institutional components. They conform to a key internal tool to ensure an efficient use of resources through the optimal allocation of resources, resource mix and the production of the highest output in quality, volume and cost.
- Administration includes activities such as bookkeeping, input purchasing, personnel management, budgets preparation and follow up, supervision and support services including many settings.
- Statistics for surveillance of human resource performance are administrative in nature whereas statistics for surveillance of health conditions are of public health nature.

- Monitoring of administrative nature involve the internal performance analysis, budget composition with efficiency purposes.
- Monitoring of public health nature involve the technical component to identify the treatment protocol, outcome analysis, related effectiveness, efficiency and equity.

Separating public health from research and administrative monitoring

114. Prevention and public health involves a cluster of interventions and tools with a service approach (see SHA pages 125-126). The primary purpose - of these interventions -is a key criterion in which to classify such activities. Examples include:

- the surveillance as a public health activity, which may involve results of surveys and studies to monitor populations or interventions with an operational purpose
- research involving surveys and studies with the primary purpose of increase knowledge
- surveillance of performance of health system's resources with an administrative primary purpose

115. Separating public health from environmental health spending SHA lists public health environmental surveillance and public information on environmental conditions as part of the public health component, in the miscellaneous class HC.6.9 (p 123). The primary focus on a health outcome instead of an environmental outcome defines their nature.

Includes: the environmental health component of health programmes such as the malaria control, dengue control, yellow fever control, tobacco control, etc.

Excludes: emergency plans and environmental protection.

COFOG 05 lists under "Environmental health", HC.R.5 in the SHA classification:

- 05 Environment protection
- 05.1 Waste management Safety measures and monitoring of health hazards connected to these services
- 05.2 Waste water management Safety measures and monitoring of environmental standards or other quality norms
- 05.3 Pollution abatement Activities relating to the prevention, monitoring, abatement and control of noise and the pollution of air, water bodies and soil
- 05.5 R&D in environmental protection R&D in public health issues of environmental protection
- 05.6 Environmental protection n.e.c Production and dissemination of public information about health risks associated with environmental situation

116. In essence, HC.6.9 may be stated as referring to health planning, monitoring & surveilling, evaluating whereas the bulk of the environment investment costs are a distinct class, frequently performed by other than HP.1 to HP.6.

ANNEX 5. METHODOLOGICAL INFORMATION

I. Data sources

The 2008 Methodological Information document has an expanded chapter on data sources compared to the 2006 version. I.1 requests only the main raw data sources used to compile public and private health spending.
Analysis of the comparability of overall estimates of total health expenditure have identified spending on Long-term Care, Households' spending and expenditure on Prevention and Public Health as areas where there continue to be significant differences in methodologies and estimations. Therefore I.2, I.3 and I.4 are additional requests and ask for more specific details regarding the sources of information for these areas of health expenditure.

Contents

I.1 Public expenditure and private expenditure
I.2 LTC expenditure
I.3 Households' out-of-pocket expenditure
I.4 Prevention and Public Health
I.5 Gross fixed capital formation

I.1. Please provide description separately for the main sources for public expenditure and private expenditure.

Public expenditure: XXX
Private expenditure: XXX

1.2. Please provide separate descriptions for the main sources for the following categories of LTC expenditure. For the boxes, please mark if the activity/service* is included in the category (Y/N). If separate information on HC.3.1, HC.3.2 and HC.3.3 can be provided then it is not necessary to complete for HC.3 also. By definition, not all the four types of services listed should be included in the categories of LTC. This question intends to clarify where the separation is not possible.

HF.1 General government			
HC3	**Long-term nursing care**		
	Services for Nursing Care	e.g. Y	
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.1	Inpatient Long-term nursing care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.2	Long-term nursing care: home care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.3	Long-term nursing care: home care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC.R.6.1	**Social services of Long-term care**		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HF.2 Private sector			
HC3	**Long-term nursing care**		
	Services for Nursing Care	e.g. Y	
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.1	Inpatient Long-term nursing care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.2	Long-term nursing care: home care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC3.3	Long-term nursing care: home care		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		
HC.R.6.1	**Social services of Long-term care**		
	Services for Nursing Care		
	Services related to ADL		
	Services related to IADL		
	Other services of Social care		

*** For full definitions, please refer to the 'Guidelines for estimating long-term care, available at the following website address:** www.oecd.org/health/sha/jointquestionnaire

I.3. Please provide description separately for the main sources for the following categories of households' out-of-pocket expenditure*.

HF.2.3 Households out-of-pocket expenditure (total)		
HC1,HC2, HC4	Services of curative and rehab. care and Ancillary services	
HC3	Long-term nursing care	
HC5	Medical goods	
HC.R.6.1	**Social services of Long-term care (LTC other than HC3)**	
HF.2.3.1 Households out-of-pocket expenditure excluding cost-sharing		
HC1,HC2, HC4	Services of curative and rehab. care and Ancillary services	
HC3	Long-term nursing care	
HC5	Medical goods	
HC.R.6.1	**Social services of Long-term care (LTC other than HC3)**	
HF.2.3.2-5 Households out-of-pocket expenditure cost-sharing with general government		
HC1,HC2, HC4	Services of curative and rehab. care and Ancillary services	
HC3	Long-term nursing care	
HC5	Medical goods	
HC.R.6.1	**Social services of Long-term care (LTC other than HC3)**	
HF.2.3.6-7 Households out-of-pocket expenditure cost-sharing with private insurance		
HC1,HC2, HC4	Services of curative and rehab. care and Ancillary services	
HC3	Long-term nursing care	
HC5	Medical goods	
HC.R.6.1	**Social services of Long-term care (LTC other than HC3)**	

* National Health Accounts. Estimation Methods: Household out-of-pocket spending in private expenditure. Draft: Sept 2006. (Rannan-Eliya, R) is available at the following website address: www.oecd.org/health/sha/jointquestionnaire

I.4. Please provide separate descriptions for the main sources for the following categories of Prevention and Public Health.

HC.6	**Prevention and public health services**	
HC.6.1	*Maternal and child health; family planning and*	
HC.6.2	*School health services*	
HC.6.3	*Prevention of communicable diseases*	
HC.6.4	*Prevention of non-communicable diseases*	
HC.6.5	*Occupational health care*	
HC.6.9	*All other miscellaneous public health services*	

I.5 Gross fixed capital formation

What are the main data sources used for reporting gross fixed capital formation?

I.6 Consumption of fixed capital

Is the consumption of fixed capital included in the current expenditure estimates for:

i) market providers?

If yes, what are the main data sources?

ii) non-market providers?

If yes, what are the main data sources?

I.7 Financial sources*

If you are currently completing the FSxHF table please provide a description of the main data sources and methodologies used:

If you are currently NOT completing the FSxHF table in the joint questionnaire please provide more information on the reasons (e.g. lack of data sources, priorities, definitional issues, etc)

* Further information on Estimating the financing sources by financing agents table is contained in Chapter 11 of the "Guide to producing national health accounts" (http://www.who.int/nha/docs/English_PG.pdf).

II. Current state of ICHA implementation

Please indicate in the following tables:
1. Any differences in your SHA-based health accounts from the definitions provided by the ICHA (or in this Methodological Note) and, by “x” in the last column, if an estimation procedure or adjustment was used specifically for the purpose of producing the SHA tables. Please provide separately a short description of the estimation procedure or adjustment applied at the end of this section.
2. If data are not available (but the category exists): “ No data available”
3. If the given category does not exist in your health system: “Category not applicable”

Contents

II.1 Current state of applying ICHA-HF
II.2 Current state of applying ICHA-HC
II.3 Current state of applying ICHA-HP
II.4 Current state of applying Financial Sources
II.5 Current state of applying Resource Costs
Description of the estimation procedures and adjustments indicated by ‘x’ in the tables II.1 to II.5:

Table II.1. Current state of applying ICHA-HF

Health Expenditure by Financing Agent/Schemes			
ICHA-HF	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Special estimation procedures and adjustments to the original data (marked by 'x')
HF.1	*General government*		
HF.1.1	General government (excl. social security) = Territorial government		
HF.1.1.1	Central government		
HF.1.1.1.1	Ministry of Health		
HF.1.1.1.2	Other Ministries		
HF.1.1.2	State / provincial government		
HF.1.1.3	Local / municipal government		
HF.1.2	Social security funds		
HF.2	*Private sector*		
HF.2.1	Private social insurance		
HF.2.2	Private insurance (other than social insurance)		
HF.2.1-HF.2.2	Private insurance		
HF.2.3	Private households out-of-pocket exp.		
HF.2.3.1	Out-of-pocket excluding cost-sharing		
HF.2.3.2-HF.2.3.5	Cost-sharing: central government; state / provincial government; Local / municipal government; Social security funds		
HF.2.3.6-HF.2.3.7	Cost-sharing: Private insurance		
HF.2.3.9	All other cost-sharing		
HF.2.4	Non-profit institutions serving households		
HF.2.5	Corporations (other than health insurance)		
HF.3	*Rest of the world*		

Table II.2. Current state of applying ICHA-HC

Health Expenditure by Function			
ICHA-HC	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Special estimation procedures and adjustments to the original data (marked by 'x')
HC.1	*Services of curative care*		
HC.1.1	In-patient curative care		
HC.1.2	Day cases of curative care		
HC.1.3	Out-patient curative care		
HC.1.3.1	Basic medical and diagnostic		
HC.1.3.2	Out-patient dental care		
HC.1.3.3	All other specialised health care		
HC.1.3.9	All other out-patient curative		
HC.1.4	Services of curative home care		
HC.2	*Services of rehabilitative care*		
HC.2.1	In-patient rehabilitative care		
HC.2.2	Day cases of rehabilitative care		
HC.2.3	Out-patient rehabilitative care		
HC.2.4	Services of rehabilitative home		
HC.3	*Services of long-term nursing*		
HC.3.1	In-patient long-term nursing		
HC.3.2	Day cases of long-term nursing		
HC.3.3	Long-term nursing care: home		
HC.4	*Ancillary services to health*		
HC.4.1	Clinical laboratory		
HC.4.2	Diagnostic imaging		
HC.4.3	Patient transport and		
HC.4.9	All other miscellaneous		
HC.5	*Medical goods dispensed to out-*		
HC.5.1	Pharmaceutical and other		
HC.5.1.1	Prescribed medicines		
HC.5.1.2	Over-the-counter medicines		
HC.5.1.3	Other medical non-durables		
HC.5.2	Therapeutic appliances and		
HC.5.2.1	Glasses and other vision		
HC.5.2.2	Orthopaedic appliances and		
HC.5.2.3	Hearing aids		
HC.5.2.4	Medico-technical devices,		
HC.5.2.9	All other miscellaneous medical		
HC.6	*Prevention and public health*		
HC.6.1	Maternal and child health;		
HC.6.2	School health services		
HC.6.3	Prevention of communicable		
HC.6.4	Prevention of non-		
HC.6.5	Occupational health care		
HC.6.9	All other miscellaneous public		
HC.7	*Health administration and*		
HC.7.1	General government		
HC.7.1.1	General government		
HC.7.1.2	Admin., operation & support		
HC.7.2	Health administration and		
HC.7.2.1	Health administration and		
HC.7.2.2	Health administration and		
HC. 9	*Not specified by kind*		
Health related expenditures:			
HC.R.1	*Capital formation of health*		
HC.R.2	*Education and training of*		
HC.R.3	*Research and development in*		
HC.R.4	*Food, hygiene and drinking*		
HC.R.5	*Environmental health*		
HC.R.6	*Admin. and provision of social*		
HC.R.6.1	Social services of LTC (LTC		
HC.R.6.9	All other services classified		
HC.R.7	*Admin. and provision of health*		
Memorandum items:			
M.1(HC)	*Other (Non-health care/health-*		
M.2(HC)	*Total pharmaceuticals and*		
M.3(HC)	*Total of ancillary services*		

Table II.3. Current state of applying ICHA-HP

Health Expenditure by Provider			
ICHA-HP	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Special estimation procedures and adjustments to the original data (marked by 'x')
HP.1	*Hospitals*		
HP.1.1	General hospitals		
HP.1.2	Mental health and substance		
HP.1.3	Speciality (other then mental		
HP.2	*Nursing and residential care*		
HP.2.1	Nursing care facilities		
HP.2.2	Residential mental retardation,		
HP.2.3	Community care facilities for		
HP.2.9	All other residential care		
HP.3	*Providers of ambulatory health*		
HP.3.1	Offices of physicians		
HP.3.2	Offices of dentists		
HP.3.3	Offices of other health		
HP.3.4	Out-patient care centres		
HP.3.5	Medical and diagnostic		
HP.3.6	Providers of home health care		
HP.3.9	Other providers of ambulatory		
HP.3.9.1	Ambulance services		
HP.3.9.2	Blood and organ banks		
HP.3.9.9	Providers of all other amb.		
HP.4	*Retail sale & other providers of*		
HP.4.1	Dispensing chemists =		
HP.4.2	Retail sale and other suppliers		
HP.4.3	Retail sale and other suppliers		
HP.4.4-HP.4.9	Retail sale/other suppliers of		
HP.5	*Provision & admin. of public*		
HP.6	*General health administration*		
HP.6.1	Government administration of		
HP.6.2	Social security funds		
HP.6.3	Other social insurance		
HP.6.4	Other (private) insurance		
HP.6.3-6.4	Providers of private insurance		
HP.6.9	All other providers of health		
HP.7	*Other industries (rest of the*		
HP.7.1	Est. as providers of		
HP.7.2	Private households as providers		
HP.7.9	All other ind. as secondary		
HP.9	*Rest of the world*		
Memorandum items:			
M.1(HP)	*Providers of health related*		

Table II.4. Current state of applying Financial Sources

Financing sources provided by			
		Which deviations from ICHA are currently found in the country's SHA compilation?	Special estimation procedures and adjustments to the original data (marked by 'x')
FS.1	*General government units*		
FS.1.1	Territorial government		
FS.1.2	All other public units		
FS.2	*Private sector*		
FS.2.1	Corporations		
FS.2.2	Households		
FS.2.3	NPISH		
FS.3	*Rest of the world*		

Table II.5. Current state of applying Resource Costs

Resource Costs			
		Which deviations from ICHA are currently found in the country's SHA compilation?	Special estimation procedures and adjustments to the original data (marked by 'x')
RC.1.1	Human resources (employed		
RC.1.1.1	Compensation of employees		
RC.1.1.1.1, RC.1.1.1.2	Wages and salaries Social benefits		
RC.1.1.3	Self-employed income		

Description of the estimation procedures and adjustments indicated by 'x' in the tables II.1 to II.5:

III. Revisions and preliminary estimates

III.1 Revision Practice

Please provide a general description of any revision envisaged with relation to these SHA Tables. Included in this description should be whether the current data are preliminary data, any details of a time-table of revisions and reasons for the revision, if planned (i.e. due to availability of new source data, revision of associated sources, such as National Accounts, plans for revision of previous years based on new methodology employed in this year's estimates, etc.)

III.2 Preliminary estimates

Please provide a description of the methodology used in providing preliminary estimates of health expenditure aggregates e.g. the data sources used and/or the forecasting techniques employed.