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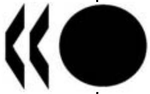

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development

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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE

Health Accounts Experts

SHA MANUAL REVISION: ISSUES FOR CONSULTATION AND QUESTIONNAIRE

SHA Expert Advisory Workshop
Headquarters of the International Energy Agency, Paris
14-15 June 2010

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Note from the Secretariat

This questionnaire refers to DELSA/HEA/HA(2010)1, a draft of the first eight chapters of SHA 2.0, and some supplementary documentation. Please complete the questionnaire or any part of it and return it to the OECD Secretariat ***or*** *email to william.cave@oecd.org by 30 June 2010 at the latest.*

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Structure of the Manual

Following discussions with countries, the SHA 2.0 Manual is to be split into two parts with some annexes:

Part 1 introduces the overview concept of a core SHA accounting framework around the so-called consumption approach, plus accounting extensions which enrich the accounting tools. Annexes show detailed links to other systems such as SNA and other classifications. The rest of Part 1 is devoted to the core accounting framework of health care functions, provision and financing (restricted to financing schemes in the core accounts).

Part 2 sets out a selected set of extensions to the core accounting framework, some guidance on accounting and compilation plus some standard tables. Part 2 begins with financing sources, resource costs, expenditure by type of beneficiary, and capital formation in health.

More precisely the proposed structure is:

Structure of the Manual

Contents

[Foreword
Acknowledgements
List of acronyms
Executive Summary]

PART 1 FOUNDATIONS OF THE SYSTEM OF HEALTH ACCOUNTS

Chapters

1 Introduction
2 Purposes and Principles of Health Accounts
3 Global Boundaries of Health Care
4 Key Concepts and Definitions
5 Functional Classification of Health Care ICHA-HC
6 Classification of Health Care Providers ICHA-HP
7 Classification of Financing Schemes ICHA-HF

PART II FURTHER CLASSIFICATIONS, APPLICATIONS AND METHODS

8 Classification of Financing Sources ICHA-FS
9 Classification of Beneficiary/Recipient Characteristics
10 Classification of Resources for the Production of Health Goods and Services
11 Capital Formation in Health Systems
12 Trade in health care
13 Health Care Prices and Volumes
14 Basic Accounting Rules, Guidelines and Compilation Processes
15 Presentation of Results and Basic Indicators [includes all standard tables]
[Possible inclusion of a chapter on products if it can be provided and agreed according to timetable]

Boxes
Charts
Tables

Annexes
A1 Links to other statistical systems
A2 Supplementary accounting tools
A3 Human resources in health
A4 Financing of health systems – supplementary tools
A5 International Classification of Procedures in Medicine
A6 International Classification of Primary Care
A7 Health activities and the ISIC
A8 Health products and the CPC
A9 Health in the SNA classifications by purpose
N.B. Annex 7, 8,and 9 to be reviewed for Overlaps with Annex 1
Glossary
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Index

Question 1a) Do you agree with the proposed structure of the SHA Manual as set out above Yes/No………… ………………………………………..

Any comments………………………………………………………………………………

Q 1bi) The financing chapters look at i) financing schemes and how they fund health care services as well as ii) how the schemes raise their funding. It is proposed to keep the two financing chapters close together. Do you agree? Yes/No………………………………………………………

Q 1bii) In particular do you agree with the placing of Chapter 8 Financing sources in Part 2 of the Manual on the grounds that Financing sources are further away from the consumption of health care than the financing schemes and therefore may be regarded as an extension to the core accounting framework? Yes/No…………….

(N.B. That if No then the alternative is to place "Financing sources" in Part 1)

Any comments………………………………………………………………………………………

Chapter 2 Principles and purposes of Health Accounts

Chapter 2 sets out the principles and purposes of health accounts. It also gives some examples of the uses of health accounts.

Q 2a) The purposes of the SHA 2.0 are :

- to provide a framework of main aggregates relevant to international comparison of health expenditures, and health systems analysis,
- to provide a tool, expandable by individual countries, which can produce useful data in monitoring and analysis of the health system.
- to define internationally harmonized boundaries of health care for expenditure tracking of consumption

Do you agree?

Yes/No……………………………………………………

Comments…………………………………………………………………………

Q2b) Is the content of this Chapter appropriate and clear? Yes/No ……………………

Comments ……………………………………………………………………….

Q2c) Is there some use of Health Accounts related to policy which you would want to document in the Manual? Could you please provide additional references to where the particular use is presented?.

Summary of example and reference..

Chapter 3 Boundaries of Health Accounts

The Manual acknowledges that health systems in different countries are different in scope, in organisation, and have different health priorities and cultural expectations to deal with. Chapter 3 also argues that, for the purposes of international reporting the scope of health care activities (to be taken into consideration under core framework) has to be limited to some extend that will allow cross- country data comparability Countries are encouraged to relate their national health accounts to common boundaries for international reporting and comparisons of SHA. Achieving a consensus on these common boundaries provides a key set of definitional challenges for the Manual.

Chapter 3, paragraph 54 states that “Four main criteria are set out for determining whether an activity should be included within the core expenditure account of SHA; these are presented below, in order of importance:

- The primary intent of the action is to improve, maintain or prevent the deterioration of the health status of individuals, groups of the population or the population as a whole as well as to mitigate the consequences of ill-health;

- Medical or health care knowledge[1] is needed in the execution of the function, or it is executed under the supervision of those with such knowledge, or the function is governance and administration of health care programs and health care financing;

- The consumption is for final use[2] of health care; and

[1] It is a known fact that the numbers of medical and nursing staff involved in the provision process differ enormously across the world. This boundary issue is to be tackled in the Annex on health care human resources.

- There is a transaction of health care services or goods."

Q 3ai) Do you find the criteria for inclusion in core health expenditure appropriate? Yes/No…….

Any comments………………………………………………………………….

Q 3aii) Is the description in Chapter 3 of the core accounting framework (related to functions, health providers and financing schemes) and its extensions clear and appropriate? Yes/No ……..

Comments…………………………………………………………………..

Q 3a iii) Do you find Figure 3.1 useful and appropriate? Yes/No ……..

Comments…………………………………………………………………..

Q 3a iv) Do you agree with the terminology "health care goods and services" to describe the universe of functions or products within the SHA health care boundary?

Selected borderline cases:

Q 3b) **Cosmetic surgery** is provided by health professionals, but in many cases with no particular health purpose. Where establishments specialise in cosmetic surgery for aesthetic rather than health purposes, it may be possible to separately identify this activity.

Q 3 bi) where cosmetic surgery with a primary aesthetic purpose **can be separately identified** should it be **excluded**? Yes/No………

Q3 bii) where cosmetic surgery with a primary aesthetic purpose **cannot be separately identified** from cosmetic surgery with a health care purpose should it be **included**? Yes/No…….

Any Comments……………………………………………………………..

3c) **Prevention** interventions within the health boundary must have a primary purpose of health. Interventions in other domains can have an impact on health although their primary purpose is not health.

Vaccinations are provided with a clear health purpose of prevention, normally by trained health professionals and thus are included within the health care boundary.

In other domains, old and new interventions may need to be assessed to test them against the health boundary criteria, including health regulation, regulatory enforcement and health monitoring (paragraphs 240-252 discuss these ideas). Selected examples may set out below may inform a discussion:

The establishment and monitoring of food hygiene and drinking water standards, safety regulations on construction sites, traffic regulations on drinking and driving or seat belts or crash helmets, physical

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[2] The concept of final use is more fully described in Chapter 4

recreation facilities like parks or gyms, environmental services such as refuse collection, sanitation, sewerage systems and water treatment against mosquitoes and malaria may all have important health impacts but a variety of purposes.

So which have a primary health purpose and should be included in the core health accounts under prevention?

Q3ci) In paragraph 250 (and the following ones) should the following examples be included in the core health framework for prevention or only in the health related categories:

Enforcement programmes on control of fluoridation and the quality of drinking water; Include in HC? Yes/No………………..

Or include this in a Health-care related category? Yes/No……………………..

In areas where malaria is endemic - the promotion of compliance of drains to reduce mosquitoes; and distribution of bed mosquito nets? Include in HC? Yes/No……………

Or include this in a Health-care Related category? Yes/No…………..

Any comments on the proposed prevention boundaries..

c) **Long term care**

Q 3d) The proposal on the health/social boundary for long term care is to retain the same boundary as is currently used in the Eurostat/OECD/WHO Joint Health Accounts Questionnaire (JHAQ). That means that ADL services are included. Do you agree with the proposals regarding the health / social boundary for Long term care? Yes/No……….

Any comments on the proposed health boundary related to long-term care……………………………

Borderline cases

Q 3e) In Annex 1 of chapter 3: For "Borderlines cases" the rational for inclusion to/exclusion from the core framework is presented. Do you agree with recommendations provided (Two last columns)? If not please indicate the cases of disagreement together short justification of your opinion using the horizontal structure of the table

Comments (please specify which example)………

Please note that there are further issues / proposals to be discussed and decided under other chapters which may have impacts on the health care boundary (chapter 3), in particular:

Proposed categories of functional classification such as:

- Rehabilitative care (paragraphs 200 and following

- Prevention (paragraphs 233 and following),
- Layers of consumption frame (both health related functions and reporting items) Traditional, Complementary and Alternative Medicines (TCAM),

Chapter 4 Key concepts and definitions

Chapter 4 introduces some key health accounting concepts and definitions

Q 4 a) Do you agree with the definition of Current Health Expenditure? Yes/No…….

Any comments…………………………………..

Q 4 b) Do you agree with the definition of capital expenditure in health systems? Yes/No……….

Any comments………………………………….

Q 4 c) The consumption variables set in the SNA and those in SHA as well as their content are explained as Figure 4.1 and 4.2. Are the figures useful and clear? Yes/No ………………….

Comments…………………………………………

4 d) A possible extra table is set out below (overleaf).

Q 4di) Would the extra table below be clearer than Figure 4.1 and Figure 4.2 currently in Chapter 4 in the explanation of these key concepts derived from the SNA and its relationship to SHA?

Q 4d ii) Is the relationship SNA-SHA clear in the proposed table? Yes/No……………………………..

Q 4diii) Would it be useful to include the table below be included in Chapter 4? Yes/No…………………………….

Comments………………………………….

The consumption of health care goods and services according to SNA and SHA

	Total national use						
			Final use				
	Intermediate consumption		Final consumption expenditure			Gross capital formation	Exports
	Intermediate consumption of non health gods and services	Intermediate consumption of health goods and services	Households final consumption	NPISH final consumption	Government final consumption		
National Accounts							
Produced in the national economy	for production 10	for production 20					
Imported health care goods and services	for production 10	for production 15					
Produced in the national economy			X 50	X 5	X 25	produced by the branch	X 5
Imported health care goods and services			direct import for final use 5	direct import for final use	direct import for final use		
Total national use			X 55	X 5	X 25	produced by the branch	X 5
Final consumption expenditure			**∑ = X 55**	**+ X 5**	**+ X 25**		
By Households			X 55				
By NPISH				X 5			
By Government					X 25		
Actual final consumption			**∑ = X 60**	**+ X 5**	**+ X 20**		
By Households			X 55	Individual	individual 5		
By NPISH				Collective 5			
By Government					collective 20		
System of Health Accounts							
SHA Consumption of goods and services	Measured in Resource cost 50 Including VA componentns	Measured in Resource cost o.w. medical goods 35	measured in:	measured in:	measured in:		
			- provision, 85				
			-function and 85				
			- financing 85				
Capital spending						produced by the branch and other branches: Capital Account	

Questions 4e and 4f refer to Room documents 1a and 1b exploring the case for and against inclusion of investment grants to health providers.

Q 4 ei) A government provides a grant to a Hospital to build a new ward. Is this health expenditure? Yes/no…………………….

Comments……………………………………………

Q4eii) Do you agree that the inclusion of Investment Grants could improve the comparability of Health Expenditure across countries, as well as between different parts of the same health system? Yes/No…………………..

Q 4 fi) Would it be appropriate to call “Total health expenditure” the sum of Current health Expenditure and Investment grants? Yes/No …………………………………….

Q 4 fii) Taking note of Room documents 1a and 1b setting out the case *for* (1a) and *warning about* (1b) adjusting for investment grants, which do you agree with most regarding SHA 2.0? 1a or 1b……………………….

Comments……………………………………….

Q 4 fiii) Investment grants are a part of capital transfers. Is it possible in your experience to separate these two parts in the data? Yes/No…………………..

Q 4fiv) Even if you agree that investment grants should be included in principle, are there limits on which ones should be included? Yes/No……………………..

Comments……………………………….

4g) **Exports and imports**

Q4gi) Is it clear from the text in Chapter 4 how to handle the exports and imports in the system to ensure an appropriate measurement of final consumption by residents?

Yes/No …………………………………….

Comments……………………………………………………………………………………………..

Q4gii) Should the value of exports be made transparent as an explicit memorandum item or should it be evident only in a supplementary trade table? If a memorandum item is required, where should it be made explicit? HC or HP……………………………………..

Q4g)i) **Non-observed economy** (NOE). Should a financing class or memorandum item be introduced to make transparent the estimates of NOE transactions, such as "*Under the table payments"*? Yes/No…….

Q 4gii) Financing class or memorandum item? ....

Comments……………………………………………………………………..

Q 4 h) Do you find the key concepts in Chapter 4 properly covered and presented? Yes/No……

Any comments……………………………………………………………………………………..

Q 4 i) Do you have any other comments on Chapter 4?..

Chapter 5 ICHA-HC

Chapter 5 and Table 5.1 set out proposals for the functional classification of health care HC, health care related items HCR, and some additional “Reporting Items” RI.

The following questions relate to table 5.1 overleaf

Q 5a): Do you agree with the categories of Curative Care HC 1? Yes/No……………..

Any comments:…………………………………………………………………….

Q 5b): Do you agree with the categories of Rehabilitative care HC 2? Yes/No………………….

Comments:…………………………………………………………………………..

Q 5ci): Do you agree with the categories of “Long term personal care” in HC 3? Yes/No……………

Comments: …………………………………………………………………………..

Q 5cii): What should be the name of HC.3? ………………….

Table 5.1 Classification of health consumption by function HC

Health Functions SHA.2	SHA.1 codes
HC 1 Curative care	**HC.1**
HC.1.1 Inpatient care	HC1.1
HC.1.1.1 General	
HC.1.1.2 Specialised	
HC.1.2 Day care	HC1.2
HC.1.2.1 General	
HC.1.2.2 Specialised	
HC.1.3 Outpatient care	HC1.3
HC.1.3.1 General	HC.1.3.1
HC.1.3.2 Dental	HC.1.3.2
HC.1.3.3 Specialised	HC 1.3.3
HC.1.4 Home based care	HC1.4
HC 2 Rehabilitative care	**HC.2**
HC.2.1 Inpatient care	HC2.1
HC.2.2 Day care	HC2.2
HC.2.3 Outpatient care	HC2.3
HC.2.4 Home based care	HC2.4
HC 3 Long-term Personal Care	**HC.3**
HC.3.1 Inpatient care	HC.3.1
HC.3.2 Day care	HC.3.2
HC.3.3 Home based care	HC.3.3
HC 4 Preventive care	**HC.6**
HC 4.1 Epidemiologic surveillance & disease control programme management	part of HC.6.1-HC.6.9
HC 4.1.1 Surveillance of communicable and non-communicable diseases, injuries, and exposure to environmental health risks	part of HC.6.1-HC.6.5
HC 4.1.2 Information gathering and support services for disease control management	part of HC.6.1-HC.6.5
HC 4.2 Collective preventive programmes	part of HC.6.1-HC.6.5
HC 4.2.1 Education and information mass campaigns	part of HC.6.1-HC.6.5
HC 4.2.2 Regulation enforcement programmes	part of HC.6.1-HC.6.5, HCR.4, HCR.5
HC 4.2.3 Disaster and emergency response programmes	part of HC.6.1-HC.6.5
HC 4.3 Personal preventive programmes	part of HC.6.1-HC.6.5
HC 4.3.1 Information, Education and Communication (IEC)	part of HC.6.9
HC 4.3,2 Immunization	part of HC 6.3
HC 4.3.3 Early disease detection	part of HC.6.1-HC.6.9
HC 4.4 All other preventive care nsk	part of HC.6.1-HC.6.9
HC 5 Consumption of auxiliary services non specified by function	HC.4
HC 5.1 Laboratory services	HC.4.1
HC.5.1.1 Laboratory diagnostics	
HC.5.1.2 Clinical and other functional tests	
HC.5.1.3 Blood, sperm and organ bank services	
HC 5.2 Imaging services	HC.4.2
HC 5.3 Patient transportation	HC.4.3
HC 6 Consumption of medical goods non specified by function	**HC.5**
HC 6.1 Pharmaceuticals and other non durable goods	HC 5.1
HC 6.1.1 Prescribed medicines	HC 5.1.1
HC 6.1.2 Over the counter medicines	HC 5.1.2
HC 6.1.2 Other medical non-durable goods	HC 5.1.3
HC 6.2 Therapeutic appliances and other medical goods	HC 5.2
HC 6.2.1 Glasses and other vision products	HC 5.2.1
HC 6.2.2 Orthopaedic appliances, orthesis and prosthetics	HC 5.2.2
HC 6.2.3 Hearing aids	HC 5.2.3
HC 6.2.4 All other medical durables, including medical technical devices	HC 5.2.4- HC.5.2.9
HC 7 Governance, management and health system administration	**HC 7**
HC 7.1 Governance and health system administration	HC 7.1
HC 7.2 Administration of health financing	HC 7.2
HC 7.3 Other administrative costs not specified by kind (n.s.k.)	
Health Care Related	
HCR 1 Long Term Social Care	
of which administration and provision of Long term care in kind benefits	part of HCR 6
of which administration and provision of Long term care cash benefits	part of HCR 7
HCR 2 Traditional, Complementary and Alternative Medicines (TCAM)	
HCR.2.1 Inpatient TCAM	
HCR.2.2 Outpatient, home based and TCAM retailers	
of which Expenditure on TCAM services	
of which Expenditure on TCAM goods	
HCR 3 Non-health consumption	
Reporting Items	
RI 1 Total pharmaceutical expenditure (TPE)	
of which Pharmaceutical consumption as inpatient treatment	
RI 2 Expenditure on health research & development within health care	
RI 3 Expenditure on the job trainning of health personnel	

Q 5d): Prevention is increasingly seen as an important method for achieving health gains. Do you agree with the new proposals for categories on the accounting of personal and collective prevention in HC 4?

Yes/No……………………………………………………………………………………

Are the prevention proposals sufficiently clear and well defined? Yes/No

Comments:………………………………………………………………………………….

Q 5e): Do you agree with the proposals on the categories (that are not specified by function) of auxiliary services, medical goods and governance and administration HC5 to HC7? Yes/No……………………………..

Comments: …………………………………………………………………………..

HCR categories

The rationale for HCR Items is set out in paragraph 158.

Q5f) Are the proposed HCR categories appropriate? Yes/No……………………………………………

Comments…………………………………..

Q5gi) In particular do you agree with the introduction of an HCR item on **TCAM**? Yes/No……

Comments……………………………………………………………………………

Q5gii) Do you agree with the proposal for an HCR item Long-term social care? Yes/No……..

Comments……………………………………………………………………….

Q5giii) Do you agree with the proposal for an HCR item Non-health consumption? Yes/No……..

Comments……………………………………………………………………….

Q5h) Are the proposed HCR categories sufficiently well defined in the text? Yes/No………………. Comments……………………………………………………………………………

Q5i) As trade in health care is identified as an area for improved accounting, should a category for health care **Exports** (that is, consumption of health goods and services by non-residents) be explicitly added in HCR so it may potentially be cross-classified with the provider classification?

Yes/No………………………

Comments…………………………..

Q5j) Should the SHA 1.0 (HCR 4 and 5) items on food, hygiene and water control, and environmental health be retained in SHA 2.0? Yes/No……

Comments…………………………………..

Q5k) Should there be any other HCR categories? Suggestions……………………………….

Q5l) Should any of the proposed HCR categories be removed or amended? Yes/No……..

Which HCRs to be removed?.........................

Which HCRs amended and how?..

Please provide any other comments on HCR:……………………………………

Reporting Items

The rationale for Reporting Items is set out in paragraph 157.

Q5mi))Do you agree with the proposals for Reporting Items? Yes/No……………………

Q5mii) in particular do you agree with the RI for Total Pharmaceutical Expenditure Yes/No……………

Q5miii) In particular do you agree with the RI for Expenditure on health research and development within health care? Yes/No…………………………………………………………

Q5miv) In particular do you agree with the proposed RI on Expenditure for on the job training of health personnel? Yes/No…………………………………………………………

Comments………………………………………………………………………….

Q5n) Are the proposed RI categories sufficiently well defined? Yes/No …………………………….

Comments…………………………………………………………………..

Q5o): Paragraph 234 Should there be a Reporting item for Total Prevention Expenditure. Similar to the RI 1 item for pharmaceuticals, this would seek to bring together HC 4 with other prevention expenditure that is implicitly included in other HC categories? Do you agree? Yes/No………

Comments…………………………………………………………………

Q5pi) Should there be any other additional RI categories? Yes/No……

If yes please suggest which categories………………………………….

Q5pii) One proposal is to have a set of reporting items equivalent to some or all of the public health and prevention classes in SHA 1.0 The main criticisms of these were the lack of clarity in the description of public health (as a functional class); the overlapping of the population, health programmes and interventions; and the difficulties to identify them separately from personal care.

Please indicate if you would support reporting item(s) for any of the following:

Q5piii) Maternal and child health; family planning and counseling ? Yes/No…………………

Q5piv) School health services? Yes/No…………………………………..

Q5pv) Prevention of communicable diseases? Yes/No……………………………….

Q5pvi) Prevention of non-communicable diseases? Yes/No………………………………

Q5pvii) Occupational health care? Yes/No…………………………………………………..

Comments…………………………………….

Q5q) Should any of the proposed RI categories be removed or amended? Yes/No……

If yes please give details………………………………………………………………

Q5r) Is the name "Reporting Item" appropriate?

Any other comments: ………………………………………………………………………..

Chapter 6 ICHA-HP

Chapter 6 sets out proposals for the provider classification ICHA-HP. It takes the view that HP classification is closely based on ISIC for the very practical reason that so much classification information for establishments, organisations, government units and enterprises is based on the national industry classification, which in turn is likely to closely relate to ISIC.

Q6ai) Figure 6.1 provides an illustrative overview of the HP proposal with emphasis given to the split between primary and secondary health care providers. Among secondary providers HP7 providers of health administration and financing, and HP 8 households are classified as in both cases the provision of health care goods and services directly to the individuals/ population is not the principal activity. Please see table 6.1 as justification. As in SHA1.0 this link to ISIC also takes in the classification according to value added principle or a suitable proxy such as turnover. Do you agree with the main classes as it is presented in the figure 6.1 Health care providers in SHA ? Yes/No…………………..

Comments…………………………………….

Q6aii) Should there be any exceptions to the ISIC main activity principle? Yes/No………………

The example of a hospital owned by an Oil Corporation was raised. Where should this be classified in HP?....

And why?..........................

Table 6.2 sets out the detailed HP classification (overleaf).

Q6b) Do you agree with the proposals for HP 1 Hospitals split into 1.1 General Hospitals;

and 1.2 Specialised Hospitals? Yes/No……..

Comments……………………………………………………………..

Table 6.2: Classification of providers in SHA2.0

Type of economic unit	Providers	
	SHA2.0	*SHA1.0*
Hospitals	**HP.1**	HP.1.0
General hospitals	HP.1.1	HP.1.1
Specialised hospitals	HP.1.2	HP.1.3, HP.1.2
Nursing health care providers	**HP.2**	
Long-term nursing care facilities	HP.2.1	HP.2.1
Other providers of nursing health care	HP.2.9	HP.2.9
Providers of ambulatory health care	**HP.3**	HP.3
Medical practice	HP.3.1	HP.3.1
Offices of general medicine	HP.3.1.1	HP.3.1
Offices of medical specialists	HP.3.1.2	HP.3.1
Dental practice	HP.3.2	HP.3.2
Other health care practitioners	HP.3.3	HP.3.3,3.9
Ambulatory health care centres	HP.3.4	HP.3.4.4, 3.4.5, 3.4.9
Home nursing care providers	HP.3.5	HP.3.6
Other providers of ambulatory health care	HP.3.9	HP.3.9.9
Providers of ancillary services	**HP.4**	
Providers of patient transportation	HP.4.1	HP.3.9.1
Medical and diagnostic centres	HP.4.2	HP.3.5, 3.9.2
Dental laboratories	HP.4.3	HP.4.4
…..Other providers of ancillary services	HP.4.9	
Retailers and other providers of medical goods	**HP.5**	HP.4
Pharmacies	HP.5.1	HP.4.1
Retailers of vision products	HP.5.2	HP.4.2
Retailers of hearing aids	HP.5.3	HP.4.3
Other retailers of medical goods n.e.c.	HP.5.9	HP.4.4,4.9
Providers of preventive care	**HP.6**	HP.5
Providers of health administration and financing	**HP.7**	HP.6
Government health administration	HP.7.1	HP.6.1
Social health insurance administration	HP.7.2	HP.6.2
Private health insurance administration	HP.7.3	HP.6.3, 6.4
NPIsH health administration	HP.7.4	HP.6,4
Other health administrative units	HP.7.9	HP.6.9
Households	*HP.8*	HP.7.2
Other health care providers	**HP.9**	HP.2.2, 2.3, 2.9, 7.1
Rest of Economy	**HP10**	HP.7.9
Rest of the world	**HP.11**	HP.9

*not complete

Q6ci) Do you agree with the proposal and description of HP 4.1: Patient transportation, described as "This subclass comprises establishments primarily engaged in providing transportation of patients by ground or air in the case of emergency " ? Yes/No……………

Q6cii) Do you agree that secondary providers of patient transportation, such as taxi operators are allocated to HP 9: Other health providers. Yes/No……………..

Comments………………………………………………………………………

Q6di) Do you agree with other principal health providers' proposals HP 2-6? Yes/No…….

Q6dii) HP 5.1 is described as "This subclass comprises establishments primarily engaged in the retail sale of pharmaceuticals to the population for prescribed and non-prescribed medicines. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription. An illustrative example is public pharmacies."

Do you agree with the categories and descriptions of retail of pharmaceuticals and other medical goods? Yes/No…………………………………………

Comments……………………………………………………………………

Q6e) Do you agree with the proposals for HP 7: Health administration and financing? *Please note that its subcategories refer to the financing agent (FA) classification, which could be traced under second digit of the financing scheme (HF) classification.* Yes/No………….

Comments……………………………………………………………………..

Q6f)Do you agree with the proposal for Households HP8 as a separate class? Yes/No……………

Comments………………………………………………………………………..

Q6g) Do you agree with the proposals for HP9 Other Health Care Providers, which encompasses as secondary health care providers all other organizations or actors that deliver some of their products directly to patients? Yes/No………………………………………..

Comments……………………………………………….

Q6h) Do you agree with the proposed HP10 Rest of the economy described as "This class comprises other industries (rest of economy) which do not provide health care, but are specialised in health related activities included in extended health accounts, e.g. centres for education and research which do not provide health care..?" It may to the contrary be argued that HP should be strictly restricted to health care providers? Do you agree with proposed HP 10? Yes/No……..

Any comments?...

Q6i) TCAM activities are spread throughout the HP classification. The alternative would be to have separate class for all TCAM providers.

Do you think that TCAM activities are adequately represented and described in Chapter 6? Yes/No………….

Please suggest any improvements related to TCAM activities…………………………..

Q6j) Please indicate those categories of the HP classification that need more explanation or clarification in explanatory notes. …………….

Q6k) Do you have any other substantive comments on Chapter 6?……………………………………

Chapter 7 Financing Schemes

Chapter 7 gives a brief overview of financing of health systems and sets out a proposal to make financing schemes a central component for the international reporting of financing of health systems.

Table 7.2. Classification of Health Financing Schemes

Code	Scheme
HF.1	**Governmental schemes and compulsory health insurance**
HF.1.1	**Governmental schemes**
HF.1.1.1	Central governmental schemes
HF.1.1.2	State/regional/local governmental schemes
HF.1.2	**Compulsory contributory health insurance schemes**
HF.1.2.1	Social health insurance schemes
HF.1.2.2	Compulsory private insurance schemes
HF.2	**Voluntary private health care payment schemes**
HF.2.1	**Voluntary Private health insurance schemes**
HF.2.1.1	Primary /substitutory health insurance schemes
HF.2.1.1.1	Employer-based insurance (other than enterprises schemes)
HF.2.1.1.2	Community-based insurance
HF.2.1.1.3	Other primary coverage schemes
HF.2.1.2	Complementary / supplementary insurance schemes
HF.2.2	**NPISHs financing schemes**
HF.2.2.1	Resident foreign government development agencies schemes
HF.2.2.2	Other non profit (e.g., NGO) schemes
HF.2.3	**Enterprises financing schemes**
HF.2.3.1	Enterprises (except Health care providers) financing schemes
HF.2.3.2	Health care providers financing schemes
HF.3	**Household out-of-pocket payment**
HF.3.1	**Out-of-pocket excluding cost sharing**
HF.3.2	**Cost sharing with third-party payers**
HF.3.2.1	Cost sharing with government schemes and compulsory insurance schemes
HF.3.2.2	Cost sharing with voluntary insurance schemes
HF.4	**Rest of the world financing schemes (non resident)**
HF.4.1	**Compulsory schemes (non-resident)**
HF.4.1.1	Compulsory health insurance schemes (non-resident)
HF.4.1.2	Other schemes
HF.4.2	**Voluntary private schemes (non-resident)**
HF.4.2.1	Voluntary health insurance schemes (non-resident)
HF.4.2.2	Other schemes
HF.4.2.2.1	Philanthropy / international NGOs schemes
HF.4.2.2.2	Foreign development agencies schemes
HF.4.2.2.3	Schemes of Enclaves (e.g., international organisations or embassies)
Memorandum items	
	Governmental schemes and compulsory health insurance together with cost sharing (HF.1 + HF.3.2.1)
	Voluntary health insurance schemes together with cost sharing (HF.2.1+ HF.3.2.2)

Q7ai) Chapter 7 proposes the following **key concepts**: (i) health financing schemes as the main "building blocks" of a country's health financing systems; (ii) financing sources: types of revenues of health financing schemes; (iii) financing agents: institutional units managing financing schemes. Are they clearly defined? Yes/No………………..

Comments……………………………….

Q7aii) Is this an adequate starting point for the three classifications (HF, FS, and FA)? Yes/No………………..

Q7aiii) Which definition would require further improvement? Please specify which definition and in what way it could be improved……………………………….

Q7bi) Do you consider that the main proposed categories of ICHA-HF are appropriate? Yes/No……..

Q7bii) Are there any financial arrangements of countries that cannot be brought under any of these categories? Please specify……………………………………..

Q 7ci)) Do you consider the categories of ICHA-HF clearly defined? Yes/No……

Q7cii) Which of the categories' definitions would require further improvement? Please specify………………………

Q7di) The HF classification is primarily designed for the financing of current health expenditure?

There are likely to be at least some different arrangements for the financing of capital expenditure in health systems. Do you agree that HF should be focused on current health expenditure? Yes/No……

Q7dii) Should the financing of capital expenditure be considered separately? Yes/No…….

Comments……………………………………..

Q7 e) Referring to Tables 7.5 and 7.6, do you consider the interpretation of the concepts "*public*" and "*private*" appropriate? Yes/No……………………….

Comments……………………………………..

Q 7 f) Room Document 3 presents three annexes to Chapter 7 on financing as a background room document for the workshop. The annexes cover:

1.…..Main Problems with the ICHA-HF Classification in SHA 1.0

2.……The Classification of Financing Agents (ICHA-FA);

3.……Sectoral Accounts related to Health Financing

Which if any of these three annexes should be next to Chapter Seven in Part 1 of the revised SHA Manual; presented in Part 2 of the Manual as an annex to the SHA Manual; or not be included at all?

Annex 7.1 include in Part 1/or Part 2/or Not at all? ....

Annex 7.2 include in Part 1/or Part2/or Not at all?..........................

Annex 7.3 include in Part 1/or Part2/or Not at all?..........................

Q7g) What other issues would be useful to present in Chapter 7? ………………………………

Q7h) Do you have any other comments on Chapter 7? Comments…………………..

Chapter 8 Financing sources

Paragraph 515 states that "Financing sources are defined as the revenues of health financing schemes received or collected from institutional units of the economy. "

Q8a)Do you agree with this approach? Yes/No…………………………………………

Comments:………………………………………………………..

In Chapter 8 Table 8.2 (overleaf) presents the proposals for the Classification of Financing Sources.

Table 8.2 Classification of Financing Sources (Types of Revenues)

FS.1	Taxes and social insurance contributions
FS.1.1	Tax revenues
FS.1.1.1	Un-earmarked taxes
FS.1.2.1	Earmarked taxes
FS.1.2	Social insurance contributions
FS.1.2.1	Employee social insurance contributions
FS.1.2.2	Employer social insurance contributions
FS.1.2.3	Self-employed social insurance contributions
FS.1.2.5	Other social insurance contributions
FS.2	Compulsory private insurance premiums
FS.2.1	Compulsory private insurance premiums paid by insurees
FS.2.2	Compulsory private insurance premiums paid by employers
FS.2.3	Other compulsory private insurance premiums
FS.3	Voluntary private insurance premiums
FS.3.1	Voluntary private insurance premiums paid by insurees
FS.3.2	Voluntary private insurance premiums paid by employers
FS.4	Voluntary domestic revenues (other than voluntary insurance premiums)
FS.4.1	Voluntary domestic revenues from households
FS.4.2	Voluntary domestic revenues from corporations
FS.4.3	Voluntary domestic revenues from NPISHs
FS. 5	Foreign revenues
FS.5.1	Foreign revenues earmarked for health
FS.5.1.1	ODA revenues
FS.5.1.2	Non-ODA revenues
FS.5.2	Non-earmarked foreign revenues
FS.5.2.1	ODA revenues
FS.5.2.2	Non-ODA revenues
FS.6	Other revenue (not elsewhere classified)
	Memorandum items (1)
	Loans
	Domestic loans
	Foreign loans (ODA loans; Loans other than ODA)
	Memorandum items (2): Revenues by institutional units
	General government
	Corporations
	Households
	Non-profit Institutions Serving Households (NPISHs)
	Rest of the World

Q8bi) Do you agree that the categories in FS 1 and FS 2 are appropriate? Yes/No………………..

Q8bii) Should there be an explicit category for Government contributions to social insurance schemes (not including government contributions as an employer) (FS1.2.4) ? Yes/No………………………………..

Q8biii) Is the simplification in Paragraph 523 appropriate? Yes/No………..

Comments…………………………………..

Q8c) Do you agree that the categories FS 3 and FS 4 are appropriate? Yes/No……….

Comments…………………………………..

Q8d) Do you agree that the categories FS 5 and FS 6 are appropriate? Yes/No……….

Comments……

Q8e) Are FS categories defined adequately? Yes/No……………………………..

If No then please suggest specific improved definitions………………..

Issue: Valuation of in kind assistance and technical support

Paragraph 539 "According to GFS, assistance in kind should be valued at current market prices. If market prices are not available then the value should be the explicit costs incurred in providing the resources or the amounts that would be received if the resources were sold. In some cases, the donor and the recipient may view the value quite differently. In this case, according to GFS, the valuation from the viewpoint of the donor should be used."

Q 8fi): Should SHA 2.0 follow the GFS accounting rule and apply the valuation by the donor? Yes/No………………………..

Q 8fii) Should SHA 2.0 recommend that valuation of in kind assistance be estimated from the view point of the recipient? Yes/No…….

Comments……………………………………………………

Q 8g) Do you have any other comments on Chapter 8?...

Any other comments

Q 9 Do you have any other comments on the first 8 Chapters of SHA 2.0?

……
………

Thank you for your input. [Please add your name and Organisation…………………………..]