

**The State of Implementation of the OECD Manual:  
A System of Health Accounts (SHA) in OECD Member Countries, 2001**

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## Summary

This paper provides an overview on the current state of SHA pilot implementations in OECD countries. It summarises the background of the new OECD manual *A System of Health Accounts* (SHA), which was published in May 2000, and provides an overview on the latest developments in international co-operation of work on health accounts and the SHA.

The SHA manual provides a conceptual framework and estimation rules for health accounting and proposes a three-dimensional *International Classification for Health Accounts* (ICHA) that provides breakdowns of health expenditure by functions of care, provider industries, and sources of funding. The SHA is intended for use as a model to set up national health accounts, for revising and amending existing national health accounts or as a model to map detailed national health accounts to SHA standard tables for the purpose of international comparisons. The main concepts of the SHA and of the ICHA are used in *OECD Health Data*, an annually updated database of health statistics in OECD countries.

The expected core outputs of the SHA pilot implementations are three different two-dimensional tables, cross-tabulating health expenditure by sources of funding and functions of care; by source of funding and provider category; and a table cross-classifying expenditure by provider and function of care (SHA standard tables 2, 3, and 4). These tables are intended to provide more detail on health expenditure for national health policy purposes and better-harmonised data for international comparisons.

Around half of all OECD countries have started work on a pilot implementation of the SHA manual. Ten countries have made draft estimates of several of the standard tables of the SHA manual, and seven of these countries have already completed drafts of the core SHA tables 2, 3, and 4.

Countries may differ in the role that SHA implementation plays in the future development of national health accounts. Some countries may use the SHA manual to revisit existing national health accounts and to review available data sources and estimation methods with a view of possibly complementing or amending national systems. Other countries, particularly ones with highly advanced national health accounts, may choose to use the SHA framework mainly for international reporting and comparisons.

The OECD Secretariat is involved in several activities of co-operation with other international organisations. There is a close co-operation with EUROSTAT on SHA implementation in European Union countries. Members of the OECD Health Policy Unit also participate in a steering committee of the *Producers Guide on National Health Accounts for Middle- and Low-income countries*, which will build on the SHA framework and classifications. Bilaterally, the OECD Secretariat provides advice on SHA pilot implementation in several Central and Eastern European countries.

## **Introduction**

Health expenditure as a percent of gross domestic product (GDP) has grown in OECD countries from 5.3% to 8.2% during the period of 1970 to 1998.<sup>1</sup> Although the share of health expenditure in GDP has stabilised in many countries during the 1990s, it is difficult to project if this trend will continue or whether health expenditure ratios will again start to increase in coming years.

As health systems have grown and become more complex, policy makers need better tools to understand what is happening within their own countries and to learn from the experience of other countries. A major concern is resources – Are there sufficient resources allocated to health care in countries with increasingly ageing populations? Are existing health resources being used efficiently? Will continued advancements in medical technology result in higher shares of health care in the economy? What amount of savings can be expected from cost-effective interventions and division of labour? What are the effects of increasing cost sharing on equity and access to health care?

In order to be better able to address these and other frequently asked question of health care planning and policy, an increasing number of countries are investing in national health accounts that are comprehensive in scope, detailed in focus, consistent over time, and comparable across countries.

## **Background of the SHA and health accounting**

Until recently, health accounts in OECD countries were typically produced in co-ordination with other statistical outputs, such as government finance accounts or the System of National Accounts (SNA). Many countries continue to use information from national accounts based on the 1968 or 1993 SNA to derive estimates of health spending.

Around the time of the publication of the 1993 SNA, a consensus emerged among experts in health accounts on the need for a standard health accounting framework that was comprehensive and detailed enough to provide useful information for health care planning and analysis. Moreover, the framework had to follow standardised accounting rules and be linked to existing classification principles in order to integrate data from a wide range of economic and social statistics (see Chapter XXI on Satellite Accounts of the 1993 SNA).

By 1995, several countries had already made substantial progress in developing the methodological concepts of the framework, and work on international comparisons had been intensified (see SHA manual, p. 13-14, for an overview).

In May 1996, the OECD convened an Ad Hoc Meeting of Experts in Health Statistics, which was attended by delegates from most Member countries as well as experts from EUROSTAT and from the European and Pan-American regions of the World Health Organisation (WHO). Participants were asked for their advice on ways to improve the content of OECD Health Data, OECD's annual collection of health statistics from Member states. The development of international standards for data on health care expenditure and

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1. An un-weighted average of 20 OECD countries that have a relatively complete set of data for the years 1970-1998 and have not reported any major breaks in their series. They include: Australia, Austria, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Spain, Switzerland, Turkey, United Kingdom, United States.

financing was singled out as a priority area of work for OECD. A first draft of the manual, *A System of Health Accounts* (SHA), was presented and discussed at the Second Ad Hoc Meeting of Experts in Health Statistics in December 1997.

In 1998, a second draft of the SHA manual was presented at the OECD Meeting of National Accounts Experts, the OECD Meeting of the Working Party on Social Policy, and at a Workshop of Experts on Health Accounts was hosted in Dublin by the Irish Department of Health. The discussions during these meetings focused on the methodological framework of the SHA and the design of the proposed *International Classification for Health Accounts*. Ultimately, the manual was recommended for publication and use in pilot implementations.

Planning for pilot implementation of the SHA manual was discussed during a joint OECD/EUROSTAT Meeting on Health Accounting held in Luxembourg in May 1999. Two follow-up workshops were held in 2000 to review the progress of the implementation in European countries. Delegates to the Working Party on Social Policy have continued to emphasise the importance of health accounting work in improving the comparability of data for health system monitoring. To this end, the Working Party has asked the Secretariat to work closely with Member countries on pilot implementation.

### **Basic structure of the SHA**

With the SHA manual, the OECD Secretariat has developed the *International Classification for Health Accounts* (ICHA) and cross-referenced this scheme with the standard classifications and definitions used in the SNA. To the extent appropriate, the accounting rules of the SHA have been harmonised with the SNA.

Because the provision of health care and its funding is a complex, multi-dimensional process, the set of core tables in the SHA addresses three basic questions:

- What kind of (functionally defined) services are performed and what types of goods are purchased?
- Where does the money come from? (source of funding).
- Where does the money go to? (providers of health care services and goods).

Consequently, the SHA organises health care expenditures according to three main categories:

- health care **functions** (ICHA-HC);
- health care **service provider industries** (ICHA-HP);
- sources of **funding** health care (ICHA-HF).

The choice of categories in the three dimensions of the ICHA was guided by their relevance for health policy and reform issues, in particular for monitoring structural changes, such as shifts from in-patient to out-patient care and the emergence and spread of multi-functional providers in national health care systems. The ICHA provides basic links with non-monetary data such as employment and other health care resources.

Existing national and international classifications served as a starting point for the proposed ICHA classifications. The ICHA classification of health care industries, for example, presents a refinement of the *International Standard Industrial Classification* (ISIC, Rev. 3, United Nations, 1990). Recently designed

or revised classifications such as the *Central Product Classification*, Version 1 (United Nations, 1998a) and the 1998 revision of the SNA 93 functional classifications are frequently referred to in the SHA manual in order to assist statisticians in establishing links between with the ICHA and existing reporting systems.

## **Objectives of the SHA**

The main objectives of the SHA are to:

- define internationally harmonised boundaries of health care and basic categories thereof;
- distinguish core health care functions from health-related functions and to emphasise inter-sectoral aspects of health as a common concern of social and economic policy in various fields;
- present tables for the analysis of flows of financing in health care together with a classification of insurance programmes and other funding arrangements;
- provide a framework of main aggregates relevant to provide guidance for comparative research into the meso and micro structure of health care services;
- propose a framework for consistent reporting on health care services over time;
- provide a set of internationally comparable health accounts in the form of standard tables;
- provide a framework for analysing health care systems and for monitoring the consequences of health care reforms from an economic point of view;
- to present an economic model of supply and use of health care services – as a tool to show the conceptual links between the SHA and health satellite accounts.

## **Current state of SHA implementation in OECD countries**

### ***Pilot implementation of the SHA manual: a snapshot***

OECD Member countries are currently at various stages in implementing the SHA manual. Administrations in a majority of countries are engaged in discussions either to construct national health accounts according to the SHA framework or to revise their existing reporting systems by applying elements of the framework.

About half of OECD countries have begun work on a pilot implementation. Ten countries have estimated several of the standard tables of the SHA manual for at least one year, and among these, seven have already completed drafts of the core SHA tables (tables 2, 3 and 4).

In assessing the current status of SHA implementation in Member countries, the existence of national health accounts in OECD countries should be kept in mind. Some countries already produce comprehensive and detailed health accounts, while other countries mainly rely on national accounts to estimate health care spending. For the countries that already produce health accounts, the implementation of the SHA manual serves two functions:

1. The SHA framework improves the comprehensiveness of existing health accounting systems by adding greater detail, most importantly in separating the provider and functional dimensions. Existing national health accounts, in many cases, do not adequately distinguish functions of care from providers. Thus, it is difficult to separate the effects of changes in the way health care is provided (e.g., due to technological advancements) from changes in the division of labour and remuneration of health care providers.
2. The SHA framework builds a bridge between national reporting systems and international reporting on health expenditure and financing.

The second objective can serve the first one: countries that decide to implement the SHA manual for purposes of international reporting are likely to find some gaps in their own reporting systems. These discoveries may influence the development of their own reporting systems. Among the OECD countries that currently use the SHA framework as a model for a major revision of their own reporting systems are the Netherlands, Spain and Switzerland. Among the countries that currently use the SHA framework for mainly international reporting are Australia, Canada, Germany, and the United States.

The majority of OECD countries fall into the group of countries that historically have relied on national accounts for health expenditure reporting in international comparisons. Among those are Austria, the Czech Republic, Denmark, Greece, Hungary, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Poland, Portugal, Norway, Slovak Republic, Spain, Sweden, Turkey, and United Kingdom.

Several of these countries have administrative reporting systems of public spending on health care (or at least for part of it). However, it is often difficult to reconcile records of public spending reported in national accounts with the detailed classifications of the SHA because of methodological differences in the two reporting systems. Moreover, the lack of transparency with respect to data sources and estimation methods in national accounts considerably limits the comparability of expenditure data.

Many of the countries in the last group are now in the process of setting-up NHA following the SHA framework. Among these are: Denmark, Hungary, Korea, Japan, Poland, and the United Kingdom. Other countries are considering bringing together national teams for the same purpose: Belgium, Czech Republic, Greece, Ireland, Italy, Norway, Slovak Republic, and Sweden. Several of these countries have nominated a team of NHA experts and work has either recently begun or is soon to begin.

## **Current state of international co-operation in health accounting**

### ***Co-operation with the European Union***

Planning for pilot implementations of the SHA manual was discussed during a joint OECD/EUROSTAT Meeting on Health Accounting in 1999. Two follow-up EUROSTAT workshops were held in 2000 to review the progress of the implementations (see page 5).

The NorthEastern Health Board in Ireland completed a project under the European Union (EU) Health Monitoring Programme to collect structural information on EU Member states' health care systems. The objectives of this project were to provide background information on the structure of health care systems and meta-data to support work on both health accounting and the collection of other (non-monetary) health care statistics, such as employment data by professional groups. Elements of the SHA framework were used for to meet these objectives.

### ***Co-operation with other international organisations***

In December 1999, an exchange of letters between OECD and WHO established a framework for co-operation between the two organizations. The two organizations agreed that consistency in international standards for data and for health accounts is vital. To this end, they are participating in a steering committee to supervise the development of a “*National Health Accounts Producer’s Guide*”, which is specifically targeted for use in middle and low-income countries. This guide will provide practical guidance in the design, construction, and use of health accounts. It follows the same principles recommended in the SHA manual, and promotes the use of the ICHA for the design of national classifications. The steering committee for the guide includes experts on health accounts from the World Bank, USAID and other international organisations.

The Asian Pacific Regional Network on Health Accounting (<http://www.unescap.org/aphen/nha.html>) has chosen to use the SHA as methodological starting point for their work. A number of countries, including Sri Lanka and Hong Kong Region (China), have carried out SHA pilot implementations. The Pan American Health Organisation (PAHO) has plans to publish a Spanish translation of the SHA manual. Bilaterally, the OECD Secretariat provides advice on SHA pilot implementation in several Central and Eastern European countries.

### **Related documents**

OECD (2000), *A System of Health Accounts*, Version 1.0, Paris.

1993 SNA: CEC/IMF/OECD/UN/World Bank (1993) *System of National Accounts*