

ORGANISATION
FOR ECONOMIC
CO-OPERATION
AND DEVELOPMENT



PROGRAMME OF WORK FOR THE SHA REVISION

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Purpose and progress of the document

1. The revision of the System of Health Accounts (SHA) manual 1.0 is a collaborative activity of the OECD, Eurostat and the WHO. Collectively the health accounts experts of the 3 organisations are known as the International Health Accounts Team (IHAT)¹.
2. This document, *Programme of Work for the SHA Revision*, was prepared by IHAT with the purpose of informing relevant organisations and experts of the programme of work for the revision of the System of Health Accounts and inviting and encouraging their participation. This document should be read in conjunction with the document, *Framework for the consultation process related to the revision of the System of Health Accounts (SHA)*, which describes the reasons for developing global Health Accounts standard and a framework for the co-operation between OECD, Eurostat and WHO.
3. A draft version of the current document entitled *Draft Programme of Work for the SHA Revision* was circulated by email as widely as possible at the end of 2007². The circulation had the explicit objectives of notifying interested parties that the revision process was underway and receiving feedback on the draft programme with the intention of revising the draft.
4. Comments and feedback were received from numerous countries and fall into 3 types. First, there were comments of support for the revision. Second, there were general comments on the process. These comments are summarised in the paragraphs below and are grouped into 3 broad headings. Third, comments were received of a specific nature and these comments have been incorporated as much as possible into the outline of the units in the latter part of this document. All types of comments and feedback were positive, supportive and informative in moving the Draft programme of work into its revised and final version and thus aiding the revision process. We would like to thank all countries and individuals for their feedback.
5. The revision of the SHA has as one of its aims the development of a global standard for the compilation of health accounts. Thus the revised manual has to be applicable to a diverse range of countries and conditions. Meeting the requirements of the revision under conditions of diversity is challenging and this complexity was reflected in the feedback and comments.
6. The first group of comments on the revision was based on the magnitude of the task. A number of respondents believed that the draft programme of work is too ambitious and that establishing priorities is essential to ensure that the goal of SHA Manual 2.0 is achieved in a reasonable time frame. We

¹ IHAT represents The Health Division of the Organisation for Economic Cooperation and Development, the Unit of Health and Food Safety Statistics in the Directorate General of Eurostat of the European Commission, and the Department of Health Systems Financing in the Cluster on Health Systems and Services, World Health Organization.

² The following organisations and experts were sent the Draft Programme of Work and were invited to take part in the consultation process: Ministries of Health of all WHO member countries, WHO Regional Offices, Heads of Statistical offices of all OECD and EU member and candidate and acceding countries, Heads of National authorities other than statistical offices involved in work on national health accounts in OECD and EU member and candidate and acceding countries, Experts serving as focal points for the Joint OECD, Eurostat and WHO Health Accounts data collection, Health accounts regional networks, European Commission, UNSD, OECD Statistics Directorate, World Bank, Regional Development Banks and IMF.

acknowledge that the revision of the SHA manual 1.0 is an ambitious project, but feel it is inevitably so. Nonetheless, IHAT considered these comments seriously and nominated some units as high priority and some as low priority. The high priority units are those where critical issues require resolution before other problems and issues may be resolved. Four high priority issues will be analysed in the first wave of the revision process³. The issue of the boundaries of the health care system featured prominently in the list of high priority issues, necessitating resolution of the definition of the boundaries in the early stages of the process.

7. Establishing priorities has also enabled the IHAT to develop a timetable for the commencement and finalisation of work unit-by-unit. The timetable spaces the workload associated with the revision of units and thus enables as much as possible country and individual experts to manage the provision of comments on documents and contribute input documents in the time frame. Allowance will be made for unforeseen conflicts in scheduling either within the revision process due to incompatible timetabling of units or due to domestic activity of a higher priority. Thus, flexibility is built into the timetable. Announcements of important dates and timelines of units are provided on the webpage for the SHA revision.

8. The second group of general comments on the *Draft Programme of Work* addressed the reasons for revising. Some respondents expressed the view that the current system of health accounts methodology is working quite well and thus no or minimal change is required. We recognise both the strengths and weaknesses of the current methodology. Our focus is on improving the weaker points but not on changing the whole system. Revision of a complex system such as that laid out in the SHA Manual 1.0 or the Producers Guide is necessarily, due to its complexity, an incremental and cautious process.

9. Finally, another issue expressed in the feedback was a concern that data requirements for countries under the new SHA framework would be both quantitatively and qualitatively more onerous than under the current SHA framework. It should be noted, however, that in common with current practices under the framework of the Joint OECD/Eurostat/WHO Health Accounts Questionnaire (JHAQ) Data Collection, the revised manual will strive to set out some minimum reporting requirements, necessary to maximise the possibilities for international comparability. Intensive country testing will also entail consideration of availability in routine data collection, measurability, feasibility and cost. Importantly, the development of additional classifications e.g. human resources of health or expenditure of disease, age and gender, and compilation of accounting tables within the manual will allow countries to compile much of these data independently of international coordination but with the aim that where countries do so, it is done in an internationally harmonised way.

³ The four units are Unit 1 (Purposes and Principles of the SHA), Unit 2 (Global Boundaries of Health Care), Unit 5 (Types of Health Accounts) and Unit 7 (ICH-HC Functional Classification of Health Care).

INTRODUCTION

Main reasons for revising SHA 1.0

1. The *Framework for the consultation process related to the revision of the System of Health Accounts (SHA)* describes the main arguments, purposes and a framework of co-operation of OECD, Eurostat and WHO in working towards a global Health Accounts standard. Therefore, in the following only the most important technical issues are summarised.
2. Health accounting experts have been encountering growing expectations from policy-analysts, policy-makers and the general public alike: reliable, timely, and comparable health expenditure data – both across countries and over time - are indispensable for analysing trends in health expenditure and underlying factors of growth, as well as for making projections for future spending.
3. Health accounts are increasingly expected to provide relevant information for health policy analysis in evaluating health systems performance, that is, to provide adequate input (together with other statistical resources) for the analysis of the sustainability of financing, macro-level efficiency and equity of utilisation of resources.
4. A further conceptual and methodological challenge is to produce information on the importance of the health sector within the national economy and the contribution of health care to economic development.

General approach of the SHA revision

5. These general goals require an accounting framework able to meet the information need of health policy analysis and solid in statistical terms, that is, comprehensive, consistent and appropriately linked to other statistical systems, in particular to the System of National Accounts (SNA).
 - The structure and functions of the health system and the criteria used for assessing health system performance form the starting point to define how to describe the actors and transactions under SHA, as well as the key indicators SHA is expected to provide for policy-analysis.
 - These requirements will be applied to review the current version of SHA and define how its basic characteristics and components, such as boundaries of health sector, classifications, basic tables and accounting rules should be revised and extended. As a major extension, SHA 2.0 intends to introduce a set of accounts and a set of key indicators.
 - All these will determine what modifications are needed in requirements for data collection and the related guidelines. Policy need and statistical features together will determine the desirable changes in presenting the results.
 - The issue of whether SHA can be considered as a satellite account to SNA will be considered. From this approach, the linkage between SHA and SNA will also be reviewed, in particular, which departures are justified by the requirements to provide relevant information for health policy analysis.

Key methodological issues

6. Meeting the requirements entails considerable effort and time. In the following only a few of the most important methodological issues are presented. Comparability of health expenditure data is limited by several factors. Although the System of Health Accounts provides a consistent functional approach in defining the boundaries of the health system, several specific issues have not yet been adequately resolved (e.g., estimating Long-term care, boundaries of public health and prevention, treatment of informal care, etc.).

7. Estimation of private expenditure seems at the moment one of the weak points of health accounting, mainly due to uncertainties with respect to the amount of out-of-pocket payments to health care providers. It is therefore can be one of the major sources of estimation error in total expenditure on health care, in particular lower and middle income countries.

8. Comparison overtime and cross-country of health expenditure data is limited by the lack of health-specific price indexes and output measurement. Because at this moment health expenditure for cross-country comparisons is adjusted by economy-wide PPPs, the resulting data (expenditure at PPPs) not only reflect variations in the volume of health services, but also variations in the prices of health services relative to GDP prices.

9. The current categories of health care financing (ICHA-HF) do not enable an adequate reflection of the complex and changing systems of health financing. Insurance and financing schemes are heterogeneous and have evolved significantly as a result of recent reforms and policy initiatives.

10. In order to more adequately answer the question of “*Who gets what, where, and how*” (that is, the key questions of health policy related to efficiency and equity), the incorporation of further dimensions of health expenditure, namely disease categories and socio-economic, age and gender characteristics of beneficiary/recipient into the International Classifications for Health Accounts (ICHA) is required.

11. At this stage, SHA-based health accounts provide information about final consumption of health services and goods. The SHA Manual does not distinguish appropriately between the production and the final consumption of health services. However, information on the production of health services within the context of national economy is also important for policy analysis, for example, demand generated by the health sector for other industries, employment effects of health care, changes in productivity of particular sectors of the health system, etc.

Key challenges

12. The revision work is facing several challenges both in technical and procedural sense. In particular the following issues require consideration:

- Several issues are not resolved due to the lack of adequate scientific knowledge. For example, how to take into account quality change in output measurement. Therefore, in some cases SHA 2.0 will only be able to provide partial solutions. This, in turn, may affect several other issues.
- SHA 2.0 intends to better serve the requirements of health policy analysis. On the other hand, as a satellite account, stronger linkage with SNA is desirable. These two requirements may be in conflict with each other.

- To ensure that SHA 2.0 reflects the needs of higher and lower income countries with heterogeneous health systems and differences in key policy concerns
- To reconcile the different requirements of building up a sound, reliable statistical system producing high-quality health expenditure data on the one hand and, on the other hand, the provision of timely data for the routine work of national and international agencies. In addition, it is necessary to consider the differences in statistical capacity of higher and lower income countries.
- The SHA 2.0 is designed to be used over a significant timeframe, therefore, it should be flexible enough to incorporate future changes in the health financing systems.
- To clarify the relationship of SHA 2.0 to other methodologies tracking health expenditure, in particular with disease-specific sub-accounts that are of great importance for lower-income countries;
- To produce a first draft by the end of 2009 and ensure a wider consultation process, allowing sufficient time for debate and reconciliation of differing views.
- While extending and refining the International Classification for Health Accounts, it is of vital importance to ensure backward comparability of data based on the current classification and those based on the revised one.

Antecedents

13. Experience provides a sound basis for the revision work. First, there has been 7-8 years of experience with SHA implementation in OECD countries. Second, a growing number of non-OECD/non-EU countries, particularly middle and lower income countries, are implementing National Health Accounts based on SHA or the *Guide to producing national health accounts with special applications for low-income and middle-income countries* published by WHO, World Bank and USAID in 2003 (PG); and in the case of many Latin-American countries based on Satellite Account developments. Third, many countries have a long history in health expenditure accounts which predates the SHA Manual, such as Canada, France, the Netherlands and the United States. Finally, the experience of the 2006 and 2007 Joint OECD, Eurostat and WHO Health Account data collection has contributed to countries' implementation and methodological developments at the same time.

14. The *Framework for the consultation process related to the revision of the System of Health Accounts (SHA)* has taken into account the problems and issues identified throughout SHA implementation. OECD Meetings of Health Accounts Experts have regularly discussed methodological problems (e.g., LTC, health financing). In 2006-2007, Eurostat workshops discussed specific methodological issues (e.g., prevention, ancillary services). In December 2006, Eurostat and OECD invited health accounts experts to report problems to be included in the SHA 2.0. WHO also compiled problems with SHA/PG implementation. Information from these sources is being carefully assessed and used for preparing the Programme of Work.

Draft structure of SHA 2.0

15. The structure presented in this paper should be considered as preliminary and may change during the consultation and revision process. Three main parts of SHA 2.0 are envisaged:

- Part 1: Principles and concepts;
- Part 2: International Classification for Health Accounts; and
- Part 3: Basic indicators, tables and compilation of Health Accounts.

16. Annex 1 shows the units currently planned under each part. The section on Units of SHA 2.0 provides a description of the importance and key issues to be addressed in preparing each unit, therefore only the most important issues are highlighted below.

Part 1: Principles and concepts

17. As already described, the SHA 2.0 should better meet the information needs of health policy analysis and provide a solid statistical framework over a significant timeframe. From a health policy perspective it is of vital importance to define the key indicators SHA Manual is expected to provide.

18. A shortcoming of the SHA Manual Version 1.0 is that it does not adequately reflect the main characteristics of health care systems. SHA 2.0 will provide a stylized model of health care systems describing key actors and their possible roles; as well as the basic transactions between them in financing and providing health services for the population. The description should take into account that the institutional structure of health care systems is changing over time and is becoming increasingly differentiated across countries. The description should also clarify the difference between health systems and health care systems and that to what extent SHA goes beyond the health care system.

19. Health accounting methodology is expected to provide an adequate framework to monitor the flow of money as related to the basic functions of the health system, namely administration (stewardship), resource generation (e.g., education of health professionals), financing (resource collection, fund pooling, purchasing) and provision (personal and non-personal health services). Therefore, a description of the health care system and a set of key indicators should provide one of the starting points to define the items that SHA intends to measure and to review/revise the key features of SHA Version 1.0, including the International Classification for Health Accounts.

20. The other main requirement for reviewing and defining the principles and basic concepts of SHA is that SHA intends to meet the requirements of a Satellite Account to SNA. The revised SHA will be formulated to make the relationship to the SNA clear and explicit.

21. Key components of health accounting methodology will be put forward in the units on global boundaries of health care, key concepts and definitions in health accounts, dimensions of health expenditure, and types of health accounts.

Part 2: International Classification for Health Accounts

22. The International Classification for Health Accounts Version 1.0 provides classifications, with detailed definitions for three dimensions of health expenditure: ICHA-HC Functional Classification Health Care, ICHA-HP Classification of Health Care Provider Industries and ICHA-HF Classification of Health Care Financing.

23. SHA implementations have shown that to fulfil better the requirements of international comparability and at the same time have more flexibility to accommodate different national health systems the refinement of ICHA is required. The work will include not only a revised structure of the existing dimensions (that is, function, financing schemes and provider) and new dimensions (such as, expenditure by disease, age and gender and socio-economic characteristics of the beneficiary/recipient), but detailed guidelines for some specific issues. Three basic requirements will be considered in the revision: policy relevance, feasibility of measurement and possibility of regular reporting. Furthermore, link to other classifications (such as ISIC, NACE, etc.) will also be assessed. As ICHA 2.0 intends to provide a classification system for the coming 8-10 years, when assessing feasibility of data reporting, the potential for improvements in data systems also should be taken into account.

24. In order to improve the comparability of total health expenditure, it is of vital importance to clarify and define more precisely the boundaries of health services, in particular guidelines for the estimation of expenditure on long-term care. More detailed definitions and explanations are needed in some cases in order to avoid large variations in interpretation and estimation practices. Definitions should also be supplemented with more advice concerning estimation methods.

25. A review of the internal structure of each classification is needed both from the point of view of international comparability and suitability to national systems. Furthermore, links to other classifications (such as ISIC, NACE, etc.) and their current revision process will also be considered. Currently SHA-ICHA has up to three digit level categories. A number of countries have added more detailed categories (at three or four digit level) to better reflect national characteristics of the health system, while figures for some of the two digit level categories are not reported by the majority of countries. Furthermore, it is desirable to clarify at what level international comparability is required.

26. A consensus seems to be developing that ICHA 2.0, in order to enable SHA to provide better information for policy-makers, should contain several new components, namely: Financial Sources, Classification of Beneficiary/recipient' characteristics, Classification of Resources for production of health goods and services, and Classification of Health care products. Two of these (Financial Sources and a partial classification of Resources for production, viz. Human Resources) have already been introduced in the Joint OECD, Eurostat and WHO health accounts data collection.

27. In revising the internal structure of each component of ICHA it is vital importance to make a distinction between what is essential and what is not for international comparison. There could be a hierarchy established that would define the minimal type of reporting by the member countries that could be used on a comparative basis.

Part 3: Basic indicators, tables and compilation of Health Accounts

28. This part is planned to consist of the following units: Presentation of results; Basic accounting rules and guidelines; Possible compilation processes; and Methods for improving timeliness.

29. The SHA Version 1.0 presents tables with very detailed information which is not easily understandable for health policy-makers. While, the detailed information is useful for policy analysts and health accounts experts, the SHA Manual Version 1.0 does not highlight the most important information that the SHA can provide for international comparisons and national policy makers

30. It is desirable to define a core set of the most important indicators from SHA-based health accounts that will serve as a basis for international comparison of health expenditure across countries

31. Implementation has shown that more detailed definitions and explanations are needed in some cases in order to avoid large variations in interpretation and estimation practices. Definitions should also be supplemented with more advice, guidelines concerning estimation methods (e.g., estimation of long-term care expenditure); as well as examples of best practices.

32. Currently, several countries present different values of total expenditure for national and international reporting purposes. A more harmonised practice could be developed for the presentation (and interpretation) of different national and international estimates.

UNITS OF SHA 2.0

33. The following sections describe the rationale behind each unit, the key issues to be addressed, and the coordinating organisation.

INTRODUCTION OF THE SHA MANUAL, VERSION 2.0

Coordinating organisation: OECD

Principles

34. Health accounting experts have been encountering growing expectations from policy-analysts, policy-makers and the general public alike for more sophisticated health expenditure data. In particular, it is desirable to have data which is reliable, timely, and comparable, both across countries and over time.

35. The development of a global standard can assist in avoiding the development of divergent methodologies for compilation of health expenditure data. At the same time, the content of the manual has to have relevance and applicability for institutions and individuals in countries at very different stages of both economic development and development of statistical system for compiling health accounting data.

36. The manual draws on country best practice, which contributes to the best data sources and estimation methods. It is the result of a wide-ranging consultation process. The emphasis in development of the material is both policy relevance and sustainability. Thus our desire is to develop guidelines that will endure for a reasonable time period (8-10 years).

Key issues

- purpose of health accounts,
- the reasons for revising the SHA Manual;
- new elements of the SHA 2.0. emphasising differences between SHA 1.0 and 2.0
- an overview of the SHA Manual 2.0.

PART I. PRINCIPLES AND CONCEPTS

UNIT 1. PURPOSES AND PRINCIPLES OF THE SHA

Coordinating organisation: WHO

Principles

37. There are different health systems in the countries which need one common standard framework to describe and capture all the flow of funds in health systems. This challenge involves an initial effort to describe different health systems and capture the diversity of their structures in a single framework. A standard framework which consolidates previous work on health accounts such as SHA1.0, NHA Producers Guide, Satellite accounts, SNA is required for collating data to meet the national requirements and international reporting needs. A framework for health accounts is proposed which would provide data for research and analytical use.

38. *Principles*

- Health expenditure definition to be reviewed in view of the current accounting practices (SNA, SHA/PG), health system definitions and analytical dimensions
- The boundaries for health accounts will have to be set based on the health functions covered by the health systems,
- The classification schemes for health expenditure
 - i) To be aligned with the current existing accounting system to ease the migration for countries already producing NHA
 - ii) To follow the principles of statistical systems such as consistency, comprehensiveness, completeness, etc.
 - iii) To contain mutually exclusive and exhaustive categories regarding financing, Production and consumption of health services and 6 classifications: financing sources, financing schemes/agents, providers, factors of production, functions and recipients/beneficiaries
 - iv) To address the analytical issues relevant to most health systems and also allow for basic international reporting and country specific reporting.
 - v) Requires comprehensiveness to facilitate the passage from any distinct national institutional and information system to a common reporting system. Some experts recommend that the classifications follow international classification systems (ISIC/NACE, COFOG, COICOP etc.) to make them more consistent with National Accounting methods. (These would need to be briefly reviewed and discussed). This is important for presenting the health sector within the national economy.
 - vi) Requires coherence across the dimensions and classifications of SHA 2.0
 - vii) To consider feasibility of measurements

39. *Analytical relevance*

- Need a framework to address analytical issues to support decision making such as
 - i) planning the health resource requirements,
 - ii) monitoring and evaluation,
 - iii) future projections,
 - iv) measuring technical and allocative efficiency,

- v) measuring if the resources are allocated according to the priorities in the country - e.g. according to the burden of disease, or for the population groups needing most, or for the geographical areas poorly financed.
- There is need for
 - i) improving comparability of health expenditure to provide information for analysis of international trends and comparison across countries
 - ii) adequately tracking how the resources are generated and used in a health system
 - iii) better contributing to the evaluation of health systems performance at national level
 - iv) better presentation of the importance of health sector within the national economy
 - v) advocacy for donors and governments to support the appropriate funding requirements for health services
 - vi) evidence for policy makers to improve leadership and governance in health through increased accountability.
- Discuss applications of NHA that will assist health care administrators, policy makers, academe and researchers and advocates to strengthen national health systems.

Key issues

- Review the health systems of certain countries
- Describe the health system framework and building blocks
- Specify the models that could evolve from these different systems - in terms of institutions, main actors, funding flows, and interactions between them
- Use the above models to lead to the definitions of boundaries and classifications.

Look at which dimensions of health care will be used for what analytical use. Discuss what needs to be taken care for the mapping between the current classification ICHA 1.0 and the revised ICHA 2.0 and the mapping between ICHA 2.0 and the relevant classification in SNA should be made clear

Linkage to other units:

40. This unit is linked to all units in the manual, specifically the ones related to health expenditure definitions, boundary definitions and classifications.

UNIT 2. GLOBAL BOUNDARIES OF HEALTH CARE

Coordinating organisation: Eurostat

Principles

41. The global boundaries of the health (care) system need to be determined to make a solid clear description possible of the subjects to be included, to determine the areas related to the consumption, production, and financing.

42. Common functional boundaries of health care have been already proposed in the framework of SHA 1.0. The list of activities of health care, such as disease prevention, health promotion, treatment, rehabilitation and long- term, strengthened by the application of medical, paramedical and nursing knowledge and technology was chosen as a basis for the delineation of the health care sector. However, the implementations of SHA in various countries made it evident that some areas within the existing borderlines need further and more detailed clarification and guidance, while some others require discussion on their inclusion or exclusion.

43. Taking into consideration a comprehensive notion of health both with respect to health of individual persons and of population, determinants such as life style, environment, social or economic factors and health care itself it becomes evident that health encompasses a very wide area. However, common global boundaries of health care sector to be the subject of international comparison, even if generally agreed, are of little value unless there is a realistic possibility of collecting the data that are fit for such boundaries. Therefore, when designing the health care boundaries for the purpose of international comparisons the necessity of compromising between academic and research theories and the possibility of its practical implementation has to be kept in mind. This may imply the introduction of borderlines created for the purpose of international comparison. This however, does not exclude the possibilities that for national policy purposes the health care boundaries of individual countries may be designed and reported differently.

44. Several areas need special attention in SHA revision due to its policy relevancies and the experience with SHA implementation in various countries. A growing interest for indicators that could be used for social protection policy, including social inclusion and exclusion indicators, may lead to verification of existing SHA borderlines between health and social care. LTC services due to their economic significance are of great importance. Furthermore information on health care and LTC expenditure are needed for running a short and long term projections relating to population aging and sustainability of health / social care system that ensure cross-generation security. The switch from institutional care of dependant people into home care requires the decision on inclusion /exclusion of certain health and social services provided by household (as health care providers) as well as detailed guidance on how to estimate this expenditure in case of shortage of information sources. Free movement of goods and services among EU members leads to cross-border mobility of patients both with respect to the use of services and the flow of related funds.

Key Issues

45. Key issues in determining the area under study deal with the definition of functional description (with respect to all variables) as opposed to the institutional description (on main activity principles) used in national accounts. A basic issue is the selection of the criteria to be used in the determination of the activities related to health care which are on the borderlines. In the creation of the health system the activities and products are a core criterion. In the next step, the production and consumption approach, the domestic versus national approach and the problems resulting from exports

and imports need to be considered. Finally the system has to be designed to be useful for policy and be able to link to other statistical systems used in the economy.

The following areas need special attention in the SHA revision due to their policy importance and economic significance.

- The mix and delineation of health and social care,
- Long term care,
- health services produced at home,
- prevention and public health services,
- health goods and services exported and imported, as opposed to those produced and consumed domestically.

Potential differences between SHA 1.0 and SHA 2.0

Majority of changes may refer to SHA internal boundaries: personal health vs. public health, health vs health related goods and services.

UNIT 3. KEY CONCEPTS AND DEFINITIONS IN HEALTH ACCOUNTS

Coordinating organisation: OECD

Principles

46. The unit provides definitions for aggregate measures of expenditure on health care. It is therefore central to the SHA. The proposed concepts and accounting rules correspond to SNA guidelines and are thus compatible with the common internationally recognised accounting rules for defining national economic aggregates. Consistently measured health expenditure estimates are important for undertaking comparative analysis. Total health expenditures may be compared using current expenditures, real expenditures (volumes) and expenditures deflated using a denominator (such as PPPs). What is most useful for analysing growth rates, productivity and inflation is health expenditure estimates and components that can be disaggregated in terms of prices and volumes.

47. Measurement of the volume of output of health services is difficult for complex services and particularly so in a context where there are no economically significant prices⁴. Previous methodologies assumed that the value of outputs equalled those of inputs. This method is inappropriate for obtaining a measure of the productivity of health services as it is implicitly based on an assumption of zero productivity. This assumption has now been rejected for national accounts compilations as amongst other weaknesses it precludes the measurement of productivity. More details of the development of output measures can be found in the Eurostat Handbook on Price and Volume Measures in National Accounts (2001) and in the draft of the OECD handbook *Towards Measuring Education and Health Volume Output*.

48. Thus this unit of the work will develop a framework for the measurement of volumes of health services that can be applied whether provision is by market or non-market producers and which can be used to compare output volumes over time and between countries. This unit replaces Chapter 5 “Measurement of Expenditure on Health Care” and Chapter 7 “Price and Volume Measurement” in the SHA manual 1.0.

Key issues:

- Definitions of aggregate measures of expenditure on health such as:
 - Total and current expenditure on health,
 - Expenditure on health related functions,
 - Whether a distinction between ‘social’ and ‘individual’ financing arrangement should be retained
 - Health volume output,
 - Market and non-market production of health,
 - Prices for health care services and goods and health specific PPPs.

⁴. A price which is not economically significant is deliberately fixed well below the equilibrium price that would clear the market. The SNA defines it as a price which does not influence how much the producer is willing to supply (the producer having already decided to meet all the demand which might exist at that price), and has only a marginal impact on the quantities supplied (with very few users being discouraged by this price).

UNIT 4. DIMENSIONS OF HEALTH EXPENDITURE

Coordinating organisation: OECD

Principles

49. The International Classification for Health Accounts (ICHA) is a key element of SHA. As a starting point for extending and amending ICHA, clarification is needed on what SHA intends to measure and to what extent the current version of ICHA can fulfil those requirements. ICHA should provide adequate categories to describe the basic characteristics of the key functions of the health care system, such as financing, provision of services and goods and their consumption by different population groups. SHA 2.0 intends to put more emphasis on how services are used by different population groups by introducing age, gender and disease as dimensions of health expenditure. In order to provide a better picture of the flow of financial resources, the revision of classifications of financing sources and financing schemes will be a key issue. Better methods of output measurement and development of health-specific PPPs require a product classification. To provide better information for assessing efficiency, a classification for resources for production of health goods and services is required.

Key issues

50. This chapter intends to provide an overview of the structure of the ICHA and the relationships between the dimensions of ICHA⁵. It will briefly explain and exemplify the importance of the dimensions of ICHA from a health policy point of view⁶.

51. Implication of dimensions of health expenditure will also be discussed from a statistical point of view, including the implication for data collection. A clear definition of the statistical units for SHA should also be developed.

Health services and goods

52. Under the proposal, two classifications refer to the activities, services and goods provided by health care providers. The work should clarify the relationship between ICHA-HC (Functional Classification Health Care) and Classification of Health care products. The question whether a more detailed Functional Classification or a separate Classification of Health care products would be more appropriate is to be considered.

Dimensions (components) of the ICHA

53. The following classifications – and their relevant cross-classification - serve to describe the characteristics of final consumption of health services:

- Classification of Beneficiary/recipient' characteristics;
- ICHA-HP Classification of Health Care Provider Industries;

² This chapter serves as an introduction to Part II which provides the detailed description, definitions of the components of ICHA. The information provided in this chapter is also needed for Units 5 and 6.

⁶ Chapter 1 serves as a starting point to this, by describing the main actors of the health system and the transactions between them.

- ICHA-HC Functional Classification Health Care, and
- ICHA-HF Classification of financing schemes.

54. The following classifications serve to describe the characteristics of production and provision of health goods and services

- ICHA-HP Classification of Health Care Provider Industries
- ICHA-HC Functional Classification Health Care;
- Classification of health care products
- Classification of Resources for production

55. The following classifications serve to describe the characteristics of health financing systems

- ICHA-FS Classification of Financing sources;
- ICHA-HF Classification of financing schemes

56. During the consultation process proposals for additional dimensions may emerge. Australia has already proposed to consider "Economic type framework categories"⁷. It will be included as an issue for discussion in the relevant paper to be produced for the international consultation process related to SHA revision.

Requirements for the revised SHA framework for health financing

57. The financing system of a country consists of several schemes (sub-systems): e.g., social security, private insurance, out-of-pocket payments, etc. These schemes, in turn, have different characteristics of revenue-raising, pooling and purchasing. Health Accounts (in particular, ICHA-HF and ICHA-FS classifications and the tables and T-accounts displaying the relationship between financial sources and financing schemes) should provide a clear and transparent picture regarding the structure of the health financing system of a country, as well as how each financing scheme raises and utilises their financial resources; as well as the balance of revenues and expenditure

⁷. This type of classification is used by the Australian Bureau of Statistics (ABS) in its Government Finance Statistics (GFS) collections and is reported in the format of input/output tables produced separately for health and welfare industries, similar to those produced in the SNA.

UNIT 5. TYPES OF HEALTH ACCOUNTS

Coordinating organisation: OECD

Principles

58. The SHA revision aims, amongst other things, to create a statistical framework which enables policy analysis of the health sector and to strengthen the linkages between SNA and SHA. In achieving these objectives, an effort should be put into linking the health sector to the main macroeconomic variables that comprise aggregate demand and supply. These are value added (GDP), consumption, investment, import and export. If the corresponding aggregates could be estimated for the health sector, it would then be possible to analyse the relative importance of the health sector in terms of contribution to the whole economy (i.e. the relative importance of consumption of health good and services in relation to total household final consumption or to actual consumption) and also to what extent the health sector is internationally integrated. At the same time, it could be of interest to analyse the importance of the health sector in terms of income generated, specifically health sector value added as a percentage of GDP.

Key issues

59. One of the themes in this unit is to identify a set of accounts which include balancing items (i.e. value added, operating surplus, disposable income, saving and net lending/net borrowing). Balancing items are not simply devices introduced to ensure that accounts balance as they encapsulate a great deal of information. The set of accounts which will be identified in this unit will be determined by policy usefulness, however it may comprise:

- accounts of production of health services.
- generation of income accounts.
- accounts of final use (final consumption) of health services.
- sectoral accounts (uses and resources for each main health financing category).
- accounts of gross capital formation in the health sector.
- accounts of international trade in health care.
- supply and use tables.
- Capital account

UNIT 6. RELATIONSHIP TO OTHER STATISTICAL SYSTEMS

Coordinating organisation: Eurostat

Principles

60. SHA relates to all activities carried out in economic and human life. To provide information for the assessment of health system performance requires the linkage of health accounts to other statistical systems that refer both to economic aspects of health statistics such as ESPROSS and COFOG and other systems like Diagnosis Related Group (DRG) classification.

61. The possibility of linking SHA to other statistical systems first of all shall enhance the credibility of health accounts. Linkage should be perceived here both as a direct link and as a description of SHA departures from other system.

62. Compatibility with ESA/SNA will lead to greater transparency of SHA in relation to other classifications like COFOG, COPNI, or COICOP that use the SNA/ESA framework⁸. Beside the possibility of double checking of some health expenditure aggregates, the value added of such a link is the fact that one of the main indicators used for health care policy is health expenditure presented as a share of GDP, the main aggregate that is derived from SNA. Matching SHA categories of expenditure on functions with certain categories of expenditure on benefits in kind and in cash recorded under ESPROSS, may help data compilers to double check and improve information related to social protection policy.

63. The statistical unit in the functional distribution within the SHA can be treated as a specific functionally defined health care output for final use. Here the linkage between SHA and DRG or any other output item like 'mixed cases' should follow the rule of 'treatment episode' to be taken into account when attributing them according to categories of function dimension. The examples of such mapping exercises might be of great interest and help for many SHA data compilers.

64. Available national sources of information determine the starting point in the SHA data compilation. Data sources differ between countries, therefore clear description of the links between SHA and other main statistical systems are of great importance for data compilers and for policy analysts. The policy relevance of the use of the new SHA 2.0 is highly dependent on the clarity to be created in its relations to other systems both in national and international terms. It has to be linked to the national systems in use and compatible with international systems.

Key Issues

- Cross classifications between ICHA and NACE/ISIC
- the description and demarcation in relation to the classification used in ESA/SNA, including COFOG, COICOP, COPP
- the demarcations in relation to ESSPROS

⁸ The classification of individual consumption by purpose (COICOP) is a classification used to identify the objectives of both individual consumption expenditure and actual individual consumption. The classification of the purposes of non-profit institutions (COPNI) is a classification used to identify the socio-economic objectives of current transactions, capital outlays and acquisition of financial assets by non-profit institutions serving households. The classification of the functions of government (COFOG) is a classification used to identify the socio-economic objectives of current transactions, capital outlays and acquisition of financial assets by general government and its subsectors.

PART II INTERNATIONAL CLASSIFICATION FOR HEALTH ACCOUNTS

UNIT 7. ICHA-HC FUNCTIONAL CLASSIFICATION OF HEALTH CARE

Coordinating organisation: WHO

Principles

65. Decision-making involves the allocation and the use of resources by type of function. The health spending profile by function allows to extend and to refine the planning process and to define outputs by function. Health functions have as their primary purpose to restore and maintain and to improve the health status of populations and individuals, or perhaps, secondarily, to support this primary purpose. Intrinsically, they constitute and define the boundaries of the system. The appropriate classification of function, when summed should result in the definition and measure of health expenditure. Therefore, the boundaries of the health system are set by the sum of the HC classes. The community of nations has an interest in standardising the health boundaries and so do individual countries regardless of their policy objectives and their financing or delivery arrangements.

Key issues:

66. The functional classification, (ICHA-HC), should as much as possible be purpose-defined, neutral of mode of production and /or mode-of-financing. Redefined definitions of the object and scope of subclasses will result in an expanded or restricted total boundary. An example of an expansion is HC.2 long-term care; another is public health, which presently host subcomponents of several HC and HCR classes. An example of retraction might be the removal of non-health functions from the SHA 1.0 definition.

67. The classification of functions is expected to reflect a continuum of the health care content from health promotion to prevention to maintenance to repair to palliative care

68. Some issues identified as requiring discussion include:

- Construction of classes independently of mode-of-production
- Disaggregation of HC.1 into the various products of the hospitals
- Review of HC.2: as a class of its own or possibly merge with another
- Definition of HC.3 to reflect the health - social care distinction (based on OECD advances)
- HC.4 to be analysed regardless of mode-of-production (presently accounts only for out patient care)
- HC.5 to be analysed regardless of mode-of-production (presently accounts only for out patient care). Consider the inclusion of traditional, alternative and complementary medical goods in the framework
- HC.6 to be redefined: inclusion of a genuine public health services (currently below the line as in some environmental interventions like testing potability of water for drinking) and explicit accounting of personal prevention services (e.g. immunization which is currently accounted as curative care in HC.1)
- HC.7 to be discussed as it is not a genuine health function, but only supports health functions
- HC.R.1 to be accounted in a separate classification as it is not a genuine health function

UNIT 8. ICHA-HP CLASSIFICATION OF HEALTH CARE PROVIDERS

Coordinating organisation: Eurostat

Principles

69. From the production point of view a clear notion has to be present on how to treat all economic units to be included in or excluded from health care production. It is necessary to provide a clear guideline for identifying a statistical unit to be taken into account for the purpose of the provider classification. On one side the decision should follow the SHA rules and the SHA global approach. All providers, public and private need to be part of the system of health care and as such also of the provider classification. Providers like traditional healers and providers of oriental medicine should also find their place in the health account classifications.

70. Without a clear description of the production units a clear view on the consumption and export is very difficult. Moreover production (related to output) is one of the basic tables in the National Accounts. To be able to determine how the classification will be created decisions have to be taken on which type or types of units are going to be included in the classification, which are the units of observation. A large amount of literature is available on this subject. The most relevant units to be selected can include statistical unit, economic unit and unit of observation.

71. Health care providers are also an important component in the data collection, as they are one of the sources of information. From a policy point of view providers are important as well.

Key Issues

72. The main issue in the determination of the provider industry units is the set of criteria and rules used. Not only for the determination of the inclusion or exclusion of a unit but also in which part of the classification. Then first goal will be to determine which units of observation are going to be included in the health care provider branch. For this it is imperative to know the boundary of health care. All units of observation performing any activity, providing any service or good within this boundary should be included. Another key issue is the description and determination of the classes and groups to be distinct in the classification. For the distinction of the various sub-branches, groups and sub-groups of the provider classification the rules and criteria used in the classifying economic units in the ISIC/NACE branches might be very useful.

73. The level of detail in this classification, meaning the amount of groups, sub-groups and classes to be included, is open for discussion. International comparison of health care providers – as experience showed - is problematic due to significant differences of organisational arrangement among countries. However, the possibility of identifying certain activities within particular type of provider can generate value added with respect to monitoring efficiency of these arrangements. For national purposes the classification can be more detailed. Another issue that may be of countries interest in the classification of providers is the characteristic of being a market producer or non-market producer.

74. The relation to the SNA/ESA as well as to the classifications used in those systems (like ISIC/NACE) are obvious although not by definition identical as the purpose for which the various classifications were built differ.

75. The differences with SHA 1.0 are at this moment not completely clear, but the new HP will have a close relation to the old HP in SHA.

UNIT 9. CLASSIFICATION OF FINANCIAL SOURCES (ICHA-FS)

Coordinating organisation: OECD

Principles

76. Policy relevance and key concepts of the Classification of Financial Sources and its relationship with other classifications will be dealt with in Unit 4. (In addition, some key concepts will be clarified in Unit 3 and 5.)

77. "Financing sources" are the entities providing funds (through taxes, contributions to insurance, premiums paid, transfer payments, and discretionary allocation) for financing schemes. Financing sources are institutional units (including households as a generic group) whose resources are mobilised and managed by financing schemes.

78. The relationship between financing sources and financing schemes shows the "burden" of financing the health care system placed on the main actors in the economy: governments, non-profit institutions, corporations and households.

79. The main question for health policy analysis is: from where do third-party payers receive their revenues. Therefore, ICHA-FS contain, in economic terms, both primary sources (households and firms) and secondary sources (governments and donor agencies).

Key issues

80. This chapter will provide a table of the ICHA-FS classification and detailed definition of each category. With this aim, the current classification showed below and definitions used in the Joint Health Accounts data collection will be reviewed and amended. In particular, the "Private sector" as a major aggregate under FS classification has been questioned.

Classification of Financing sources under the Joint Health Accounts Questionnaire

FS.1		General government units
	FS.1.1	Territorial government
	FS.1.2	All other public units
FS.2		Private sector
	FS.2.1;2.3	Corporations and NPISHs
	FS.2.2	Households
FS.3		Rest of the world

81. Accounting Rest of the world (FS.3) is of key importance for lower income countries. Therefore, the revision will review whether sub-categories (such as international agencies, private foundations, etc.) should be created.

Relationship between financing sources and financing schemes

82. A basic task is to find the appropriate way to show the relationship between financing sources and financing agents. To display the revenue collection and pooling by a financing actor/scheme, the T-account form seems more appropriate than a two dimensional table. SHA 1.0 Annex 6.1. presents a set of sectoral flow-of-funding accounts, based on SNA terminology. The work on SHA 2.0 intends to review and revise these sectoral flow-of-funding accounts.

UNIT 10. CLASSIFICATION OF FINANCING SCHEMES (FINANCING AGENT)

Coordinating organisation: OECD

Principles

83. The current categories of health care financing (ICHA-HF) do not enable the complex and changing systems of health financing to be adequately reflected. Insurance and financing schemes are heterogeneous and have evolved significantly as a result of recent reforms and policy initiatives. Furthermore, ICHA-HF does not contain such schemes that play an important role in several lower income countries, e.g., community-based insurance. This calls for the revision of the terminology and structure of ICHA-HF.

Key issues

Finding an adequate terms for ICHA-HF

84. Experience has shown that there is a great deal of ambiguity regarding the current terminology and definitions of ICHA-HF categories in the SHA Manual. It has already been agreed that the terms "source of funding" and "health care financing" used in SHA 1.0 are not unambiguous enough and should be replaced by terms that refers to the entity pooling resources and purchasing services (paying for services).

85. The categories under ICHA-HF represent different entities / arrangements for raising and pooling funds and purchasing health care. The distinction between categories of ICHA-HF centres on whether they have different rules, methods for fund raising and pooling resources. As a given organisation (e.g., a commercial insurance company) can operate different financing arrangements (both compulsory insurance and voluntary insurance), the categories of ICHA-HF should not be understood as organisations involved in financing health care.

86. The Joint Health Accounts data collection uses the terms "financing agent/ scheme". It should be discussed and decided which one is applied under ICHA 2.0..

Revision of the structure of ICHA-HF

87. The first step is to agree on the basic criteria to distinguish between different financing schemes. A paper presented at the 2006 Meeting of Health Accounts Experts [DELSA/HEA/HA(2006)7] proposed the following criteria: *Mode of participation* (mandatory by law; mandatory by condition of employment; voluntary); *Basis for benefit entitlement* (based on a public law or a contract between an insurance carrier and the individual); *Method for raising funds* (general taxation, mandatory income-related insurance contribution, mandatory non income-related premium, out-of-pocket payments); and *Mechanism and extent of pooling and re-allocation of contributions*⁹:

88. After an agreement on schemes (or a modified version) as the key components of ICHA-HF, the following steps are to compose aggregate categories and, on the other hand, to define sub-categories for each, if needed.

⁹. For example: income-related contributions pooled at national level; mandated community rating of premium at national level; community rating of premium at financing agent level; risk-adjusted contributions; households direct payments.

89. The two major aggregate components of the current version of ICHA-HF are General government (HF.1) and Private sector (HF.2). Due to recent changes in insurance schemes (e.g., in the Netherlands¹⁰), this division has become inadequate. Emerging insurance and financing schemes can involve, at the same time, elements of what traditionally was considered as “public” and what was referred to as typical of the “private sector” from several perspectives, such as the nature of the institution managing the scheme, the regulatory framework underpinning the scheme, the sources of the funds used by the scheme, the methods for raising funds used by the scheme, the degree of obligation in participation in the scheme, and so forth. This can make the use of the terms ‘public’ and ‘private’, when referring to some financing schemes, ambiguous. This calls for the revision of the terminology and structure of ICHA-HF¹¹.

Issues for clarification

90. SHA implementations have raised several specific issues for which the SHA Manual does not provide adequate guidance¹². These can be grouped as follows:

- the interpretation of some key terms of health care financing, such as public vs. private, and social vs. private;
- the clarification of some terms currently used in health accounting (definitions of financing source, financing scheme and financing agent);
- accounting rules, such as treatment of tax subsidies; or hospitals' revenues from activities other than patient care, etc.

91. Earlier this year countries were invited to raise issues to be dealt with under the SHA revision. Among others, the need for clarification of private social insurance, NPISH as a financing agent; and the "Rest of the world" as a financing agent (HF.3) vs. as a financing source (FS.3) has been mentioned.

92. A further issue for clarification arises from the fact that several private insurance schemes do not directly contract providers, but reimburse (fully or partly) the medical bill of the patients. Because the actual payments to providers are made by patients, this causes some ambiguity in accounting for these payments. The proposed interpretation is that services are consumed (and their costs are covered) under the private insurance scheme, therefore they should be accounted under private insurance.

93. Several previous works can serve as important input to the preparation of this unit. Among others to mention: the paper on households out-of-pocket payments published by WHO; documents of the Tallinn workshop on health financing organised by Eurostat; recent World Bank publications on health financing, OECD's *Interim report on the work on refinement of the SHA framework for health financing*, etc.

¹⁰. Compulsory health insurance in Netherlands serves similar purpose as that of social security schemes, but can not be considered part of the General government sector.

¹¹. [DELSA/HEA/HA(2006)7] proposed to replace "HF.1. General government" by “Compulsory social protection schemes”, as a temporary terminology and include: General government (excluding social security), Social security funds and compulsory private insurance. Under the SHA revision consultation process a wider debate among health policy and health accounts experts will be initiated on these issues.

¹². During the revision process, countries will be invited to identify such further issues. Only a few are mentioned in the following.

UNIT 11. CLASSIFICATION OF BENEFICIARY/RECIPIENT CHARACTERISTICS

Coordinating organisation: WHO

Principles

95. "Beneficiaries/recipients are the people who receive health goods and services or benefit from those activities (beneficiaries/recipients can be categorised in many different ways, including their age and sex, their socioeconomic status, their health status, and their location)" (*Guide to producing national health accounts, 5.06*).

96. Statistics on expenditure by the different groups of population helps to address issues related to sustainability, equity and fairness. Statistics by beneficiaries/recipients can reveal when population groups are spending more on health than others, be it an age group, a region, a group of patients, etc. They can also highlight efficiency differences; and they support informed priority setting decision.

97. Building expenditure by beneficiaries/ recipients means allocating expenditure to groups of population formed around a chosen characteristic: disease, programme, cluster of interventions, etc. These include:

- demographic characteristics (e.g. sex, age)
- socio-economic characteristics (income/wealth quintile, poverty level/vulnerable groups, expenditure quintile, education, insured/not insured, ...)
- health characteristics (by health status, disease, intervention/symptoms)
- geographical characteristics (institutional coverage by subnational regions, geopolitical regions, rural/urban, etc.)

Key issues

The unit will explain how to build each of these beneficiaries/recipients expenditure.

- This includes explanations on how to set up the groups and deal with overlapping issues (offering as many known solutions as possible). For example, under demographic characteristics (age, sex), the chapter could provide solutions for distributing by disease, e.g. how do you classify people living with HIV/AIDS (*PLWHA*) who are treated for tuberculosis? Where do you classify expenditure provided for the resident of one region by a provider of a different region?
- Another issues addressed under boundaries and classifications would be that of Health Boundaries and what total is to be distributed and why (total expenditure on personal health care. Total current expenditure on health or total expenditure on health).

UNIT 12. CLASSIFICATION OF RESOURCES FOR PRODUCTION OF HEALTH GOODS AND SERVICES

Coordinating organisation: Eurostat

Principles

94. For the large economic units, the costs side of this equation is indispensable. Without a clear description of the cost structure of the production units, a clear view on the balance of the institutions and the branch as a whole is impossible. Moreover financial information on production costs offer possibilities to use as a measurement of productivity and input efficiency. For policy decisions the productive efficiency can be an important issue for which also information on the cost components used in the branch are necessary. Information on the cost structure also makes it possible to have an insight in the losses incurred (or possibly also profits generated) by the production units in the health care branch.

Key Issues

95. Key in this area is the groupings of the variables and cost items to provide a global insight in the cost structure of a group of providers. One of the most important groups of variables to be included in the cost structure has to do with employment. This group not only has to include the wages and salaries but also social dues to be paid on earnings. As we are dealing with health care another group of variables that could be important for providers of health deals with the medical goods used in the process of producing health services. Other types of resources that could be included deal with issues like consumption of fixed capital, interest payments for loans, food and other non-durable inputs.

96. However the main question here is whether or not there is possibility for identifying all type of resources within health care providers. It is known that providers of health produce not only health care but also some production outside the strict area of health care. The receipts for these producers outside the health care area may possibly be separated. However, attention has to be paid to the consequences for the cost structure. In the cost structure it is usually very difficult to have a unique relationship between the production and the inputs used. Observations cannot be limited to health care; as care related production costs should be taken into account. It is difficult to separate the production costs for health and non-health production.

97. As this unit is dealing predominantly with economic type of data it is obvious that definitions and calculation and classification methods have a strong link with the SNA/ESA (although they are not necessarily identical). The classification of resources for the production of health goods and services was not included in SHA 1.0.

UNIT 13: CLASSIFICATION OF HEALTH CARE PRODUCTS

Coordinating organisation: WHO

Principles

98. This unit proposes a new classification for ICHA SHA 2.0. The unit replaces Chapter 7 “Price and Volume Measurement” in the SHA manual 1.0. The definition of health care products will determine the classification. Products need to be defined to enable definition across countries. The physical properties and intrinsic nature of products are distinguishing characteristics of the products themselves. These include, for example, the raw materials of which goods are made, the stage of production or the way in which goods are produced or services rendered, the purpose or user category for which products are intended and the prices at which they are sold.¹³ In the health sector, just as in the product classification for national accounts, the products can be classified as goods, services or mixed (where goods in form of equipments or drugs are provided during a treatment service).

99. The major challenge in the health sector is the definition of the unit of measurement of the product and specifically for complex services sold at non market prices. The key challenge is to define a product, specifically a service which is homogenous in its characteristic. At the same time we do not want to fragment services and need a more homogenous unit of output which can be compared over time and space and which may be able to capture changes fostered by technological advances or delivered with different technologies in different countries. We need classifications along a dimension which are feasible to define and measure.

100. The traditional approach to measure output is days of inpatient care, number of outpatient consultations, etc. Recent approaches to measure products are treatment of episode of illness, which take into account patients’ age, sex, disorder, severity of case, and interventions used; or diagnosis related groups systems for output indicator for inpatient care. It would be worthwhile to assess whether the treatment of disease can be associated with the provider and functions classifications of SHA2.0 to define a quality adjusted product.

101. There are a number of approaches which may be considered for the definition of products. First, the World Bank has standard product descriptions for PPP purposes of hospital services, medical care services, dental services, paramedical services, pharmaceutical goods, and therapeutic appliances and equipments in which they take into account patient characteristics, mode and type of treatment procedures, quantity and packaging and several other characteristics to define a service or good. A second possibility is the WHO health care technology package tool which links health care interventions to health technologies (defined by using different mix of medical equipment, human resources, drugs and facilities) to define a particular output. On the other side, health care interventions are defined by linking international classification of diseases (ICD) to clinical procedures terminology (CPT). Standard data bases are available for such linkages and could be explored. This may be specifically useful as some of the interventions are performed without identifying underlying disease and can be linked directly to the CPT classifications such as integrated management of child illness (IMCI), Adult lung health initiative (ALHI) etc. Further interventions can also be defined for personal, preventive, promotion, rehabilitative and self care.¹⁴

^{13.} CPC classification, National accounts: <http://unstats.un.org/unsd/statcom/doc02/cpc.pdf>)

^{14.} The essential Health care technology package- A new tool for planning and managing resources for health interventions: P. A. Heimann and A. Issakov

102. The Product classification is important to define the output or volume of goods and services produced in a country and see how much is spent on that output. This in turn enables an examination of whether country is achieving better indicators because of differences in volumes or just expenditures. It is important to take technology into account in product definition as it is a significant contributor of costs but also helps the provider to provide services more effectively and efficiently. Products defined according to technology can help health care providers to know if cost effective methods are being used for providing better quality health care. Additionally, there is a need to classify health care products to construct a comparable basket of goods and services and determine their prices. The development of a product classification would assist in the construction of health-specific Purchasing Power Parities (PPPs).

Key Issues:

- The classification list of products should be exhaustive and should be representative of current health expenditure in the country and also exclusive so as not to double count goods that are included as part of mixed services.
- The classification list should take account of broader list of health goods and services on which the value, quantity, quality and prices can be determined and similar characteristics can be defined across the countries. Using quality indicators to define similar products is a key challenge. E.g. Can an outpatient consultation in a health centre in a wealthy urban setting be treated the same as the outpatient consultation in a health centre in rural area which does not have comparable facilities? Measuring differences within and across countries is a key challenge.
- The classification list should be based on country experiences of defining products, especially for public health.
- Classification should be based on possibilities for collecting the data and needs clear guidance on the estimation methods.

UNIT 14. HUMAN RESOURCES IN HEALTH

Coordinating organisation: Eurostat

Principles

103. A number of national and international data sets contain information on health workers or human resources in health. However, coverage varies across data sets, across countries and over a time. Frequently classifications used, concepts, definitions and methodologies applied are not harmonized and collection systems differ. Furthermore data sets are created for a specific purpose or use and display different structures and use different analytical and measurement units, all of which explains the need of a common framework of the Health Labour Accounts (HLA).

104. The issues relevant for human resources development within the health area in the context of HLA are among others (i) migration of health professions, (ii) human capital formation, and (iii) productivity measurement. The migration of health professions between Member States and between Member States and the rest of the world, as well as changes in current and future requirements for human resources in health are of particular interest in view of shortages of some health professions. Education and training is an important dimension of the analysis of inflows to labour market and the qualifications of health professions. Finally, labour productivity is a key economic indicator for the analysis of economic growth, planning for human resources in health, and efficiency.

105. Two different angles of approach are possible in discussing the human resources in health (care). One approach starts in the *professions* which are seen of primary importance to health in whichever branch these occupations are employed. Another approach is starting in the *economic units or providers of health* and strives to determine all human resources included in the health branch, whichever occupation is carried out. Both approaches are policy relevant. The first approach is necessary to be able to decide on the surpluses and shortages of certain professions/occupations. The second one is necessary for the determination of efficiency and efficacy of the services provided. This approach should be then treated as an ultimate goal as the information on the salaries (of employees and self-employed persons) is important, especially for establishing the link between SHA and HLA in monetary terms.

Key Issues

106. Any useful link of health care human resources data to health accounts requires comparability of the production boundary and of the breakdown to production units. The international classification of providers ICHA-HP in the framework of SHA offers the link between the output produced by health care providers and the input of human resources in the production process. However due to both the lack of information sources and its diversity, certain aspects of HLA methodology have to be carefully tackled:

- production units (ICHA-HP)
- the choice in human resources in health measurement units (the hours worked, FTE, jobs, head count as well as e.g. the full-time/part-time workers split)
- occupation (ISCO vs. national classification including health and non health professions)
- education (ISCED vs. national classification)

PART III. BASIC INDICATORS, TABLES AND COMPILATION OF HEALTH ACCOUNTS

UNIT 15. PRESENTATION OF RESULTS

Coordinating organisation: WHO

Principles

107. Health Accounts are designed to link observed patterns and results of a process to policy planning and policy evaluation. The observations and results need to be translated into meaningful and relevant indicators.

108. Indicators for international reporting purposes are a product or a synthetic presentation with a potential coverage as wide as possible. Comparability is important for cross national analyses. A standardised derivation and presentation of indicators is a key for comparability. International agreement on labels and content of indicators is a first step. Two approaches may be relevant of the choice of a minimum data set and/or an expanded list of indicators.

109. The linkage of results into the policy debate is a country responsibility. This unit is designed to illustrate some of the more frequent applications of Health Accounts data in various stages of the planning process. The data sources would correspond to the three dimensions: financing, provision and consumption.

Key issues

110. This new unit aims to discuss a standard minimum data set and to illustrate their linkages to various policy uses. Its focus will be largely on international reporting and comparisons.

- Indicators will be constructed using exclusively Health Accounts data and complemented with other data.
- Illustration of applications of indicators to policy uses will involve budgetary, equity, effectiveness and efficiency analysis

UNIT 16. BASIC ACCOUNTING RULES AND GUIDELINES

Coordinating organisation: OECD

Principles

111. This unit will cover some specific rules for accounting health expenditure and guidelines for selected issues. Such rules and guidelines are essential for ensuring consistency and comparability in health expenditure data collections. The power of the SHA as an analytical tool stems largely from its ability to link numerous, very varied economic phenomena by expressing them in a single accounting unit. The System does not attempt to determine the utility of the flows and stocks which come within its scope but measures the current exchange value of the entries in the accounts in money terms, i.e., the values at which goods and other assets, services, labour or the provision of capital are in fact exchanged or else could be exchanged for cash. The development of rules for health accounting will rely heavily on the accounting rules laid out in the SNA and will include issues such as cash vs. accrual accounting and the development of guidelines for subsidies, rules for estimation of consumption of fixed capital, valuation of exports and imports. Estimation of health expenditure faces some particular issues which are not well covered in the SNA. Examples are discriminating between long-term care health and social expenditures, estimating out-of-pocket household expenditures and accounting for illegal payments in health care.

Key issues:

112. Guidelines for estimating total current expenditure. The following requirements for estimating internationally comparable total current expenditure will be discussed:

- The functional classification of health care (ICHA-HC) is applied in an internationally harmonised way (in particular, LTC)
- Expenditure by all the financing agents defined by the SHA is accounted for (in particular, HF.2.4; HF.2.5)
- All primary and secondary providers of health care are included (in particular, HP.7)
- Foreign trade of health services is estimated (in particular, HP.9)
- Common methods for valuation of health services are applied following the SHA framework
- Guidelines for estimating gross capital formation
- Guidelines for estimating long-term care
- Guidelines for estimating private expenditure
- Guidelines for estimating expenditure by disease, age and socioeconomic grouping

UNIT 17. POSSIBLE COMPILATION PROCESSES

Coordinating organisation: Eurostat

Principles

113. In SHA 1.0 as well as in the Guidelines (EUROSTAT) and the Producer Guide (WHO) some attention is given to possible compilation processes. Also in the Joint Questionnaire, there is some focus on the problem but certainly not sufficient and not always consistently. However the rules and processes set out in the Guidelines and the Producer Guide may be a good starting point.

114. To be able to determine the comparability across countries and consistency across time it is imperative to have information on how data are compiled, calculated, estimated etc. Meta data are necessary to provide insight in the actual processes.

115. The principles in compilation are basically the same as in national accounts. Emphasis may be on preventing double counting and white spots in the accounting framework. Data sources need to be described. Another important starting principle is that the new system should be easier to use.

116. For policy purposes usually, the final data sets created are to be supplemented by more recent data. This means that producing data with a time lag of less than one year is also necessary, but at a high level of aggregation. For this now-casting rules and guidelines need to be produced as well.

Key Issues

117. Key issues relate to descriptions of the procedures used in the calculation or estimation also to prevent double counting and prevent or clarify the white spots in the system. Data sources and metadata are indispensable. Another key issue relates to the ease of use of estimation processes (possibly including multi-layered solutions, i.e. different levels of details for different countries). Estimation techniques are to be simple and accompanied by clear examples. Calculation and estimation techniques and procedures should ultimately result in a standardised set, a cook book, to be used by all countries.

118. In creating the information and data leading up to a set of accounts that will ultimately result in the set of required tables, various starting points can be used. The process of calculation can start by using the data in the provider classification, the data available on financing arrangements or in the functions that constitute the actual boundary of the health system. Each of these three approaches needs its own set of guidelines but in the end the integration process needs to produce one single integrated data set. A key issue in building the data structures is to produce consistency across all dimensions (not only the three core dimensions).

119. Another key issue has to do with the data itself. Not all cells in a database are being filled, but the reasons for these lacking data are not identical. As an example the following positions which are used for EUROSTAT publications are provided:

: Not available, confidential or unreliable value

- Not applicable or zero by default

0 Less than half the final digit shown and greater than real zero

UNIT 18. ANALYTICAL USE OF SHA

Coordinating organisation: WHO

Principles

120. This unit will provide the summary from all the definitions and classifications and focus the use of each of the classifications and cross classifications to highlight the importance of the accounts in analysis to generate evidence. This Unit will be based on the practical experience and will give a systematic list of detailed potential analytical uses.

121. This unit will mention the budgeting process and links between budgets and expenditures. Other examples such as expenditures on end-of-life linked to ageing, or on child health linked to MDGs will be discussed.

122. The unit will also summarize some essential indicators that must be produced by countries on a regular basis for international comparability.

123. The unit will discuss the importance of data collection in a timely manner, and conditions necessary for institutionalisation of health accounts.

Key Issues

124. Identify practical examples from countries where health accounts have been used for analytical purposes; including examples of effective communication devices/ presentations that facilitate the use of data.

Linkage to other units

125. This unit will have links to all other units in the Manual specifically relating to classifications and tables.

Table 1 - Links between different units in the SHM Manual 2.0

	PART I PRINCIPLES AND CONCEPTS						PART II INTERNATIONAL CLASSIFICATION FOR HEALTH ACCOUNTS								PART III BASIC INDICATORS, TABLES AND COMPILATION OF HEALTH ACCOUNTS				Annex Glossary
	Unit 1.	Unit 2.	Unit 3.	Unit 4.	Unit 5.	Unit 6.	Unit 7.	Unit 8.	Unit 9.	Unit 10.	Unit 11.	Unit 12.	Unit 13.	Unit 14.	Unit 15.	Unit 16.	Unit 17.	Unit 18.	
	Purpose and Principles of the HA	Global boundaries of health care	Key concepts and definitions in health accounts	Dimensions of health expenditure	Types of health accounts	Relationship to other statistical systems	ICHA, HC Functional Classification Health Care	ICHA-HP Classification of Health Care Provider Industries	Classification of Financial Sources	Classification of Financing Schemes (incl. financing agents)	Classification of Patients' characteristics	Classification of Resources for production of health goods and services	Classification of Health care products	Health human resources	Presentation of results indicators/IDS	Basic accounting rules and guidelines	Possible completion processes	Analysed use of HA	
Unit 1.		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Unit 2.	•					•	•	•	•	•	•	•	•	•			•		
Unit 3.	•				•	•			•	•	•	•	•			•	•		
Unit 4.	•						•	•	•	•	•	•	•	•			•		
Unit 5.	•		•			•	•	•	•	•	•	•	•			•			
Unit 6.	•	•	•		•		•	•	•	•	•	•		•			•		
Unit 7.	•	•		•	•	•				•						•	•		
Unit 8.	•	•	•	•	•	•					•		•	•	•	•	•	•	
Unit 9.	•	•		•		•			•								•		
Unit 10.	•	•	•	•	•	•				•					•	•	•	•	
Unit 11.	•	•	•	•	•	•	•	•	•				•	•	•	•	•	•	
Unit 12.	•	•	•	•	•	•				•			•	•	•	•	•	•	
Unit 13.	•	•	•	•	•					•							•		
Unit 14.	•	•	•	•		•				•							•		
Unit 15.	•							•		•	•	•					•		
Unit 16.	•		•		•		•	•	•	•	•	•					•		
Unit 17.	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•		•	
Unit 18.	•							•		•		•					•		

**ANNEX LIST OF UNITS OF THE WORK PROGRAMME ON SHA REVISION AND
PROPOSED COORDINATING ORGANISATION**

Part/Unit	TOPIC	Coordinating organisation
	INTRODUCTION	OECD
PART I.	PRINCIPLES AND CONCEPTS	
Unit 1.	PURPOSES AND PRINCIPLES OF THE SHA	WHO
Unit 2.	GLOBAL BOUNDARIES OF HEALTH CARE	EUROSTAT
Unit 3.	KEY CONCEPTS AND DEFINITIONS IN HEALTH ACCOUNTS	OECD
Unit 4.	DIMENSIONS OF HEALTH EXPENDITURE	OECD
Unit 5.	TYPES OF HEALTH ACCOUNTS	OECD
Unit 6.	RELATIONSHIP TO OTHER STATISTICAL SYSTEMS	EUROSTAT
PART II	INTERNATIONAL CLASSIFICATION FOR HEALTH ACCOUNTS	
Unit 7.	ICHA-HC FUNCTIONAL CLASSIFICATION HEALTH CARE	WHO
Unit 8.	ICHA-HP CLASSIFICATION OF HEALTH CARE PROVIDER.	EUROSTAT
Unit 9.	CLASSIFICATION OF FINANCIAL SOURCES	OECD
Unit 10.	CLASSIFICATION OF FINANCING SCHEMES (FINANCING AGENTS)	OECD
Unit 11.	CLASSIFICATION OF BENEFICIARY/RECIPIENT CHARACTERISTICS	WHO
Unit 12.	CLASSIFICATION OF RESOURCES FOR PRODUCTION OF HEALTH GOODS AND SERVICES	EUROSTAT
Unit 13.	CLASSIFICATION OF HEALTH CARE PRODUCTS	WHO

Unit 14.	HUMAN RESOURCES IN HEALTH	EUROSTAT
PART III.	BASIC INDICATORS, TABLES AND COMPILATION OF HEALTH ACCOUNTS	
Unit 15.	PRESENTATION OF RESULTS	WHO
Unit 16.	BASIC ACCOUNTING RULES AND GUIDELINES	OECD
Unit 17.	POSSIBLE COMPILATION PROCESSES	EUROSTAT
Unit 18.	ANALYTICAL USE OF SHA	WHO
Annex	GLOSSARY	