A System of Health Accounts 2011

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A System of Health Accounts 2011

‘a long and winding road’

• Process given approval in 2006 with project formally starting in 2007
• Worldwide consultation with refocus in 2009
• Final IHAT agreed draft in March 2011
• Publication October 2011
• Co-edition/joint copyright OECD, EU and WHO
• Initially in English - French translation by WHO and other languages (Spanish, etc) to follow
What is it?

- A statistical reference manual with concepts, definitions for all health systems – from simplest to most complex

What is it not?

- A data collection guide
- A set of guidelines for compilers

Countries will refer to particular aspects and apply parts relevant to their circumstances
• Is it complicated?
  – It is clearer than SHA 1.0 - concepts have been clarified and examples added
  – It retains the same guiding principles
  – It is longer because it responds to the needs of health systems around the world with different organisational and financing systems and different priorities
SHA 2011: What is new and improved?

- Refined boundary setting
- Continuity facilitated: – HC, HP, FA
- Refined health care classifications: – Factors of provision – Financing revenues
- Introduction of capital classification – Separate reporting for current and capital

Consistent labelling and categories introduced:
- SNA 2008, Revised standard classifications (e.g. ISIC)
- Larger compatibility HC-HP
- Closer to functional financing environments
• New and developing methodologies
  • Price and volume measures in the health sector
  • Measuring international trade in health care
  • Approach to product classification

• Guidance to compilers
  • Compilation processes
  • Measurement issues

• Presentation of results
  • HA dissemination
  • Reports, indicators and tables
• So what next?
  – **Detailed mapping** of SHA 1.0/PG to SHA 2011 to facilitate the continuity in international reporting
  – **Guidelines** for compilers in some areas – financing framework, resource tracking with case studies and testing
  – **Implementation** in an orderly manner in consultation with partners and countries before any modifications are made to the data collections
HC: Main feature (Rationale of classes)

- **Principles:**
  - Distribution by type of need
  - Purposes: natural history of disease stages – health conditions
  - Contact with health system events

- **Components:**
  - Contact components: diagnosis, prescription & monitoring
  - Contact purposes: prevention, cure, rehabilitation, LTC, NSF
  - Purposes distinguished by MoP

- **Complementary:**
  - On diagnosis: imaging + laboratory
  - On therapeutic: pharmacological, orthesis, prosthesis
  - On ancillary: transport

- **Overarching:** governance and administration
HC: Improvements on SHA 1.0

- Clearer criteria on classes and definitions
- Changes on classification are minimal:
  - Some labels
  - HC 6 into prevention broken down by type of service
  - HC 7 introduced governance and finance management
  - Memorandum items have major changes
HC: Reporting issues

• When data not easy dissociated:
  – an aggregate of curative and rehabilitative care is reported
  – Day care and Home care reported as IP and/or OP pending on country records
  – Preventive services structured under programmes otherwise incl. as part of HC.1-HC.5
  – LTC by agreement: medical and personal are reported as LTC health and assistance as "social"

• Information systems are not adjusted to HC classes in most countries
  – Criteria to map to international codes are needed
Key question:
- What is the organisational structure that is characteristic of the provision of health care within a country?

Continuity with SHA 1.0
- Classes based on characteristics set by country: e.g. what is a hospital, or whether is specialised or general
- Different providers performing the same type of activities can be indentified by cross-classifying HC x HP

Main criterion is principal activity:
- all organizations and actors involved in health care provision
- health and non-health production
- output or wage based (based on value added or its substitutes)
HP: Main features

- Economy
  - HP.9 Rest of the world
  - Domestic Economy HP.1-HP.8.9
    - Primary providers HP.1-HP.6
      - HP.1 Hospitals
      - HP.2 Residential long-term care facilities
      - HP.3 Ambulatory care providers
      - HP.4 Ancillary services providers
      - HP.5 Retailers and other providers of medical goods
      - HP.6 Preventive care providers
    - Secondary providers HP.7-HP.8.2
      - HP.7 Providers of health system administration and financing
      - HP.8 Rest of the economy
        - HP.8.1 Households as home health care providers
        - HP.8.2 All other industries as secondary health care providers
  - HP.8.9 Other industries n.e.c
HP: Improvements on SHA 1.0

• Better alignment with other international classifications and ongoing changes in health care providers industry
  – general and specialist medical practices; residential care activities following NACE rev 2 / ISIC Rev 4:
  – qualified /non-qualified self-employed providers according to ISCO 08
  – A separate class on providers of ancillary services due to its special characteristics and growing importance of this services

• More comprehensive and illustrative explanatory notes
Larger enterprises can be identified by subcomponents as health care provider following the NACE

Indicators of different levels of care can be traced using HP classification (see Chapter 15)

HP has no memorandum items (subclass HP.8.9 offers possibilities to capture other industry involved in provision health related functions)

Ownership not identified
HF/FA/FS: Questions to answer

• How is financing in a country’s health care sector structured and how is it managed;
• How does a particular health financing scheme collect its revenues;
• Where does the money go;
• How are the particular health care services or goods financed? e.g., what share of the spending on inpatient care is covered by out-of-pocket (OOP) payments;
• How are the resources of the different financing schemes allocated among the different groups of beneficiaries, such as by disease?
HF/FA/FS: Main features

**Collection of Revenues (FS) of financing schemes**

- Institutional units of the economy providing revenues

- Basic structural relationships of health financing

- Money flow

**Pooling**

- Financing scheme (HF)
  - Financing agent (FA)
  - Functions (HC)
  - Providers (HP)

**Allocation of funds of financing schemes**
## HF/FA/FS: Classifications

<table>
<thead>
<tr>
<th>SHA 2011</th>
<th>SHA 1.0 / PG</th>
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| **ICHA-HF**  
Classification of Health Financing Schemes | **ICHA-HF**  
Classification of Health Care Financing (SHA 1.0)  
Classification of Financing Agents (PG) |
| **ICHA-FA**  
Classification of Financing Agents | |
| **ICHA-FS**  
Classification of Revenues of Health Financing Schemes | **ICHA-FS**  
Classification of Financing Sources (PG)  
defined as institutional units |
Why HF (schemes) and FA (agents)?

- One financing agent managing more than one financing scheme (e.g. private insurance corporations, may offer voluntary insurance and manage social insurance);
- Different financing agents managing identical financing scheme (e.g. the compulsory social insurance scheme can be managed by both a social insurance agency and private insurance corporations);
- The same actor (e.g. the tax office) can act as a collecting organisation for more than one financing scheme (e.g. central government scheme and social insurance, etc.).
New system enables:

- Distinguishing between government schemes and government as an institutional unit

- Distinguishing between Rest of the World financing schemes, foreign entities as providers of revenues and foreign entities as financing agents

- Public vs Private can be approached from various angles
SHA 2011: Factors of provision:

• Value inputs in provision of health care goods and services
  – Compensation of employees
  – Self-employed professional remuneration
  – Materials and services used
  – Consumption of fixed capital
  – Other items of spending on inputs

• Concepts and scope
  – Boundary of provision factors determined by boundary of health care

• Reporting issues
  – Households as providers
  – Providers of governance and administration of health care financing
SHA 2011: Beneficiary characteristics

• Builds on SHA 1.0/PG and recent methodological work (OECD, EUROSTAT, WHO)

• By disease, age, gender, SES, region

• Scope and linkage to SHA framework
  – OECD Expenditure by disease, age and gender
  – WHO Guide to producing Regional Health Accounts
  – Malaria account, Mother and Child Health account, HIV/AIDS accounts, etc.
  – EQUITAP / ECuity
SHA 2011: Capital formation

- Separate reporting – change from SHA 1.0
- HK Classification by type of asset
- Description of estimation methodologies
- Capital account
- Memorandum items: R&D, Education & Training
SHA 2011: Trade in Health Care

- Higher profile re. SHA 1.0
  - Increased policy interest
  - Poor guidance and reporting
- Concepts and definitions
  - Re. BPM 6, MSITS, etc
  - Valuations, timings
- Examples under SHA
  - Borderline cases – cosmetic surgery, spas, etc
- Inventory of data sources and methodologies
- Supplementary reporting of imports / exports
SHA 2011: Price and volume

- Builds on SHA 1.0
- Methodological discussion in SHA framework
- Illustrative examples of price/volume measurement – by provider industries
- Issues:
  - Market and non-market measures
  - The question of quality
- PPPs – developments to date
• Basic accounting criteria
  – Comprehensiveness of coverage, Consistency and comparability of data, International compatibility, Timeliness and accuracy, Relevance

• Steps in the compilation process

• Some general measurement issues
  – Timing
  – By dimension – HC, HP, HF/FA/FS, FP
  – Prorating

• Specific issues
  – Private expenditure, a/o OOPs
• Reporting for national use & international comparability
• Single dimension tables and cross-classified tables; single year and time series
• 3 distinct roads:
  – Regular dissemination of selected indicators;
  – Regular reporting in national & international databases;
  – Reports summarising the results
SHA 2011: Presentation of results

• Health accounts report focus
  – Uses for analysis and policy
  – Dissemination of the results and recommendations

• Suggested table of indicators:
  – using purely HA results
  – or in combination with additional macro-economic and non-expenditure data

• Proposed set of tables
SHA 2011: Annexes

A. Relationship of the ICHA to other classifications
B. The Relationship between SHA and SNA
C. Health and Health Associate Professionals
D. Financing of Health Systems – Supplementary Tools
E. Classifying Health Care Products
F. Medical Classifications
G. International Standards and Classifications of Trade and Tourism