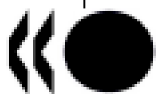

Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

27-Sep-2002

English text only

DIRECTORATE FOR EDUCATION, EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

DEELSA/ELSA/WP1/HS(2002)3
For Official Use

Working Party on Social Policy. Health Policy Statistics.

MEETING OF EXPERTS IN NATIONAL HEALTH ACCOUNTS

THE STATE OF IMPLEMENTATION OF THE OECD MANUAL
A SYSTEM OF HEALTH ACCOUNTS (SHA)

To be held at the Château de la Muette, Paris
on 10-11 October 2002, starting at 9h30 on the first day

Unclassified

JT00132220

Document complet disponible sur OLIS dans son format d'origine
Complete document available on OLIS in its original format

English text only

NOTE BY THE SECRETARIAT

1. This report summarises the information available to the OECD Secretariat on the current state of implementations of the OECD manual, *A System of Health Accounts* (SHA), in member countries. It provides an overview on the availability of results from SHA studies, the most important methodological challenges encountered, and further tasks ahead in harmonising health expenditure estimates.

2. Member countries are currently at different stages of implementing the SHA manual. In several countries, the reporting on health accounts according to the SHA framework is now part of regular national reporting. For a larger number of countries, SHA pilots are still in an experimental stage and results are not yet made publicly available. Even where results of the detailed matrix representations and standard tables of the SHA are not available, some experience with the SHA has been gained from countries where statisticians have re-examined their overall expenditure estimates and its basic functional breakdown, following the proposed *International Classification on Health Accounts* of the SHA manual. For this reason, the paper summarises lessons learned from all countries that have started work with the SHA, irrespective of the current state of implementation.

3. The description in this paper on the current status of SHA implementations is preliminary and provides a snapshot picture as of August 2002. It may be incomplete for some countries and will be updated with the information provided by the Delegates to the meeting.

4. The Delegates to the Meeting of Experts in National Health Accounts are invited to:

- REPORT, where available, on experiences with implementation of the *System of Health Accounts* and recent initiatives for improving national health accounts in member countries.

- INFORM the Experts' meeting on plans and time schedule for implementations of the SHA manual and about the role of improved national health accounts in their countries from a health policy perspective.

- CONTRIBUTE to the discussion on the major methodological challenges of the implementation of the OECD SHA Manual and the harmonisation of estimation practices.

TABLE OF CONTENTS

NOTE BY THE SECRETARIAT 1

SUMMARY 4

1. INTRODUCTION 5

2. OVERVIEW ON THE CURRENT STATE OF SHA IMPLEMENTATION IN OECD COUNTRIES ... 6

3. MAJOR CHALLENGES AND LESSONS LEARNED FROM WORK IMPLEMENTATION OF THE SHA MANUAL 10

3.1 Estimating total expenditure and harmonising overall functional boundaries in health accounts 10
3.2. Implementing the Classification of Health Care Financing (ICHA-HF) 11
3.3. Applying the classification of health care providers (ICHA-HP) 12
3.4. Applying the functional classification (ICHA-HC) 13

4. CURRENT STATE OF INTERNATIONAL CO-OPERATION IN HEALTH ACCOUNTING 16

5. FURTHER TASKS OF THE OECD SECRETARIAT CONCERNING THE IMPLEMENTATION OF THE OECD SHA MANUAL 17

ANNEX 1. MAIN OBJECTIVES AND BASIC STRUCTURE OF THE SYSTEM OF HEALTH ACCOUNTS 18

ANNEX 2 DOCUMENTATION ON SHA IMPLEMENTATION 23

SUMMARY

5. In the interests of better evaluation of the performance of health systems, the monitoring of the effects of health reform measures or the predicting of the likely consequences of planned interventions, many countries are nowadays investing in improved health expenditure reporting instruments. *The System of Health Accounts* provides an integrated system of comprehensive, internally consistent, and internationally comparable accounts to provide a uniform framework to support this challenging task.

6. The first phase of the pilot implementation of the SHA in a majority of the countries concentrated on: the introduction of the new classification system proposed by the SHA manual, the *International Classification for Health Accounts* (ICHA); an overview of the available data sources, and the identification of, and access to, new data sources to calculate health expenditure; the preliminary estimation of basic tables (SHA standard Table 2, 3 and 4); the development of methods to estimate the parts of the matrixes for which data were not readily available. Several pilot implementations estimated accounting matrices with certain departures from the OECD SHA Manual, mainly because of limitations in the availability of the necessary data. Pilot implementations helped to identify the gaps and data deficiencies in the current reporting systems. They also have highlighted that there is a need for further methodological developments, improving the availability and reliability of data, and further international co-operation for harmonising the way boundaries and basic functional breakdown of health expenditure are estimated.

7. Experience from SHA pilot implementations generally suggests that the SHA framework contributed to a substantial improvement in the comprehensiveness and consistency of health expenditure estimates in these countries. The effects of SHA pilots on international comparability, however, are more difficult to assess. Not surprisingly, the implementation of the SHA usually leads to a break in time series for the given country. International comparability in the current transitory period might improve for certain groups of countries in recent years, but remain unchanged for earlier years.

8. This report provides an overview on availability of results from SHA studies, the most important methodological challenges encountered in estimating total expenditure and harmonising overall functional boundaries in health accounts; implementing the classification of health care financing (ICHA-HF), the classification of health care providers (ICHA-HP) and the functional classification (ICHA-HC).

9. Furthermore, the report summarises the most important future tasks. So far, the Secretariat has concentrated its activities on the methodological issues of the SHA and to facilitate the exchange of experiences concerning pilot implementations. In the coming years, besides continuing these activities, greater emphasis will be put on applying results from SHA studies from a health policy perspective.

1. INTRODUCTION

10. Growth in real health expenditure has, on average, been outpacing economic growth in OECD countries by 50% during the last decade (see PAC/COM/NEWS(2002)70 for latest expenditure data from *OECD Health Data 2002*). The combined effect of slower economic growth and dynamic health spending, in particular on innovative technology and prescription drugs, has in 2001 resulted in a growing share of gross domestic product consumed by health care for several of the major OECD economies (for example France and the US). To better understand expenditure trends and for assessing health care reform, there is a continuous interest in analysing health expenditure trends both within individual countries and also in an international context. To support the health policy assessment and development, detailed analyses of health expenditures are essential, based on timely, reliable data that are comparable over time and across countries. To evaluate the performance of health systems, to monitor the effects of health reform measures or to predict the likely consequences of planned interventions, many countries are nowadays investing in improved health expenditure reporting instruments.

11. A better understanding of the interrelated driving forces behind health expenditure growth and a better estimation concerning particular factors, such as ageing, medical technology, increasing expectation of the population, etc., contribute to growth, are of key importance for health policies. For these reasons, more detailed and better standardised health accounts are required to more adequately answer the questions of "who gets what where and how": that is, how are expenditures distributed between different types of care and between different service providers. Reliable methods to estimate overall health expenditure and its distribution are a prerequisite for getting sound answers to these basic questions.

12. To meet these challenges, OECD in co-operation with experts from OECD member countries has developed the manual, *A System of Health Accounts* (SHA) and published its 1.0 version in 2000. Furthermore, OECD encouraged the pilot implementation of the SHA in the member countries.

13. In Part 2, this paper reviews overall progress with SHA implementation and the availability of results. The next part gives a more detailed account on main methodological challenges encountered during SHA implementation. Two final sections report on international co-operation in health accounting and the next steps of SHA implementation in member countries. Annex 1 summarises meeting objectives and the scope of the SHA and reproduces standard tables 2-4 for reference. Annex 2 lists the sources and documents of SHA pilots on which the analysis in Part 3 is built.

2. OVERVIEW ON THE CURRENT STATE OF SHA IMPLEMENTATION IN OECD COUNTRIES

14. OECD member countries are currently at different stages both as to producing national health expenditure statistics and to the implementation of the SHA manual[1]. Some countries already produced comprehensive and detailed health accounts before the publication of the OECD SHA Manual. For example, comprehensive publications are available on health expenditure in Australia, Canada, France, Germany, New Zealand, and the United States. Other countries have, in the past, mainly relied on national accounts to estimate aggregate health expenditure. Several countries are still at an early stage of mobilising resources, translating the SHA manual, forming working teams and checking data availability (e.g., Czech Republic, Ireland, Portugal).

15. Co-operation between countries has recently intensified. For example, the EU recently initiated several projects in order to assist the development of health accounting and the implementation of the SHA in the EU member countries (see chapter 4). A Nordic Network has been formed in order to share experiences in implementing the SHA in NOMESCO countries.

16. For the countries that already produced health accounts, the implementations of the SHA manual serves two functions: (i) adopting the SHA framework improves the comprehensiveness of existing health accounting systems by adding greater detail, most importantly in separating the provider and functional dimensions in the accounts; and (ii) the SHA framework builds a bridge between national reporting systems and international harmonised reporting on health expenditure and financing.

17. Table 1. shows the current status of SHA implementation in OECD member countries:

- A major SHA study has been undertaken or it is currently under way in 17 countries;
- Preparatory work has already started in seven countries;
- Three countries are considering the SHA implementation; and
- At present there are no immediate plans for SHA implementation in another three countries.

18. So far, in most countries, pilot implementations have been concentrating on the SHA standard tables 2., 3., and 4. Table 2. shows the availability of results.

---

[1] The Secretariat had the following information to prepare this report: country reports presented at the Expert Meeting in 2001; a survey conducted by the Secretariat in mid-2001; the "sources and methods" in *OECD Health Data*; and recent reports from a few OECD member countries (see Annex 2 for a complete list of documentation on SHA studies). The Secretariat intends to complete the report with the information the participants provide during the meeting and the conclusions of the discussions. The finalised report will be sent to the NHA experts in the OECD member countries and later put on the OECD web-page.

Table 1. Status of implementation of the OECD SHA manual

	Major SHA study already undertaken or currently under way	Preparatory work for SHA project underway	Considering the implementation; resources not yet allocated	No immediate plans for SHA implementation as of summer 2002
Australia	X			
Austria				X
Belgium	X			
Canada	X			
Czech Republic		X		
Denmark	X			
Finland	X			
France		X		
Germany	X			
Greece			X	
Hungary	X			
Iceland			X	
Ireland		X		
Italy				X
Japan	X			
Korea	X			
Luxembourg		X		
Mexico	X			
Netherlands	X			
New Zealand				X
Norway		X		
Poland	X			
Portugal			X	
Slovak Republic	X			
Spain	X			
Sweden		X		
Switzerland	X			
Turkey	X			
United Kingdom	X			
United States	X			

Source: See footnote 1.

Table 2. Availability of pilot SHA tables as of summer 2002

	Table 2. HC. – HP.	Table 3. HF. – HP.	Table 4. HF.-HC.
Australia		1998-1999	1998-1999
Austria			
Belgium	1998	1998	1998
Canada	1996	1996	1996
Czech Republic			
Denmark	1999	1999	1999
Finland			
France			
Germany		1992-2000	1992-2000
Greece			
Hungary	1998-2000	1998-2000	1998-2000
Iceland			
Ireland			
Italy			
Japan	1999	1999	1999
Korea			1998-2000
Luxembourg			
Mexico			
Netherlands	1998-2000	1998-2000	1998-2000
New Zealand			
Norway			
Poland		1999	1999
Portugal			
Slovak Republic		1999	1999
Spain	1997-1999		
Sweden			
Switzerland	1999	1999	1999
Turkey			
United Kingdom			
United States	1997	1997	1997

Source: See footnote 1.

19. The SHA provides an integrated system of comprehensive, internally consistent, and internationally comparable accounts. To achieve these goals, in particular that of international comparability, an iterative procedure of national estimations and international cross-checking may, in some cases, be necessary. The following provides a general assessment of the experiences gained so far with SHA implementations and the different steps taken by administrations in member countries.

20. The first phase of the pilot implementation in majority of the countries concentrated on:

- The introduction of the new classification system proposed by the SHA manual, the *International Classification for Health Accounts* (ICHA);
- An overview of the available data sources, and the identification of and access to new data sources to calculate health expenditure;
- The preliminary estimation of basic tables (SHA standard Table 2, 3 and 4);
- The development of methods to estimate the elements of the matrixes for which data were not available.

21. Experience from SHA implementations undertaken so far suggests that the OECD SHA Manual provides an appropriate general framework to develop national systems for health accounting by providing a theoretical description and a basic structure for national classifications. However, there is also some evidence that it currently does not provide enough guidance to help solve all the practical problems of implementations. Consequently, there are now various initiatives under way on EU and international level to develop guidelines for practical implementation.

22. It has also been found that several pilot implementations estimated accounting matrices with certain departures from the OECD SHA Manual, because of the limitations in the availability of the necessary data. Pilot implementations helped to identify the gaps and deficiencies in the current reporting systems.

23. To develop, sustain and improve a SHA-based health accounting system needs considerable human resources and the establishment or increase of a network of information gathering across a wide range of primary data producers, involving governments and statistical agencies at different regional levels. The task of establishing such a network may usually require that even in an early phase of pilot implementation, there is a need for advocating and “marketing” the new accounting system and to show that it can provide new and relevant information for decision-makers, research community and the general public. This can be a resource intensive task.

3. MAJOR CHALLENGES AND LESSONS LEARNED FROM WORK IMPLEMENTATION OF THE SHA MANUAL

3.1 Estimating total expenditure and harmonising overall functional boundaries in health accounts

24. To develop comprehensive and internationally comparable data on total expenditure according to the SHA manual, the following requirements need to be fulfilled:

- The functional classification of health care (ICHA-HC) is applied in an internationally harmonised way;
- Expenditure by all the financing agents defined by the SHA need be accounted for;
- All primary and secondary providers of health care should be included regardless of whether or not they are classified as health care institutions in national industry statistics;
- Foreign trade of health services needs to be estimated;
- Similar methods for valuation of health services must be applied following the SHA framework.

25. Current pilot implementations have smaller or greater departures from these requirements. Some items of departures from the OECD SHA Manual are of minor importance, while the effects of others on total expenditure are not negligible.

26. The most important issues and challenges in estimating total expenditure during pilot implementations are the following:

1. Where National Account based data systems were used as a starting point, the estimations frequently do not include expenditures such as secondary activities of non-health organisations. Examples are occupational health care, school health services, and part of long-term nursing care. Countries seem to follow different practice to produce estimations for these activities.

2. National Accounts based estimates usually include expenditure on R&D in health under estimated "total expenditure on health". The functional classification of the SHA manual does not include health R&D under "total expenditure on health" but records health R&D as a separate health-related function

3. Private expenditure in some countries does not include certain types of NGOs, excludes part of private insurance, and expenditure by corporations because of the lack of surveys for their estimation.

4. With very few exceptions, international trade in health services has not yet been integrated into health expenditure statistics. Health services provided to foreigners are (partly or entirely) included and out-of-country care is (partly or entirely) not included in total expenditure. An exception is Switzerland.

5. There are still important variations in the definition of the boundary between health and social care across OECD countries, in particular, for long-term care provided in nursing homes. (See 3.4 below.)

6. There are variations in the definition of the boundary between health and health related functions across OECD countries (e.g. as to separation of prevention and health related activities of the public health authorities).

7. *There are different practices in valuation of health services*
The value of the services produced by public providers can be estimated based on the outlays of providers. Outlays by public providers might be: (i) outlays on activities producing *health services*; (ii) outlays on *health related functions* (education, research, etc.); and (iii) *outlays on secondary activities* that are not related to produce health services (kindergarten, renting parking plots, shops etc.) SHA pilot projects followed different practices in separating these activities.

3.2. Implementing the Classification of Health Care Financing (ICHA-HF)

27. There are generally two basic perspectives on classification of health care financing:

– The classification according to financing agents. Financing agents are the organisations or individuals that directly pay for the health care, that is third-party-payment arrangements and direct payments by households

– The classification according to primary sources of funding, such as social insurance premiums and general taxation, that are bearing the ultimate burden of financing

28. Following the suggestion of the SHA manual, pilot implementations commonly use the first perspective. The OECD Manual in addition provides a model for a set of sectoral flow-of-funding accounts. So far, however, they were produced only in Spain. A dimension for reporting the primary sources of funding exists in several national health accounts (e.g. France, USA).

29. So far, SHA implementation projects seem to manage to apply the ICHA-HF classification for public financing agents to their domestic systems of health care financing. In the case of the private sector, however, the availability of data sources for estimating expenditure by private insurance, non-profit institutions and corporations are in many countries far from complete. Furthermore, there is a well-known tendency of data from household surveys to underestimate private health spending. Household surveys can provide only a less detailed functional distribution than it is needed by the SHA.

30. The three-digit classification of the ICHA-HF requires a distinction between out-of-pocket payments excluding cost-sharing (HF.2.3. 1.) and different types of cost-sharing (HF.2.3.2. - HF.2.3.9). Distinguishing between these two categories of household expenditure would be of great importance from a health policy point of views. At this moment there are no pilot projects that provide this information and only limited information seems to be available in most cases from surveys or other sources that would allow estimating the overall cost-sharing burden of private households by type of financing agents and/or type of services and goods (ICHA-HC classification).

31. And finally, as already mentioned, several pilot implementations do not have information on health expenditure directly financed by corporations, such as on occupational health care (e.g. Denmark, Switzerland).

3.3. Applying the classification of health care providers (ICHA-HP)

32. Because of the country specific division of labour in health systems across health care providers, data by provider categories are, by their very nature, less comparable across OECD countries. It is in combination and cross-classification with the functional classification in the standard tables of the SHA manual, that this dimension contributes to a better description of the structure of a health care system. From a health policy perspective, health care providers (e.g. hospitals) are key actors of a health care system. The SHA tables provide information about the changes in their relative share of the resources of the health system. The standard tables show the evolution of the changing division of labour in health care systems over time. These changes are currently not easily disentangled by pre-SHA health accounts, making it difficult to separate the factors that are drivers of these changes and to distinguish between medical and technological trends on the one hand and structural changes that are due to changes in health care regulation, such as payment systems, on the other hand.

33. Pilot tables suggest[2] some use of the classification, at least at the one-digit level (for hospitals (HP.1); nursing and residential care facilities (HP.2); and public health programs (HP.5.), and partly a two-digit classification (for ambulatory health care (HP.3.); medical goods (HP.4); administration (HP.6) and other industries (HP.7.).

34. The most important challenges are posed by those complex institutions that perform health and non-health activities at the same time, such as residential-care facilities for the elderly and handicapped; public health authorities; medical universities; furthermore, economic and educational organisations providing health services for their employees or members. The pilot projects had to identify the relevant organisations and estimate the expenditure on their health care activities[3].

Nursing and residential care facilities

35. A wide range of institutions providing long-term care (both health and social services) exists in most countries. In national statistics long-term nursing care provided in residential homes for the elderly and residential homes for the handicapped are classified as social institutions and social expenditures. Pilot implementations should clarify which institutions they should consider under (HP.2.) and find the methodology to separate health and social expenditure in the given institutions. Countries followed different practices (see chapter 3.4).

Provision and administration of public health programs

36. National public health agencies are complex institutions providing prevention, research and environmental health activities. These organisations can be considered as combining two or more types of providers: one classified as “Provision and administration of public health programs” under HP.5 and one or more organisations performing only health related functions (e.g., HCR.4. *Food, hygiene and drinking water control* and HCR.5. *Environmental health*).

---

2 The OECD SHA Manual provides a three-digit classification.

3 Majority of the issues discussed in this chapter affect the overall boundaries of health accounts and the estimation of total health expenditure too.

Medical universities

37. Medical universities provide personal health services and education and research. The separation of these activities is especially difficult when a medical university is a part of a general university and information on medical education and research are only available from the individual organisations.

Rest of the economy

38. Rest of the economy comprises private households as providers of home care and secondary providers of health care, for example occupational health care, military health services that are not provided in separate health care establishment. Estimation of the activities of these providers is not fully solved in several pilot projects.

3.4. Applying the functional classification (ICHA-HC)

39. For international comparability of data, the functional classification is the most crucial element of the SHA. It is also of vital importance for national health policy-making. It is the breakdown of expenditure by function that describes "who gets what and how". SHA pilots have shown that important aspects of the functional classification in the SHA Manual are still subject to debate and may lead to different interpretations. It is this part more than any other part of the SHA manual which apparently needs to be backed by further detailed guidance and further harmonisation of national estimation strategies. Some pilot implementations (e.g., Denmark, Germany, Netherlands) use a different functional classification for national purpose and have put in place an elaborate system of the SHA for reporting data to the OECD.

40. The OECD SHA Manual applies two approaches in functional classification: (i) "functions" in terms of the purpose of health care (curative care, rehabilitation and long-term care, etc.); and (ii) the mode of production. Pilot tables suggest a basically two-digit classification.[4]

41. In the health care systems data usually are generated in correspondence with the administrative structure of the health care provision and health care financing. Usually provider organisations constitute the basic elements of health expenditure databases. Therefore, a basic task in applying functional classification is to separate functions within provider organisations, in particular within hospitals.

42. The most important challenges in applying the ICHA functional classification are as follows:

1. In a few countries inpatient expenditure is still identical with hospital expenditures in current reporting practice and consequently includes some outpatient care provided in hospitals (e.g. Spain). In the United States, the category of "hospital care" is used instead of inpatient care and it is defined to cover revenues received for all services provided by hospitals to patients[5].

---

[4] The OECD SHA Manual provides a three-digit classification. For how the ICHA-HC classification is applied in standard tables, see Annex 1.

[5] Thus, expenditures include for example, hospital-based nursing home care, hospital-based home health care and fees for any other services billed by the hospital. It, however, does not include doctors' fees for services provided in hospitals, except the payment for the physicians working under salary for a hospital. Consequently expenditures reported in the category of nursing home care contains only services provided by free-standing nursing homes. The same applies for home health care.

2. Ancillary services might be provided by separate health care organisations (laboratories, diagnostic centres) and might be activities performed in complex health care organisations. In the latter case, separation of ancillary services from outpatient or inpatient care is not yet solved in several pilots. Countries follow different practices:

    1. Ancillary services includes only expenditure on services provided by free-standing clinical laboratory and diagnostic imaging (e.g. Germany);

    2. Ancillary services includes expenditure on services provided in out-patient care both by free-standing clinics and out-patient centres (e.g. Hungary);

    3. Ancillary services are treated differently for national statistics and OECD statistics. In national statistics it includes all laboratory and diagnostic imaging services regardless of whether they are provided in inpatient or outpatient care (e.g. Netherlands).

3. Separation of day-care from inpatient care is not yet solved in several of the pilots (e.g., in Germany). The data usually are available in those countries where day-care has a separate financing (e.g., in DRGs), and data are available from the financing agents (e.g. Denmark, Hungary).

4. Separation of long-term nursing care within inpatient health care and also the separation of long-term nursing care from social care is not yet solved in several cases. Long-term care is typically a mix of medical and social services provided in hospital, nursing homes (classified usually as health care providers) and other forms of residential-care facilities for the aged and handicapped (classified usually as social-care institutions). In theory, expenditure on services provided because of ‘health-related needs’ should be separated within all the residential care facilities and reported under *services of long-term nursing care*. Information concerning the costs of medical services provided in social institutions is limited in many countries[6]. A special problem is how to treat the costs of ‘health-related’ accommodation in institutions providing mainly social services. Furthermore, in several countries there is tendency for blurring the distinction between health and social-care facilities (e.g., Australia[7]).

43. As a consequence, inpatient care in some countries might include expenditure that in other countries are reported as out-patient care, day-care, home care and ancillary services. Currently, this limits the comparability of the functional structure of health expenditure across countries.

44. Laboratory services and diagnostic imaging are provided as part of an inpatient episode and also as outpatient services. Usually when they are part of inpatient care they are not financed separately. The OECD SHA Manual considers them in a similar way as medical goods, that is they are considered as intermediate elements of providing inpatient care. However, in this way ancillary services and medical goods consist of only these services provided to outpatients, and they *do not show the total expenditure on ancillary services and medical goods regardless of the mode of production*. The changes in mode of

6 In Denmark, for example a “time study” was conducted in several municipalities. The municipalities divided the total time consumption in the nursing-care sector on the functions that take place there and estimated the health expenditure based on its time-share.

7 In Australia from 1997-98, there is no distinction made between nursing-home facilities and other residential care for the aged. The rates of subsidy paid by the government are based on the dependency level of the residents. In the Australian NHAs the highest four levels of dependency were assumed to have a health purpose.

production might lead to an increase in pharmaceutical expenditure while the total expenditure on pharmaceutical would not change[8].

45. On the other hand, there are arguments supporting the current classification. Ancillary services and pharmaceuticals are integral elements of the inpatient services using modern technology. If the expenditure on inpatient care did not include these elements, the expenditure could not show the structure of services and the cost of episodes of care.

8 The introduction of a new dimension of the ICHA that is the cost items of service production might be a way to treat this shortcoming of the SHA functional classification.

4. CURRENT STATE OF INTERNATIONAL CO-OPERATION IN HEALTH ACCOUNTING

Co-operation with the European Union

46. Since the beginning of the drafting of the SHA manual, the OECD and the EUROSTAT have had a fruitful co-operation in developing and implementing the SHA Manual. In 2001 two EU sponsored projects have been launched in order to assist the implementation of the OECD SHA Manual in the EU member countries. The project of a "Support package for applying the manual of health accounts in the EU" project is being implemented by the Office of National Statistics (UK), and the "Statistical analysis and reporting of data on Health Accounts" project by the BASYS (Germany). Two other ongoing EU projects also have relevance for health accounting: the "Health expenditure by age and gender" and the "Hospital Data" projects. The OECD Secretariat has been involved in the planning and also in the implementation of these projects by giving advice and participating in the relevant meetings.

Co-operation with other international organisations

47. The OECD Secretariat together with experts on health accounts from the WHO, the World Bank, USAID and other international organisations are participating in a steering committee to supervise the development of a "*National Health Accounts Producer's Guide*", which is specifically targeted for use in middle- and low-income countries. This guide is intended to provide practical guidance in the design, construction, and use of health accounts.

48. The Asian Pacific Regional Network on Health Accounting has chosen to use the SHA as methodological starting point for their work. A number of countries, including Sri Lanka and Hong Kong Region (China), have carried out SHA pilot implementations. The Pan American Health Organisation (PAHO) has published a Spanish translation of the SHA manual

5. FURTHER TASKS OF THE OECD SECRETARIAT CONCERNING THE IMPLEMENTATION OF THE OECD SHA MANUAL

49. The OECD Secretariat has concentrated its activities on the methodological issues of the SHA and on facilitating the exchange of experiences concerning pilot implementations. In the coming years, besides continuing these activities, the Secretariat intends to put greater emphasis on analysis from a health policy perspective.

50. The main concepts of the *International Classification of Health Accounts* have, in the meantime, been introduced into the *OECD Health Data 2001* as a reference for variable definitions in Parts 4 (expenditure on health) and Part 5 (financing) of the database. A major task is to further harmonise the OECD Data with the SHA Manual and with data available from the pilot implementations. Currently several countries implementing the SHA still report to the *OECD Health Data* according to their pre-SHA information system.

51. Further methodological development is needed in several areas; for example, price and volume measurement; development of a set of basic indicators to be produced by NHAs; connecting in-kind health and health care data to expenditure data in NHAs, etc.

52. The Secretariat plans to further advance the OECD "Health Accounts" web page to strengthen its role as an tool of disseminating information about the new developments in health accounting in member countries.

ANNEX 1.
MAIN OBJECTIVES AND BASIC STRUCTURE OF THE SYSTEM OF HEALTH ACCOUNTS

Main objectives of the SHA are to:

- develop an integrated system of comprehensive, internally consistent, and internationally comparable accounts, which should be compatible with other aggregate economic and social statistics as far as possible.

- help health policy-making by providing a framework for analysing health care systems and for monitoring the consequences of health care reforms from an economic point of view. Within this, to describe the position of health care within the national economy, the main tendencies of health care expenditures, as well as to provide multifaceted investigation of the resource allocation (allocation among functions, service provider types, regional and social groups in the population).

- provide information for comparative research in expenditure on health care services, as well as better information for the general public in OECD member countries.

Major tasks of development of the SHA are to:

(OECD SHA Manual, p.13.)

- define internationally harmonised boundaries of health care and basic categories thereof;

- distinguish core health care functions from health-related functions and to emphasise inter-sectoral aspects of health as a common concern of social and economic policy in various fields;

- present tables for the analysis of flows of financing in health care together with a classification of insurance programmes and other funding arrangements;

- propose a framework for reporting and analysing the structure of the health expenditures by major functions, providers and utilisation by different population groups;

- propose a framework for consistent reporting on health care services over time;

- provide a set of internationally comparable health accounts in the form of standard tables;

- provide a framework for linking health expenditure and other in-kind data of health services, as well as health statistics and other social statistics;

- to present an economic model of supply and use of health care services – as a tool to show the conceptual links between the SHA and health satellite accounts.

Basic structure of the SHA

53. With the SHA manual, the OECD Secretariat has developed the *International Classification for Health Accounts* (ICHA) and cross-referenced this scheme with the standard classifications and definitions used in the SNA[9]. To the extent appropriate, the accounting rules of the SHA have been harmonised with the SNA.

54. The SHA organises health care expenditures according to three main categories:

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

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

56. After having a well-established system of the above three dimensions of the ICHA, the OECD Manual proposes to incorporate further dimensions of health expenditure into NHAs: regions, age and gender groups, diseases categories, etc.

[9] Existing national and international classifications served as a starting point for the proposed ICHA classifications. The ICHA classification of health care industries, for example, presents a refinement of the *International Standard Industrial Classification* (ISIC, Rev. 3, United Nations, 1990). Recently designed or revised classifications such as the *Central Product Classification*, Version 1 (United Nations, 1998*a*) and the 1998 revision of the SNA 93 functional classifications are frequently referred to in the SHA manual in order to assist statisticians in establishing links between with the ICHA and existing reporting systems.

SHA Table 2. Current expenditure on health by function of care and provider industry

		Health care provider industry																				Other industries	RoW
		HP.1	**HP.2**	**HP.3**	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	**HP.4**	HP.4.1	HP.4.2-4.9	**HP.5**	**HP.6**	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	**HP.7**	**HP.9**
Health care by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory health care	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home health care services	All other providers of ambulatory health care	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
In-patient care																							
Curative and rehabilitative care	HC.1.1; 2.1																						
Long-term nursing care	HC.3.1																						
Services of day-care																							
Curative and rehabilitative care	HC.1.2; 2.2																						
Long-term nursing care	HC.3.2																						
Out-patient care																							
Out-patient curative and rehabilitative care	HC.1.3; 2.3																						
Basic medical and diagnostic services	HC.1.3.1																						
Out-patient dental care	HC.1.3.2																						
All other specialised health care	HC.1.3.3																						
All other out-patient care	HC.1.3.3																						
Home care																							
Curative and rehabilitative care	HC.1.4; 2.4																						
Long-term nursing care	HC.3.3																						
Ancillary services to health care	HC.4																						
Medical goods dispensed to out-patients	HC.5																						
Pharmaceut. and other medical non-durables	HC.5.1																						
Therap. appliances and other med. durables	HC.5.2																						
Total expenditure on personal health care																							
Prevention and public health services	HC.6																						
Health administration and health insurance	HC.7																						
Total current expenditure on health care																							

SHA Table 3. Current expenditure on health by provider industry and source of funding

		Total current expenditure on health	**HF.1** General government	HF.1.1 General government (excl. social security)	HF.1.2 Social security funds	**HF.2** Private sector	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3** Rest of the world
Health care goods and services by provider industry													
Hospitals	HP.1												
Nursing and residential care facilities	HP.2												
Providers of ambulatory health care	HP.3												
Offices of physicians	HP.3.1												
Offices of dentists	HP.3.2												
Offices of other health practitioners	HP.3.3												
Out-patient care centres	HP.3.4												
Medical and diagnostic laboratories	HP.3.5												
Providers of home health care services	HP.3.6												
Other providers of ambulatory health care	HP.3.9												
Retail sale and other providers of medical goods	HP.4												
Dispensing chemists	HP.4.1												
All other sales of medical goods	HP.4.2-4.9												
Provision and administration of public health programmes	HP.5												
General health administration and insurance	HP.6												
Government (excluding social insurance)	HP.6.1												
Social security funds	HP.6.2												
Other social insurance	HP.6.3												
Other (private) insurance	HP.6.4												
All other providers of health administration	HP.6.9												
Other industries (rest of the economy)	HP.7												
Occupational health care	HP.7.1												
Private households	HP.7.2												
All other secondary producers	HP.7.9												
Rest of the world	HP.9												

SHA Table 4. Current expenditure on health by function of care and source of funding

		Total expenditure	**HF.1**	HF.1.1	HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
								HF.2.1	HF.2.2				
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance schemes	Other private insurance	Private household out-of-pocket payments	Non-profit institutions (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Current expenditure on health care													
Personal health care services	HC.1-HC.3												
In-patient services													
Day care services													
Out-patient services													
Home care services													
Ancillary services to health care	HC.4												
Medical goods dispensed to out-patients	HC.5												
Pharmaceuticals and other medical non-durables	HC.5.1												
Therapeutic appliances and other medical durables	HC.5.2												
Personal health care services and goods	HC.1 - HC.5												
Prevention and public health services	HC.6												
Health administration and health insurance	HC.7												

ANNEX 2
DOCUMENTATION ON SHA IMPLEMENTATION

Country	Main source(s)
Australia	- Health Expenditure Bulletin (No. 17), AIHW, September 2001 - "First Experience with SHA Pilot Implementation in Australia", Room document 3, Meeting of the Experts in National Health Accounts, March 2001
Austria	-
Belgium	- Tables sent to the OECD Secretariat - "De non-profitsector in Belgïe", Katholieke Universiteit Leuven, 2001
Canada	- "National Health Expenditure Trends, 1975-2001", CIHI, 2001 - "Canada's Experience", Room document 5, Meeting of the Experts in National Health Accounts, March 2001
Czech Republic	-
Denmark	- "The Danish Health Account 1997-1999 – A pilot project based on A System of Health Accounts", Ministry of Health, May 2002 - "Danish SHA Pilot Implementation – with Special Focus on Boundary Problems", Room document 10, Meeting of the Experts in National Health Accounts, March 2001
Finland	- Presentation, Nordic SHA Network Seminar, November 2001
France	- "Document de travail – Comptes nationaux de la Santé 2001", DREES, September 2002
Germany	- Tables sent to OECD Secretariat, 2002 - "Gesundheitswesen – Neue Gesundheitsausgabenrechnung", Statistisches Bundesamt, 2001 - "Germany: Classification of Health Care Financing, Functions of Health Care, and Providers of Health Care", Room document 6, Meeting of the Experts in National Health Accounts, March 2001
Greece	-
Hungary	- "National Health Accounts in Hungary – Feasibility Study", Room document 8, Meeting of the Experts in National Health Accounts, March 2001
Iceland	-
Ireland	-
Italy	-
Japan	- "Japan", Room document 11, Meeting of the Experts in National Health Accounts, March 2001
Korea	- "Estimation of Health Expenditures in Korea", Room document 13, Meeting of the Experts in National Health Accounts, March 2001 - Tables sent to the OECD Secretariat, 2001
Luxembourg	-
Mexico	- "Report of Status of the Implementation of the System of National and State Health Accounts, Mexico", Ministry of Health, 2002
Netherlands	- "Working paper, Health and Social Care Accounts 1998-2000", C.J.P.M. van Mosseveld and J.M. Smit, Statistics Netherlands, February 2002 - "Pilot Implementation of the System of Health Accounts in the Netherlands", Room document 4, Meeting of the Experts in National Health Accounts, March 2001
New Zealand	-
Norway	-

Poland	-	"A System of Health Accounts in Poland", Markus Schneider, Dorota Kawiorska, et.al., November 2001
Portugal	-	
Slovak Republic	-	"Brief Report on Implementation Experience of the Implementation of the National Health Accounts / NHA of the Slovak Republic According to the OECD SHA Manual", 2002
Spain	-	"The Implementation of SHA in Spain", Room document 14, Meeting of the Experts in National Health Accounts, March 2001
Sweden	-	
Switzerland	- - -	1999 SHA Tables "Coûts du système de santé", Office Federal de la Statistique, 2002 "Switzerland", Room document 9, Meeting of the Experts in National Health Accounts, March 2001
Turkey	-	
United Kingdom	-	ONS web site [http://www.statistics.gov.uk/healthaccounts]
USA	- -	"National Health Accounts: Definitions, Sources, and Methods – U.S. National Health Accounts", Room document 2, Meeting of the Experts in National Health Accounts, March 2001 CMS web site [http://cms.hhs.gov/statistics/nhe/]