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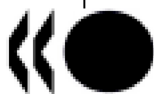

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DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

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Working Party on Social Policy. Health Policy Statistics.

SUMMARY RECORD OF THE MEETING OF EXPERTS IN NATIONAL HEALTH ACCOUNTS

Held on 10-11 October 2002

English - Or. English

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INTRODUCTION

1. The objectives of the meeting were to assess the current state of implementation of the OECD manual *A System of Health Accounts* (SHA), to discuss the major methodological challenges for implementation and to discuss the main goals for the OECD Secretariat's future work with member countries on SHA implementation.

ITEM 1: OPENING

Mr. Dan WALDO (US) was elected as chairperson.

ITEM 2: ADOPTION OF THE AGENDA [DEELSA/ELSA/WP1/HS/A(2002)2]

The draft agenda was adopted.

ITEM 3: APPROVAL OF THE SUMMARY RECORD [DEELSA/ELSA/WP1/HS/M(2001)3]

The summary record was approved.

ITEM 4: THE STATE OF IMPLEMENTATION OF THE OECD MANUAL, *A SYSTEM OF HEALTH ACCOUNTS* (SHA) [DEELSA/ELSA/WP1/HS(2002)3]

2. The Secretariat presented an overview on the current state of the implementation of the OECD SHA Manual and on the main methodological challenges encountered by member countries while implementing the SHA. A major SHA study has been undertaken or it is currently under way in 18 countries. Preparatory work has already started in six countries and three countries are considering implementation. The report summarised the major challenges for implementing the classification of financing and applying cross-classification of providers and health care function. Besides continuing methodological work for support of SHA implementation, the Secretariat intends to put in the future greater emphasis on testing the analytical power of the new expenditure data from a health policy perspective.

3. In the ensuing discussion it was emphasised that experts working in health accounting should better inform policy-makers and the general public about the results of their work to generate support for health accounting in the long run. The idea of bringing together country case studies from SHA pilot implementations in a joint publication and to test the analytical power for health policy research of the new data was welcomed by delegates. Another key issue of the discussion was the relationship between health accounts and the core system of economic statistics. Health expenditure estimates in national accounts, in SHA-based health accounts and in the EU social statistics (ESSPROS) differ by definition and there is a need for clarification of these differences and how to reconcile the different reporting systems. The participant from the Netherlands provided a country example where work on national accounts, social and health care accounts has recently been integrated.

ITEM 5: DEVELOPMENT OF GUIDELINES FOR SHA IMPLEMENTATION AND REVIEWS OF CURRENT ACCOUNTING PRACTICE

4. The following progress reports were presented on international activities connected to health accounting:

- Introduction to, and overview of, current EU-sponsored SHA-related projects (by Mr. Gunter Brückner, Eurostat);
- EU-sponsored United Kingdom ONS project on SHA implementation guidelines (by Mr. Phillip Lee, United Kingdom);
- Status of WHO/World Bank/USAID *Producers' Guidelines to National Health Accounts* (by Mr. Jean-Pierre Poullier, WHO);
- Status of EU sponsored project on comparative analysis of current accounting practice on health expenditure and financing (by Mr. Markus Schneider, BASYS);
- Activities of the Nordic Network on SHA implementation (by Ms Nina Haapanen, Nordic SHA Network);
- Experiences of the Asian Pacific Health Accounting Network (by Mr. Ravindra Rannan–Eliya).

5. A key issue of the discussion was the relationship between the World Bank/WHO's Producers' Guide (PG) and the OECD SHA manual. According to Mr Poullier, the PG is an attempt to create at world level a system of reporting on health accounts, similar to the development of National Accounts many decades ago. Mr Huber explained that, according to the Secretariat's understanding, the original idea had been to develop a producer guide for middle and low-income countries to set up health accounts. The project of a world manual would need substantial resources and the broad involvement of experts from OECD member countries, which was not in the scope of the guidelines' project. In addition, the timing of such a project should take into account the need to leave administrations in member countries sufficient time to gain experience with the current SHA manual.

6. Several participants emphasised that substantial revisions of the SHA manual at this moment could be counter-productive for the implementation process in OECD countries. Mr Brückner (Eurostat) reminded the audience that there was an agreement among OECD member countries that the OECD SHA Manual would not be revised until around 2005. The representative of the *Asian Pacific Health Accounting Network* supported this view from the experience with, and current use of, the OECD SHA framework in his region. Mr Poullier clarified that it was not the intention of the guidelines' project to introduce a new standard.

ITEM 6: SEPARATION OF EXPENDITURE BY FUNCTION WITHIN HOSPITALS

7. Delegates presented two country cases from Australia and Hungary that had a focus on the national experience with separation of expenditure by function within hospitals.

Country case: Australia

8. The Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and the Private Health Insurance Administration Council (PHIAC) collect and analyse national statistics on hospital services. The development and implementation of methods in order to allocate costs and revenues to the different categories of the functional dimension of the *International Classification for Health Accounts* (ICHA-HC) are under way. So far only two years of data have been allocated in this way and these have not yet been published.

9. The inpatient share of total expenditure for each hospital is applied to each of the expense items for that hospital to allocate them to 'admitted' and 'non-admitted' service categories. The National Hospital Cost Data Collection provides information on Diagnosis-related group (DRG) costs for those hospitals that participate in the collection. These can be allocated to categories that broadly relate to the OECD functions of 'curative care' and 'rehabilitative care'.

10. The Australian delegate also summarised the main challenges in applying the ICHA-HC classification. For example, in the case of patients who choose to be treated by their doctor of choice, the costs of the medical services they receive are excluded from the costs of the hospitals (and reported as expenditure under "Offices of physicians"). The data used to split the admitted patient expenditure into the ICHA-HC functional classifications come, essentially, from large hospitals. These do not necessarily reflect the mix of patients in other hospitals, particularly in smaller hospitals in rural areas.

Country case: Hungary

11. A volume will be published that contains the first results of the work on National Health Accounts for 1998 to 2000. Estimations were made separately for public and private providers. Annual reports of the budgetary institutions and financing data of the *National Health Insurance Fund* (NHIF) provided data for public providers.

12. In a first step health, health-related and non-health functions of public hospitals were separated. Separation of day care (*e.g.* kidney dialysis), clinical laboratory, diagnostic imaging services and home care was possible using the financing data of the NHIF. As a second step, expenditure by NHIF to *private providers* were added. Then private expenditure was divided in two groups: private expenditure to public providers and private expenditure to private providers. The estimates for private expenditure are derived from a variety of different sources.

13. A conclusion of the discussion was that countries have currently different practices to separate ancillary services within inpatient and outpatient care. The OECD Secretariat was asked to provide more detailed guidance concerning this issue.

ITEM 7: HARMONISATION OF NATIONAL AND OECD SHA FUNCTIONAL CLASSIFICATION

14. Country cases from the Netherlands and Germany were presented with a focus on harmonisation of national classifications with the OECD SHA functional classification.

Country case: Netherlands

15. The Netherlands does not distinguish between mode of production (inpatient, day care and outpatient care) in the national functional classification. The "curative care", "rehabilitative care" and "nursing care" do not include medical goods and the ancillary services, regardless of whether these are provided as inpatient or outpatient care, while they are included in the SHA categories. Furthermore the nursing care activities linked to inpatient curative care are classified as "nursing care" in the national system, while considered as curative care in the SHA. A methodology was developed to reconcile the national to the OECD functional classification.

Country case: Germany

16. In Germany, the major challenge for applying ICHA-HC is that the distinction between inpatient care and outpatient care does not exist in the national functional classification. The German NHA has to be converted into SHA classification, using estimations based on the German functional and provider classification. At this moment, however, outpatient care provided within hospitals cannot be separated.

17. In the ensuing discussion it was emphasised that for international comparability of data, the functional classification is the most crucial element of the SHA. The participants' remarks pointed to design principles in the ICHA-HC that are not followed in a uniform way in national reporting systems. This refers mainly to the current compromise in the ICHA-HC between the concept of mode of production and other functions such as consumption of medical goods by outpatients. In addition, participants asked for further detailed guidance on boundary cases. As a project for the future, there is a need for further methodological work in detailing the activity classification implicitly underlying the ICHA-HC.

ITEM 8: ESTIMATING EXPENDITURE ON LONG-TERM CARE (LTC)

18. Participants presented four country cases: Sweden, Switzerland, United Kingdom and Japan. The Secretariat provided an overview on the *Core Study on Long-term Care* of the *OECD Health Project*.

Country case: Sweden

19. Main findings were presented of a study aimed at quantifying the amount of health care delivered in social services under the responsibility of local municipalities. This detailed time-use study is an important input for further work on SHA implementation because it provides basic statistics for drawing the boundary line between health and other social expenditure. As the second component of the study, the proportion of non-professionals with delegated health care tasks was estimated using a stratified random sample of 100 municipalities (around one third). Based on this study, the share of health expenditure delivered as part of "social services" according to current national classifications was estimated as 0.7% of GDP.

Country case: Switzerland

20. Three years ago, the Swiss NHA adopted a new method to estimate LTC. The sources of data are health care providers. Long-term care expenditure includes all three settings specified in the SHA manual: inpatient long-term care, day-care nursing and home-care nursing. The institutions are as follows: institutions for the elderly suffering from chronic diseases, centres for the handicapped and home care. Homes for the elderly are classified into two groups, according to the time devoted on average to daily

medical care per person. Institutions that provide less then one hour of medical care per person per day are excluded from health expenditure. Using this method, the estimates for expenditure on homes for the elderly in 1998 were 15% higher compared to previous estimates.

Country case: United Kingdom

21. Previously only nursing care managed and financed by the National Health Service (NHS) was included in reported health spending. New estimates of total nursing care are currently undertaken in order to estimate nursing care expenditure (as part of health spending) outside the NHS. These estimates illustrate the impact of different interpretations of the SHA definition of long-term (health) care. According to these preliminary estimates, long-term care provided by the NHS amounted to 0.5% of GDP, and non-NHS long-term care to between 0.6% and 1.3% of GDP, for alternative interpretation of the health care boundary. The Secretariat is requested to provide guidance on where exactly to put the boundary line.

Country case: Japan

22. LTC is high on the health policy agenda in Japan. In 1999 total expenditure on long-term nursing inpatient care amounted to 7.7% of total health spending, and expenditure on long-term home health care was 0.2%. A new *Public Long-term Care Insurance System* (LTCI) was established in 2000. The LTCI integrates welfare and medical services for the aged. Provision of home care, long-term care welfare facilities for the aged, long-term care health facilities for the aged, and long-term care medical facilities are covered by the LTCI. Six categories are defined by the degree of need of LTC and only part of them are included in the NHA. The long-term care welfare facilities do not provide health care – these institutions are not included in the NHAs.

23. In the discussion, participants raised the issue that the SHA Manual needs to be complemented by additional guidance as to what services should be included under long-term health care. The Secretariat replied that the *Core Study on Long-term Care*, which is part of the *OECD Health Project*, will address these issues.

ITEM 9: ESTIMATING BOUNDARIES BETWEEN PUBLIC HEALTH, PERSONAL HEALTH AND HEALTH-RELATED FUNCTIONS

24. Delegates presented three country cases from Denmark, Finland and Poland that had a focus on estimating boundaries between public health, personal health and health-related functions.

Country case: Denmark

25. The Danish functional classification is more detailed than the ICHA-HC; the mode of production is applied as a parallel variable; furthermore age, municipalities, diagnoses are also included. The following items were presented as specific boundary problems between personal health care, collective health care and health-related functions: vaccinations, intervention against alcohol, substance abuse, screening of blood and health check-ups, screening, blood banks, prenatal screening, administration and research. Expenditure on collective health care in the first version of the SHA calculations amounted to 1.3% of the total health expenditure, while in the second version it reached 4.4% according to the more detailed functional classification now in use.

Country case: Finland

26. Health centre organisations in Finland consist of a number of outpatient clinics (*e.g.* maternal-, family planning, child- and mental clinics, school and student health care) which sometimes provide inpatient care too. Therefore, it is difficult to classify them under the provider component of the ICHA (ICHA-HP) and also to separate personal health care and prevention activities. The calculations are to be based on estimating unit costs. For future revisions of health accounts statistics, expenditure by a number of government agencies might have to be split into health and health-related functions.

Country case: Poland

27. The delegate from Poland provided a general overview of the NHA project in Poland that was financed by the World Bank. She presented the most important items of estimations made by each financing source. As to general government, the key issue was to distinguish long-term care and social expenditure and to classify sanitary inspection services as HC.R.4 (of the ICHA-HC classifications). In the case of social insurance, cash benefits should be separated. Private insurance expenditure was distributed among functions based on experts' opinion. A separate line was created for expenditure that could not be classified by function. Debts of the institutions, for instance, were put there.

28. In the discussion participants pointed out that prevention activities can be both personal and collective, while "prevention" in the SHA Manual is a function under the collective expenditure. Countries have different practice as to reporting personal preventive care. Some countries report these expenditure under curative care, while, *e.g.*, in the Netherlands, they do not make the distinction between collective and personal expenditure. There is a tendency to underestimate the expenditure on prevention. Prevention activities like screening tend to be easier to separate in social insurance systems (where they are financed through fee-for-service) than in health systems financed through state budgets. Countries also have different practices concerning environmental health. In Mexico, for example, it is included in prevention, while the SHA Manual classifies it as a health-related function.

ITEM 10: EXPENDITURE ON HEALTH AND THEIR FINANCING IN *OECD HEALTH DATA 2002*

29. The Secretariat presented an overview on the current state of data reporting to Parts 4 and 5 of *OECD Health Data 2002* and the links of these data with the SHA framework. The harmonisation of the structure of the SHA and the *OECD Health Data* started in 2000. Major new (one-digit level) categories of functional classification were introduced. There are still differences between the scope of reporting in *OECD Health Data* and the SHA standard tables. In *OECD Health Data*, there is no cross-classification between functions and industries or financing. Moreover, the breakdown is less detailed than in the SHA (there is no two-digit level breakdown for outpatient services). The Secretariat emphasised that there are currently huge gaps in data reporting, especially in the case of private expenditure and in the reporting according to the classification by function. In general, only a few countries report day cases.

30. During the discussion, the problem of comparability of longer time series was raised, because the introduction of the SHA will lead to breaks in time series. Delegates emphasised the importance of strong co-operation between the SHA projects and data reporting to *OECD Health Data*.

ITEM 11: ESTIMATING PRIVATE EXPENDITURE

Country case: Spain

31. Since 1995 a new estimation method has been applied that resulted in considerable higher private expenditure. The estimations are based on household final consumption expenditure (health care and private health insurance) and final consumption expenditure by non-profit organisations serving households. There are still unresolved issues. For example, it is debated whether civil servants' insurance (that is publicly funded and privately provided) should be counted as public or private expenditure. Information on private investments in out-patient care is not available.

ITEM 12: REPORTING ON CAPITAL FORMATION IN HEALTH ACCOUNTS

32. The Secretariat presented a brief overview on the status of reporting on investment in *OECD Health Data 2002*. At present, many countries report either the public or the private sector only, or include only investments in hospitals limiting the comparability of overall spending figures. There is a need for better co-ordination with industry statistics.

33. In the discussion it was emphasised that investment data are very important from a health policy perspective, because technology is the most dynamic element of the health system. Currently, countries have very different practices, *e.g.*, in the USA only constructions of hospitals and nursing homes are included in investment statistics, while mobile capital and construction of physicians offices are not included.

ITEM 13: MISCELLANEOUS ISSUES OF SHA IMPLEMENTATION

Country case on regional accounts: Mexico

34. The Mexican example shows that implementation of SHA is possible at a sub-national level. The delegate from Mexico argued that there is a need to include “stewardship” as one of the functions of health systems, and to include a gender dimension in the classification. In Mexico, each state has different ways of reporting expenditure to the Ministry of Finance. States are not obliged to report to the central level a detailed breakdown of health expenditure. Working groups have been established at central and state levels to establish regional and national health accounts. There are now four pilot states working on a refined methodology.

35. Participants in the ensuing discussion from other countries mentioned that there is no need for a separate (first-digit level) functional category for stewardship, because administration in the SHA includes a majority of the activities classified under “stewardship” by the Mexican delegate. A major difference is health service research which would be more appropriate to report as administration instead of as a health-related function. According to one participant, stewardship might be a sub-category within administration.

ITEM 14: CONCLUSIONS AND DISCUSSION OF NEXT STEPS

36. The Experts Meeting confirmed that considerable progress has been made with SHA implementations in several countries since last year's meeting. The ongoing exchange on methodological questions should be intensified and remaining gaps filled.

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