

PROPOSAL FOR PROCEDURES AND SCOPE OF SHA DATA COLLECTION UNDER THE CO-OPERATION BETWEEN OECD, EUROSTAT AND WHO

**Extract from [DELSA/HEA/HA(2005)1] presented at the 7th Meeting of Health Accounts Experts
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DOCUMENTS OF THE QUESTIONNAIRE

**Summary of the Practical working arrangements for cooperation between OECD, EUROSTAT and
WHO**

Questionnaire to be completed:

Tables

Methodology

Technical notes

Structure of the classifications and tables presented in the Common Questionnaire based on the
OECD manual on the System of Health Accounts (SHA)

Additional descriptions and definitions used in the Common Questionnaire

SUMMARY OF THE PRACTICAL WORKING ARRANGEMENTS FOR COOPERATION BETWEEN OECD, EUROSTAT AND WHO

1. This note aims to inform member countries about the most important steps related to the practical working arrangements for a joint SHA (System of Health Accounts) data collection by two international organisations (OECD and WHO) and one supranational organisation (the European Commission, of which EUROSTAT is the responsible authority regarding community statistics), that started in 2005.

Background

2. The most important goal of the collaboration between OECD, EUROSTAT and WHO is to reduce the burden of data collection for the national authorities responsible for the provision of statistical information to the international organisations. Moreover a joint effort will increase the use of international standards and definitions.

3. In response to the growing demands for international comparable information on health spending, the OECD, in co-operation with the EUROSTAT Task Force CARE members and experts in the field of health accounting, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. The System of Health Accounts (SHA) proposes an integrated system of comprehensive and internationally comparable accounts and provides a uniform framework of basic accounting rules and a set of standard tables for reporting health expenditure data.

4. The implementation of SHA requires political commitment, clear institutional responsibility, and co-operation on the national level between institutions with relevant data sources. There is a growing global interest in health expenditure information. Nearly all EU MS and OECD countries have, by now, at least started a pilot implementation of the SHA framework. Many WHO Member States have also implemented a health accounting standard (many of them following the *Guide to producing national health accounts with special applications for lower and middle-income countries*), and many others are initiating the process. OECD, EUROSTAT and WHO will continue to support the SHA implementation by providing training and advice.

5. Through common efforts in SHA implementation, the three international organisations agree to intensify their collaborative actions through a joint data collection. Letters are planned to be sent to the heads of the relevant national organisations (statistical offices and/or health ministries), emphasising the importance of SHA implementation and the upcoming joint SHA data collection.

6. All organisations have their own correspondents supplying information on health care and health care expenditure in particular. These correspondents or focal points may not be the same for all three organisations. However, it is considered necessary that at the national level a single person be designated as responsible for SHA data reporting to all the relevant three organisations. As a second step, each of the three organisations will send a letter to its direct contact to ask for the nomination of a focal point for their country (in most cases, they may simply confirm the current member of the OECD Network of Health Accounts Experts and/or the members of the Technical Meeting Care of EUROSTAT).

Scope and approach to data collection

7. The joint 2006 SHA questionnaire initially consists of three elements, agreed by all three parties: 1) a set of SHA tables requesting data for 2003 and 2004; 2) a section on methodology (questions and tables requesting methodological information); and 3) some explanatory notes/guidelines (including the description of the practical arrangements of the common data collection).

8. Based on the analysis of the results, it may be desirable to collect SHA Tables for the preceding years (from 2000 onwards) at a future date. It is also envisaged that a fully-fledged production factor cost classification will be developed for subsequent questionnaires. Additionally, the feasibility of collecting data by disease category and by age and gender will be examined for possible future data collection.

Data validation process

9. OECD, WHO and EUROSTAT will have the opportunity to check the data submissions of all their member countries and carry out related correspondence with countries, putting the other organisations on copy. Countries are requested to return their answers to the organisations of which they are a member.

10. The aim is to finalise the data validation process within two months after data submissions.

Distribution of the data

11. The subsequent use and distribution of the data will be done independently by the three organisations, in accordance to the existing regulations and practices of OECD, WHO and EUROSTAT.

Summary of the proposed process

12. The member countries of the EU, WHO and OECD will be involved in the joint OECD, EUROSTAT, and WHO SHA data collection.

1. The joint questionnaire will be sent to countries concerned by 15 December. EUROSTAT will be responsible for distributing the questionnaire to the 25 EU Member States and the OECD will distribute the questionnaire to the eleven OECD members which are not members of the EU. The questionnaire will be accompanied by a joint e-mail, or a time-synchronised mailing from OECD, WHO and EUROSTAT to the designated focal points.
2. The deadline for return of the completed questionnaire will be: 31 March, 2006
3. The joint questionnaire consists of three elements: SHA tables; Methodology (questions and tables requesting methodological information), and Explanatory notes / guidelines. (The guidelines include the description of the practical arrangements of the common data collection.)
4. The questionnaire requests data for the years 2003 and 2004
5. Format for data collection: Excel tables.
6. Correspondents are invited to send the completed questionnaires by the same e-mail to the organisations of which they are a member.
7. Countries are requested to address their questions to OECD, WHO and EUROSTAT. **Generally, all correspondence concerning the SHA data collection should be sent to all of the three organisations, in case countries are member of these organisations.**

8. Countries might be sent questions by EUROSTAT, OECD and WHO with the other organisations on copy. Countries are requested to return the answer to all the organisations of which they are members.
9. If validated by all three international organisations, countries will be informed about verification of the data by the organisation that sent the questionnaire to them.
10. Correspondents are kindly asked to provide their feedback about the applied process of common data collection and proposals for modifications if needed.

TABLES USED IN THE JOINT OECD - EUROSTAT – WHO HQ SHA QUESTIONNAIRE

The data questionnaire consists of five two-dimensional tables which are based on the following classifications. The proposed Excel files containing the tables are available at:

http://www.oecd.org/document/30/0,2340,en_2649_34629_35378512_1_1_1_1,00.html

- Health Expenditure by Financing agents/schemes and Functions of Health Care (HFxHC)
- Health Expenditure by Health Care Providers and Functions of Health Care (HPxHC)
- Health Expenditure by Health Care Providers and Financing agents/schemes (HPxHF)
- Financing agents/schemes x Financing sources (HFxFS)
- Human resources x Health Care Provider (RCxHP)

CLASSIFICATIONS

Functions

HC.1			Services of curative care
	HC.1.1		In-patient curative care
	HC.1.2		Day cases of curative care
	HC.1.3		Out-patient curative care
		HC.1.3.1	Basic medical and diagnostic services
		HC.1.3.2	Out-patient dental care
		HC.1.3.3	All other specialised health care
		HC.1.3.9	All other out-patient curative care
	HC.1.4		Services of curative home care
HC.2			Services of rehabilitative care
	HC.2.1		In-patient rehabilitative care
	HC.2.2		Day cases of rehabilitative care
	HC.2.3		Out-patient rehabilitative care
	HC.2.4		Services of rehabilitative home care
Or alternatively fill in the following lines on the aggregated HC.1 and HC.2 functions:			
HC.1; HC.2			Services of curative and rehabilitative care
	HC.1.1; HC.2.1		In-patient curative and rehabilitative care
	HC.1.2; HC.2.2		Day cases of curative and rehabilitative care
	HC.1.3; HC.2.3		Out-patient curative and rehabilitative care
		HC.1.3.1	Basic medical and diagnostic services
		HC.1.3.2	Out-patient dental care
		HC.1.3.3	All other specialised health care
		HC.1.3.9	All other out-patient curative care
	HC.1.4; HC.2.4		Services of curative home and rehabilitative home care
HC.3			Services of long-term nursing care
	HC.3.1		In-patient long-term nursing care
	HC.3.2		Day cases of long-term nursing care
	HC.3.3		Long-term nursing care: home care
HC.4			Ancillary services to health care
	HC.4.1		Clinical laboratory
	HC.4.2		Diagnostic imaging
	HC.4.3		Patient transport and emergency rescue
	HC.4.9		All other miscellaneous ancillary services
HC.5			Medical goods dispensed to out-patients
	HC.5.1		Pharmaceutical and other medical non-durables
		HC.5.1.1	Prescribed medicines
		HC.5.1.2	Over-the-counter medicines
		HC.5.1.3	Other medical non-durables
	HC.5.2		Therapeutic appliances and other medical durables
		HC.5.2.1	Glasses and other vision products
		HC.5.2.2	Orthopaedic appliances and other prosthetics
		HC.5.2.3	Hearing aids

		HC.5.2.4	Medico-technical devices, including wheelchairs
		HC.5.2.9	All other miscellaneous medical durables
HC.6			Prevention and public health services
	HC.6.1		Maternal and child health; family planning and counselling
	HC.6.2		School health services
	HC.6.3		Prevention of communicable diseases
	HC.6.4		Prevention of non-communicable diseases
	HC.6.5		Occupational health care
	HC.6.9		All other miscellaneous public health services
HC.7			Health administration and health insurance
	HC.7.1		General government administration of health
		HC.7.1.1	General government administration of health (except social security)
		HC.7.1.2	Administration, operation and support activities of social security funds
	HC.7.2		Health administration and health insurance: private
		HC.7.2.1	Health administration and health insurance: social insurance
		HC.7.2.2	Health administration and health insurance: other private
HC. 9			Not specified by kind
			Total current expenditure HC.1-HC.9
HC.R.1			Capital formation of health care provider institutions
			Total expenditure HC.1-HC.9, HC.R.1
Health-related functions			
HC.R.2			Education and training of health personnel
HC.R.3			Research and development in health
HC.R.4			Food, hygiene and drinking water control
HC.R.5			Environmental health
HC.R.6			Administration and provision of social services in kind to assist living with disease and impairment
	HC.R.6.1		Health-related social services of LTC (LTC other than HC.3)
	HC.R.6.9		All other HC.R.6 expenditure
HC.R.7			Administration and provision of health related cash-benefits
Memorandum items:			
			Expenditure on Social Care Activities of health care providers
			Expenditure on Other Activities of health care providers
			Expenditure on non-health care activities of health care providers
			Total pharmaceutical expenditure (including in-patient)
			Total expenditure on ancillary services (including in-patient)

Providers

HP.1			Hospitals
	HP.1.1		General hospitals
	HP.1.2		Mental health and substance abuse hospitals
	HP.1.3		Speciality (other than mental health and substance abuse hospitals)
HP.2			Nursing and residential care facilities
	HP.2.1		Nursing care facilities
	HP.2.2		Residential mental retardation, mental health and substance abuse facilities
	HP.2.3		Community care facilities for the elderly
	HP.2.9		All other residential care facilities
HP.3			Providers of ambulatory health care
	HP.3.1		Offices of physicians
	HP.3.2		Offices of dentists
	HP.3.3		Offices of other health practitioners
	HP.3.4		Out-patient care centres
	HP.3.5		Medical and diagnostic laboratories
	HP.3.6		Providers of home health care services
	HP.3.9		Other providers of ambulatory health care
		HP.3.9.1	Ambulance services
		HP.3.9.2	Blood and organ banks
		HP.3.9.9	Providers of all other ambulatory health care services
HP.4			Retail sale and other providers of medical goods
	HP.4.1		Dispensing chemists = Pharmacies
	HP.4.2		Retail sale and other suppliers of optical glasses and other vision products
	HP.4.3		Retail sale and other suppliers of hearing aids
	HP.4.4-HP.4.9		All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods
HP.5			Provision and administration of public health programs
HP.6			General health administration and insurance
	HP.6.1		Government administration of health
	HP.6.2		Social security funds
	HP.6.3		Other social insurance
	HP.6.4		Other (private) insurance
	HP.6.3-HP.6.4		Providers of private insurance
	HP.6.9		All other providers of health administration
HP.7			Other industries (rest of the economy)
	HP.7.1		Establishments as providers of occupational health care services
	HP.7.2		Private households as providers of home care
	HP.7.9		All other industries as secondary producers of health care
HP.9			Rest of the word
			Total expenditure HP.1-HP.9
Memorandum items			
HP.X			Health care related activities providers n.e.m. (not investment)

Note: The HPxHC, HPxHF and RCxHP tables allow a default look and an expanded look, by clicking on the (1) and (2) in the top left hand corner of the spreadsheet. The default (1) presents the standard ICHA classification of providers – **the expanded (2) allows countries the possibility to report data separately for public and private providers.**

Financing agents / schemes

HF.1.			General government
	HF.1.1.		General government (excl. social security) = Territorial government
		HF.1.1.1.	Central government
		HF.1.1.1.1	Ministry of Health
		HF.1.1.1.2	Other Ministries
		HF.1.1.2.	State / provincial government
		HF.1.1.3	Local / municipal government
	HF.1.2.		Social security funds
HF.2.			Private sector
	HF.2.1.		Private social insurance
	HF.2.2.		Private insurance (other than social insurance)
	HF.2.1-HF.2.2		Private insurance
	HF.2.3.		Private households out-of-pocket exp.
		HF.2.3.1	out-of-pocket excluding cost-sharing
		HF.2.3.2- HF.2.3.5	Cost-sharing: central government; state / provincial government; Local / municipal government; Social security funds
		HF.2.3.6- HF.2.3.7	Cost-sharing: Private insurance
		HF.2.3.9	All other cost-sharing
	HF.2.4.		Non-profit institutions serving households
	HF.2.5.		Corporations (other than health insurance)
HF.3.			Rest of the world
			Total expenditure HF.1-HF.3
Memorandum items:			
	HF.2.2.A		Private insurance - Compulsory
	HF.2.2.B		Private insurance - Voluntary

Financing sources

FS.1			Public funds
FS.2			Private funds
	FS.2.2		Household funds
FS.3			Rest of the world funds
			Total expenditure FS.1-FS.3

Human resources

	RC.1.1		Human resources (employed and self-employed)
		RC.1.1.1, RC.1.1.2	Compensation of employees
		RC.1.1.3	Self-employed income

METHODOLOGY

I. Data sources

13. (Please provide description separately for the main sources for public expenditure and private expenditure.)

II. Correspondence tables between health expenditure categories used in national practice and the ICHA

Please give in the following tables the concise description of the mapping of categories of the national data sources used to compile the SHA tables, to each dimension of the SHA. Different data sources often use different classification systems. Therefore, please prepare the correspondence table to cover all relevant data sources. (For example, data covering compulsory insurance usually use different categories in their reporting system than categories used in households surveys.) As an example, a table from *OECD Health Technical Papers No. 2* presenting the mapping to ICHA-HC in the Canadian Health Accounts is shown after table M3.

Table M1. Correspondence between 'old' national categories and ICHA-HF

Categories of national statistics mapped to ICHA-HF	ICHA-HF

Table M2. Correspondence between 'old' national categories and ICHA-HC

Categories of national statistics mapped to ICHA-HC	ICHA-HC

Table M3. Correspondence between 'old' national categories and ICHA-HP

Categories of national statistics mapped to ICHA-HP	ICHA-HP

Example – Table of Correspondence Between Uses of Funds in Current Canadian Health Accounts and ICHA-HC

Uses of Funds in Canadian Health Accounts Broken Down by Function		
Uses of Funds in Canadian Health Accounts	ICHA-HC	
Hospitals Canadian hospitals report their expenditures to the Canadian Institute for Health Information according to the MIS (Management Information System) Guidelines. A mapping from the MIS accounts to the functional classification was prepared and is available from CIHI upon request.	HC.1.1 In-patient curative care HC.1.2 Day cases of curative care HC.1.3 Out-patient curative care HC.1.4 Services of curative home care HC.2.1 In-patient rehabilitative care HC.2.2 Day cases of rehabilitative care HC.2.3 Out-patient rehabilitative care HC.3.1 In-patient long-term nursing care HC.4.1 Clinical laboratory HC.4.2 Diagnostic imaging HC.4.3 Patient transport and emergency rescue HC.5.2 Therapeutic appliances and other medical durables HC.6.4 Prevention of non-communicable diseases HC.R.2 Education and training of health personnel HC.R.3 Research and development in health HC.R.4 Food, hygiene and drinking water control HC.R.5 Environmental Health	
Other Institutions Type I and lower care was excluded. Expenditures for Type II and Type III care were put under HC.3.1. Expenditures for care above Type III were put under HC.1.1	HC.1.1 In-patient curative care HC.3.1 In-patient long-term nursing care	
Physicians The National Physician Database at the Canadian Institute for Health Information contains fee-for-service payments by provincial medical care plans, grouped by type of service according to the National Grouping System (NGS). A mapping from the NGS to the functional classification was prepared and is available from CIHI upon request.	HC.1.1 In-patient curative care HC.1.2 Day cases of curative care HC.1.3 Out-patient curative care HC.1.4 Services of curative home care HC.3.1 In-patient long-term nursing care HC.4.1 Clinical laboratory HC.4.2 Diagnostic imaging	
Other Professionals The sub-category "Vision Care Services" includes expenditures for eyeglasses and contact lenses. These expenditures were put under HC.5.2.1 when they could be identified separately from professional services.	HC.1.3.2 Out-patient dental care HC.1.3.9 All other out-patient curative care HC.5.2.1 Glasses and other vision products	
Drugs	HC.5.1.1 Prescribed medicines HC.5.1.2 Over-the-counter medicines HC.5.1.3 Other medical durables	
Capital	HC.R.1 Capital formation of health care provider institutions	
Public Health and Administration	HC.6 Prevention and public health services	
Other Health Spending	HC.3.3 Long-term nursing care: home care HC.4.3 Patient transport and emergency rescue HC.5.2 Therapeutic appliances and other medical durables HC.5.2.3 Hearing aids HC.6 Prevention and public health HC.6.5 Occupational health care HC.7 Health administration and health insurance HC.R.2 Education and training of health personnel HC.R.3 Research and development in health Undistributed	

III. Current state of ICHA implementation

Please indicate in the following tables:

1. Any differences in your SHA-based health accounts from the definitions provided by the ICHA (or in this Methodological Note and, in the last column, if an estimation procedure or adjustment was used specifically for the purpose of producing the SHA tables..
2. If data are not available (but the category exists): “No data available”
3. If the given category does not exist in your health system: “Category not applicable”

Table M4. Current state of applying ICHA-HF

Health Expenditure by Financing Agent/Schemes			
ICHA-HF	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Estimation procedures and adjustments
HF.1.	General government		
HF.1.1.	General government (excl. social security) = Territorial government		
HF.1.1.1.	Central government		
HF.1.1.1.1	Ministry of Health		
HF.1.1.1.2	Other Ministries		
HF.1.1.2.	State / provincial government		
HF.1.1.3	Local / municipal government		
HF.1.2.	Social security funds		
HF.2.	Private sector		
HF.2.1.	Private social insurance		
HF.2.2.	Private insurance (other than social insurance)		
HF.2.1- HF.2.2	Private insurance		
HF.2.3.	Private households out-of-pocket exp.		
HF.2.3.1	out-of-pocket excluding cost-sharing		
HF.2.3.2- HF.2.3.5	Cost-sharing: central government; state / provincial government; Local / municipal government; Social security funds		
HF.2.3.6- HF.2.3.7	Cost-sharing: Private insurance		
HF.2.3.9	All other cost-sharing		
HF.2.4.	Non-profit institutions serving households		
HF.2.5.	Corporations (other than health insurance)		
HF.3.	Rest of the world		
	Total expenditure HF.1-HF.3		
<i>Memorandum items:</i>			
HF.2.2.A	Private insurance - Compulsory		
HF.2.2.B	Private insurance - Voluntary		

Table M5. Current state of applying ICHA-HC

Health Expenditure by Function			
ICHA	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Estimation procedures and adjustments
HC.1	Services of curative care		
HC.1.1	In-patient curative care		
HC.1.2	Day cases of curative care		
HC.1.3	Out-patient curative care		
HC.1.3.1	Basic medical and diagnostic services		
HC.1.3.2	Out-patient dental care		
HC.1.3.3	All other specialised health care		
HC.1.3.9	All other out-patient curative care		
HC.1.4	Services of curative home care		
HC.2	Services of rehabilitative care		
HC.2.1	In-patient rehabilitative care		
HC.2.2	Day cases of rehabilitative care		
HC.2.3	Out-patient rehabilitative care		
HC.2.4	Services of rehabilitative home care		
HC.3	Services of long-term nursing care		
HC.3.1	In-patient long-term nursing care		
HC.3.2	Day cases of long-term nursing care		
HC.3.3	Long-term nursing care: home care		
HC.4	Ancillary services to health care		
HC.4.1	Clinical laboratory		
HC.4.2	Diagnostic imaging		
HC.4.3	Patient transport and emergency rescue		
HC.4.9	All other miscellaneous ancillary services		
HC.5	Medical goods dispensed to out-patients		
HC.5.1	Pharmaceutical and other medical non-durables		
HC.5.1.1	Prescribed medicines		
HC.5.1.2	Over-the-counter medicines		
HC.5.1.3	Other medical non-durables		
HC.5.2	Therapeutic appliances and other medical durables		
HC.5.2.1	Glasses and other vision products		
HC.5.2.2	Orthopaedic appliances and other prosthetics		
HC.5.2.3	Hearing aids		
HC.5.2.4	Medico-technical devices, including wheelchairs		
HC.5.2.9	All other miscellaneous medical durables		
HC.6	Prevention and public health services		
HC.6.1	Maternal and child health; family planning and counselling		
HC.6.2	School health services		
HC.6.3	Prevention of communicable diseases		
HC.6.4	Prevention of non-communicable diseases		
HC.6.5	Occupational health care		
HC.6.9	All other miscellaneous public health services		
HC.7	Health administration and health insurance		
HC.7.1	General government administration of health		
HC.7.1.1	General government administration of health (except social security)		
HC.7.1.2	Administration, operation and support activities of social security funds		
HC.7.2	Health administration and health insurance: private		
HC.7.2.1	Health administration and health insurance: social insurance		
HC.7.2.2	Health administration and health insurance: other private		
HC.9	Not specified by kind		
	Total current expenditure HC.1-HC.9		
<i>Health related expenditures:</i>			

HC.R.1	Capital formation of health care provider institutions		
	Total expenditure HC.1-HC.9, HC.R.1		
HC.R.2	Education and training of health personnel		
HC.R.3	Research and development in health		
HC.R.4	Food, hygiene and drinking water control		
HC.R.5	Environmental health		
HC.R.6	Administration and provision of social services in kind to assist living with disease and impairment		
HC.R.6.1	Expenditure on Long Term Care (other than HC.3)		
HC.R.6.9	All other HC.R.6 expenditure		
HC.R.7	Administration and provision of health related cash-benefits		
<i>Memorandum items:</i>			
	Expenditure on Social Care Activities of health care providers		
	Expenditure on Other Activities of health care providers		
	Total pharmaceutical expenditure (including in-patient)		
	Total expenditure on ancillary services (including in-patient)		

Table M6. Current state of applying ICHA-HP

Health Expenditure by Provider			
ICHA	SHA Manual	Which deviations from ICHA are currently found in the country's SHA compilation?	Estimation procedures and adjustments
HP.1	Hospitals		
HP.1.1	General hospitals		
HP.1.2	Mental health and substance abuse hospitals		
HP.1.3	Speciality (other than mental health and substance abuse hospitals)		
HP.2	Nursing and residential care facilities		
HP.2.1	Nursing care facilities		
HP.2.2	Residential mental retardation, mental health and substance abuse facilities		
HP.2.3	Community care facilities for the elderly		
HP.2.9	All other residential care facilities		
HP.3	Providers of ambulatory health care		
HP.3.1	Offices of physicians		
HP.3.2	Offices of dentists		
HP.3.3	Offices of other health practitioners		
HP.3.4	Out-patient care centres		
HP.3.5	Medical and diagnostic laboratories		
HP.3.6	Providers of home health care services		
HP.3.9	Other providers of ambulatory health care		
HP.3.9.1	Ambulance services		
HP.3.9.2	Blood and organ banks		
HP.3.9.9	Providers of all other ambulatory health care services		
HP.4	Retail sale and other providers of medical goods		
HP.4.1	Dispensing chemists = Pharmacies		
HP.4.2	Retail sale and other suppliers of optical glasses and other vision products		
HP.4.3	Retail sale and other suppliers of hearing aids		
HP.4.4- HP.4.9	Retail sale and other suppliers of medical appliances; All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods		
HP.5	Provision and administration of public health programs		
HP.6	General health administration and insurance		
HP.6.1	Government administration of health		
HP.6.2	Social security funds		
HP.6.3	Other social insurance		
HP.6.4	Other (private) insurance		
HP.6.3- HP.6.4	Providers of private insurance		
HP.6.9	All other providers of health administration		
HP.7	Other industries (rest of the economy)		
HP.7.1	Establishments as providers of occupational health care services		
HP.7.1.1	General government as provider of occupational health care		
HP.7.1.2	Private corporations as provider of occupational health care		
HP.7.2	Private households as providers of home care		
HP.7.9	All other industries as secondary producers of health care		
HP.9	Rest of the word		
	Total expenditure HP.1-HP.9		
<i>Memorandum items:</i>			
HP.X	Providers of Health care related activities providers n.e.m. (not investment)		

Table M7. Current state of applying Financial Sources

Health Expenditure by Financing Sources			
		Which deviations from definitions given in this document are currently found in the country's SHA compilation?	Estimation procedures and adjustments
FS.1	Public funds		
FS.2	Private funds		
FS.2.2	Household funds		
FS.3	Rest of the world funds		
	Total expenditure FS.1-FS.3		

Table M8. Current state of applying Human Resources

Health Expenditure by Human Resources			
		Which deviations from definitions given in this document are currently found in the country's SHA compilation?	Estimation procedures and adjustments
RC.1.1	Human resources (employed and self-employed)		
RC.1.1.1, RC.1.1.2	Compensation of employees		
RC.1.1.3	Self-employed income		

STRUCTURE OF THE CLASSIFICATIONS AND TABLES PRESENTED IN THE COMMON QUESTIONNAIRE BASED ON THE OECD MANUAL ON THE SYSTEM OF HEALTH ACCOUNTS (SHA)

(Draft note to be finalised by the end of November)

1. SHA is a tri-axial system in which three dimensions are covered by ICHA (International Classification of Health Accounts). Each of the three dimensions (financing, provision, consumption) have specific classifications (HC health care functions, HP health care providers, and HF health care financing agents/ schemes) which are linked and dependent of each other. Since a tri-axial cube is not easily presented, tables on two pairs of axes are typically used. This means expenditure data are collected by the following tables: Providers (HP) by Financing (HF); Functions (HC) by Providers (HP), and finally Functions (HC) by Financing (HF).
2. The tables in the Common Questionnaire are based on the original set of classifications of the SHA manual. This means tables are available on the expenditure of providers by function, providers by financing unit and financing unit by function. To make the picture of the classifications on health care more complete, the HC.R (health care related) activities are added to the tables on functions. In addition, a table showing the financing sources of the categories of financing schemes/agents (FS x HF), and a table on human resources (HRxHP) are also included in the requested set of tables.
3. The tables include a number of items in addition to the original ICHA classifications. For the functional classification an additional line is included specifying HC. 9: not elsewhere mentioned or not specified in kind.
4. In each table some memorandum items are included for specific purposes.
5. In the tables consisting of the functional classification (HPxHC and HFxHC tables) the expenditure of providers of health care for activities outside the health care branch are included. (This completes the table from a provider point of view in some countries.)
6. Total expenditure (including in-patient and out patient) on the items of pharmaceuticals and ancillary services are included. (This provides information on the total consumption of these items.)
7. In two of the tables on providers of health care (HPxHC and HPxHF tables) the providers of health care related activity are inserted (excluding providers of investment goods).
8. In the tables on the financing units or financing schemes (HPxHF and FS x HF tables) the distinction in the private insurance (HF.2.2) between compulsory and voluntary private insurance is made as a memorandum item.
9. For all tables on providers (HPxHF and HPxHC tables) a distinction in expenditure by sector of activity (government – private) is introduced to provide information on the importance of the private sector in the totality of the expenditure by providers and by functions.

10. The functional classification can be supplemented (below the line) with items presented in the HC.R classification, the health care related activities. At the minimum the HC.R.1, investments need to be added, especially in case depreciation is not included in the expenditure of the providers of care. Moreover Research and Development (HC.R.3) and Education (HC.R.2) are presented by the countries as important topics.

11. Basically the classifications as presented in the OECD manual on the SHA are best to be followed in all the details. [www.oecd.org/dataoecd/49/51/21160591.pdf] (The Guide to producing national health accounts with special applications for low-income and middle income countries. WHO-WB-USAID, 2003 [<http://www.who.int/nha/docs/en/> available in English, Spanish, Russian and other languages] and the Guidelines produced under a Eurostat project [http://forum.europa.eu.int/Public/irc/dsis/caretf/library?l=/feedback/projectsreports/guidelines_project/sha_guidelinespdf/] might also provide useful advice to populate the tables.)

12. A special understanding is needed of the intertwining of the Functional classification and classification of the Modes of Production in the manual of the OECD on the System of Health Accounts (SHA). Countries are advised to send their questions arising during the preparation of the tables. Due to the different way countries produce their SHA tables, advice can be most appropriately given on a country-by-country basis.

13. To get the best result possible it is necessary to collect the information on expenditure on all possible levels of aggregation; adding the information collected at the lowest level (2nd or 3rd digit level) of classification items possible is not enough. For some countries data on these low levels are not available or conflicting with data confidentiality. Adding information on expenditure from the three digit level over the two digit level to the one digit level is only possible in the countries that have all the information available at the lowest level of aggregation. For other countries tables on expenditure at higher (two digits or one digit level) would suit their purposes better. Ideally, tables on all two digits or three digits levels of aggregation are needed.

ADDITIONAL DESCRIPTIONS AND DEFINITIONS USED IN THE COMMON QUESTIONNAIRE

(Draft note to be finalised by the end of November)

This note only includes descriptions for those expenditure categories that are not included in the current version of the ICHA.

Addendum items to the Functional (HC) classification:

HC.R.6.1: Health-related social services of LTC (Long term care other than HC.3)

1. This item comprises services of home help and residential care services: care assistance which are predominantly aimed at providing help with IADL restrictions to persons with functional limitations and a limited ability to perform these tasks on their own without substantial assistance, including supporting residential services (in assisted living facilities and the like). Note: home help or, more generally, help with instrumental activities of daily living (such as help with activities of home making, meals etc., transport and social activities) may be provided and remunerated as integrated services with long-term nursing and personal care services. In these cases these services are accounted together (under HC.3)

2. **Includes:** Subsidies to residential services (including costs of accommodation) in assisted living arrangements and other kinds of protected or "services" housing for persons with functional limitations (including residential services to people with mental retardation, mental illness or substance abuse problems and homes for the physically and mentally handicapped); services of housekeeping, meals on wheels for persons with functional limitations, social services of day care such as social activities for dependent persons; transport to and from day-care facilities or similar social services for persons with functional limitations.

3. **Excludes:** services that aim predominantly to combat social isolation rather than protecting persons with functional limitations (body/mental functioning). In particular this is the case for services and/or living arrangements where eligibility criteria explicitly require recipients to be without health impairing chronic conditions which would require substantial help with IADL or ADL restrictions. Expenditure on these services should be excluded even from HC.R.6.

HC.R.6.9 All other HC.R.6 expenditure

4. This item comprises all other social services provided for people with disease and impairment, not included in HC.R.6.1. For example: special schooling for the handicapped, sheltered employment and vocational rehabilitation.

Expenditure on Social Care activities of health care providers

5. The expenditure on social care activities are limited to the expenditure originating in the actors included in the classification of providers. Providers of health care can and do produce goods and services that cannot be classified as health care goods and services. These goods and services relate to providing

accommodation, assistance needed for functioning, assistance with functioning in society and information and support in these areas. These activities are not classified as health care, but are provided to patients, clients and the like.

Expenditure on other activities of health care providers

6. This item comprises all financial transactions of activities not related to the provision of health care services or goods of health care providers. These activities are not related to patients or treatment. Examples are the provision of a hostel for nurses employed in the hospital, child care facilities for employees.

Total pharmaceutical expenditure

7. Policies related to pharmaceuticals require a comprehensive measurement of this expenditure. The current SHA HC is limited to the measurement of the final consumption of pharmaceuticals in out patient care, for prescribed and non prescribed medicines purchased in retail outlets. Other distribution channels may amount to 20%-40% of this level in some cases. These should be included in an integrated or total measurement.

8. **Total pharmaceutical expenditure** includes the provision of pharmaceuticals, medicinal chemicals and botanical products used for therapeutic uses regardless of their distribution channel and their financing path. Specifically, this measure comprises out patient plus in patient plus all other forms of consumption of these goods. Products such as medicinal preparations, patent medicines, serums, vaccines, vitamins and minerals, cod liver oil, oral contraceptives, traditional herbs, as well as other medical non durables such as clinical thermometers, adhesive and non adhesive bandages, syringes, first-aid kits, hot water bottles and ice bags, medical hosiery, incontinence articles, pregnancy tests, condoms and other mechanical contraceptive devices. Products for veterinary uses should be excluded.

9. Health accountants are invited to report both government and private financing of total pharmaceuticals in the cross-classified tables.

Total ancillary services

10. Resource allocation policy requires more detail on total expenditure on some special services.. The current SHA HC is limited to the measurement of the final consumption of ancillary services in out-patient care (laboratory, imaging, transportation and all other services). In-patient care involves, however, similar expenditures that are presently not identified nor used in decision-making. Ancillary services are services complementary to the provision of core curative, rehabilitative and preventive services, which are technologically and instrumentally independent of these. Ancillary services are mainly diagnostic activities.

11. **Total expenditure on Ancillary services** are those performed by paramedical or medical technical personnel with or without the direct supervision of a medical doctor, such as laboratory diagnosis, imaging and patient transport and emergency rescue regardless of the provision channel. Laboratory test performed are those described in the ICD-9-CM code 90, general microscopic examination, and code 91, specialized microscopic examination. Imaging includes simple and more complex imaging diagnosis in ICD-9-CM codes as 87 and 88. All other miscellaneous ancillary services include the other paramedical ancillary activities such as psychological diagnostic procedures.

Addendum items to the Provider (HP) classification:

Providers of health care related services (excluding investment)

12. **Providers** to be potentially reported include: entities involved in the provision of education and training of health personnel, such as paramedical schools, undergraduate medical and paramedical departments, graduate medical/biomedical schools, research and development entities in hospitals, in general administration, in education and training institutions, in specific research centres in pharmaceutical, and in bio-engineering industries (e.g. automotive and environmental).

13. Note: When an entry is included in total financing (HF), or in total final use (HC), a provision value must also exist (HP) so as to maintain the equivalence among the three aggregates. This applies also to the HCR entries. As in the case of the other health care providers, the units reported include those internal and external to the health system.

Financing Sources

The identification of the ultimate source of financing serves to measure the burden on various actors, the potential pooling sources of the health system's purchasers.

The three main classes of Financing Sources are:

a) General government

- ☐ Taxation
- ☐ Sale of government goods and services
- ☐ Return on assets

b) Private sources

- ☐ Enterprises
- ☐ Households

The household total source entry is larger than the household "financing agent" entry because of contributions to health insurance (public and private) and donations.

c) External funds (non-resident institutions)

- ☐ International and supranational agencies
- ☐ Bilateral funds and technical assistance
- ☐ Financing intermediaries (insurance, NGOs, charities and foundations)
- ☐ Earmarked household remittances.

Classification of Human Resources

Human Resources on Health

14. This category measures the remuneration of all persons employed by provider industries irrespective of whether their primary output relates to health care professions or not. All workers performing health services as described in HC.1 to HC.7 are included, regardless of specialization, or kind of employment. Services contracted are considered as purchases and need not be reported under this item.

15. **Compensation of employees** refers to total remuneration in cash or in kind, paid by an enterprise to an employee in return for work performed by the latter during the accounting period, i.e. wages and salaries and all forms of social benefits, payments for overtime or night work, bonuses, allowances, as well as the value of in-kind payments.

16. Wages and salaries of employees include remuneration in-cash and in-kind for health activities, as a regular interval payments, piecework, overtime, night work, weekend or other unsocial hours, allowances for working away from home, on disagreeable or hazardous circumstances, as allowances linked to housing, travel or sickness benefits, ad hoc bonuses, commissions, gratuities, and in kind provision of goods and services required to carry out their work, as meals and drinks, uniforms, transportation. Compensation of employees includes social security paid by the employer. Social contributions paid on behalf of employees are the actual or imputed payments to social schemes to secure their entitlement to social benefits such as social security.

17. **Self employment income** includes a return on property rights and a remuneration of labour performed. It refers to the sole owners or to the joint owners of unincorporated enterprises in which they work, excluding those unincorporated enterprises classified as quasi-corporations, the acquisition of supplies and estimated capital consumption deducted.

18. Gross operating surplus is used as a proxy for non salaried health workers' income. It measures the surplus or deficit accruing from production before taking account of any interest, rent or similar charges payable on financial or tangible non-produced assets borrowed or rented by the enterprise, or any interest, rent or similar receipts receivable on financial or tangible non-produced assets owned by the enterprise; (note: for unincorporated enterprises owned by households, this component is called "mixed income"). It includes the remuneration for work performed by the owner and other household members, and the return to the owner as entrepreneur.