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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.

OECD PUBLICATIONS ON "SHA-BASED NATIONAL HEALTH ACCOUNTS"

Meeting to be held at the Château de la Muette, Paris, 30 September and 1 October 2004, starting at 14:00 on the first day and ending at 17:00 on the second day

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NOTE BY THE SECRETARIAT

1. Member countries have given high priority to future health accounting work at the OECD [SG/ADHOC/HEA(2004)7]. The Secretariat is expected to further encourage and support the implementation of SHA in OECD member countries and to publish the results, as well as to further develop health accounting methodology, in particular by refining the health expenditure classification.

2. The OECD Secretariat, along with experts from thirteen member countries, has carried out a project to publish the initial results from the implementation of the System of Health Accounts. The results are presented in the OECD *Health Working Paper* No 16 (*SHA-based National Health Accounts in Thirteen OECD Countries: A Comparative Analysis*) and the OECD *Health Technical Papers* No. 1 to13 (*SHA-based National Health Accounts in Thirteen OECD Countries: Country Studies*).

3. Based on the experience gained during this initial project, this paper presents a plan for disseminating results from SHA implementations on a regular basis, focusing on organisational issues and the links with other relevant activities of the Secretariat.

4. The Secretariat invites participating experts to:

- COMMENT on the proposals presented in this paper; in particular,
- COMMENT on the proposed content and appearance of the *SHA Implementation web-page* being under preparation (see Annex 4); and
- COMMENT on the expectation towards member countries' involvement in the proposed work.

INTRODUCTION

5. Since the beginning of its work on health accounts, the Secretariat has invited reports from experts in member countries on SHA implementation, and disseminated them at the experts' meetings. These materials were also posted on the OECD SHA web-page. It was, however, recognised that the Secretariat should undertake a greater role in analysing and disseminating results from SHA implementations in OECD countries. This activity is expected to reveal the issues needing further harmonisation across countries and point out elements of the SHA methodology needing further clarification or development, which, in turn, can contribute to improvement in comparability of health expenditure data, and to their better analysis. In this spirit, a project on *SHA-based National Health Accounts in OECD Countries* has been carried out.[1]

6. Based on the experience and new ideas gained during this work, the Secretariat has developed the following plan for disseminating SHA-related results.

Main purposes

7. The Secretariat intends to issue technical and working papers[2] on SHA-based National Health Accounts, as well as to operate an *SHA Implementation* web-page with information regarding the results and status of SHA implementation in each OECD country. Main purposes of this activity are:

- to provide policy-relevant, comparative data and analysis on health expenditure (focusing on those findings have newly become available from health accounts);
- to facilitate harmonisation across national health accounting practice;
- to encourage methodological development in member countries;
- to provide data sources for research on health expenditure by experts in member countries;
- to make country-specific SHA results and latest information more widely available for international audiences.

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1. A letter of invitation, together with a draft outline of country studies, was sent to all member countries in December 2002. Thirteen countries decided to participate. The purpose, structure and presentation of a comparative analysis and the country papers were put forward in: [DELSA/ELSA/WP1/HS(2003)6]. The Meeting of Health Accounts Experts held on 27-28 October 2003 agreed with these proposals, and discussed the first drafts of the country chapters. The original plan was to publish one volume with a comparative chapter and with thirteen country chapters. In August of 2004, considering the whole publishing activity of the Health Policy Unit, the Secretariat decided to launch a new series, namely the *OECD Health Technical Papers*, and to publish the country papers in that way.

2. The country studies continue to be published in *OECD Health Technical Papers.* This series is designed to make available to a wider readership methodological studies and statistical analysis presenting and interpreting new data sources, and empirical results and developments in methodology on measuring and assessing health care and health expenditure. The comparative analysis continues to be published in *OECD Health Working Papers.*

8. Considering these purposes and possible target audiences, the Secretariat plans the following papers and web-page.

SHA-related working and technical papers

9. The next working paper presenting *SHA-based National Health Accounts in OECD Countries* will be issued in December 2006. Besides similar analysis of comparative SHA tables, it will include initial time series, and will have a special focus on selected issues (perhaps on pharmaceuticals and/or long-term care expenditure). Supplementary methodological analysis – targeting mainly a health accounting audience - would be provided on the SHA web-page. (Much of the methodological detail presented in the 2004 paper would be omitted.)

10. Individual country studies will be presented in the *OECD Technical Papers* series when they become available. This makes it possible to present new country reports ahead of the next comparative study, planned for 2006.

SHA Implementation web-page

11. A web-page**,** presenting information on SHA-based health accounts in OECD countries, is currently being developed[3] (See Annex 4). It is planned to present:

- country studies
- SHA tables with short methodological notes,[4]
- comprehensive methodological studies on implementation of the SHA in countries,
- methodological studies on specific issues of the SHA methodology (for example, estimating expenditure on long-term care; expenditure by non-profit institution, etc.),
- interim reports about SHA implementation in countries,
- links to web-pages of institutions in member countries, which present data and information related to health expenditure,
- other relevant information (e.g. diagrams of health financing systems – similar or the same as in OECD Health Data, etc.).

12. In addition, it needs to be decided, whether SHA tables should only be presented in PDF format, or also in Excel. The latter would give better opportunity to researchers in member countries to utilise health accounts.

Involvement by member countries

13. The success of this work depends primarily on contributions by member countries. The plans put forward in this paper anticipate different types of involvement by member countries, due to the fact that they are currently at varying stages of SHA implementation.

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3. The SHA Implementation web-page at this moment displays documents of the thirteen countries that have prepared SHA country studies (see Annex 2). The Secretariat plans bilateral discussions with the remaining countries regarding their possible contribution to the web-page.

4. Countries can present SHA tables when they become available, and latter on complement them with analysis of health expenditure.

14. Of the thirteen countries that have prepared SHA country papers, in 10 countries (Australia, Canada, Germany, Hungary, Japan, Korea, Mexico, Netherlands, Spain and Switzerland) SHA-based National Health Accounts are institutionalised and also serve for data reporting to international organisations. These countries are expected to further harmonise their health accounts with the SHA-ICHA,[5] and report annually the basic SHA tables which will be displayed on the SHA Implementation web-page. Reports by these countries on specific methodological issues – that might occur during further harmonisation with the SHA-ICHA – would be also welcome.

15. Country studies by Denmark, Poland and Turkey present results of pilot projects carried out on an experimental bases for only one (or two) years. It is hoped that these countries will institutionalise health accounting and regularly produce SHA-based health accounts in the future.

16. The United Kingdom's health expenditure data reported to *OECD Health Data 2003* were also based on SHA pilot implementation by the Office of National Statistics. At this moment, however, only major aggregate data are available for UK. It is hoped that UK will extend its health accounting work and provide the basic SHA tables and prepare a country report for *OECD Health Technical Papers*.

17. In several other countries, the SHA is currently being implemented or preparatory work has been started (Austria, Belgium, Czech Republic, Finland, France, Ireland, Luxembourg, Norway, Portugal, Slovak Republic and Sweden). These countries are invited to provide interim reports about SHA implementation and pilot SHA tables with methodological notes when they become available in order to display them on the *SHA Implementation web-page*. Afterwards, they are also invited to prepare country studies for *OECD Health Technical Papers.*

18. United States has produced SHA tables for 1997 on an experimental basis, which were presented at the OECD Meeting of Health Accounts Experts in 2001. It is hoped that the National Health Statistics Group, Centers for Medicare & Medicaid Services will continue work of mapping the US National Health Accounts to the SHA-ICHA.

19. All countries listed above are welcome to submit studies on methodological issues in implementation of the SHA.

20. Finally, according to the latest information available, implementation has not yet commenced in 4 OECD countries (Greece, Iceland, Italy and New Zealand). The Secretariat will continue consultations with these countries to explore the feasibility to start a pilot SHA implementation project in these countries.

Tasks related to dissemination of SHA results

21. Policy relevance, timeliness, comparability and harmonised, user-friendly formats are considered as major requirements for the planned SHA papers and web-page. To this end, the Secretariat intends the following.

Review of the papers

22. Involvement of experts in the review of publications is expected to ensure that the discussed questions are relevant for both policy-makers and health accounting experts. While keeping the forms of

5. Methodological annexes in the relevant *OECD Health Technical Papers* highlight those areas requiring further harmonisation.

review applied so far,[6] it seems to be desirable to also have a more formal review of the papers. Health accounts experts will be invited to review future working and technical papers.[7] Reviewers, however, might also come from outside the OECD network of health accounts experts.

Collecting SHA tables on an ongoing basis[8]

23. So far SHA tables have been requested and distributed as room documents at OECD expert meetings. The timeliness of the web-page on SHA implementation, and that of the SHA comparative paper requires[9] a different timing:

- One option would be to connect reporting of the SHA tables to reporting data for Parts 4 and 5 of the *OECD Health Data*. (In this case, SHA tables for 2003 would be reported in February/March 2005.) Standard tables and guidelines (similar to those for Parts 4&5) would be prepared.
- The other option would be to collect SHA tables separately from data collection for the *OECD Health Data*, preferably in April/May every year. This seems to be the latest date to ensure that the comparative tables present data with 2 years time-lag, at least for most of the countries.

Harmonisation of the format in which country studies are presented

24. In the case of the technical papers issued, the Secretariat tried to ensure a certain degree of harmonisation among country papers, both in terms of content and style. An outline was proposed at the beginning of the work, additional general notes and country-specific notes were provided after the first drafts, as well as extensive bilateral correspondence was performed. Also, the Secretariat produced the standard charts and tables presented in the country papers. At the same time, it was agreed during the 2003 Meeting of Health Accounts Experts to country studies could provide information additional to the standard outline.

25. The Secretariat considers this outline as appropriate for future country studies subject to the following proposal. The introduction of the papers would contain a short description of the financing system in the country concerned.[10] (Annex 1 presents the original outline completed with this proposal.)

6. In the case of the working and technical papers issued, basic questions to be covered in the comparative analysis and first drafts of the country papers were discussed at the 2003 Meeting of Health Accounts Experts. Furthermore, feedback to the first draft of the comparative analysis was requested from the participating experts. The country papers were reviewed by the Secretariat.

7. It is planned that each new comparative and country paper will be reviewed by one or two reviewers.

8. The technical details of a regular collection of SHA tables will also need to be discussed under the perspective of moving towards a joint data collection with the Eurostat and the WHO.

9. It is desirable to present 2004 data (or 2003 for countries with budgetary-year different than the calendar one) in the 2006 edition.

10. This information is provided in most country studies connected to the analysis of health expenditure data. Despite this, it would be useful to present a concise description of the health financing system at the beginning of the papers.

ANNEX 1: OUTLINE OF THE COUNTRY PAPERS[11]

Introduction

- A one to two page description of the health financing system (main financing agents and their institutional characteristics, features of risk-pooling and relationship between financing agents and providers).

- Information concerning the history, relevance and organisation of producing health accounts in your country.

Structure and trends of health expenditure

It is proposed that each country chapter contains the following four charts and three matrixes, together with brief descriptive analysis of the health expenditure structure they show:

- Summary data on health expenditure (four charts):
  - Heath expenditure by financing source
  - Health expenditure by function (curative-rehabilitative care; long-term care; ancillary services; medical goods; public health services; administration)
  - Current health expenditure by mode of production (inpatient care, day care, out-patient care; home care)
  - Current health expenditure by provider
- Current health expenditure by function and provider (see SHA Table 2)
- Current health expenditure by provider and financing agent (see SHA Table 3)
- Current health expenditure by function and financing agent (see SHA Table 4)

Major issues of analysis

In the following we list the most important issues that the analysis in the country chapters could focus on (in providing descriptive comments / analysis). Not all items will have the same relevance for all countries. It is proposed to focus on the most significant findings and/or comments and descriptions, such as on the structure of the health care system that directly relates to these numbers.

A. Summary data on health expenditure

A.1. Heath expenditure by financing source

- A statement about whether the calculation of total expenditure based on the SHA resulted in substantial change in the value of total expenditure or in the structure by financing sources compared to previous estimates (if available).
- Per capita total, public and private health expenditure in NCU and US$PPP.
- Public share in total expenditure; and structure of public expenditure

11. Apart from the first point of the Introduction, this outline is the same as the one sent to countries in February 2003, complemented with the general notes sent in October 2003. (There are no significant differences between this outline and the final publications.)

- Private share in total expenditure; and structure of private expenditure (private insurance, out-of-pocket, non-profit, corporations). A short paragraph on the major features of these private sources (such as the role of out-of-pocket spending; co-payment rules, etc.).
- Total health expenditure as share of GDP
- If possible trends in health expenditure (real growth rate) for recent years (if available)
- Share of current expenditure and investments in total expenditure

A.2. Health expenditure by function

- Structure of health expenditure by major functional categories. If possible, reasons/trends in changes in functional structure of health expenditure.

A.3. Current health expenditure by mode of production

- Structure of health expenditure by categories of mode of production (inpatient, day care, out-patient care, home care). If possible, changes in structure of health expenditure by mode of production.

A.4. Current health expenditure by provider

- Structure of health expenditure by major types of providers

B. Current health expenditure by function and provider

- Share of hospitals (HP.1.), nursing care facilities (HP.2.) and other providers (if relevant) in provision of inpatient care
- Share of hospitals (HP.1.) and providers of ambulatory health care (HP.3.) in provision of day-care
- Share of major types of providers in provision of out-patient care
- Share of major types of providers in provision of home care
- Share of major types of providers in provision of ancillary services
- Functional structure of the hospitals' expenditure

C. Current health expenditure by provider and financing agent

C.1. Spending structure of the financing agents

- The distribution of general government expenditure (HF.1.) between providers
- The distribution of general government (excluding social security) expenditure (HF.1.1) between providers
- The distribution of social security expenditure (HF.1.2) between providers
- The distribution of private expenditure (HF.2.) between providers
- The distribution of private insurance (HF.2.1.+2.2.) between providers
- The distribution of out-of-pocket payments (HF.2.3.) between providers

C.2. How different providers are financed

- Expenditure on hospitals' services by source of funding
- Expenditure on services of nursing and residential care facilities by source of funding
- Expenditure on services of ambulatory health care providers by source of funding

D. Current health expenditure by function and financing agents

D.1. Functional structure of spending by financing agents

- The distribution of general government expenditure (HF.1.) between functions
- The distribution of general government (excluding social security) expenditure (HF.1.1) between functions
- The distribution of social security expenditure (HF.1.2) between functions
- The distribution of private expenditure (HF.2.) between functions
- The distribution of private insurance (HF.2.1.+2.2.) between functions
- The distribution of out-of-pocket payments (HF.2.3.) between functions

D.2. How the different functions are financed

- Expenditure on inpatient services by source of funding
- Expenditure on day care services by source of funding
- Expenditure on out-patient services by source of funding
- Expenditure on home care services by source of funding
- Expenditure on ancillary services by source of funding
- Expenditure on medical goods by source of funding
- Expenditure on pharmaceuticals by source of funding
- Expenditure on prevention and public health services by source of funding

Conclusions

(Conclusions concerning trends in health expenditure, main issues yet to be solved and plans for the next few years).

Annex 1: Methodology

Data sources:

- main sources for public expenditure
- main sources for private expenditure

Differences (if they exit) between classification of health expenditure in national practice and the International Classification for Health Accounts:

- differences between classification of financial sources in national practice and the ICHA-HF

- differences between functional classification in national practice and the ICHA-HC

- differences between classification of providers in national practice and the ICHA-HP

(Participants are kindly requested to use the attached or similar tables to illustrate these differences. Relevant charts are also welcome.)

Estimates on total expenditure

1. Effects of implementation of the SHA on the value of total health expenditure and its major sub-aggregates. (How big was the difference between the pre-SHA and the SHA-based values of total health expenditure in the year of SHA-implementation?).

2. Difference (if they exists) between the value of total health expenditure in current national statistics and the SHA-based value (presented in this working paper).

3. In cases were substantial deviations in methodology are reported under point 2, an assessment as to what degree these might limit the international comparability of main aggregates would be welcome.

Other methodological issues

(Further methodological issues participants consider as interesting for an international audience.)

Annex 2: Tables

Four standard tables presenting the summary data of the first and last available years.

Annex 3: SHA tables

In national currency units and percentage values.

ANNEX 2: PROPOSED WEBSITE

When you click on the country flag, you will access the relevant country chapter in PDF format.