A System of Health Accounts (SHA)

*Item 11.2 of the agenda*

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ESTAT-F5

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Why has A System of Health Accounts (SHA) been developed?

• Health care expenditure and financing accounting framework

• Growing health policy needs:
  • Main drivers for health expenditure growth?
  • Main structural differences in countries' health spending?
  • What factors explain the observed differences between countries?
  • Relations in the structure of health spending and performance of health systems?

• To improve availability and comparability of health care expenditure data

10th April 2014
Dimensions of SHA

• SHA addresses three basic questions:
  
  • Where does the money come from?
    Financing side

  • Where does the money go to?
    Providers side

  • What kinds of services are performed and what types of goods are purchased?
    Health care functions
Eurostat-OECD-WHO joint SHA data collection

• First Joint Eurostat-OECD-WHO joint Health Account Questionnaire launched in 2005

• **Reduced burden** of data collection for the national authorities

• Increase the use of international standards and definitions
  • Further **harmonisation** across national health accounting practices → **availability** and **comparability** of health expenditure data

• **Encouraging** SHA Implementation

**Quality of data depends primarily on contributions by countries**
What is the System of Health Accounts?

- **International statistical standard**
  - an integrated system of comprehensive and internationally comparable accounts and basic accounting rules
- **Functional definition of health care goods and services**
- **ICHA (1.0): International Classification for Health Accounting:**
  - Functions of health care services and goods (ICHA-HC)
  - Categories of providers (health care industries) (ICHA-HP)
  - Sources of funding (financing agents/schemes) (ICHA-HF)
- **Standard SHA tables** cross-classify expenditures under the three basic dimensions
The core and extended accounting framework of SHA 2011

Characteristics of beneficiaries (Diseases, age, gender, income, etc.)

Consumer health interface

Functions ICHA-HC

SHA Core accounting framework

Financing schemes ICHA-HF

Providers ICHA-HP

Revenue of financing scheme ICHA-FS

Financing interface

Financing agents ICHA-FA

Gross capital formation

Provision interface

Factors of provision ICHA-FP

External trade

Source: IHAT for SHA 2011.

10th April 2014
SHA: Definition of health care

• Health care means all activities with the primary purpose of:
  • improving,
  • maintaining and
  • preventing the deterioration of the health status of persons and
  • mitigating the consequences of ill-health through the application of qualified health knowledge

Regardless whether provided by health care or other institutions

10th April 2014
SHA: Characteristics

- Consumption
  - Final
- Resident Units
  - imports vs. exports
- Timing
  - Accrual basis
- Consistent with SNA basic concepts
- Financing Schemes (SHA 2011)
  - Inspired by ESSPROS
- Non-observed economy
  - Included

10th April 2014
Changes from SHA 1.0 (2000) to SHA 2011

- **HC**: better boundaries for LTC, reclassification at 2\textsuperscript{nd}-level digit for preventive care & broader in scope, better separation of capital account

- **HP**: consistent with SHA 1.0

- **HF**: new unit for measuring financing axis, financing schemes vs. financing agents

10\textsuperscript{th} April 2014
JHAQ data submitted by countries

• Currently, SHA 1.0-based

• Commission Regulation to be put in force in 2014
  
  • SHA-2011 based

• First SHA 2011-based data transmission in 2016
  for reference year 2014 (in 2015 under GA)
# ESSPROS – SHA linkage (HC functions)

<table>
<thead>
<tr>
<th>Function</th>
<th>SHA relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sickness / Health care</td>
<td>HC.1 Curative care&lt;br&gt;HC.2 Rehabilitative care&lt;br&gt;HC.3 Long-term care (health)&lt;br&gt;HC.4 Ancillary services (non-specified by function)&lt;br&gt;HC.5 Medical goods non-specified by function&lt;br&gt;HC.6 Preventive care</td>
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<tr>
<td>2. Disability</td>
<td>HCR.1 Long-term care (social)</td>
</tr>
<tr>
<td>3. Old age</td>
<td>HCR.1 Long-term care (social)</td>
</tr>
<tr>
<td>4. Survivors</td>
<td>Not relevant</td>
</tr>
<tr>
<td>5. Family / Children</td>
<td>Not relevant</td>
</tr>
<tr>
<td>6. Unemployment</td>
<td>Not relevant</td>
</tr>
<tr>
<td>7. Housing</td>
<td>Not relevant</td>
</tr>
<tr>
<td>8. Social exclusion n.e.c.</td>
<td>Social care in relation to health care</td>
</tr>
</tbody>
</table>
### ESSPROS – SHA linkage (HC financing schemes)

**SHA health care financing schemes**

<table>
<thead>
<tr>
<th>HF.1 Government schemes &amp; compulsory contributory health care financing schemes</th>
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<tbody>
<tr>
<td>HF.1.1 Government schemes</td>
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<tr>
<td>HF.1.2 Compulsory contributory health insurance schemes</td>
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<td>HF.1.2.1 Social health insurance schemes</td>
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<td>HF.1.2.2 Compulsory private insurance schemes</td>
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<table>
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<th>HF.2 Voluntary health care payment schemes</th>
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<td>HF.2.1.2 Complementary/supplementary insurance schemes</td>
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<tr>
<td>HF.2.2 NPISH financing schemes</td>
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<td>HF.2.3 Enterprise financing schemes</td>
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<tr>
<th>HF.3 Household out-of-pocket payment</th>
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</table>

| HF.4 Rest of the world financing schemes (non-resident) |
ESSPROS – SHA linkage (HC financing schemes)

- SHA financing schemes border lines
  - Mandatory coverage (imposed by law)?
  - Prepaid contribution? (if no, OOP)
  - Contributory nature?
  - Pooling interpersonal?
  - Purchase of insurance policy?
- Almost one-to-one relation between ESSPROS social protection schemes and SHA financing schemes
- However, different health care boundaries
Conclusions

• Are there countries where the same (group of) people compile both ESSPROS and SHA data?

• Do they think that studying further the linkage between ESSPROS and SHA can provide deeper insight to policy analysts?

• Would they be willing to assist Eurostat in further studying the linkage between SHA & ESSPROS?