

# SHA 2011

Why?

What's New?

What are the Challenges?

Ravi Rannan-Eliya

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**Why standards?**  
**Why classifications?**

# Origins of the “System of Health Accounts” (SHA)

## Pre-SHA

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### **No standards**

- Ad-hoc national standards & international frameworks
- Lack of comparability in international estimates
- Realization in OECD that lack of comparability of numbers limited policy learning from each other

## 2000

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### **OECD System of Health Accounts (SHA)**

- First international standard
- Developed by OECD primarily to facilitate collection of comparable statistics from OECD members
- Recommended by WHO for international reporting

# A “System of Health Accounts” OECD (SHA 1.0)



## Developed by OECD:

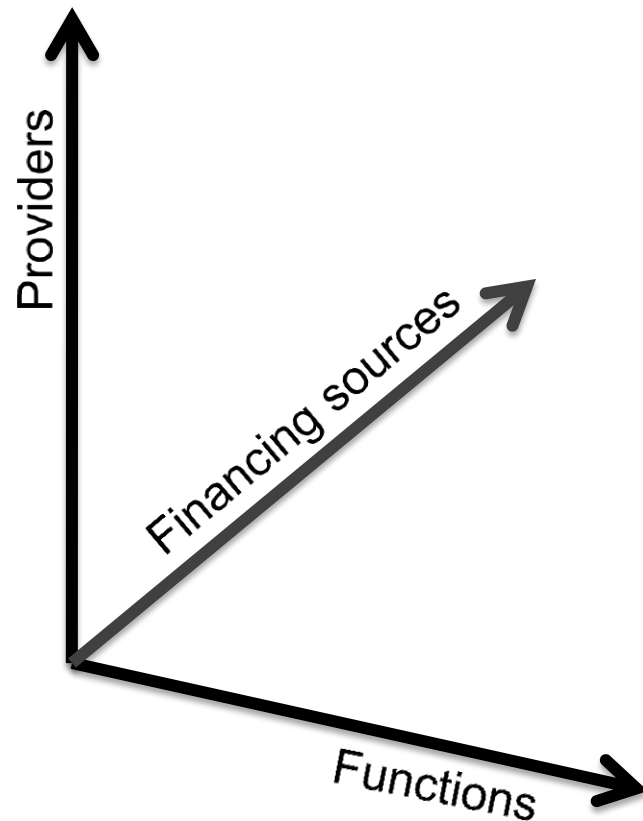
- To provide standard reporting tables for OECD (international) comparison
- To provide an internationally harmonised boundary for health care activities
- To provide a consistent framework for analysing health systems
- To provide a rigid framework for building NHA to permit consistent reporting over time

# Features of OECD SHA 1.0



- Provides explicit and comprehensive boundary of health and health-related production
- Analyzes health expenditures in three dimensions: sources, providers and functions
- Detailed sets of classifications for the uses of spending: providers and functions
- Linkages with other international classifications, including SNA
- Basis for adaptation to meet specific national requirements

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# Why classifications?

- Description and comparison demand the ability to categorize consistently
- Classification critical to defining what is health spending



# Classification of Functions

- HC.1 Inpatient curative care
  - HC.1.1 Inpatient curative care
  - HC.1.2 Day curative care
  - HC1.3 Outpatient curative care
  - HC1.4 Home-based curative care
- HC.2 Rehabilitative care
- HC.3 Long-term care
- HC.4 Ancillary services
- HC.5 Medical goods
- HC.6 Preventive care
- HC.7 Governance, and health systems and financing administration
- HC.9 Other healthcare services n.e.c.

# Health-Related Functions

- HC.R.1 Capital formation of health providers
- 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.7 Administration and provision of health-related cash-benefits

# ICHA-HC key elements

- Defines functional boundaries of health care
- Basic breakdowns of health functions
  - **core health activities** vs. **health-related activities**
  - **personal services** vs. **collective services**
  - **curative** vs. **preventive services**
  - **Inpatient** vs. **outpatient**
  - **current** vs. **capital**
- Totals for health reporting
  - Total Current Expenditure on Health (HC.1-7)
  - Total Expenditure on Health (HC.1-7 + HC.R.1)
  - General Expenditure on Health (HC.1-7 + HC.R.1-7)

# SHA 1.0: Reporting National Spending

HC.1 Services of curative care  
HC.2 Services of rehabilitative care  
HC.3 Services of long-term nursing care  
HC.4 Ancillary services to health care  
HC.5 Medical goods dispensed to out-patients  
HC.6 Prevention and public health services  
HC.7 Health administration and health insurance

HC.R.1 Capital formation  
HC.R.2 Education and training  
HC.R.3 Research and development  
HC.R.4 Food, hygiene and drinking water control  
HC.R.5 Environmental health  
HC.R.6 Social services in-kind  
HC.R.7 Health-related cash-benefits

**Total  
Current  
Expenditure  
on Health**

**Total  
Expenditure  
on Health  
(TEH)**

**General  
Expenditure  
on Health  
(GEH)**

# **SHA 2011**

## **Why?**

# Why?

## 1. Revision is normal for any classification system

- E.g., International Classification of Disease (ICD)
- Mistakes have to be corrected, ambiguities removed, new concepts included and adjustments made based on experience

## 2. SHA 1.0 was felt to be limited in what it described

- Concerns that it did not fully describe how money flowed and was managed within health system
- Increasing interest to extend NHA to new questions such as disease or equity or links to the wider economy

## 3. SHA was not “owned” by everyone

- SHA 2011 is a joint product of OECD, WHO and Eurostat, unlike SHA 1.0

# **SHA 2011**

## **What's New?**

# New boundary for national spending

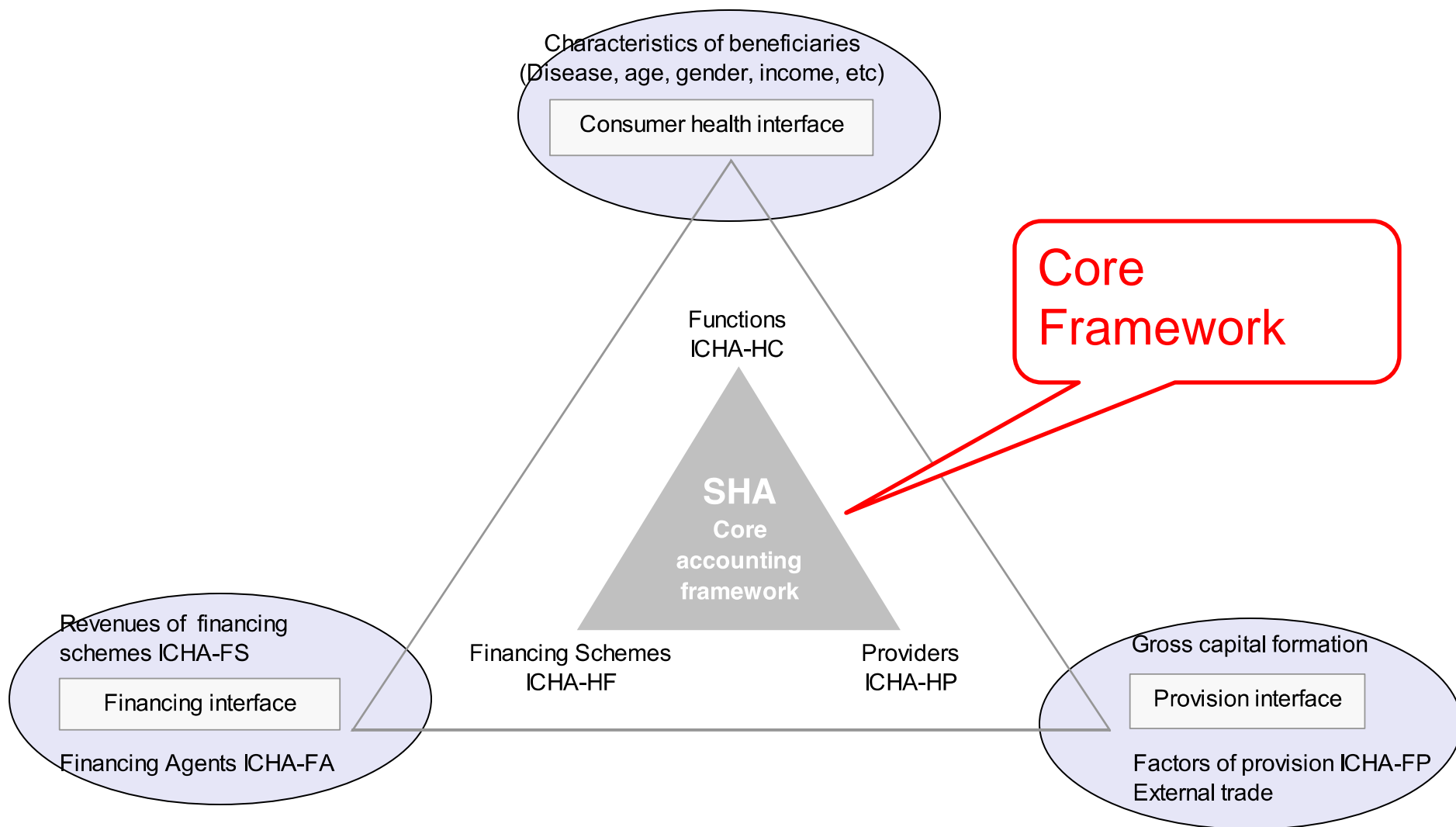
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**Current  
Expenditure  
on Health**

HC.R.1 Capital formation  
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# “New” overall framework



# New classifications

## ***SHA 1.0***

- Health care by function (ICHA-HC)
- Health care by provider industry (ICHA-HP)
- Sources of healthcare financing (ICHA-HF)

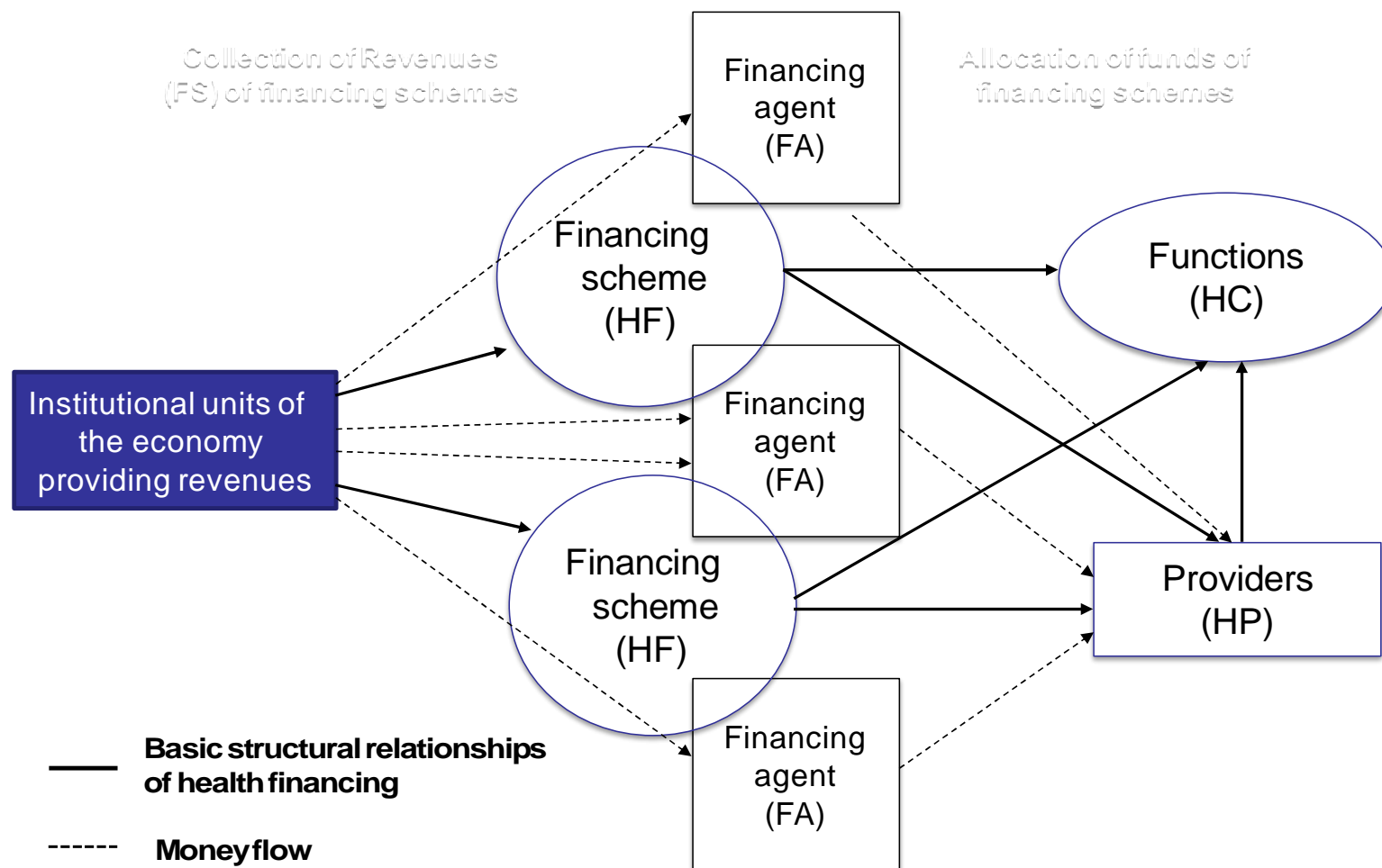
## ***SHA 2011***

- Health care by function (ICHA-HC)
- Health care by provider industry (ICHA-HP)
- Health Financing Schemes (ICHA-HF)
- Financing Agents (ICHA-FA)
- Revenues of Health Financing Schemes (ICHA-FS)

# Key changes to primary classifications

1. Capital investment no longer counted in grand total – tracked in separate capital account
2. Preventive health expenditure classification reorganized
3. Medicines distributed to outpatients
  - Change in definition of OTC from legal status of medicine to whether physician prescribed or patient initiated

# SHA 2011 Financing Framework



# Revenues of financing schemes

“Revenue is an increase in the funds of a health care financing scheme, through specific contribution mechanisms. The categories of the classification are the particular types of transaction through which the financing schemes obtain their revenues.”

## Types

- Government transfers (from budget)
- Government from foreign sources
- Social insurance contributions
- Other compulsory prepayments
- Voluntary prepayments
- Other domestic revenues
- Direct foreign transfers

# Spending by beneficiaries

**Aim: Disaggregate spending by type of recipient**

## **Types**

- Age/sex
  - Disease/condition
  - Socioeconomic status/income group
  - Geographical region
- 
- But only general guidance provided, No definitive classifications!

**☹ Is this a big, really difficult change?**

# Short Answer

**NO ! ☺**

- Current expenditure on health should not change
- The core framework is basically the same
  - We still have to split spending by sources (schemes), providers and functions
  - Only minor changes in the classifications and labels
- Elements of the extended framework are optional and not essential to implement SHA 2011
- OECD countries have typically implemented the core framework first, then gradually implemented some but not all elements of the extended framework



# **What are the challenges?**

# Key Challenges

## Core Framework

- **Changes in the detailed classification categories within the core framework**
  - Requires careful review of classifications, data and methods
  - Likely identification of some new data sources and methods where changes have occurred
- **Maintaining continuity of existing time series**
  - Important for policy makers
  - New data sources/methods should be back-estimated, but can take time when data are old, and may require adjustments when data cannot be accessed
- **Maintaining SHA 1.0 time series**
  - May want to produce SHA 1.0 in parallel with SHA 2011 during transitional period. What OECD countries generally have done.
  - Requires extension of database to allow dual/triple reporting

Code	Description	SHA 1.0 codes
<b>HP.1</b>	<b>Hospitals</b>	<b>HP.1.0</b>
HP.1.1	General hospitals	HP.1.1
HP.1.2	Mental health hospitals	HP.1.2
HP.1.3	Specialised hospitals (other than mental health hospitals)	HP.1.3
<b>HP.2</b>	<b>Residential long-term care facilities</b>	<b>HP.2</b>
HP.2.1	Long-term nursing care facilities	HP.2.1
HP.2.2	Mental health and substance abuse facilities	HP.2.2
HP.2.9	Other residential long-term care facilities	HP.2.3, 2.9
<b>HP.3</b>	<b>Providers of ambulatory health care</b>	<b>HP.3</b>
HP.3.1	Medical practices	HP.3.1
HP.3.1.1	Offices of general medical practitioners	HP.3.1
HP.3.1.2	Offices of mental medical specialists	HP.3.1
HP.3.1.3	Offices of medical specialists (other than mental medical specialists)	HP.3.1
HP.3.2	Dental practice	HP.3.2
HP.3.3	Other health care practitioners	HP.3.3
HP.3.4	Ambulatory health care centres	HP.3.4
HP.3.4.1	Family planning centres	HP.3.4.1
HP.3.4.2	Ambulatory mental health and substance abuse centres	HP.3.4.2
HP.3.4.3	Free-standing ambulatory surgery centres	HP.3.4.3
HP.3.4.4	Dialysis care centres	HP.3.4.4
HP.3.4.9	All other ambulatory centres	HP.3.4.5, 3.4.9
HP.3.5	Providers of home health care services	HP.3.6
<b>HP.4</b>	<b>Providers of ancillary services</b>	
HP.4.1	Providers of patient transportation and emergency rescue	HP.3.9.1
HP.4.2	Medical and diagnostic laboratories	HP.3.5, 3.9.2
HP.4.9	Other providers of ancillary services	HP.3.9.9
<b>HP.5</b>	<b>Retailers and other providers of medical goods</b>	<b>HP.4</b>
HP.5.1	Pharmacies	HP.4.1
HP.5.2	Retail sellers and other suppliers of durable medical goods and medical appliances	HP.4.2, 4.3, 4.4
HP.5.9	All other miscellaneous sellers and other suppliers of pharmaceuticals and medical goods	HP.4.9

**SHA  
2011**

Changes in  
provider  
classification  
are minor

# SHA 2011

Changes in functions classification are small:

- Specialized vs. general IP care
- Some additional detail to LTC
- Explicit recognition that traditional medicine is counted

Code	Description	SHA 1.0 codes
<b>HC.1</b>	<b>Curative care</b>	<b>HC.1</b>
HC.1.1	Inpatient curative care	HC.1.1
HC.1.1.1	General inpatient curative care	
HC.1.1.2	Specialised inpatient curative care	
HC.1.2	Day curative care	HC.1.2
HC.1.2.1	General day curative care	
HC.1.2.2	Specialised day curative care	
HC.1.3	Outpatient curative care	HC.1.3
HC.1.3.1	General outpatient curative care	HC.1.3.1
HC.1.3.2	Dental outpatient curative care	HC.1.3.2
HC.1.3.3	Specialised outpatient curative care	HC 1.3.3
HC.1.4	Home-based curative care	HC.1.4
<b>HC.2</b>	<b>Rehabilitative care</b>	<b>HC.2</b>
HC.2.1	Inpatient rehabilitative care	HC2.1
HC.2.2	Day rehabilitative care	HC2.2
HC.2.3	Outpatient rehabilitative care	HC2.3
HC.2.4	Home-based rehabilitative care	HC2.4
<b>HC.3</b>	<b>Long-term care (health)</b>	<b>HC.3</b>
HC.3.1	Inpatient long-term care (health)	HC.3.1
HC.3.2	Day long-term care (health)	HC.3.2
HC.3.3	Outpatient long-term care (health)	part of HC.3
HC.3.4	Home-based long-term care (health)	HC.3.3
<b>HC.4</b>	<b>Ancillary services (non-specified by function)</b>	<b>HC.4</b>
HC.4.1	Laboratory services	HC.4.1
HC.4.2	Imaging services	HC.4.2
HC.4.3	Patient transportation	HC.4.3
<b>HC.5</b>	<b>Medical goods (non-specified by function)</b>	<b>HC.5</b>
HC.5.1	Pharmaceuticals and other medical non-durable goods	HC.5.1
HC 5.1.1	Prescribed medicines	HC.5.1.1
HC 5.1.2	Over-the-counter medicines	HC.5.1.2
HC 5.1.3	Other medical non-durable goods	HC.5.1.3
HC.5.2	Therapeutic appliances and other medical goods	HC.5.2
HC.5.2.1	Glasses and other vision products	HC.5.2.1
HC.5.2.2	Hearing aids	HC.5.2.3
HC.5.2.3	Other orthopaedic appliances and prosthetics (excluding glasses and hearing aids)	HC.5.2.2
HC.5.2.9	All other medical durables, including medical technical devices	HC.5.2.4- HC.5.2.9

HC.6	Preventive care	HC.6, part of HC.R.4, HC.R.5
HC.6.1	Information, education and counseling programmes	Part of HC.6.9, part of HCR 4, HC.R.5
HC.6.2	Immunisation programmes	Part of HC.6.3
HC.6.3	Early disease detection programmes	Part of HC.6.3, HC.6.4
HC.6.4	Healthy condition monitoring programmes	Part of HC.6.1, HC.6.2, HC.6.5
HC.6.5	Epidemiological surveillance and risk and disease control programmes	HC.6, part of HC. 4, HC. 5
HC.6.6	Preparing for disaster and emergency response programmes	Part of HC.6

## SHA 2011

Largest changes in functions classification are in categorization of preventive care

- MCH, School health, communicable disease prevention, etc remapped to new modalities, but still remain

HF.1	Government schemes and compulsory contributory health care financing schemes	HF.1	General government
HF.1.1	Government schemes	HF.1.1	General government excluding social security funds
HF.1.1.1	Central government schemes	HF.1.1.1	Central government
HF.1.1.2	State/regional/local government schemes	HF.1.1.2	State/provincial government
		HF.1.1.3	Local/municipal government
HF.1.2	Compulsory contributory health insurance schemes		
HF.1.2.1	Social health insurance	HF.1.2	Social security funds
HF.1.2.2	Compulsory private insurance		
HF.1.3	Compulsory Medical Saving Accounts		
		HF.2	Private sector
HF.2	Voluntary health care payment schemes (other than OOP)		
HF.2.1	Voluntary health insurance schemes		
HF.2.1.1	Primary/substitutory health insurance schemes	HF.2.1	Private social insurance
HF.2.1.2	Complementary/supplementary voluntary insurance schemes	HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.2	NPISH financing schemes	HF.2.4	NPISH (other than social insurance)
HF.2.3	Enterprise financing schemes	HF.2.5	Corporations (other than health insurance)
HF.2.3.1	Enterprises (except health care providers) financing schemes		
HF.2.3.2	Health care providers financing schemes		
HF.3	Household out-of-pocket payment	HF.2.3	Private household out-of-pocket expenditure
HF.3.1	Out-of-pocket excluding cost-sharing	HF.2.3.1	Out-of-pocket excluding cost-sharing
HF.3.2	Cost sharing with third-party payers:	HF.2.3.2	Cost sharing: central government
HF.3.2.1	Cost sharing with government schemes and compulsory contributory health insurance	HF.2.3.3	Cost sharing: state/provincial government
		HF.2.3.4	Cost sharing: local/municipal government
HF.3.2.2	Cost sharing with voluntary insurance schemes	HF.2.3.5	Cost sharing: social security funds
		HF.2.3.6	Cost sharing: private social insurance
		HF.2.3.7	Cost sharing: other private insurance
		HF.2.3.9	All other cost sharing
HF.4	Rest of the world financing schemes	HF.3	Rest of the world
HF.4.1	Compulsory schemes (non-resident)		
HF.4.1.1	Compulsory health insurance schemes (non-resident)		
HF.4.1.2	Other schemes (non-resident)		
HF.4.2	Voluntary private schemes (non-resident)		
HF.4.2.1	Voluntary health insurance schemes (non-resident)		
HF.4.2.2	Other schemes (non-resident)		

# SHA 2011

Changes in financing sources/schemes classification:

Public/Private >>  
Compulsory/Voluntary

# Key Challenges

## Core Framework

### **Maintaining continuity of existing time series**

- Important for policy makers
- New data sources/methods should be back-estimated

### **Practical problems**

- Often data for new methods cannot be traced back to beginning of time series. Data no longer archived, or no longer possible to collect primary data.
- May need to extrapolate new data sources backwards using older data as guide

# Key Challenges

## Core Framework

### **Maintaining SHA 1.0 time series**

- May want to produce SHA 1.0 in parallel with SHA 2011 during transitional period. What OECD countries generally have done.
- Requires extension of database to allow dual/triple reporting

### **Policy makers/users may be confused by change in totals**

- Needs careful preparation of users
- Having parallel time series using SHA 1.0/old framework will be helpful
- $\text{SHA 1.0 Current Expenditure} = \text{SHA 2011 Current Expenditure}$ , so SHA 1.0 TEH can be computed by simply maintaining tracking of capital spending
- Parallel time series also valuable to allow continued comparison with other countries still reporting SHA 1.0



# Key Challenges

## Extended Framework

### **Revenues of financing schemes**

- Requires careful review of classifications, data and methods
- Likely identification of some new data sources and methods where changes have occurred

### **In practice**

- In many cases, trivial to do
- Revenues of government largely taxes
- Revenues of social insurance/private insurance schemes require separating premium sources

# Key Challenges

## Extended Framework

### **Beneficiaries**

- Requires combining micro data analyses with NHA results
- Separate micro data sets required for SES/income groups (“Equity analyses”) and disease/age/sex.

### **In practice**

- Involves methods/expertise already available in other groups
- Challenge is to combine NHA core work with collaborative work with other groups
- For Malaysia, most of the relevant work already exists

# Expenditure on inpatients by disease groups and age 2013 (RM million)

