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New insights into health financing: First results of the international data collection under the System of Health Accounts 2011 framework

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ABSTRACT

International comparisons of health spending and financing are most frequently carried out using datasets of international organisations based on the *System of Health Accounts* (SHA). This accounting framework has recently been updated and 2016 saw the first international data collection under the new *SHA 2011* guidelines. In addition to reaching better comparability of health spending figures and greater country coverage, the updated framework has seen changes in the dimension of health financing leading to important consequences when analysing health financing data. This article presents the first results of health spending and financing data collected under this new framework and highlights the areas where *SHA 2011* has become a more useful tool for policy analysis, by complementing data on expenditure of health financing schemes with information about their revenue streams. It describes the major conceptual changes in the scope of health financing and highlights why comprehensive analyses based on *SHA 2011* can provide for a more complete description and comparison of health financing across countries, facilitate a more meaningful discussion of fiscal sustainability of health spending by also analysing the revenues of compulsory public schemes and help to clarify the role of governments in financing health care – which is generally much bigger than previously documented.

Introduction

International analyses of health spending and financing trends to identify their drivers have frequently relied on data collected by supra- or international organisations [1–5]. Whereas data comparability had historically been an issue, a milestone in increasing comparability was achieved with the release of the System of Health Accounts 1.0 (SHA) in 2000 [6]. *SHA 1.0* provided an international framework to define and demarcate health spending and developed a set of classifications for the three core dimensions of health care, namely the functions, providers and financing and also pointed to areas where additional analysis could be relevant. Since then, many countries have used this framework to construct national health accounts (NHA) or adapted their existing framework accordingly. Additionally, further assistance was also provided to help low and medium income countries to implement this framework with some adjustments of particular relevance to this group of countries [7]. But some challenges in constructing NHA remained in a number of countries [8]. This refers, for example, to data availability and the incorporation of information from non-routine data collections and the institutionalisation of NHA beyond pilot studies; this in turn can impede the reporting of break-free time series. From a conceptual point of view, experience in the implementation of the framework highlighted a number of issues with SHA 1.0 that were either unclear or were open to different interpretation by countries affecting cross-country comparability. This included, for example, questions such as to what extent spending on long-term care should be considered as health care expenditure, the different perspectives of health care financing, and conceptual challenges around combining expenditure on the consumption of health care goods and services with investments in the health provider infrastructure. To resolve these issues and meet the needs of evolving health care systems, the System of Health Accounts was revised in a collective effort by the Organisation of Economic Co-operation and Development, the World Health Organization and the Statistical Office of the European Union in 2011 [9]. In addition to being more precise in defining the transactions to be subsumed under health expenditure, *SHA 2011* further developed additional analytical possibilities. The provider interface, for example, includes a breakdown of the input factors and associated costs that go into the production of health care goods and services; the

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consumer health interface proposes a breakdown of health spending into characteristics of the beneficiaries, such as age, gender and disease categories; and the financing interface facilitates the conceptual distinction between the expenditure of financing schemes (e.g. National Health Service, Social Health Insurance), the revenues of these schemes (e.g. transfers from the central government, social insurance contributions by employees) and the institutional units managing the financing schemes – namely, the financing agents (e.g. municipal health boards, social health insurance funds, private insurance companies).

SHA 2011 is now considered as the global standard for the construction of NHA and has been adopted by all countries of the European Union, nearly all member countries of the OECD and many additional countries beyond that.

New look at health financing

One of the main objectives of the new SHA 2011 framework was to introduce a new perspective to better analyse the financing of health care systems. Within the 'core' SHA framework, the main focus of the financing dimension becomes the "financing schemes" – that is, the type of financing arrangements or "body of rules" that provide health care coverage. On the most aggregate level, these can be divided into 'compulsory schemes' where coverage is either due to residence-based entitlements provided by government schemes or through mandatory social or private insurance, and 'voluntary schemes' which are at the discretion of the payer such as voluntary health insurance or out-of-pocket payments (Appendix A). This latter category also includes non-profit schemes that may finance health care services out of charities as well as employer-based schemes which typically finance occupational health care but may also pay for services beyond that.

In addition to the shift away from financing agents to financing schemes, the financing dimension under SHA 2011 has been updated to make it more universally applicable to all countries and to reflect new and evolving financing arrangements in the health sector. For example, Compulsory Medical Savings Accounts were introduced as a separate category, although they currently do not appear to play a role in any of the 35 OECD countries.

A second important element introduced into the framework that enhances the possibility to analyse health financing, is to complement the information on spending of financing schemes with information about their *sources of revenue*. The possible policy uses of this analysis are manifold: (i) a comprehensive description of how resources are raised in health systems, both for the system as a whole and for each individual financing scheme; (ii) monitoring the financial sustainability of health care delivery by comparing revenues and expenses of financing schemes; (iii) better forward-looking planning by projecting revenues and spending separately to identify fiscal gaps. Appendix B gives an overview of the classification of revenues of financing schemes proposed in SHA 2011.

On a more detailed level, for some sources of revenues the classification includes information concerning the burden of the 'final payers' – that is, the entities ultimately bearing the costs of health care service delivery: for example the employees and employers in the case of social insurance contributions. The new classification of revenues also allows for a more holistic evaluation of the role of financing from foreign sources, i.e. via development aid. Again, this may not be relevant in most OECD countries, but can give a more comprehensive overview about how funds from foreign sources are induced in health systems of low- and middle income countries.

The next sections present some initial results of the first comprehensive international data collection based on the new framework with a focus on the new financing interface before highlighting some policy relevant issues that the change in financing perspective entails to make SHA 2011 a useful tool in monitoring health spending and financing and also for policy planning.

Material and methods

Although a number of countries have already reported data based on this new framework in previous years, *SHA 2011* was used in 2016 for the first time as the exclusive framework for the joint OECD, WHO and Eurostat data collection on health care spending and financing. This coincided with the first year the Commission Regulation 2015/359 came into effect which made the reporting of a minimum data set on health expenditure and financing based on SHA 2011 mandatory for countries of the European Union. OECD took this opportunity to switch the publication of health spending and financing data in 2016 to the new SHA 2011 framework accordingly [10]. To guarantee break-free time series, countries have been encouraged to recalculate and submit data for earlier years incorporating the new framework.

The data presented in this article stems from the 2016 Joint Health Accounts Questionnaire data collections carried out collectively by OECD, WHO and Eurostat. 29 out of 35 OECD countries were able to provide near complete information on health expenditure for the dimensions functions, provider and financing schemes for 2014; in some few instances one of the three dimensions was not reported or the level of detail in the reported categories was limited. Four additional countries submitted some preliminary aggregates for 2014. Additionally, on a very aggregate level 15 countries reported preliminary data for 2015. Missing data for spending by financing schemes was estimated by the OECD for 2014 and 2015 using available national health spending projections or based on trends of available economic indicators such as private consumption and government consumption retrieved from National Accounts databases.

Across country averages of health spending shares and growth rates were calculated as an unweighted arithmetic mean of the country-specific values. 'Real' spending growth rates were calculated adjusting nominal spending with the country-specific GDP deflator. Country-specific average annual growth rates are calculated as geometric means.

Results

In 2015, current health expenditure (that is, excluding investment in health sector infrastructure) is estimated to have stood at 9.0% of Gross Domestic Product (GDP) across OECD countries, ranging from less than 6% in Turkey, Latvia and Mexico to nearly 17% in the United States (Appendix C). The implementation of SHA 2011 has led to significant changes in reporting for a number of countries. For example, Ireland, Japan, Sweden and the United Kingdom have all seen substantial increases in their health spending estimates, mainly due to the implementation of the boundaries demarcating long-term care [11,12]. These countries now all report health spending above the OECD average.

After average annual growth rates per capita of between 3 and 5% in the first decade of the millennium, real health spending growth slowed markedly to 0.8% in 2010, stagnated in 2011 before picking up again in 2012 with moderate annual growth of around 1–2% since, closely following GDP growth (Appendix D).

In a number of countries, health spending was severely affected by the economic and financial crisis starting in late 2008 when many governments tried to rein in health spending in an effort to balance public budgets. Average annual health spending growth per capita was negative between 2009 and 2015 in Greece (-6.6%), Portugal (-2.0%), Italy (-1.1%), Spain (-0.1%). Measures to cut health spending included the freeze of salaries for health workers,