3 Australia's approach to national health and welfare services accounts—OECD classification systems

Australia has traditionally reported expenditure on health and welfare services in terms of the broad types of services provided (for example, hospital care, medical services, pharmaceuticals) and the source of funding (for example, Commonwealth, state/territory). Since 1998–99, the AIHW has begun to classify health expenditure in terms of the OECD's three-faceted System of Health Accounts (SHA) categories (OECD 2000). These include the service provider 'industry' as well as the functional and funding aspects that already exist in Australia's reporting system. We are also looking at some restructure of our reporting on welfare services expenditure to show more fully the flows between the various players. This will enable us to report using a similar three-faceted approach, which shows who provides the services that are funded.

System of Health Accounts

The primary international reporting requirement for Australia, so far as health expenditure is concerned, is through the OECD. In order to enable it to comply with that requirement, AIHW has, to the greatest extent possible, structured its collection of health expenditure estimates in line with the OECD's International Classification for Health Accounts (ICHA).

The OECD's SHA is built around three aspects of health expenditure:

- function (ICHA–HC)
- provider (ICHA–HP)
- funding sources (ICHA–HF).

Although not itself a fully-fledged system of satellite accounts, the SHA provides many of the initial building blocks that will be useful in the future development of health satellite accounts for Australia.

The SHA was developed by the OECD to:

- provide internationally comparable tables of health expenditure;
- define boundaries for health care that are internationally consistent; and
- provide a framework for economic analyses of health care systems that are consistent with national accounting rules.

The way estimates are recorded in Australia involves a combination of its traditional two-axis matrix (areas of expenditure by sources of funds) and the three-faceted ICHA. All these addresses are recorded against each input into the database, which makes it possible to produce tables identifying:

- the sector that ultimately provides the funding for expenditure;
- the provider type involved; and
- the sector incurring the final expenditure.

The functional aspect of the SHA (ICHA–HC)

The functions of health care used in the SHA refer to the final consumption of goods and services in undertaking health and health-related functions aimed at achieving a defined set of goals, namely:

- promoting health and preventing disease;
- curing illness and reducing premature mortality;
- caring for people affected by chronic illness who require nursing care;
- caring for people with health-related impairment and disability who require nursing care;
- assisting terminally ill patients;
- providing and administering public health programs; and
- providing and administering health programs, health insurance and other funding arrangements.

The types of functions covered by the SHA include not only direct health activities such as treatment in hospital, doctors' visits or vaccination campaigns, but also the supporting activities that are involved in the production and provision of these direct services (Table 3). These include the various clerical/administrative tasks and technical and other supportive activities that support the provision of direct services. Such support services are often provided in-house, as is the case in respect of many hospital-based support services, which include food, cleaning and laundry services provided by hospital staff. These services may also be bought-in services, for example where a health service provider uses a commercial laundry service to provide laundry services.

The ICHA–HC classifications broadly map to the SNA93 Classification of the Functions of Government and the Classification of Individual Consumption by Purpose (see Appendix Table A1 on page 66). Within the ICHA–HC, the OECD has also tried to cross-classify many of its categories with other international classification systems. An example of this is the cross-classification with the World Health Organization's *essential public health services* classifications (see Appendix Table A2 on page 68).

Table 3: ICHA–HC functional classification of health care

ICHA code	Functions of health care
HC.1–HC.5	Personal health care services and goods
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 outpatients
HC.6–HC.7	Collective health care services
HC.6	Prevention and public health services
HC.7	Health administration and health insurance
HC.R	Health-related functions
HC.R.1	Capital formation
HC.R.2	Education and training of health personnel
HC.R.3	Research and development
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

Source: OECD 2000.

Within the functional classifications HC.1 to HC.3, expenditures are categorised into four modes of production:

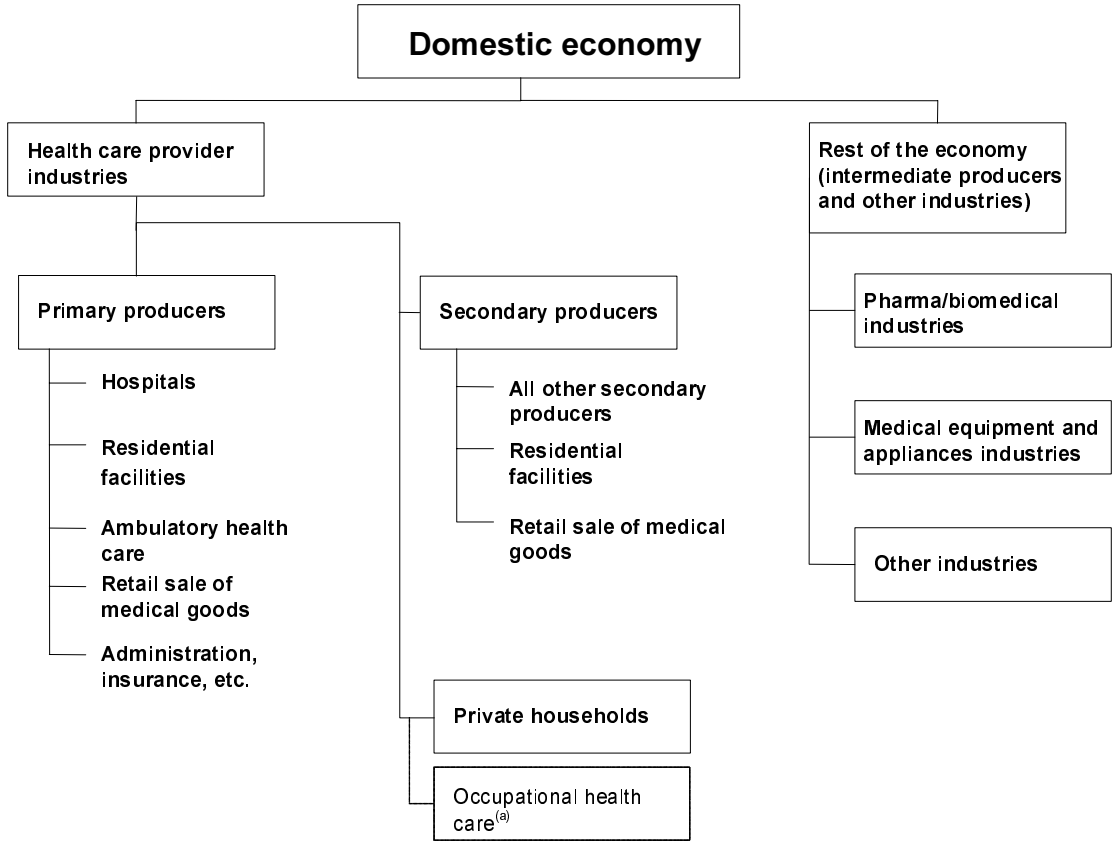
- in-patient care
- day care
- outpatient care
- home care.

The SHA's in-patient care category is roughly equivalent to Australia's admitted patient care category, but excludes care provided to admitted day-only patients. Day care refers to admitted patient care for day-only patients. Outpatient care, in the SHA context, relates to any activity, within the functional classifications HC.1–HC.3, that does not involve the formal admission and discharge of a patient with its associated administrative paperwork and statistics. This includes any medical, dental and other professional services provided to patients who are not admitted to a hospital. In theory, home care should include any health services provided to patients in their own home. In practice, Australia would include such things as doctors' home visits and obstetric services delivered in the home within the 'outpatient care' mode. Home care, in Australia, has been limited to home visits by nursing services. A detailed breakdown of the ICHA–HC classifications can be found in the OECD's publication on the System of Health Accounts (OECD 2000).

Providers of health care services (ICHA–HP)

The ICHA–HP classification was developed by the OECD from the International Standard Industrial Classification (see Appendix Table A3, page 70). It identifies providers in terms of:

- primary providers—producers of health services whose primary activity is health care services; and
- secondary providers—producers of health services whose health care activities are secondary to their primary activity, which is non-health (Figure 2).



(a) Occupational health care is not included in Australia's estimates of health expenditure.

Source: OECD 2000:52.

Figure 2: Health care providers within the economy

Under this classification system, residential care facilities can appear as either primary or secondary producers, depending on whether the major activity of the particular facility is the provision of care to highly dependent patients or less dependent residents.

Funders of health care services (ICHA–HF)

The financing of health care services is presented in the SHA as the ultimate source of funding for health services. For example, who funds health services that are paid for by individuals who, in turn, receive a related transfer payment from the central government? The SHA shows the funding as a central government funding source for the part covered by the transfer and private households for what is not covered (Table 1, page 16).

Table 4: ICHA–HF classification of sources of funding

ICHA code	Funding sources
HF.1	General government
HF.1.1	General government excluding social security funds
HF.1.1.1	Central government
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.2.3	Private households
HF.2.4	Non-profit institutions serving households (other than social insurance)
HF.2.5	Corporations (other than health insurance
HF.3	Rest of the world

Source: OECD 2000.

The main drawback of the OECD's SHA, at least as it has been applied in Australia, is that it does not provide for a sectoral split of the actual incidence of expenditure—particularly in relation to hospital care. This can, however, be achieved in Australia's case, because expenditure on public hospitals is separated from expenditure on private hospitals.

Social expenditures (SOCX) database

The OECD's social expenditures (SOCX) database contains estimates of government expenditure in 13 categories of social expenditure (Table 5). This database is in its early stages of development. Social expenditure in the SOCX database includes expenditure on health services derived from OECD's health database, which is based on the SHA.

Table 5: Categories of social expenditure used in the OECD's Social Expenditures 2000

SOCX code	Measure	SOCX code	Measure
1	OLD AGE CASH BENEFITS	8	FAMILY SERVICES
1.1	Old age pension	8.1	Formal day care
1.2	Old age civil servant pension	8.2	Personal services
1.3	Veterans' service pension	8.3	Household services
1.4	Old age other cash benefits	8.4	Family other benefits-in-kind
1.5	Early retirement pension	9	ACTIVE LABOUR MARKET PROGRAMS
2	DISABILITY CASH BENEFITS	9.1	Labour market training
2.1	Disability pension	9.2	Youth measures
2.2	Disabled civil servant pension	9.3	Subsidised employment
2.3	Disabled child pension	9.4	Employment measures for disabled
2.4	Disabled veterans' pension	9.5	Employment service and administration
2.5	Disability other cash benefits	10	UNEMPLOYMENT
3	OCCUPATIONAL INJURY AND DISEASE	10.1	Unemployment compensation
4	SICKNESS BENEFITS	10.2	Early retirement for labour market reasons
5	SERVICES FOR ELDERLY AND DISABLED PEOPLE	10.3	Severance pay
5.1	Residential care	11	HEALTH
5.2	Home-help services	12	HOUSING BENEFITS
5.3	Day care and rehabilitation services	13	OTHER CONTINGENCIES
5.4	Other benefits-in-kind	13.1	Low income
6	SURVIVORS	13.2	Indigenous persons
6.1	Survivor pension	13.3	Miscellaneous
6.2	Survivor civil servant pension	13.4	Immigrants/refugees
6.3	Survivor benefits-in-kind		
6.4	Survivor other cash benefits		
7	FAMILY CASH BENEFIT		
7.1	Family allowances for children		
7.2	Family support benefits		
7.3	Benefits for other dependants		
7.4	Loan parent cash benefits		
7.5	Family other cash benefits		
7.6	Maternity and parental leave		

Source: OECD 2003.

Conclusions

As regards the broad national estimates of economic activity, Australia follows the internationally agreed SNA approach to the presentation of its national accounts. This has the advantage of international standardisation but the disadvantage that some features of the SNA are found to be problematic. This is especially true in the health and welfare area. Satellite accounts—purpose-oriented additions to the

national accounts—provide a means of adding to or revising the information contained in the national accounts while still preserving the standardised features of the main accounts. The SNA approach is receptive to the use of satellite accounts in this way. Satellite accounts are already under development within Australia in other areas such as tourism and natural resource depletion and promise to be useful in the health and welfare area.

The preceding discussion of satellite accounts has been centred around the rearrangement, extension and revaluation of main accounts information.

The objective of this discussion is not to describe in detail how satellite accounts will be applied in the health and welfare area. Rather, the objective has been to set out a conceptual framework that may be helpful in thinking about the detailed application of these ideas in specific health and welfare contexts.

In the meantime, the AIHW has begun organising its estimates of expenditure into the OECD's SHA categories for health care functions, providers and funding sources. This has required some additional manipulation of reported data to develop appropriate splits into the SHA categories and is seen as a helpful first step in the evolution of health satellite accounts for Australia.

Much work still needs to be done on identifying final and intermediate consumption before useful input–output tables, that are integral to the production of full satellite accounts, can be developed from the SHA. As far as welfare services expenditure is concerned the AIHW continues to use the government purpose classifications to allocate expenditure to the various welfare services categories.