GUIDELINES TO IMPROVE ESTIMATES OF EXPENDITURE ON HEALTH ADMINISTRATION AND HEALTH INSURANCE

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EXECUTIVE SUMMARY

4. The purpose of this document is two-fold. First, it summarises countries' current practices in reporting administrative expenditure under SHA 1.0, highlighting some of the issues limiting international comparability. Second, the document is forward-looking as it aims to assist countries in better estimating expenditures on governance, and health system and financing administration under SHA 2011, leading to enhanced comparability in the future.

5. 32 countries responded to an initial questionnaire on their current accounting practices and a further questionnaire sent to 12 of these countries provided more detailed insights on methodological issues. The overwhelming majority of countries are already in a position to provide data for the different aggregates of administration. However, based on the analysis, the study identifies three issues that would lead to improved international comparability of administrative expenditure aggregates:

- Separation between health-related and non-health related administrative expenditure across governmental agencies and social security funds;
- Application of common valuation techniques for the recording of expenditure of finance administration of private insurance;
- Improved understanding of "administrative expenditure" and in particular the cost items that are included.

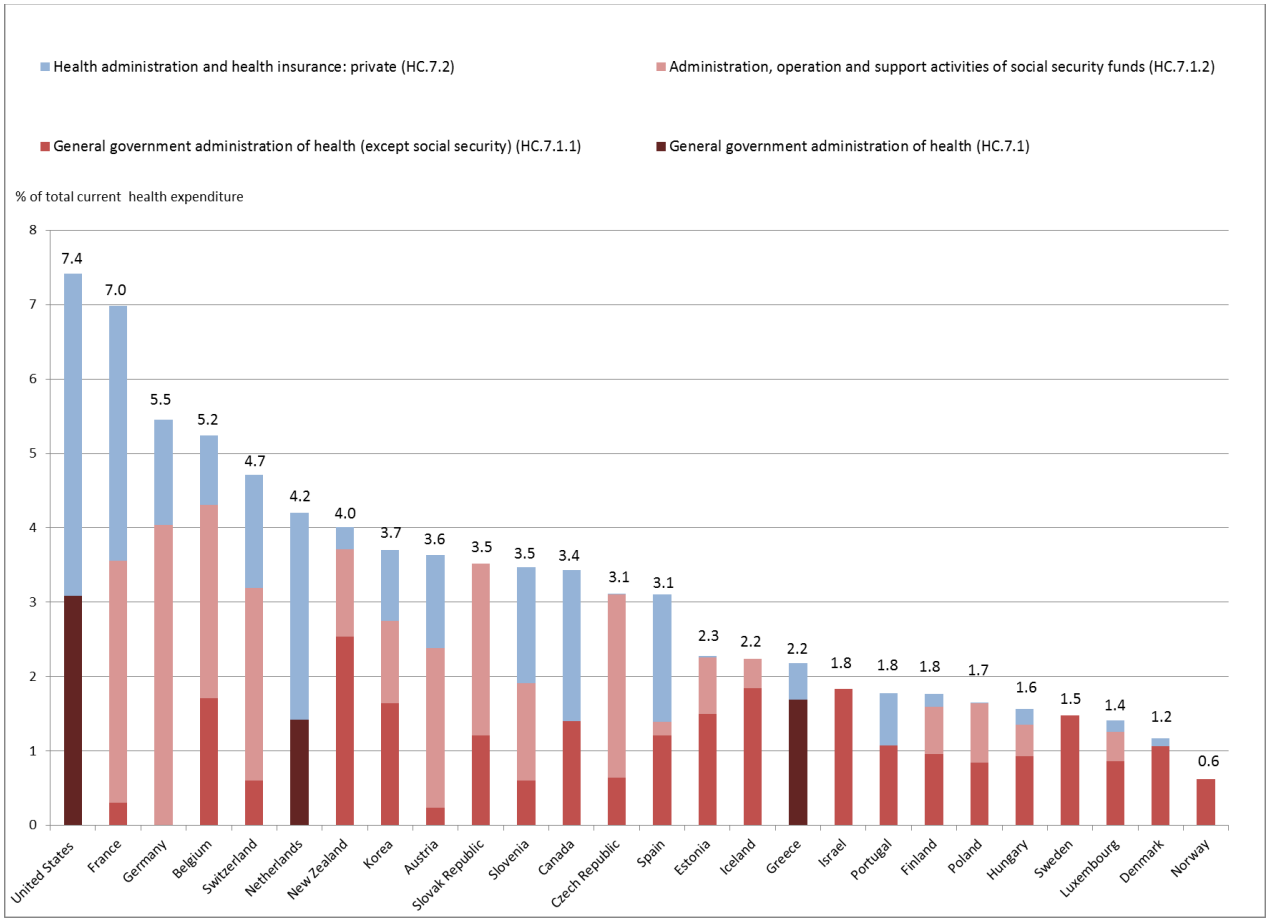
6. The following table summarises the main recommendations that should help countries move towards a comprehensive accounting of expenditure for health system administration and financing under SHA 2011:

TOPIC	RECOMMENDATION
Coverage	Expenditure for governance and health administration (HC.7.1) and health administration financing (HC.7.2) exists in all countries and should be identified for all financing schemes.
Reporting	Generally, expenditure for administration should only be reported for health administration agencies (HP.6). The exception is where other health providers perform a regulatory or health system administration role or are involved in administration financing.
Boundaries of health administration	Health administration activities should be estimated for all government units and social security funds involved in governance, health system administration and financing even if health provision is not their main activity. Estimations can be based on the share of health spending to total spending, staff involved in health administration compared to total staff or expert estimation. By the same token, non-health activities by health administration agencies should be excluded wherever possible.
Valuation of health administration	For government units and social security funds which are typically involved in non-market production the value of administration expenditure should be measured by the costs of their inputs, namely intermediate consumption, compensation of employees, consumption of fixed capital and other taxes on production. The administrative costs of private health insurance companies should be estimated taking into account premiums, premium supplements and adjusted claims.

I. INTRODUCTION AND AIMS

7. Although spending on administration occupies a relatively small share of overall health spending across OECD countries (around 3% of current expenditure on health on average), how much a country allocates is high on the policy agenda and remains an area for potential efficiency savings. However, the harmonised accounting of expenditure on administration (HC.7 under the System of Health Accounts framework) has been identified as an area of health accounts where issues of completeness and comparability between countries remain. There is large cross-national variation in the figures reported (Figure 1), due to both health system differences as well as statistical issues. However, it is important to base any analysis on robust and comparative data and provide guidance on how to improve estimates.

Figure 1 Expenditure on HC.7: Administration in OECD countries, 2011 or the latest year



Source: OECD Health Data 2013

8. Differences in the level of administration spending between countries can be partly explained by the type of health system and financing. For example, a single-payer NHS-type health system, such as in Spain or Denmark, might be expected to have less public spending on administration than multi-payer social health insurance systems, such as in France or Germany. In addition, different types of private health insurance arrangements with their associated administrative costs can play a greater or lesser role and add to the overall administration costs. System factors aside, the differences are generally due to data gaps and under-, or in some cases over-estimation of one or more of the components.

9. This study assesses current reporting practices with information on sources and methodologies through a series of questionnaires, and provides general guidance and recommendations to countries to both complete and improve their estimates of spending on administration in an effort to ultimately improve comparability.

10. The remainder of this report is organised into four sections. First, there is a section on the organisation of the category of health administration under the System of Health Accounts and the differences between SHA 1.0 and SHA 2011. Based on this framework, the subsequent sections deal with the three main subcomponents of administration – health system administration, administration of public health financing and administration of private health financing. Each of these sections draws on the extensive information and feedback provided by the countries. Data sources and important accounting issues are described, the most important administrative providers are discussed and mapping issues from SHA 1.0 to SHA 2011 are presented. In addition, best country practices and data sources are identified and recommendations given.

2. ADMINISTRATION (HC.7) UNDER SHA 1.0 AND SHA 2011

11. Since countries currently report health accounts according to SHA 1.0, the information on data sources and methodologies refers to the current categories and definitions of HC.7. However, as countries start towards the implementation of SHA 2011 in their health accounts, it is important to map current reporting practices from SHA 1.0 to SHA 2011 for future reporting according to the new categories and definitions. At the aggregate level there is little difference expected between the two systems. However, under the SHA 1.0 framework, expenditure on governance, and health system and financing administration is based on a distinction between public and private schemes. SHA 2011 provides a more developed classification based on a distinction between the function of health system administration and that of financing administration – both public and private.

12. Most administrative services are provided by specific agencies concerned with the governance of the health system and/or the administration of financing and are either public or private. Apart from changes in coding there are no substantial differences in the content of the categories of administrative agencies in the provider classification between SHA 1.0 and SHA 2011, as can be seen in Table 1.

13. Administrative expenditure should be identified for all financing agents that are involved in the management and operation of financing schemes of the health system. There is a precision in SHA 2011 concerning administrative costs of non-profit-organisations and enterprises that provide health care which should also be accounted for. In addition, the operational expenditure of agencies that are concerned with the collection and the pooling of funds should also be considered when calculating administrative expenditure.

Table 1 Administration expenditure categories under SHA 1.0 and SHA 2011

SHA 1.0	SHA 2011
Function	
HC.7 Health administration and health insurance	HC.7 Governance, and health system and financing
HC.7.1.1 General government administration of health (except social security)	HC.7.1 Governance and health system administration
HC.7.1.2 Administration, operation and support activities of social security funds	HC.7.2 Administration of health financing
HC.7.2 Health administration and health insurance: private	
Provider	
HP.6.1 Government administration of health	HP.7.1 Government health administration agencies
HP.6.2 Social security funds	HP.7.2 Social health insurance agencies
HP.6.3 Other social insurance	HP.7.3 Private health insurance administration agencies
HP.6.4 Other (private) insurance	
HP.6.9 All other providers of health administration	HP.7.9 Other administration agencies

What are administrative costs?

14. The definition of expenditure for governance, health system and financing administration in Chapter 5 of SHA 2011 is relatively detailed on how to identify health spending with administrative purposes but has less information on which spending components should be included in administrative costs. For this we have to refer to other parts of the SHA manual, especially Chapter 3 on how to measure consumption and output. There exists a difference in measurement of market and non-market production which is relevant for providers of administrative services.

15. The provision of administrative services by government or social security funds will, in most cases, fall under the category of non-market production since the services created are usually not sold and market-prices therefore do not exist. The value of non-market production is measured to be equal to the sum of its production costs, including:

- Intermediate consumption (e.g. electricity, water, office equipment not considered as assets, phone costs, rents for office buildings);
- Compensation of employees (gross salaries in cash and in kind, actual and imputed social contribution and taxes);
- Consumption of fixed capital;
- Other taxes paid on production (taxes on ownership or the use of land, buildings or other assets used in production)

16. Private insurance companies do not typically fall in the category of non-market producers. Their outputs – which are basically their administrative services – are therefore valued differently. SHA 2011 refers explicitly to this and suggests using the calculation of insurance output as defined by the System of National Accounts (see paragraph 6.185 of SNA 2008). This would cover expenditure on sales, enrolment and policy services, claim adjudication, actuarial functions, legal support services, investment functions, corporate overheads and risk charges. The valuation of private health insurance services is discussed in more detail in Chapter 4.2.

3. GOVERNANCE AND HEALTH SYSTEM ADMINISTRATION [HC.7.1.1 (SHA 1.0)/HC.7.1 (SHA 2011)]

17. The main activities to be captured under "Governance and health system administration" are aimed at planning, policy formulation and information intelligence for the health system as a whole. Supervisory and regulatory functions are part of the governance role. Activities of government units that have a pure financing role, e.g. a revenue-raising or pooling, should be recorded under health administration financing (HC.7.2 under SHA 2011).

18. Most OECD countries report some expenditure on central administration of the health system, although for a minority the expenditure is not separated from expenditure on financing administration and reported at a higher aggregate level.

19. The main issues regarding the reporting of expenditure on health system administration are the following:

- Identifying available data sources;
- Separating administration expenditure from other health functions, such as public health;
- Separating administration expenditure of health activities from non-health activities;
- Identifying all agencies and health providers engaged in administrative activities; and
- General accounting issues

Data sources

20. The main sources of information to compile health system administration expenditure tend to be public accounts (summarised budget documents) combined with National Accounts (that is, information on government expenditure by function).[1]

Public accounts/budgetary information

21. Public accounts of central, regional and local governments are a primary data source to measure expenditure on governance and health system administration for many countries.

22. For example, in the Netherlands, most government units submit their public accounts to Statistics Netherlands. These include expenditure items allocated according to government function (e.g. security, health, household support, IADL) and structured according to the type of cost (operating cost, income transfer, etc.). Statistics Netherlands validates and completes the expenditures for non-responding units. The health accounts unit receives these statistics for the relevant functions with types of cost and maps them into SHA categories. To this are added the operating costs of the central Ministry of Health, the (health-relevant) operating costs of Statistics Netherlands and the Institute of Public Health (RIVM).

23. Canada collects data on governance and health system administrative expenditure from data sources at both central and regional level. At the regional level, provincial/territorial government accounts

[1] That said, it should be borne in mind that the National Accounts – as a statistical system – are not a data source in themselves but also rely on primary data sources such as public accounts.

include administration expenditure on the provincial/territorial ministries of health and a few additional departments related to health services. At the central level, the public accounts of the Ministry of Health and a few other federal departments such as Veteran Affairs Canada are used. In all the public accounts, expenditures on the administration of health services are reported as line items; therefore, it is easy for health accountants to identify the specific data for this category.

24. Instead of relying on aggregated public accounts some countries analyse in detail the individual budget documents. In the case of Belgium, the budget information of all relevant ministries (both federal and regional) covering health, social affairs, interior and justice are scrutinized to find all budget items related to health and long term care, including the administrative costs of the services. In Estonia, this is done by the relevant ministries themselves via a special survey requiring them to fill in their expenses on different health care functions, including administration.

25. Public accounts should be available in all countries and include detailed government spending items categorised according to national or international public sector accounting rules. Depending on these categories it might be easy or more challenging for a country to map them into SHA categories. Instead of relying on summarized public accounts, it might also be feasible to use information at a disaggregated level. However, the sheer number of public accounts or budget information might render it impractical to analyse each individually.

26. Concerning the use of budget information, it should be noted that by their nature these are forward-looking documents and in addition to historic figures include planned expenditure figures that will deviate from executed expenditure figures which will become available at a later stage.

27. Expenditure figures in budget and public accounts documents are generally recorded on a cash basis. As SHA is based on the accrual principle, health accountants should adjust figures taken from budgets. For example, when retrospective wage increases for public officials are made as one-off payments in period t+2 but in fact covering periods t and t+1, the wages recorded (and hence the administrative costs) in the budgets t and t+1 should be increased accordingly for SHA purposes.

National accounts (Government expenditure by function)

28. As noted, government expenditure data (usually based on public accounts data) broken down by functions of government (according to COFOG categories[2]) are an integral part of National Accounts. They are also one of the main data sources to compile expenditure on governance and health administration.

29. Indeed, COFOG includes a category of health affairs and services related to the category of administration, operation or support activities (COFOG 7.6):

30. "Administration, operation or support of activities such as formulation, administration, coordination and monitoring of overall health policies, plans, programs and budgets; preparation and enforcement of legislation and standards for the provision of health services, including the licensing of medical establishments and medical and paramedical personnel; production and dissemination of general information, technical documentation and statistics on health."

[2]The classification of functions of government (COFOG) has 10 main categories and structures government outlay according to its purpose; the purpose of category 7 is "health" and is broken down into more operational sub-categories on the 2nd digit level.

31. On the face of it, the mapping to SHA would appear close, although there is normally an overlap with public health administration and other non-allocated health expenditures. A number of countries, such as Iceland, do use COFOG 7.6 as an estimate for expenditure of the SHA-category governance and health system administration.

32. It should be noted that other sub-categories of COFOG 7 do make reference to administration e.g. COFOG 7.3: Hospital services mentions "non-medical expenditure of hospitals on administration, non-medical staff, food and drink, accommodation (including staff accommodation), etc." Under the SHA framework, such administration expenditure is included under the provision of hospital services (e.g. inpatient, outpatient, etc.) and not under HC.7.

33. In addition to COFOG 7, other categories of COFOG may also be relevant for SHA purposes to identify administrative costs. Some planning activities and e.g. statistical services related to health may be included under COFOG subcategory 1.3, general public services, and administration activities related to long-term care services are accounted under COFOG 10.9, social protection not elsewhere classified.

34. The specificity of the data and the widely accepted SNA methodology are principal advantages of using government expenditure by functions also for SHA purposes. Like SHA, the SNA requires the recording of expenditure applying the accrual principle. Thus, using COFOG data could make the comparison between countries more reliable. Nevertheless, government expenditure may not be available at the level of detail required in some countries and therefore its use as an estimate for governmental administrative spending might not be feasible for all. Even if available, above-mentioned adjustments to exclude non-health administrative activities should be considered.

Separating governance and health administration expenditure from other health functions

35. Separating government administration expenditure from other health expenditure can be problematic, for example in the case of public health activities and if there is no clear distinction between costs for regulatory and operational purposes.

Public health activities

36. In general, countries make a distinction between prevention / public health services (HC.6) and administration of health (HC.7). However, attention should be paid to identifying the primary goal of some activities which may have combined functions of public/preventive care and government administration. For example, under the new SHA 2011, HC.6.5 (Programme design, monitoring and evaluation) may be carried out by the same agency or institution and therefore not easily separable from administration. [3] The main inclusion of expenditures under HC.7 should refer to the regulatory or policy nature of the activity rather than the primary goal of public health.

37. In Belgium, some expenditure of scientific advisory bodies and associations are included under administration even when dealing with prevention issues because the primary objective of the work of these bodies is considered to be policy support. On the other hand, in Austria, administration expenditure of local health authorities cannot be identified separately and are included in the respective health function - often public health services.

[3] Guidelines on how to define the boundary between preventive care and administration of health on regulation and enforcement which are available at http://www.oecd.org/els/health-systems/Expenditure-on-prevention-activities-under-SHA-2011_Supplementary-guidance.pdf

Separating regulatory expenditure and operational expenditure on health

38. This issue was not explicitly dealt with in SHA 1.0, but is better documented in SHA 2011: The formulation of regulations and enforcement mechanisms are considered part of the governance role, while the implementation of regulatory enforcement within specific programme controls is part of the relevant function (HC.1-HC.6). In practice, splitting the operational expenditure and regulatory expenditure is not always an easy task. It is recommended that in the absence of sufficient information to distribute between regulation and operational functions, all expenditure should be allocated to the category that suits the primary activity.

39. One small additional point to note is that expenditure on health programmes for employees in administrative offices should be accounted as health care services, rather than included under the administrative costs – where possible.

Separating administration of governance and health system administration from administration of health financing

40. This is a new issue countries will face when implementing SHA 2011. Unlike SHA 1.0, the separation on the 2nd digit level of administration expenditure does not depend on whether the expenditure is borne by a public or private unit but only by the activity performed by the unit.

41. Activities of governance and health system administration are generally carried out by governmental agencies but this does not imply that the reverse also holds. For example, Austria has established so-called state health funds on a regional level, which are purchasing agents to collect and pool revenues from central, state and local governments as well as from social security funds and private households. Their main function is to pay for hospital services. The set-up is similar in Germany where a federal health fund has been created at central level and whose main task is the revenue collection and re-distribution of money to Statutory Health Insurance Funds after risk-equalisation. The administrative costs of these agents should be accounted for as administration of health financing (SHA 2011: HC.7.2) rather than as governance and health system administration (SHA 2011: HC.7.1).

42. In some cases there might be issues in separating the two administrative categories. In that case it might be helpful to determine the primary purpose of the agency and, on this basis, allocate all administration costs accordingly.

Separating health administration from non-health administration

43. In some countries, ministries managing health affairs have a wider scope and may be responsible for additional activities and services, such as the joint ministry for health and social affairs in France, or the ministry of health, welfare and sport in the Netherlands. The inclusion of non-health administration costs for all or some agencies could potentially lead to an overestimation of administrative expenditure.

44. In some countries (e.g. Iceland) the different administrative costs can be clearly identified in the underlying budgets. In others, certain administrative functions are not so clearly separated between health and non-health purposes.

45. In the absence of any detailed information, an approach frequently used (e.g. United States, Croatia) is to estimate health administrative costs in joint agencies or ministries based on the share of health spending to total spending and apply this share to total administrative costs. Alternatively, experts may also be in position to assess the health-related administration costs. For example in the case of the French ministry of health and social affairs most reported costs can be clearly split into health and social

but for some items that concern both activities (e.g. costs of the statistical service of the ministry) it was decided to split the costs evenly and thus to include 50% in HC.7.1.

Providers of general government administration on health (except social security)

46. In the majority of countries there is usually a clear link between the functional and provider classifications concerning health system administration, in that all or most of the administration function of the health system (HC.7.1.1 [SHA 1.0]/HC.7.1 [SHA 2011]) is provided by government health administration agencies (HP.6.1 [SHA 1.0]/HP.7.1 [SHA 2011]). But other providers or agencies may also play a part in administration in a number of countries and all should be considered.

Government health administration agencies

47. As discussed above, typical providers include central, regional and local ministries and departments of health, national health institutes/agencies and health regulatory authorities (e.g. pharmaceutical and medical device control associations).

Ministries of health

48. Nearly all countries include the ministry of health in their estimate of expenditure on governance and health system administration. In some instances other units financed from the ministry of health via subsidies and transfers are also attached to the ministry of health as the costing side of these units is unknown.

Local and regional departments or ministries of health

49. The administrative expenditures of local and regional departments or ministries of health are included for a large proportion of countries (e.g. Australia, Canada), but this might not be relevant in others due to different federal structures across countries (e.g. the Czech Republic, Latvia).

Other ministries

50. Apart from ministries of health, other ministries where health is not a primary activity may also be involved in the provision of health care goods and services and as such the administrative costs relevant to this should also be considered. The following shows examples of various ministries, departments and agencies currently included in health accounts:

- Department of Defense - providing health care for active duty military personnel, retirees and dependents (United States);
- Department of Justice - managing prison clinics and hospitals (United States);
- Department of Education - operating school health programmes (United States);
- Department of Veteran Affairs - managing the health costs of war veterans (Australia, Canada)
- Ministry of Social Affairs (Belgium) and Ministry of Social development (Canada)
- Department of Seniors and Community Supports - providing ADL programmes and operation of cabinet policy committee on health (Alberta, Canada)
- Ministry of Interior - emergency services (Belgium)

51. However, it may be problematic to identify the health-related administrative cost in these government agencies. At best they can be found directly in accounts or budget documents or indirectly (e.g. in Canada, this problem is solved through sending special requests for programme descriptions to provinces). If this is not feasible, the health share of administrative costs can either be estimated using the share of health care costs to total costs of the concerned ministry or the share can be calculated comparing the ministerial staff engaged in health activities to total staff.

52. Although these central or regional ministries do not have the prime purpose of managing and operating the health system, from a practical viewpoint they should still be considered together with government health administration and classified as HP.6.1/HP.7.1. That is, they should not be considered as secondary providers of health care and, therefore, not be classified as HP.7.9/HP.8.2.

National health institutes/Health regulatory authorities

53. Many countries include the administration expenditure of various national health institutes in their accounts. They can have a country-specific scope (e.g. a cancer institute in the case of Croatia) and can be very similar to public health agency. As mentioned earlier, in some cases the expenditures borne by these institutes are identified via transfers from the ministries of health. This is, for example, the case in Croatia where the budget of the ministry of health includes administrative expenditure for national health institutes and in France where the ministry of health finances the health regulatory authority.

54. Other countries may exclude such institutes from their health accounts. Switzerland, for example, follows COFOG to determine the primary purpose of transactions and subsequently excludes the administrative expenditure of the Swiss Health Observatory from health accounts since it is allocated to general administration/public finance in COFOG 1.3 and not 7.6. Luxembourg currently classifies the administrative expenditure of national health institutes under health-related costs, rather than health expenditure.

55. In summary, national health institutes and regulatory authorities primarily engaged in the regulation and administration of the health system should be included under health administration spending. In case they provide health and non-health services it may be necessary to examine their financial accounts for a separate estimation of their expenditures in more detail.

Other providers

56. Apart from government health administration agencies (HP.6.1/HP.7.1) some countries also include expenditure on administration from other providers:

Public health agencies

57. Very few countries include any administration expenditure for public health agencies under HC.7. In theory, the operative administration expenditure of public health institutes (HP.5 [SHA 1.0]/HP.6 [SHA 2011]) should be included under their primary activity of preventive care (HC.6). However, as previously explained, the regulatory expenditure of such agencies may be allocated under HC.7.

58. In one case, the expenditure related to the provision of statistics on health of these public health agencies is allocated to this category. However, since it is not related to the administration of the whole health system, it might be better to allocate the expenditure on health statistics for public health agencies to the category of all other miscellaneous public services (HC.6.9).

59. Hungary has some public health agencies in which national public health and services of medical officers are provided. Since the definition and content of these activities are too general to be considered as

prevention or public health purpose, they are allocated to general government administration of health. Again, it is necessary to determine the primary goal of public health institutes first, and then decide which category this expenditure should fall into based on its purpose.

Other health services providers (HP.1-HP.5, HP.8-HP.9)

60. SHA stipulates that any administrative costs associated with health services providers such as hospitals or practices of physicians are considered as part of the cost of providing the services and should be included under the respective health care function (e.g. in-patient care, ambulatory care) rather than under expenditure on governance and health system administration. Hence, reporting of administrative expenditure by those providers should be exceptional.

61. A number of countries, however, do report governance and health system administration expenditure for other health service providers. Why this is the case is not always entirely clear. One country accounts the subsidies to health service providers under administration expenditure. Another country allocates some spending generated by health services providers that cannot be allocated to a specific health good or service, such as expenditure on maintaining an office of the chief medical officer to administrative services. A third country identifies governance and health system administration costs in the financial account of hospitals.

62. However, countries that do report expenditure for administration for other health service provider should carefully analyse the underlying transactions. In some instances they might be correctly reported in case the provider is partly engaged in governance and administration of the health system. Generally, however, the expenditure items should rather be allocated to expenditure of the respective health services (HC.1-HC.6) or to "not specified by kind" (HC.9), or even excluded completely from health spending.

General Accounting Issues

Double accounting of administration

63. One issue to be considered is the case of current transfers between various levels of government (e.g. transfer from a central government health unit to a local government health agency) that are intended to cover the administration costs of the unit concerned. In this case, the figures have to be consolidated to avoid double-counting of administration expenditure. This means that either the transfer from the central government to the local government (recorded in the central budget) or the administrative costs of the local government (recorded in the local budget) are included, but not both.

64. Nearly all countries seem to be able to avoid the issue of double-counting by properly consolidating their data sources. Austria, for example, precludes double-counting by reporting expenditure on governance and health system administration using consolidated COFOG figures.

65. In a different example, the United States include the current transfer between a government health unit (Medicare) and a non- health unit (social security administration) to cover the administration costs of collecting taxes for Medicare. This transaction is only recorded once under the administration costs of Medicare, since the social security institute itself sits outside the boundary of health care but the administration costs relate to the Medicare financing scheme (However, the transaction might be better grouped into HC.7.2. due to the health financing nature of this administrative activity).

Identification of administrative transactions

66. As discussed in the introduction, the administrative costs of the government in the case of non-market production should be valued by the sum of its inputs. In practice, this would refer to:

- Intermediate consumption (e.g. electricity, water, office equipment not considered as assets, phone costs, rents for office buildings);
- Compensation of employees (gross salaries in cash and in kind, actual and imputed social contribution and taxes);
- Consumption of fixed capital;
- Other taxes paid on production (taxes on ownership or the use of land, buildings or other assets used in production)

67. It is not always clear what transactions are subsumed under "administrative expenditure" but limited feedback from countries suggest that in general, most countries seem to value their government administration cost in similar fashion, although some differences remain:

68. Some countries exclude taxes and consumption of fixed capital from administrative expenditure. Whereas the exclusion of incidental tax payments for units involved in governance and health system administration might not play a huge role in the measurement (many government agencies will be exempt from paying taxes on production) the exclusion of consumption of fixed capital has the potential of a major underestimation of government administrative costs.

69. Another issue is the reporting of health care costs for employees of administrative agencies. Theoretically, instead of reporting these transactions as administrative costs they should be considered as occupational health services (HC.6.5/HC.6.4) but it can be difficult to separate this cost item from regular administrative costs.

70. In addition to the above-named transactions, one country includes subsidies paid in their administrative costs. This can however only be justified in the case that when the administrative costs of the unit receiving the subsidy is not accounted elsewhere otherwise the problem of double counting would persist. Also, it must be clear that the unit receiving the subsidy is engaged in governance and health system administration activities.

4. ADMINISTRATION OF HEALTH FINANCING

71. The administrative costs of a financing scheme are the costs related to collecting and pooling revenues as well as the costs related to purchasing services and goods under the given scheme. These activities may involve several agencies. In theory, administrative costs of a financing scheme should include all administrative costs of all these functions regardless of how many intermediaries are involved.[4]

72. Detailed estimation issues of administrative expenditure on public financing schemes and private financing schemes are discussed separately in sections 4.1 and 4.2.

4.1 Administration of Health Financing: Public [HC.7.1.2 (SHA 1.0)/HC.7.2 (SHA 2011)]

73. A large number of OECD countries currently report expenditure on the administration of public health funds. However, for a few, these expenditures are either included at a more aggregated level rather than being reported separately or are not reported at all. Reasons for non-reporting are either difficulties in isolating administration costs for public health funds from those of the general government or the non-existence of a social security system in countries.

74. It should be noted that while SHA 1.0 focuses explicitly on the "administration, (...), of social security funds", SHA 2011 is broader in considering the administration of health financing in general. Countries without a social security system are thus expected to report the costs related with collection and pooling of e.g. their tax-based system under this category.

75. The main issues regarding the reporting or lack of reporting of administration of public health financing are:

- Identifying the available data sources;
- Separating administration of health expenditure from other expenditure of social security funds;
- Separating from other public administrative spending;
- Including other providers in the administrative expenditure of public funds.

Data sources

76. Based on current reporting and definitions, the financial records of the social security funds are a primary data source to identify the administrative expenditure on public health financing. In the absence of financial records, budget documents or other administrative documents are often used.

Financial records of social security funds

77. For countries operating social health insurance schemes, the financial records normally provide a good available data source. For example, France uses data extracted from the financial accounts of the health department of social security to make their calculations. Belgium collaborates with another national

[4] http://www.oecd.org/els/health-systems/Guidelines_Implementation-SHA-2011-Framework-for-Accounting-Health-Care-Financing.pdf

institute (institute for health and disability insurance) that is responsible for establishing annual accounts of the social security funds.

78. Generally, the financial records of social security funds are the preferable source. However, in some cases it may be difficult to map the data from the financial records of social security funds directly into health accounts. Furthermore, in certain countries where the national scheme is composed of multiple social insurance programmes concerned with the financing of health goods and services, collecting extensive data of all insurance programmes can be more challenging and time-consuming.

Budget documents or other administrative documents

79. In the absence of detailed financial reports, costs for the administration of public health financing can be identifiable in budget documents of the social security funds. This is the source of information used in the United States and Luxembourg, for example.

80. In other cases, there are bespoke reports from the funds. For example, in the case of Estonia, the fund itself provides a detailed report for the purposes of health accounts where they identify the administration expenditure themselves.

81. In the case of public accounts and budget information, adjustments should be made by health accountants to report in accrual and not in cash terms.

82. To meet future requirements of SHA 2011, countries without social health insurance system should try to separate those administrative costs, for example in the Ministry of Health, that relate to the financing function – revenue raising, pooling, purchasing – from the costs related to the governance of the health systems.

Separating administration of health insurance from other expenditure

83. Administrative costs of social security funds for health purposes is regularly combined with the costs of administering other social spending (e.g. pensions). However, the share between the costs for health and non-health administration can differ between social security funds within a country and across countries as the magnitude of non-health spending can differ.

84. For health insurance funds the share of non-health or social spending will generally be rather small and may be restricted to cash payments in the case of sick leave and disability allowances. For other social insurance funds that also provide some health care goods and services –and thus have to be considered in SHA- the provision of non-health services will be much more significant. In Austria and Germany, for example, the statutory pension insurance funds provide some rehabilitative services but clearly this is not their main purpose.

85. In the case where different social security schemes exist it should generally be feasible for countries to separate administration costs for each insurance scheme. They are usually recorded in separate financial accounts (e.g. Social Insurance Administration and Icelandic Health Insurance in the case of Iceland).

86. In the case of health insurance funds, countries tend not to exclude any non-health administration from total administrative expenditure, although part of their service provision might have to do with the payment of cash-benefits or social services.

87. In the case of other social insurance funds most countries report that splitting non-health administration from health administration for social security funds should be feasible.

88. Austria, for example, calculates the health administration share of pension insurance funds by dividing health benefits by total benefits. In Belgium, an allocation is made based on the same approach for the social security scheme concerned with occupational hazard. Germany (in the case of pension insurance) and Switzerland rely on expert estimations although Switzerland does not account for health administration expenditure of social security schemes that only play a minor role in health care financing. In the case of the workers compensation board in Canada, the health administration expenditure in not identified as they cannot separate administrative costs for health benefits from administrative costs for other benefits (e.g. compensation for loss of wages).

89. Generally, it is recommended to estimate the health administration share of all social security funds. The most accurate approach might be to split administration expenditure of the funds according to the human resources involved for health and non-health purposes. In the absence of such information, a split according to the total expenditures seems like a good alternative. It would also be theoretically desirable to exclude any non-health administrative activities for health insurance funds. A similar estimation method could be applied for this purpose.

Separating public health administration financing from other public administrative spending

90. Public health administration financing should be recorded for all intermediary agents involved in the financing process. In many financing processes, revenues used by a health financing scheme for purchasing health care goods and services will pass through multiple intermediaries before reaching the financing agent. Each will have some administration costs attached. In addition to the practical measurement issues, it is important to set a boundary on which institutions are included in the health system. As a general rule of thumb, the boundary could be set at the point where the funds become "earmarked" for health purposes. In this case, a proportion of the administration costs involved in general tax collection would be inappropriate. When budgetary decisions are made and funds are then transferred to another government agency for further distribution, then from this point, the administration costs should be taken into account.

91. For example, the National Tax Office in a country might be responsible for collecting the health insurance contributions from employers and employees for the social health insurance scheme before transferring this revenue to the Social Health Insurance Agency. Ideally, all costs related to collecting and pooling and purchasing under the given scheme should be accounted as spending by the social health insurance scheme (that is, including the relevant costs occurring at the National Tax Office). In this case it could be argued that the tax office acts as an outsourced collection service for the social health insurance since, if the tax office did not collect the premiums the social health insurance would do it and incur the necessary costs.

92. This is the case in the aforementioned example of Medicare and the social security administration in the United States. Other examples would be the state health funds in Austria and the federal health fund in Germany that only serve as intermediary agents.

93. In case any of the financing agents are also involved in activities related to governance and health system administration the costs should be accounted under HC.7.1 (in SHA 2011).

Social health insurance operated by private agencies and voluntary health insurance operated by social security agencies

94. Health financing systems are evolving. In some countries, mandatory health insurance is operated by private insurance agencies. In other cases, social security funds manage voluntary health insurance schemes. These possibilities were not adequately addressed in SHA 1.0 and hence the allocation of the

administrative costs of these schemes was not clear. For example, administration costs for voluntary health insurance should be separated from social insurance administration costs and allocated in their entirety to HC.7.1.2 (SHA 1.0). For example, the Netherlands and Switzerland are able to distinguish administration costs for voluntary insurance from administration costs of compulsory insurance because this is included in the administrative records. Similarly, Belgium allocates administrative costs of all the activities within the framework of social security under HC.7.1.2 and administrative expenditure of complementary insurance operated by sickness funds under HC.7.2.

95. Classification methodology of these expenditure items under the framework of SHA 1.0 is recommended to be consistent with current layout under HC.7 according to public or private financing scheme regardless of the types of providers. In this case specifically, administrative expenditure on social health insurance operated by private institutes is supposed to be mapped to HC.7.1.2, while administrative spending on voluntary health insurance operated by social security agencies ought to be allocated under HC.7.2.

96. This classification problem is solved to some extent under the framework of SHA 2011, for all the expenditures on health financing financed through either a public scheme or a private scheme are included under the same category of health financing administration (HC.7.2).

97. A similar accounting issue arises when private health insurance companies are financing agents of the social health insurance and additionally provide private insurance coverage. One country where this arrangement exists is the Netherlands which splits the majority of administration costs between a social insurance part and a private insurance part based on the information included in the accounts of private insurers.

98. The need for separate accounting of the two cost items will end with the implementation of SHA 2011. Both transactions should then be reported under HC7.2 administration of health financing.

Providers of administration, operation and support activities of social security funds

99. Most countries report that this administration expenditure item is provided exclusively from social insurance agencies (HP.6.2 [SHA 1.0]/HP.7.2 [SHA 2011]).

100. Concerning social security funds that are not health insurance funds (e.g. pension insurance funds) it is suggested to follow a similar treatment as for other ministries where health is not the main activity. We recommend accounting for the administrative services of these funds implementing the scheme under HP.7.2 and not under HP.8.2.

101. As in the case of governance and health administration, the extent to which countries include and exclude different cost items in the measurement of administration costs for public health financing can differ. In a number of countries the different administration cost items cannot easily be identified in existing data sources so there is some uncertainty as to whether all relevant cost items are included in the valuation of the administration services or not.[5] The cost items more often excluded are consumption of fixed capital and the intermediate consumption of goods. One country reports that possible operating surpluses of social security agencies are included in their administration costs whereas they are excluded or

[5] One country includes subsidies reported from national health agencies (HP.6.1/HP.7.1) that receive funds from central government and from social security under administration costs. According to their nature, these national health agencies are supposed to be included under government health administration agencies (HP.6.1/HP.7.1). The subsidies, which can be regarded as one type of final consumption expenditure of these agencies, should be allocated under HC.7.1.1 financed by government scheme (HF.1.1) and social health insurance (HF.1.2).

non-existing in the majority of countries. However, for social security funds, an operating surplus or deficit should not affect the administrative costs involved.

102. Apart from social security agencies, the other main provider relates to cases where social insurance is managed by private insurance companies (HP.6.4/HP.7.3). The case of the Netherlands is presented above.

4.2. Administration of Health Financing: Private [HC.7.2 (SHA 1.0)/HC.7.2 (SHA 2011)]

103. The majority of OECD/EU countries currently report expenditure on the administration of private health insurance. Most of these countries report the data separately; only two include the expenditure at an aggregate level.[6] In other cases, the absence of a private health insurance scheme in a country will explain the non-reporting in some countries. However, while SHA 1.0 restricted the administrative expenditure to private insurance financing only, SHA 2011 is more explicit in including the administrative related to all private financing.

104. The main issues regarding the reporting or lack of reporting are:

- Identifying the data sources available;
- Separating administration cost of health insurance from other non-health insurance;
- Applying appropriate methodologies to calculate spending on private health insurance;
- Additional issues with private administration of health financing

Data sources

105. Private insurance associations and national regulatory authorities are widely-used data sources to estimate the administrative expenditure on private health financing. A small number of countries base their estimations directly on company accounts and survey results.

Private insurance associations

106. The majority of countries choose private insurance associations as their primary data source in reporting the expenditure on private health administration and health insurance. However, the level of detail included in the summarised reports concerning administration expenditure might be on a very aggregate level. In these cases it would be worth investigating if all relevant cost items are covered.

107. Canada, for example, obtains specific data from the Canada Life and Health Insurance Association (CLHIA) which distributes surveys to individual private health insurance companies to collect information on health insurance and identify administrative expenditure. Belgium uses aggregate information on administration costs of health insurance policies recorded by the professional organisation of insurers.

[6] Sweden has only information on total expenditure from private health insurance *companies* but no functional breakdown and thus categorizes all expenditure – including administrative costs– under HC.9 (not specified by any kind).

108. If private insurance associations are used as a data source to estimate private administrative costs, health accountants should verify that the data represents the total universe of private insurance companies.[7]

National regulatory authorities

109. Various national regulatory authorities are also used as a data source to identify administrative expenditure. For example, data is collected from private health insurance administration council in Australia, the financial market authority (Austria), insurance surveillance authority (Switzerland), prudential supervisory authority (France), and in the Netherlands, from the central bank, that also supervises private insurance. Data collected by the regulatory authorities are submitted applying standardised accounting rules and are usually mandatory for all private health insurance companies. These data sources should thus cover all private health insurance companies in a country.

Company accounts

110. Company accounts are also used as a data source in a few cases. Company accounts can either be analysed on a company level directly or accessed via third-party data providers.

111. The United States have developed a sophisticated method to calculate private health insurance expenditure. To identify total premiums and total claims they use – among others sources – data from AM Best, a rating agency analysing individual insurance accounts and data from Blue Cross and Blue Shields - an association of private insurers providing special private health care plans. Croatia and Hungary also report using company accounts directly.

112. Using the annual statements of private insurance companies as data sources might have the advantage that expenditure items are displayed in more detail than in summarised accounts of private insurance associations or national regulatory authorities. However, considering the potentially large number of private insurance companies, data compilers may find it complex and time consuming to collect the fractional data from diverse provider company accounts. Analysing individual company accounts seems therefore a possible way to estimate private insurance administration costs mainly in countries with a limited number of private insurance enterprises.

Surveys

113. Several countries (e.g. Estonia and Slovenia) indicate that specific surveys are used to estimate private administration expenditure. The United States also uses survey data –directed at insurers as well as employers, households and health providers– to accurately estimate total premiums paid to insurers and claims incurred.

114. The principal advantage is that bespoke surveys can help countries to identify specific expenditure items required for SHA purposes directly. However, conducting a survey is often time-consuming, and sometimes incurs high costs. In the case that the survey covers only a sample of private insurance companies, a sound estimation methodology has to be applied to extrapolate for the entire private insurance company universe.

[7] In Germany, for example, administrative data for private health insurance companies collected by the private insurance association PKV does not include two private insurers for formerly state-employed civil servants of rail, post and telecommunication which have to be added to the aggregated administrative costs submitted by the PKV.

Split between administration costs on health insurance and other insurance

115. Private insurance companies often sell multiple types of insurance policies, including health insurance, life insurance, indemnity insurance, etc. When creating an estimate of the expenditure on private health insurance administration, countries should exclude those expenditures associated with the administration of other types of insurance. In most countries this does not appear to be a problem, especially where data is used from regulatory authorities.

116. The French prudential supervisory authority requests data on the basis of health contracts which covers administration costs for health separately. The same is true in the Austrian Insurance Statistics, which are compiled by Austrian Financial Market Authority. They record expenditure claims and premiums separately for different types of insurance (life insurance, non-life insurance, health insurance).

117. In the case where such a separation is not easily available, other estimation methods should be employed. For example, the share of administration related to health insurance can be linked to either total premiums or total benefits for health insurance compared with corresponding figures for other types of insurance in case appropriate data is available.

Methodology to estimate the value of expenditure on private health administration and health insurance

118. In general, two approaches are used by countries: (i) estimation of private insurance output based on SNA and (ii) estimation of total private administrative cost by adding up all the administrative cost items of private health insurers. Other methods, such as percentage estimation, are used by a smaller proportion of countries. SHA recommends the first approach, where possible.

SNA methodology

119. SHA 2011 recommends applying the accounting rules of SNA to calculate the expenditure on administration of private health financing. Based on these accounting rules, the value of the output of an insurance enterprise (which is identical to administration expenditure) is defined as the sum of total premiums earned plus premiums supplements less adjusted claims incurred. This would cover expenditure on sales, enrolment and policy services, claim adjudication, actuarial functions, legal support services, investment functions, corporate overheads and risk charges.

120. A proper calculation of private insurance output therefore requires the identification of the premiums earned and the claims incurred by the private insurance enterprises in the accounting period. Added to this figure are capital gains from disposal reserves which accrue to the policy holders and are treated as premium supplements. The value needs to be adjusted taking into account changes in the technical reserves and equalization provision. In health insurance the actuarial reserves set aside to take account of the foreseeable rise of health spending of policy holders in the future are of particular importance. They are not part of the insurance output and should not be part of administrative expenditure.

121. In case the information on premiums, claims and adjustments are not available, SNA recommends to measure health insurance output by the sum of costs including an allowance for normal profits (including corporate tax)[8].

122. A number of countries (e.g. Austria, Canada and Portugal) calculate private insurance expenditure according to this method. The United States has developed a slightly different three-tier approach to estimate their administrative expenditure. They use data from the three different perspectives

[8] See paragraph 6.191 of SNA 2008

(insurance industry, employees and employers, health services providers) to estimate total premiums received by insurance companies and total benefits financed.[9]

123. A universal application of SNA methodology to estimate private health insurance expenditure should result in more internationally comparable figures. However, the identification of premiums, claims and all adjustment factors might present a problem of data availability in some countries.

Summing up all the expenditure of administrative activities of private health insurance

124. An alternative approach is to sum up all the expenditure of administrative activities of private health insurance companies. However, countries that calculate according to both methods show a large variation between the two values (from 2% in France to 50% in the Netherlands) and this thus points to potential issues of comparability. Differences can relate to the range of cost items included in the calculations. In theory, the difference between the two concepts should only be the gross profits (before corporate taxes) of the insurance companies which are not a cost item.

125. The costs of private health insurance companies should include the compensation of their employees, intermediary consumption of services and goods used for the provision of insurance services (electricity, office equipment not considered as assets, rent), consumption of fixed capital and taxes on production. One item of particular note would be acquisition costs that private health insurance companies have to incur to "acquire" new clients - for example, commissions paid to a broker for the sale of an insurance policy. These are part of intermediate consumption.

126. One other potential area of difference is that a number of countries exclude taxes payable by the private insurance companies from their estimations. Others disregard the consumption of fixed capital and the acquisition costs.

Percentage estimation

127. Another more rudimentary approach to estimate the expenditure on private health administration and health insurance is by applying a specific percentage to the aggregate of total spending.

128. One example uses information obtained from ESSPROS- the percentage of administration cost on the total expenditure (all schemes) - and multiplies this share with total health premiums paid by households to estimate the administration cost of private health insurance.

129. Korea uses a ratio of administration to total spending as collected in a one-off survey in the past for all years. However, whether the current situation could be fully reflected through past survey needs to be considered case by case for different countries.

130. Though estimating private health administration expenditure as a constant share of total spending is an easy alternative, it will be less accurate than the other two approaches. It should only be used as a last resort in case the previous two estimation methods are not feasible to implement.

Providers of health administration and health insurance: private

131. The principal provider of administrative expenditure on private health insurance is other private insurance (HP.6.4 [SHA 1.0]/HP.7.3 [SHA 2011]). Few countries report private administration expenditure

[9] In this approach, capital gains do not appear to be added and additions to reserves are not subtracted and thus the concept differs somewhat from SHA methodology.

for other providers, except in cases where private health insurance (compulsory or complementary) is covered by social insurance agencies (HP.6.3/HP.7.2).

132. In SHA 2011, an agency administering complementary health insurance with the status of a non-profit-institution should be reported under the category HP.7.9: other administration agencies. This would for example apply to the "mutualities" in France.

133. As in the case of governance and health administration, administrative activities related to the financing of providers (e.g. collecting provider revenues) should be considered as an integral part of the service provision (e.g. HC.1) and not identified as a separate functional category in SHA.

134. Germany indicates that expenditure for private insurance administration is also reported from foreign health providers abroad which render assistance services for tourists abroad and are contracted by domestic insurance companies. These providers can be categorized to HP.9 (Rest of the world).

Additional issues with administration of health financing under SHA 2011

135. SHA 2011 aims to cover administrative expenditure for all financing schemes, that is, non-profit institutions financing schemes (HF.2.2), enterprise financing schemes (HF.2.3) and rest of the world financing schemes (HF.4).[10] In most OECD countries their financing role for the health system and therefore administration costs will be small.

136. Non-profit institutions may finance a variety of health care activities, e.g. medical treatment for homeless or people in need that have limited access to primary health care, special medical treatment for children or palliative care which is insufficiently covered in many public health care baskets. Revenues of non-profit institutions usually consist of transfers from the government, donations from individuals or companies as well as membership contributions. The management and pooling of these funds should be classified as administrative costs (HC.7.2) if they can be separated from the cost of the health care activity. Fund-raising activities would also be included under this item. From a provider perspective these administrative services should be allocated to HP.7.9 other administration agencies. It can be challenging for countries to identify these services separately.

137. Occupational services are the main health care activity financed by enterprise financing schemes. In case there are significant administrative costs attached to it that are separately accounted for these costs should be reported under HC.7.2 provided by HP.8.2 secondary providers of health care. The category enterprise financing schemes is also used in other cases (e.g. for health care providers financing schemes when they finance part of their services from their own resources). In case there are any finance administration activities attached to it they may also be reported here.

138. Only in very few OECD countries does the rest of the world (ROW) finance domestic health expenditure. In case there are domestic agencies engaged in the administration of ROW funds they can be classified as HP.7.9: other administration agencies**.**

[10] By convention the financing scheme HF.3 household-of-pocket payment accounts no administrative costs.