2022 JOINT OECD, EUROSTAT AND WHO HEALTH ACCOUNTS (SHA 2011)

DATA COLLECTION

ELECTRONIC QUESTIONNAIRE

EXPLANATORY NOTES

Version February 2022

QUESTIONNAIRE SENT: JANUARY 2022

DEADLINE FOR RETURN OF INFORMATION: 31 MARCH 2022

CONTACT:

SHA.Contact@oecd.org, ESTAT-SHA@ec.europa.eu, nha@who.int

Table of Contents

1. Summary of the practical working arrangements for cooperation between OECD, Eurostat and WHO

- This section aims to inform countries about the practical working arrangements for the 2022 Joint Health Accounts Questionnaire (JHAQ) coordinated by two international organisations (OECD and WHO) and one supranational organisation (the European Commission, of which Eurostat is the responsible authority regarding community statistics). ***Please note that this explanatory note includes further guidance on how to account for subsidies, financial support and other payments to health providers in the context of COVID-19 and replaces the version sent in January 2022. Any changes between the two versions are highlighted in yellow.***

- The primary goal of the collaboration between OECD, Eurostat and WHO is to reduce the burden of data collection for the national authorities responsible for the provision of statistical information to the international organisations. This joint effort also aims to increase the use of international standards and definitions.

- In response to the growing demands for international comparable information on health spending, the OECD, in cooperation with the Eurostat Task Force CARE members and experts in the field of health accounting, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. SHA sets out an integrated system of comprehensive and internationally comparable accounts and provides a uniform framework of basic accounting rules and a set of standard tables for reporting health expenditure data. *A System of Health Accounts 2011* (SHA 2011) was released in October 2011 after a four year collaborative effort between OECD, WHO and the European Commission. The manual sets out in more detail the boundaries, the definitions and the concepts of health accounting – responding to health care systems around the globe with very different organisational and financing arrangements.

- The implementation of SHA requires political commitment, clear institutional responsibility, and cooperation at the national level between institutions with relevant data sources. Most EU Member States and OECD countries have implemented the SHA 2011 framework. Many WHO Member States are also implementing the SHA 2011 standard, or initiating the process. OECD, Eurostat and WHO will continue to support the SHA 2011 implementation by providing training and technical assistance.

- Through common efforts of SHA implementation, in 2005 the three organisations agreed to intensify their collaborative actions through a joint data collection. Letters were sent to the heads of the relevant national organisations (statistical offices and/or health ministries), emphasising the importance of SHA implementation and the joint SHA data collection. Furthermore, the relevant national organisations were asked to ensure that a single person be nominated as a focal point for the JHAQ.

- The inaugural 2006 JHAQ was sent to the countries concerned in December 2005: 23 countries (20 OECD countries and 3 non-OECD EU Member States) returned the first questionnaire. For the 2021 edition of the JHAQ, 45 countries responded to the questionnaire.

Scope and approach to the 2022 data collection

- The 2022 JHAQ consists of the following elements: 1) SHA 2011 Excel data file used to submit new data and revisions of previous years[1]; 2) a methodological questionnaire (containing metadata); and 3) explanatory notes/guidelines (including this description of the practical working arrangements).

- Similar to 2021 JHAQ, the scope of data collected is slightly extended compared to the 2020 JHAQ as it includes a number of special reporting items related to the COVID-19 pandemic[2].

- The 2022 JHAQ will continue to collect preliminary t-1 (2021) estimates for current health expenditure where available. Countries submitting t-1 estimates are asked to use the standard data file, completing the appropriate aggregate total in the relevant tables and any further breakdowns available, naming the file 2021-T22-XXX (XXX represents the respective ISO country code).

- The rules for the filling of cells for "not applicable" and "not available" items remain from the 2021 JHAQ. The guidelines available in the general tab of the excel data file are therefore still in effect.

- In order to maintain a consistent long-running time series for analysis, countries are strongly encouraged to provide SHA 2011 tables for earlier years, if necessary.

Data validation process

- Since 2006, the International Health Accounts Team, set up by OECD, WHO and Eurostat, has continued to develop a methodology and a coordinated way of corresponding with national focal points in order to check the data submissions of the participating countries. Data validation will be carried out in a similar way for the 2022 data collection.

- The aim is to finalise the data validation process within two months of the initial data submission. Meeting such a target requires a suitable commitment of resources from both the three organisations and the national reporting authorities.

- In order to have internationally comparable data at a sufficiently disaggregated level, the implementation of the functional classification (ICHA-HC) is a necessary precondition. As a strict minimum requirement, countries are invited to provide the three core tables (HCxHF, HCxHP and HPxHF) with sufficiently disaggregated data, together with the methodological information necessary. However, countries are strongly encouraged to complete ALL tables. Where appropriate, national health accountants are invited to discuss possible approaches with the International Health Accounts Team in order to complement the partial deliveries and complete the basic submission.

- While not a 'core table', the HFxFS table is vital for a comprehensive understanding of a country's health financing arrangements. OECD and WHO have begun investigating methods for supporting the completion of the FS classification (ICHA-FS)

[1] Files with previously submitted data can be provided on request.

[2] The extension was discussed and approved at the meetings of the OECD Working Party on Health Statistics and the Eurostat Technical Group of Health Care.

for countries not currently producing a breakdown. All countries are strongly advised to complete this table.

- Given the importance of having timely data to assess the impact of the COVID-19 pandemic on the health sector, countries are strongly encouraged to submit preliminary data on current health expenditure for 2021 and for the additional COVID-19 reporting items.

Distribution of the data

- The subsequent use and distribution of the data will be done independently by the three organisations, in accordance with the existing regulations and practices of OECD, Eurostat and WHO.

Summary of the 2022 Joint Health Accounts Questionnaire

What countries will receive

- Countries will receive the following documents with the email addressed to them in mid-January 2022:

1. One empty SHA data table (to be used for the submission of all relevant years)
2. Methodological questionnaire (a prefilled questionnaire based on the 2021 submission to be updated for the 2022 submission[3])
3. Explanatory notes (describing the practical working arrangements of the joint data collection)
4. Technical user guide (on how to use the programmes embedded in the SHA data files)

Data collection and validation process

- The data collections and validation process is displayed in Table 1.1 below.

Table 1.1. JHAQ data collection and validation process

	EU Member States, EEA/EFTA and EU candidate countries and potential candidates	*Other OECD countries, OECD accession countries & key partners*
Questionnaire sent:	January	January
Organisation sending questionnaire:	Eurostat	OECD
Submission deadline:	**31 March 2022** *(Official deadline)* **30 April 2022** *(Regulation (EC) 2015/359 deadline)*	**31 March 2022**
How to submit:	Eurostat Single Entry Point, via the EDAMIS[4] transmission tool	Upload documents to One Drive 'Submission' folder using the link

[3] The 2022 Metadata file includes one additional worksheet for COVID-19 reporting items.

[4] EDAMIS is programmed to automatically forward/put at disposal the submitted data to OECD and WHO.

Validation confirmation:	Eurostat to confirm validation via email	OECD to confirm validation for OECD countries and WHO to confirm for non-OECD countries

- Countries are requested to submit their files at the deadline indicated using the transmission tool indicated in the table above.

- EU Members States, EEA/EFTA and EU candidate countries and potential candidates are required to use EDAMIS as a transmission tool. Countries should note that the submission is only successful if :

  - Format of the file is correct: use of the 20221 template (200X-T22-XXX). Only Excel files are accepted, no zip or archives,
  - EDAMIS Dataset Naming convention is fully respected: Dataset Identifier corresponds to the type of file (HCSHA_2011NAT_A for reference year and revised data, HCSHA_2011PRE_A for the preliminary t-1 (2021) data and HCSHA_2011MET_A for methodological information) and period of the data (Year) corresponds to the "Year of the data" in the excel file,
  - Data are in numerical format and values are positive.

  After submission of the file, data providers will receive an automatic feedback from EDAMIS that the transmission has been successful and the file is accepted or that errors have been detected. In this case, the file needs to be submitted again after correction of errors.

- Other OECD countries, OECD key partners and accession countries are asked to submit data using One Drive. Countries will receive a link to OneDrive for Business to receive the JHAQ, and are to upload documents in the 'Submission' folder. If the JHAQ is returned after the deadline, a new link to this location will be sent.

Additional information

- Countries are requested to address any questions to the International Health Accounts Team. Please email queries to all three IHAT organisations at the following addresses: SHA.Contact@oecd.org (OECD), ESTAT-SHA@ec.europa.eu (Eurostat) and nha@who.int (WHO).

- Correspondents are kindly asked to provide their feedback about the applied process of the joint data collection and proposals for modifications when needed.

2. Structure of the classifications and tables presented in the joint questionnaire based on *A System of Health Accounts (SHA 2011)*

- SHA is a tri-axial system in which the financing, provision and consumption dimensions are covered by the ICHA (International Classification for Health Accounts): Health Care Functions (HC), Health Care Providers (HP), Health Care Financing Schemes (HF), Revenues of Health Care Financing Schemes (FS), Factors of Health Care Provision (FP) and Capital (HK). The classifications and definitions presented in the *SHA 2011* manual [http://www.oecd.org/els/health-systems/a-system-of-health-accounts-2011-9789264270985-en.htm] are to be followed. Additional guidelines and material useful for compilers are also available at this address.

- These dimensions are inter-linked and dependent on each other. Due to its three-dimensional complexity, tables on two pairs of axes are typically used. This means expenditure data are organised according to the following tables: Functions (HC) by Financing (HF), Functions (HC) by Providers (HP), Providers (HP) by Financing (HF), Financing (HF) by Revenues (FS), Providers (HP) by Factors of Provision (FP) and Capital (HK) by Providers (HP).

- For the tables in the Joint Questionnaire containing the functional classification (i.e. HCxHF and HCxHP tables) the expenditure of health care (and health-care related) providers for health-related activities outside the health care branch are included – HC.R for health-related functions.

- The residual categories HC.0, HP.0 and HF.0 ("unknown"), should be regarded as "last resort" categories. Countries should make every possible effort to allocate all expenditure across the other categories of ICHA. However, these categories are available for use in those cases where there is no alternative. When using these categories, the respondent should supply information concerning the content of these cells and a detailed explanation of why an alternative expenditure item cannot be identified. It is important that expenditure allocated to the "unknown" categories remain small as a percentage of total spending in order to allow for meaningful international comparisons of the other expenditure categories. The international organisations will work with the countries concerned to discuss strategies on how to avoid the use of this category in the SHA tables and to find ways of distributing the remaining expenditure according to the categories of the ICHA classifications.

- Those responsible for the completion of the Joint Questionnaire are invited to send any questions and comments arising during the preparation of the tables. Due to the different ways countries produce their SHA tables, advice can be most appropriately given on a country-by-country basis.

- To achieve the best result possible, it is necessary to collect the information on expenditure at all possible levels of aggregation. Ideally, tables at the two-digit (and for some categories, three-digit) level of aggregation are desirable. For some countries, data at a detailed level may not be accessible or conflict with data confidentiality for some spending categories.

3. Additional guidance for JHAQ compilers

Published guidelines

- In addition to the SHA 2011 manual, the following guidelines and reports are made available to compilers to assist country implementation of SHA 2011 in certain expenditure domains:
  - Implementation of the SHA 2011 Framework for Accounting Health Care Financing;
  - Accounting and Mapping of Long-Term Care Expenditure under SHA 2011;
  - Implementing the Capital Account in SHA 2011;
  - Expenditure on Prevention Activities under SHA 2011: Supplementary Guidance;
  - Guidelines to Measure Expenditure on Over-the-Counter (OTC) Drugs;
  - Guidelines to Improve Estimates of Expenditure on Health Administration and Health Insurance;
  - Guidelines for Improving the Comparability and Availability of Private Health Expenditures;
  - Feasibility and Challenges of Reporting Factors of Provision in SHA 2011;
  - Improving Estimates of Exports and Imports of Health Services and Goods.
  - Guidance on how to account for COVID-19 related transactions in the context of the core SHA Framework (chapter 4 of this document). Note that this section will include additional detail, in particular, the treatment of compensations for loss of revenues of health care providers in an updated version to be distributed in February.
  - Guidance on the content of the special COVID-19 spending reporting items (chapter 5 of this document). Note that this section will include additional detail in particular, the treatment of compensations for loss of revenues of health care providers in an updated version to be distributed in February.
- The above documents, as well as the SHA 2011 manual, can be accessed via the following links:
  - http://www.oecd.org/els/health-systems/a-system-of-health-accounts-2011-9789264270985-en.htm
  - http://www.oecd.org/els/health-systems/health-expenditure.htm

Independent doctors or other health care professionals working in hospitals or other settings

- Page 129 of SHA 2011 refers to "… the provision of services in hospitals (concerning) individual doctors performing a specific service to patients in the hospital framework as subcontractors (integrated as offices in hospitals). In SHA 2011, offices of

self-employed doctors working in hospitals are recorded under hospitals in the same way as services of employed doctors. Only if the provision is clearly independent of the hospital's activities (i.e. the physician rents a room or equipment for his own outpatient practice) should it be separately accounted as a provider of ambulatory care."

- It is important to note the reference to *subcontractors*, such that in the case of self-employed doctors providing services to the hospital under contract, the hospital remains the provider. Only in the case of independent billing should they be considered separately as a provider of health care services to the patient and classified appropriately. It should be stressed that this typically does not apply to doctors with short-term contracts. Services of these 'locums' should hence be considered under HP.1.

- This however raises the issue regarding how such independent doctors are classified since "HP.3 Providers of ambulatory" care specifically refers to "... (establishments) primarily engaged in providing health care services directly to outpatients who do not require inpatient services." However, it is recommended that doctors predominantly providing inpatient (or day-care) services should still be classified under HP.3, for example, under HP.3.1, which specifically lists offices of surgeons as an illustrative example (p.137).

- Accounting should be analogous for other health care professionals such as nurses in case they have a similar work arrangement, and can also be applied to other settings than hospitals, if applicable.

Pharmaceutical rebates

What are pharmaceutical rebates?

- Mechanisms to lower the prices of pharmaceuticals paid by patients and/or mandatory/voluntary financing schemes exist in the vast majority of OECD countries. These arrangements are typically called rebates, claw-backs, refunds or discounts (they will only be referred to as rebates in the remainder of this document) and can involve suppliers and purchasers of health goods at different levels. Generally, rebates aim to shift some of the burden of increasing pharmaceutical consumption along the supply chain (i.e. the manufacturers, wholesalers and pharmacies).

- What these rebates have in common is that they are intended to lower the "effective price" of drugs dispensed to patients. There are many different ways by which a price reduction can be achieved, e.g. reducing the mark-up of manufacturers/wholesalers/pharmacies at the point of delivery or reducing the price of a pharmaceutical once a pre-defined volume is passed. The basis of the rebate can differ: it can refer to a "list price", "manufacturer price" or other price concepts and can take different forms, e.g. a fixed or a percentage reduction. Rebates can be decreed by law or can be negotiated directly between purchasers and manufacturers. They can exist in both the hospital and outpatient (retail) sector.

How are pharmaceutical rebates defined in SHA 2011?

- SHA 2011 does not cover this issue specifically. The way in which rebates should be treated needs to be deduced implicitly:

- The manual states clearly that "…[c]onsumption is valued at purchasers' prices including any (non-deductible) value added tax (VAT). This means that the value of medical goods and services is based on what purchasers pay" (p. 59).

- To the extent to which health care goods and services are provided by market producers this price can be considered as the market price. Regarding the valuation of transactions SNA 2008 stipulates that "[a] market price is the price payable by the buyer after taking into account any rebates, refunds, adjustments, etc. from the seller" (SNA 2008, 3.121)

Recommended treatment of pharmaceutical rebates for the JHAQ

- Pharmaceutical spending should be valued at the purchaser's price, net of rebate (e.g. gross prices minus rebates). This price refers to the price the purchaser (ultimately) has to pay and includes taxes on products like VAT.

  - Example: The gross price of pharmaceutical A in country Z is 20 NCU. The costs are completely covered by Public Health Insurance. By law, pharmacies are required to give a rebate of 10% of the gross price to the payer when dispensing the pharmaceutical to the patient.

    → The transaction should be valued at 18 NCU (HF.1.2 x HC.5.1 x HP.5.1)

- Rebates should be considered even if the financial transaction involves actors that are not part of the HP universe in SHA (e.g. manufacturer) but they have to be attributed to the provider where final consumption takes place. In most cases pharmaceutical rebates will affect the spending in pharmacies (HP.5).

  - Example: The gross price of pharmaceutical B in country Y is 30 NCU. The costs are completely covered by Public Health Insurance. By law, manufacturers are required to give a rebate of 20% of the gross price to the payer one month after the pharmacy dispensed the pharmaceutical. In February, the pharmacy dispenses pharmaceutical B to the patient and Public Health Insurance makes a payment of 30 NCU to the pharmacy. In March, the manufacturer reimburses 6 NCU to Public Health Insurance.

    → The transaction should be valued at 24 NCU (HF.1.2 x HC.5.1 x HP.5.1)

- Only rebates benefiting the purchasers (financing scheme) should be considered. If a wholesaler gets a rebate from a manufacturer for a bulk purchase which increases his profit, this would be outside of the SHA framework since it does not affect the purchaser's price.

- The principle treatment of rebates in SHA should not differ between both public and private payers.

- It needs to be stressed that SHA recommends the accrual method in accounting of health care consumption. This method is particularly relevant when it comes to rebates. Rebates should be attributed to the year when the transaction they refer to took place, which is not necessarily the year that the payment of the rebate is made. As a consequence, SHA compilers might have to recalculate pharmaceutical spending and revise earlier submissions of the JHAQ regularly in case that information on total rebates referring to year *t* only become available in later years. Given that the health accounts are currently constructed in year *t+2*, the adjustment necessary for the payment could be estimated through information on existing contracts, and/or the actual rebates made in *t+1*.

- Example: The gross price of pharmaceutical C in country X is 30 NCU. The costs are completely covered by Public Health Insurance. By law, manufacturers are required to give a rebate of 20% of the gross price to the payer six month after the pharmacy dispensed the pharmaceutical. In November of year t, the pharmacy dispenses pharmaceutical C to the patient and Public Health Insurance makes a payment of 30 NCU to the pharmacy. In May of year t+1, the manufacturer reimburses 6 NCU to Public Health Insurance.

  → The transaction should be valued at 24 NCU (HF.1.2 x HC.5.1 x HP.5.1) in year t

- Taking the lead from SNA 2008 on valuation of transaction and market prices, rebates must be known before the transactions take place: "When a price is agreed by both parties in advance of a transaction taking place, this agreed, or contractual, price is the market price for that transaction regardless of the prices that prevail when the transaction takes place" (SNA 2008, 3.120). Thus, a unilateral decision by a purchaser to pay less than the agreed price should not be considered a rebate unless it is based on legislation which comes into effect retrospectively.

- There appears to be a need to distinguish between a rebate and a tax. A rebate reduces the purchaser's price whereas a tax is part of the purchaser's price. The aim of a rebate is to reduce the price of a product or service whereas taxes are tools to raise revenues for the government. As a rule to distinguish between the two we suggest the following guiding principle:

  - A rebate must be payable directly or indirectly to the purchaser which should have discretion in the use of these funds. If a rebate payment is made to the tax authority and part of general tax collection than it is a tax and part of the purchaser price. In this case the payment should not be treated as a rebate.

- Although rebates in the pharmaceutical sector are the most common form of rebates in the health sector, the same accounting principle should be applicable to other health care goods and services.

Pharmaceuticals dispensed in hospital or other health care settings

- Regarding the use and dispensing of pharmaceuticals in hospitals: if this takes place during an inpatient treatment, then the manual is clear that the pharmaceuticals are part of the package of inpatient care and should therefore be accounted under HC.1.1 or HC.2.1. On the other hand, if a hospital pharmacy dispenses medication against a prescription to an outpatient, it is clear that the expenditure should be considered under HC.5.1 "Pharmaceuticals and other non-durable goods".

- However, the situation may be less clear when pharmaceuticals are used as a part of an outpatient treatment – in a hospital or any other setting. On page 97 the SHA 2011 manual states that "…medical goods consumed or delivered during a health care contact that are prescribed by a health professional" should be excluded from HC.5. This should be clarified such that pharmaceuticals and other medicinal products that are **consumed** during the outpatient (or day case) contact should be considered as HC.1.3 (or HC.1.2). For example, this can cover medical products used during a session of chemotherapy or dialysis as well as medication for HIV or Hepatitis C. However, in the case of a doctor dispensing prescription medication to outpatients with the intention that this is consumed away from the doctor's office, then this transaction should merely be considered as an alternative

dispensing channel. Within this context, it is recommended to categorise this transaction under HC.5.1.

Renaming and redefining category HC.1.3.9 "All other outpatient curative care"

- There has been some confusion and ambiguity about the content of the category HC.1.3.9 "All other outpatient curative care n.e.c." under SHA 2011 and the extent to which it has changed from SHA 1.0.

- It is recommended that HC.1.3.9 should be used to specifically include **outpatient curative care services provided by paramedical and other health practitioners that are neither physicians nor practice nurses**, such as physiotherapists, chiropractors, speech therapists, etc. The reason for this re-definition is the desire to distinguish such services from HC.1.3.3 "Specialised outpatient curative care", typically provided by medical doctors with a specialisation. The renaming of HC.1.3.9 to exclude the term "n.e.c." clarifies that this category should not be used as a residual category.

- Related to this, it should be noted that many of the services provided by the above mentioned paramedical and other health providers may not have a *curative* but a *rehabilitative* purpose. Health accountants should take this into consideration when deciding whether the services should be reported under HC.1.3.9 (services with a curative purpose) or HC.2.3 (services with a rehabilitative purpose).

Ancillary services

- A service should only be considered as an ancillary service (HC.4) **if provided as a separate contact.** In the case that laboratory services (HC.4.1) or imaging services (HC.4.2) such as X-ray are directly conducted as part of an initial consultation with a General Practitioner, then these services should be accounted for under outpatient curative care (HC.1.3). Only if these services are provided as a separate consultation – for example, after referral from a GP – should these services be considered as ancillary services.

The treatment of subsidies, compensations for loss of revenue and other payments to health providers in the context of COVID-19

- While "current health expenditure" generally refers to the final consumption of health care goods and services, the SHA 2011 Manual highlights on pages 45/46 that *subsidies* received by health providers should be included in this aggregate. In the terminology of the System of National Accounts "[s]ubsidies are current unrequited payments that government units,…, make to enterprises on the basis of the levels of their production activities or the quantities or values of the goods or services that they produce, sell or import" (para 7.98 of SNA 2008). The objective of subsidies can be to influence the level or mode of production, the prices of the produced outputs or the remuneration of units engaged in production. Subsidies can only be made to producers (or importers) and not to households as final consumers (they receive social benefits or other current transfers, but not subsidies). Subsidies are divided into subsidies on products and other subsidies on production. They are predominantly made to market producers but other subsidies on production can also be made to non-market producers under specific circumstances.

- In normal times, subsidies to health providers do not play a huge role in health systems of OECD or European and some other WHO countries. However, even pre-

COVID, regular transfers to public corporations and quasi-corporations in the health sector that are intended to compensate for persistent losses incurred on their productive activities as a result of charging prices that are lower than their average costs of production as a matter of deliberate government economic and social policy existed. These are subsidies on products and should be included under current health expenditure. Yet, to be considered as a subsidy (and hence included under current health expenditure), the compensation payment must refer to the current period. Transfers from government units to publicly or privately owned health enterprises to cover large operating deficits accumulated over two or more years should not be included under current health expenditure: these are capital transfers.

- In the context of COVID-19, substantial **transfers from governments to health providers** (mainly private) have been made for different reasons in a number of countries. In some instance, they are made to "purchase" or "reserve" treatment capacity for COVID-19 patients (which may also be interpreted as government final consumption rather than subsidies). In other cases, the transfers are made to compensate for lost revenues due to restrictions imposed by government or in response to a general reduction in health activity. The nature of these transfers, and the conditions attached to them can differ across countries and there are indications that there may be some variation in how these transactions are accounted for in the National Accounts (e.g. as subsidies or other). For this reason, it seems desirable to provide detailed guidelines for health accountants regarding how different types of compensation payments should be recorded in the JHAQ submission (regardless of how they are treated in country's National Accounts).

- As a general rule, the following criteria should be applied to decide whether a compensation payment should be included under current health expenditure:
    - When the financial support is specifically *targeted at health providers* to support health facilities and self-employed health professionals to maintain their business, and in case of the employers to keep their employees on the payroll, with a view of maintaining the existing health provider infrastructure, it should be included under current health expenditure.
    - When the financial support is *targeted at all industries* (and which may coincidentally also benefit health providers) to maintain their business, and in case of the employers to keep their employees on the payroll, with a view of quickly returning to normal production after the pandemic, it concerns generic support and should not be included in current health expenditure.
    - When, in contrast, financial support is *predominantly targeted at supporting the income of households*, regardless of whether they remain in employment, it concerns a social transfer and should not be included under current health expenditure.
    - When the financial support is directed at self-employed healthcare professionals (which depending on the health system can refer to GPs, dentists, nurses, etc.), it may be challenging to distinguish between support they receive in their capacity as "health professional" from support they receive as "households". However, the decision whether the support should be included under current health expenditure or not should be guided by the same reasoning as presented in the first three bullet points.

- More detailed examples how these principles should be applied and under which COVID-19 specific categories the transactions should be recorded are provided in Chapter 4.

- Subsidies and compensation payments should be allocated to health providers (HP) and health care functions (HC) within the core SHA framework following the general SHA accounting rules. The identification of the health provider (HP) receiving the subsidies or compensation payments should be straight forward. Yet, it may be difficult to clearly identify the health care function (HC). For this, two approaches are generally feasible; (i) based on the dominant character of the provider, or (ii) on a pro-rata basis, which should be the preferred approach. For example, subsidies to a hospital could be fully considered as HF.1.1xHP.1xHC.1.1 or allocated across several HC categories (e.g. HC.1.1/HC.1.3/HC.3, etc..). The allocation of a subsidy to HC.7 is not recommended, since subsidies refer to a productive activity rather than administrative activities. For the reporting of subsidies and compensation payments in the HFxFS table, the combination HF.1.1/FS.1.1 is recommended in most cases. FS.1.3 should not be used as this category refers to subsidies to *financing schemes* and not to health providers.

4. Accounting guidelines for the JHAQ for COVID-19 related activities

- While the COVID-19 pandemic may have a significant impact on health spending in 2021, the pandemic does not change the fundamental accounting principles on which the *System of Health Accounts 2011* (SHA 2011) is based. The key principles for a spending item or activity to be considered under *Current Health Expenditure* are:[5]
  - The primary intent of the activity is to improve, maintain or prevent the deterioration of the health status of the individuals, groups of the population or the population as a whole as well as to mitigate the consequence of ill health;
  - Qualified medical or health care knowledge and skills are needed in carrying out this function, or it can be executed under the supervision of those with such knowledge, or the function is governance and health system administration and its financing;
  - The consumption is for the final use of health care goods and services of residents;
  - There is a transaction of health care goods and services.
- COVID-19 is one of many health conditions that health systems treated in 2020 and 2021. Nevertheless, given the importance of tackling the pandemic and ensuring comprehensive and internationally comparable health spending data, some accounting guidelines for the most frequent activities and transactions related to the pandemic are considered useful.
- When examining COVID-19 emergency budgets, a lot of the spending in the area of health (e.g. the purchase of ventilators and ICU beds, grants for R&D into vaccine research) does not meet the criterion of final consumption of health care goods and services and therefore falls outside of "current health expenditure". As such, the SHA framework does not measure the *total* resources mobilised in a country to fight the pandemic or the total costs of the pandemic response. However, it can play an important role to better understand the impact of COVID-19 on health systems and contribute to a better measurement of overall pandemic response costs. Chapter 5 introduces some special COVID-19 reporting items that allow for an identification of some of these response costs.

Guidelines

- Table 4.1 discusses activities related to the COVID-19 pandemic response, giving recommendations as to how these should best be accounted within the SHA 2011 framework. The list is not exhaustive and compilers are invited to draw on these guidelines to treat related activities in a consistent way. Like any other disease, activities to treat and prevent COVID-19 are allocated across different health care functions if they qualify as current health expenditure (according to the principles set out above). If they do not, they may be considered as investments (to be recorded in the capital account table).

[5] Please see Chapters 3 and 4 of SHA 2011 for more specific information.

- The recommendations follow Chapter 5 of the SHA 2011 Manual but also draw on the "Supplementary guidelines" for how to account for preventive activities.[6] A number of boundary issues are apparent. This particularly concerns some preventive activities where determining whether health or another domain, such as employment or public safety, is the primary purpose. Some specific areas are discussed further:

- Spending on **personal protective equipment (PPE)** - e.g. surgical masks, other nose and mouth coverings, face shields, gloves, gowns, etc. - used by health professionals as well as by households. An initial distinction is made between the use of PPE as *intermediate consumption* (i.e. by health or LTC professionals in carrying out their tasks) and as *final use* by people wearing e.g. face masks when interacting with others. Spending on the former is *not explicitly* added into current health expenditure since the costs are *implicitly* included in the value of final health output produced by healthcare providers.

- Concerning PPE for *final use,* a practical solution on the scope of goods to be included under current health expenditure is required. For example, in the case of facemasks, most public authorities recommended the use of respirators (e.g. FFP masks), medical facemasks, as well as non-medical facemasks ("community masks") to avoid the spread of the SARS-Cov2 virus. Only the first two categories are certified products and subject to regulation; "community masks", encompassing all kinds of textile-based products, are generally not considered as health products and as such not included under COICOP category 06.1.2 (Other medical products) which is often used by many countries to estimate the SHA category HC.5.1.3 (other medical non-durable goods). ***Therefore, it is recommended to only include spending on those that can be regarded as "medical goods" in the sense of HC.5.1.3 and COICOP 06 under current health expenditure***.

- Spending on **compliance with COVID-19 public health and safety regulations.** In general, enterprise spending on *compliance* with safety at work regulations are not included under HC.6.[7] It is proposed that costs for work place adaptations (e.g. installation of plexi-glass screens, floor markings, etc.) to ensure COVID-19 compliant working conditions are not included under current health expenditure. Expenditure for facemasks might also be interpreted as compliance costs since many countries have introduced obligations to wear masks in the work place but they should be considered as occupational health care in SHA. In line with the guidance above, it is recommended that the costs are included only if the masks fulfil the criteria to be considered as a health product. The same goes for the accounting of costs for hand sanitizers.

- Related to the above are the **costs to businesses** to provide facemasks and hand sanitizers to their **clients**. It is recommended to exclude these costs from current health expenditure for two reasons. First, it can be argued that the health motive of these initiatives are secondary only as a means to be able generate business – the main motivation. Secondly, expenses for these services are not for final use but are considered intermediate consumption in the production for non-health output. The one exemption described in SHA

[6] http://www.oecd.org/els/health-systems/Expenditure-on-prevention-activities-under-SHA-2011_Supplementary-guidance.pdf

[7] Please consult the Prevention guidelines of 2017 for a more in-depth discussion.

where intermediate consumption should be included under CHE only refers to employers (when providing occupational health care for their staff) but not to businesses.[8]

- **Spending for PCR tests, antigen tests and serological tests** to detect the presence of the SARS-Cov2-Virus or resulting antibodies. Depending on the characteristics of when and where these tests were carried out, the costs should be allocated to HC.1.1, HC.1.3, HC.4 or HC.6[9]. In case a distinction between the different types of tests is not feasible they should be allocated to one category based on the majority principle. Regardless of how they are accounted in the core framework, all testing costs should be captured under the special reporting item, HC.COV.2.

- In some cases, people entering a country may have been required to follow a **monitored 14-day quarantine in dedicated facilities**, frequently hotels. The costs for these stays can generally be considered as compliance costs, and therefore outside of the SHA framework. Any incidental costs for testing and medical counselling in these facilities should be reported under current health expenditure. In case these facilities are considered more a medical facility than a hotel, all costs may be considered under current health expenditure.

- For the **identification of the health care provider** (HP) for COVID-19 activities, it should be reiterated that this is not dependent on where the activity takes place but based on the primary activity of the provider. For example, local public health employees may conduct tests on their premises, but also in car parks, stations and airports. In all cases, the provider should be HP.6. However, in many countries other professionals were trained and tasked with carrying out "test and tracing" activities, e.g. the military, the police, public servants from non-health departments, private contractors. In many of these cases, HP.8.2 seems to be the most suitable provider category. ***Due to the differences in the organisation of health systems, the accounting recommendations for HP in Table 4.1 are only indicative***.

In a number of countries, **transfers from government to health providers** (mainly private) have been made to compensate for lost revenues or to "purchase" or "reserve" treatment capacity for COVID-19 patients. Regardless whether these transfers are treated as subsidies or final consumption expenditure in National Accounts, if these transfers are specifically targeted at health care providers they should be included under current health expenditure. In addition to the general guidelines for the recording of compensation payments for lost revenues/subsidies set out in Chapter 3, the following accounting recommendations are made:

  - Transfers made due to COVID-19 related government interventions to "purchase" or "reserve" treatment capacity of health providers are to be included in current health care expenditure. This is the case, for example, when hospitals receive payments to keep treatment capacity available for COVID-19 patients and have to postpone elective activity for this purpose.

[8] See page 46 of SHA 2011 Manual. The only exemption for intermediate consumption to be included under current health expenditure is made for occupational health care.

[9] In some cases, the primary purpose for a test may also not be related to health at all if people want to travel and avoid compulsory quarantine in their destination. However, to simplify accounting practice, we suggest to refrain from distinguishing the different motivations to take a test and consider all test costs as health spending.

- Related to this are transfers to a range of different health providers (e.g. dentists, LTC providers, screening centres) to compensate for the loss of revenues as a result of reduced activity. This can be due to the fact that social distancing measures did not allow the activity to be fully exercised or caused patients to refrain from using the health services out of fear of infection. If transfers targeted at health providers exist, then if the objective is to specifically protect the financial position of health providers, allow staff to remain on the payroll, and ultimately retain a functioning health provider infrastructure, these transfers should be considered under current health expenditure.
- The recommendation above should also apply to self-employed health professionals, where it is difficult to distinguish between a compensation for provider revenue and provider income.
- The transfer of protective personal equipment (PPE) from government units to hospitals and other health providers free of charge can be considered as a subsidy and should be included in current health expenditure[10].
- It is recommended that compensation payments intended for all industries which may coincidentally also benefit health providers (e.g. as part of a compensation scheme for small and medium enterprises) are not included in current health expenditure. The general purpose of these schemes is not health specific. Transfers under these schemes to health providers should be included in the COVID-19 related category HCR.COV.1.
- Payment of unemployment benefits for health staff made redundant is not included under current health expenditure (and also not under category HCR.COV.1).
- Special sickness pay schemes for health professionals with COVID-19 infections or for vulnerable health professionals that cannot exercise their profession due to risk of infection are income support and should not be considered under current health expenditure (and also not under category HCR.COV.1).

Table 4.1. Summary of SHA accounting recommendations for COVID-19 related activity

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
Public health/Admin functions	Dissemination of information on COVID-19 of how to change health behaviour to minimise the risk of infection via different media outlets	HC61 HP6	HC.COV.5	Clear purpose is information and education about health risk
	Production and dissemination of daily updates of data on tests, positive cases, hospitalization rates, mortality, etc. Risk analysis and epidemiological operative investigation.	HC65 HP6	HC.COV.5	Key function of epidemiological surveillance

[10] This refers to hospitals considered as market producers. In non-market production the costs of the PPE would already been taken into account *implicitly* when measuring the non-market output.

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
	Emergency response (preparation and coordination); creation of multi-agency emergency task forces discussing and a wide range of policy option and planning policy response	HC66 HP6/HP7	HC.COV.5	
	Legislative changes pertaining to public health and health care organization related to COVID-19	HC71 HP7	HC.COV.5	Key function of health administration and governance (could be HC72 if related to health financing)
	Specific training of human resources related to COVID-19 (prevention, intensive care, etc.)	Intermediate consumption (for HC11, HC13, HC6 etc. HP1, HP3 etc).	HC.COV.1; HC.COV.2; HC.COV.3, etc	(intermediate consumption, only accounted in costs for services provided at a price not economically significant) HC according to the purpose of the training
	Enforcement costs of lock-down/social distancing/mask wearing regulation; costs of police and other staff to monitor lock-down, check exemptions and issue fines	Outside Current Health Expenditure (CHE)		In line with the guidelines on accounting for preventive care[11] enforcement costs are outside of the core SHA framework if implemented by non-health staff; also practical considerations
	Costs associated with quarantining suspected cases outside of their home. This can include costs for lodging, food and travel	HC6 or outside CHE or HK Maybe HP82 if HC6	HC.COV.1; HC.COV.2 or outside	Depends. For dedicated quarantine centres with health staff and medical observation -HC.6 .Investment costs for converting structures into quarantine centres –HK. Lodging costs in hotels without health staff should be considered as enforcement costs of social distancing regulation – outside CHE. Any incidental health service or testing HC1 and HC6.
Testing	PCR and other molecular diagnostic tests (to detect acute Sars-Cov-2 infection) in ambulatory setting as part of outpatient contact for patients with symptoms	HC13 HP3 (other HP possible)	HC.COV.2	Part of a curative treatment; HC63 is to be used for people before symptoms appear; HC41 requires independent contact
	PCR and other molecular diagnostic tests in hospital or LTC facility for inpatients with COVID-19 symptoms	HC11 HP1, HP2	HC.COV.2	Part of treatment episode
	Systematic PCR tests (or other molecular diagnostic tests) in hospital or LTC facility for patients without COVID-19 symptoms	HC63 Different HP	HC.COV.2	This should be considered as early disease detection if costs can be identified separately. HC63 typically requires the definition of a population group at risk – in the case of COVID-19 the argument can be made that nearly everyone is at risk.

[11] http://www.oecd.org/els/health-systems/Expenditure-on-prevention-activities-under-SHA-2011_Supplementary-guidance.pdf

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
	Systematic PCR tests (or other molecular diagnostic tests) in other setting (car park, airport etc.) carried out by public health authorities (generally for people without symptoms)	HC63 HP6 or HP82 (or other)	HC.COV.2	Early disease detection; tests will typically be carried out by trained staff from public health offices so HP6 is most appropriate provider, but HP82 may also be justified in some instances.
	Systematic PCR test (or other molecular diagnostic tests) of employees (health staff or other)	HC63 HP depending on who carries out testing (HP6 if public health office; HP1-HP5 if health facility); HP82 for antigen test for non-health providers also possible	HC.COV.2	This is part of occupational health care. Typically occupational health care is under HC64 but since it is disease-specific it should go under HC63
	PCR test (or other molecular diagnostic tests) in laboratories (as independent contact) if part of programme (for patients without symptoms)	HC63 HP4	HC.COV.2	Part of a programme; if this test series is part of a study (with a more limited number of participants) to better understand the infection rates it could go under HC65
	PCR test (or other molecular diagnostic tests) in laboratories (as independent contact) based on own initiative (without programme covering costs) – e.g. used as attestations to travel	HC41 (HC63) HP4	HC.COV.2	According to the Manual should be HC41 as this is not part of a systematic programme, and purpose may be difficult to establish. May be difficult to distinguish from HC63.
	Serological test (to detect possible immunity) if part of systematic programme to assess evolution of pandemic	HC65 HP4, additional non-health providers possible if involved in organisation of serological tests (HP82)	HC.COV.2	Part of epidemiological studies
	Serological test based on own initiative	HC41 (HC65)	HC.COV.2	Not part of programme, so HC41 may be most appropriate but may be difficult to distinguish from HC65.
	Point of entry screening – temperature control at borders	HC63 HP6 or HP82 (if e.g. done by border police	HC.COV.5	The purpose is early disease detection (although this particular activity is not mentioned in the Manual)
	Purchase of antigen test at pharmacy or other retailer with test carried out by patient himself at home or work	HC513 HP51/59 (or HP82)	HC.COV.4	Test-kits qualify as medical non-durables (HC513)
Tracing	Costs of developing tracer application for mobile phones	Capital Account	HK.COV.1	Not final consumption of health care
	Costs of tracing the contacts of infected cases (mainly staff costs) - typically part of local public health office but could also be done by other (non-health) authorities or outsourced to private companies	HC65 HP6, HP7, HP82 (and maybe other)	HC.COV.2	This is part of epidemiological surveillance. Countries use a wide range of providers since public health offices have been frequently overwhelmed with this task.

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
Treatment	Teleconsultations with GP for patients with COVID-19 symptoms	HC131 HP3	HC.COV.1	Outpatient care and not home-based care
	Physical consultation with GP for patients with COVID-19 symptoms	HC131 HP3	HC.COV.1	No difference in accounting to patients with other diseases
	Hospital treatment for severe COVID-19 cases	HC11 HP1	HC.COV.1	No difference in accounting to patients with other diseases
	Treatment of COVID-19 cases in LTC nursing home	HC11 HP2 (can also involve HP3 for visiting doctors)	HC.COV.1	COVID-19 is not related to LTC dependency so it should be accounted for as HC11 if possible
	Home-based care for patients with COVID-19 symptoms	HC14 HP3	HC.COV.1	Only when there is physical presence of health staff in patient's home
	Patient transportation for severe COVID-19 cases	HC43 HP4	HC.COV.1	No difference in accounting to patients with other diseases
	Medication	HC51 HP5	HC.COV.4	If provided outside of hospitals or other institutional setting. HC11 if part of inpatient curative treatment
	Treatment and rehabilitation of sequelae of COVID-19 after patient's remission (fibrosis, heart diseases, kidney diseases)	HC1 / HC2/ HC3 Many different HP possible	HC.COV.1	No difference in accounting to patients with other diseases
Protective equipment	Government purchase to stock certified medical face masks, visors, and other personal protective equipment to build up strategic reserve	Part of the Capital formation but no category in HKxHP table		In SNA this is a "change in inventories"; at the time when these stocks are depleted and handed out to the public they should be recorded as HC513; they are treated as intermediate consumption if given to health providers.
	Acquisition of personal protective equipment of health providers for staff use (particularly for "front-line" health workers)	Intermediate consumption		Not for final use; these costs are an input into the production of health services (included implicitly in different HC and HP)
	Purchase of personal protective equipment by population if this equipment qualifies as medical non-durable goods (e.g. medical face masks, surgical masks, FFP2, N95). In most countries, this goods needs to be certified. The purchase of face masks out of clothing, plastic face shields etc. is outside of SHA (In some countries, governments purchased PPE and supplied it to households free of charge)	HC513 HP5 (but also other HP possible, eg. HP82)	HC.COV.4	By convention, this should be considered as HC513 instead of HC6 if self-initiated purchase (see p.98 SHA 2011). Medical non-durables can be disseminated by a wide range of providers are possible. The use of re-appropriated non-medical goods is outside the scope of SHA. Since there is a link between HC513 and COICOP 6.1.2 it may be easiest to makes decision on inclusion and exclusion in SHA based on the accounting in COICOP.
	Self-manufactured personal protective equipment	Outside SHA		No transaction, not certified

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
	Purchase of alcohol-based hand sanitizers (or similar product that qualify as medical non-durable good) for final use	HC513	HC.COV.4	By convention, this should be considered as HC513 if self-initiated purchase. Might be challenging to identify. Several HP possible. Purchase of regular soap outside of SHA. Use link between HC513 and COICOP 6.1.2 to make decision to include or exclude in case of doubt
	Purchase of certified personal protective equipment by employers (non-health) for their staff (if it qualifies as health product).	HC513	HC.COV.4	Thus is intermediate consumption but can be interpreted as occupational health care and hence included in CHE.
	Purchase of non-personal protective equipment (boards dividing offices) by employers (non-health) to enable return to normal office work	Outside SHA		Cost of compliance. Main purpose is the resume of economic activity
	Reinforcement of nosocomial infection prevention	Intermediate consumption		Input costs in production of health output (included implicitly in different HC)
	Businesses handing out face masks and or hand sanitizer is to clients (in supermarkets, cinemas etc.)	Outside SHA		This transaction is interpreted as compliance costs for businesses with the main motivation to resume business and making sales (with health care being secondary). This transaction can also be interpreted as intermediate consumption and hence outside of the scope of SHA.
Vaccines	Government contribution to international vaccine R&D initiative	Outside CHE		Not directly related to domestic health care
	Government R&D grant to pharmaceutical manufacturer	Part of Capital Account but no category in HKxHP table		Should be recorded as Memorandum item in the Capital Account (see chapter 11 of SHA 2011 manual on the recording of R&D)
	Early government purchasing agreement with manufacturers. A number of governments have concluded deals with manufacturers that give them the right to purchase a set amount of vaccine in case a vaccine proves to be safe and effective and will be authorized.	Excluded – Costs for vaccination will be recorded when campaigns are rolled out. (Costs may be adjusted to take into account purchase agreements)		In case the contract foresees a financial flow for the option to purchase vaccines later; this can be interpreted as and advance payment and part of the final price. To be recorded in period of vaccination,
	Cost of vaccination, (once vaccine is available), assistance in kind from abroad as donations of vaccine, including costs of vaccine, service charge for doctors or nurse and distribution and governance costs.	HC62 different HP possible	HC.COV.3	Should include all costs components; a wide variety of providers possible

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
	Acquisition and storing of vaccines as strategic reserves	Part of the Capital Account but no category in HKxHP table		In SNA, this is a "change in inventories"; at the time when these stocks are depleted and the population is vaccinated this will be recorded under HC62.
	A number of countries have introduced different types of voucher programmes or gift certificates to encourage the uptake of vaccination	HC62 (HP82)	HC.COV.3	Treated as CCTs (Conditional Cash Transfers) and included in overall cost component of vaccination campaign
Infrastructure	Purchase of intensive care beds, ventilators and other equipment with service life of over 1 year; either by hospitals themselves or by governments that transfer it to health providers.	Capital Account	HK.COV.1	Clear example of acquisition of assets.
	(Temporary) increase of treatment capacity, e.g. mobile hospitals, hospitals beds, ventilators by using reserve capacity (in stocks)	Capital Account (only costs of installation)	HK.COV.1	These existing assets have already been accounted for when they have been acquired. The only transactions recordable in the current period are the installation and maintenance costs associated with making the assets fit for use. To be considered as capital good, expected service life needs to be at least one year. (if less, it is a cost component captured under CHE)
	(Temporary) increase of laboratory capacity for tests	Capital Account	HK.COV.1	The building of new laboratories and the acquisition of analytical equipment are GFCF
Other	Bonus payments to health and LTC staff. A number of countries have decided to pay bonuses to front-line health care staff	HC1, HC2, HC3 etc. (depends on the worker receiving bonus)] Different HP possible	HC.COV.1-3	Part of the costs of service provision. Bonus needs to be allocated to year to when bonus was earned
	Payments by government to (private) health care providers in exchange to keep space available for the treatment of COVID-19 patients.	HC11,HC13 etc.	HC.COV.5	Payments can be considered as final consumption expenditure or subsidies and should be included under CHE (see SHA 2011 p.45/46)
	Payments by government to (private) health care providers to keep staff on payroll and protect existing health provider infrastructure	HC11,HC13 etc.	HC.COV.5	Payments can be considered as subsidies and should be included under CHE (see SHA 2011 p.45/46)
	Payments by government to (private) health care providers as part of economy-wide business support and not just special earmarks for the health sector	Outside CHE	HCR.COV.1	Not health-specific provider support but which however, also benefits healthcare providers - total amount spent would still be of interest and should thus be captured under Covid-related spending HCR

	Activity	Accounting recommendation	COVID-19 memorandum item (se Ch. 3)	Rationale
	Sickness payment for health professionals that contract Covid-19	Outside CHE (but possibly implicitly included in output of non-market producers as resource cost)		Clear income payment. Not recorded since other sickness payment are also not recorded.(see SHA 2011 p.59)
	Payment of unemployment benefits or short-term work benefits to health professional who have been made redundant due to reduced health care activity during COVID-19 by their employers.	Outside CHE		These transactions are not related to the final consumption of health care
	Deferred payment of social contributions (i.e. employers get a temporary break from paying social contributions and pay them in later accounting period)	Relevant for HFxFS		If HFxFS is based on accrual principle then deferral has no effect.
	Assistance in kind from abroad. Donations of face masks, ventilators, hospital beds to domestic governments from foreign governments or international donors	Depends		If these goods are used in the production of health care services, they are part of the intermediate consumption (raising the output and consumption of domestic health care). If face masks are distributed to directly to people HC513 (probably HF11xFS2/7). If capital goods part of Capital Account.
	Purchase of thermometer or pulse oximeters	HC52 HP5	HC.COV.4	Final consumption

5. Special COVID-19 spending reporting items

- The COVID-19 pandemic has highlighted the importance of having timely health spending data available to policy makers. Hence, all countries are strongly encouraged to submit preliminary health spending data for *t-1* (2021) as part of the 2022 JHAQ data collection. The accounting recommendations discussed in the last section (Chapter 4) can help data compilers in deciding which COVID-19 related transactions should fall within the core SHA framework defining the limits of Current Health Expenditure and how to allocate them across functions and providers.

- In addition to providing more timely data within the core SHA framework, health accounts should also contribute in filling some specific data gaps related to COVID-19. While the SHA framework does not allow for a comprehensive measurement of all pandemic response costs – since many actions are outside of the health systems – SHA can still play a very important role to shed light on COVID-19 related costs within the health system. Hence, similar to the 2020 JHAQ template, the 2022 JHAQ template includes a number of special reporting/memorandum items for COVID-19 related health spending to the 2022 JHAQ template (to be filled-in for reporting year 2021 only).

- The first five items (HC.COV.1-5) refer to "Reporting Items" in the sense that these costs are distributed across the different functions within the boundary of Current Health Expenditure. The sum of these five items can be interpreted as total COVID-19 spending within the boundary of Current Health Expenditure. A further "Related Item" (HCR.COV1) refers to related transactions outside of the SHA framework which is deemed as policy-relevant in the COVID-19 response discussion. Finally, a further "Reporting item" (HK.COV1) refers to COVID-19 related investment costs that should be captured in the capital account (HKxHP table) but for practical reasons is included with the other Reporting Items.

- These items are
    - HC.COV.1: Spending for COVID-19 related treatment
    - HC.COV.2: Spending for COVID-19 testing and contract tracing
    - HC.COV.3: Spending for vaccination against SARS-CoV-2
    - HC.COV.4: Spending for COVID-19 medical goods
    - HC.COV.5: Other COVID-19 related health spending n.e.c
    - HCR.COV.1: Health related COVID-19 spending (outside of CHE)
    - HK.COV.1: COVID-19 related investments

- *HC.COV.1:* ***Spending for COVID-19 related treatment*** refers to the treatment costs of patients with a confirmed COVID-19 diagnosis in inpatient and outpatient settings. It also includes the costs of pharmaceuticals used for treatment (as part of treatment episode in inpatient or outpatient setting). It also includes follow-up costs from "long COVID-19 patients" who need health care interventions over a sustained period of time, if this spending is related to COVID-19. If possible, costs for testing should be excluded from treatment costs and allocated to HC.COV.2. Since many patients with severe COVID-19 conditions have co-morbidities such as diabetes, asthma or congestive heart failure it will

be challenging to allocate health spending to the different disease. For this reason, it is proposed to include *all* treatment costs under this special reporting item.

- *HC.COV.2:* ***Spending on COVID-19 testing and contact tracing*** refers to the laboratory costs (including staff costs) for the analysis of PCR-tests, anti-gen tests (or other molecular diagnostic tests) and serological tests. This cost item includes tests for people with and without symptoms as part of a programme or taken at people's initiatives regardless of the testing facility (e.g. hospital, laboratory, outpatient practice, pharmacy, car park, airport etc.). It should also include testing costs for people in medical treatment if these costs can be separated from treatment costs. Costs for contact tracing include all current costs incurred by public health officials or other staff to identify possible contacts of infected people. The IT costs and the costs of mobile tracing applications are not included here.

- *HC.COV.3:* ***Spending for vaccinations against SARS-CoV-2*** refers to the costs of vaccination campaigns that started to be rolled out in countries from late 2020 onwards and continued throughout 2021. It includes the costs of the vaccine, the distribution costs and the service charge by doctors, nurses or other health professional administering the vaccination. Organisational costs are included. The costs to build the necessary infrastructure and R&D costs are not included. Costs associated with clinical assessment by licencing authorities are also excluded.

- *HC.COV.4* ***Spending for COVID-19 medical goods*** mainly refers to spending on facemasks and other protective equipment for final use purchased either by people themselves or by public authorities and distributed among the population. For practical reasons this item would also include prescribed and OTC pharmaceuticals to treat COVID-19 patients in case these products are not dispensed as part of an inpatient or outpatient treatment (included under HC.5.1.1 or HC.5.1.2).

- *HC.COV.5:* ***Other COVID-19 related spending*** refers to all other COVID-19 related costs –within the SHA boundary of current health expenditure- not classified in any other category HC.COV.1-4, such as the organisation and co-ordination of the pandemic emergency response or health-specific transfers from government to health providers to compensate for lost revenues due to COVID-19 or to purchase or reserve treatment capacity.

- *HCR.COV.1****: Health related COVID-19 spending (outside of CHE)*** includes transfers made to compensate for income or revenue losses due to general economic measures not targeted at health providers (but which coincidentally benefit health providers).

- *HK.COV.1:* ***COVID-19 related investment*** should refer to the acquisition minus disposal of infrastructure capacity to treat COVID-19 patients. This includes the acquisition of medical equipment (e.g. ventilators, beds) and construction of medical facilities. It should also include costs related to the development of mobile tracing apps and any other IT infrastructure or software costs. Only "response costs" to COVID-19 should be recorded under this reporting item. "Planned" health capacity increases that predate COVID-19 (but became operational in 2021) should not be considered. Only costs that refer to Gross Fixed Capital Formation (HKxHP table) should be recorded here. This means that a change in the stock of pharmaceuticals and vaccines are not included.

- While it is clear that comprehensive reporting of all these reporting items will be challenging, it may be possible for some of the items and may be limited to certain

financing schemes or providers. Table 5.1 and Table 5.2 display how the memorandum items would be embedded in the existing template.

Table 5.1. Special COVID-19 reporting items in the 2022 JHAQ template, HCxHF table

SHA 2011 — Health care **financing schemes** (ICHA-HF)		HF.1	HF 1.1	HF 1.2/1.3	HF 1.2.1	HF 1.2.2	HF 1.3	HF.2	HF 2.1	HF 2.2	HF 2.3	HF.3	HF 3.1
Health care **functions** (ICHA-HC) — *Millions of national currency*		**Government schemes and compulsory contributory health care financing schemes**	Government schemes	Compulsory contributory health insurance schemes/CMSA	Social health insurance schemes	Compulsory private insurance schemes	Compulsory Medical Savings Accounts (CMSA)	**Voluntary health care payment schemes**	Voluntary health insurance schemes	NPISH financing schemes	Enterprise financing schemes	**Household out-of-pocket payment**	Out-of-pocket excluding cost-sharing
All HC	**All functions**												
Memorandum items:													
Reporting items:													
HC.RI.1	*Total pharmaceutical expenditure (TPE)*												
HC.RI.2	*Traditional, Complementary and Alternative Medicines (TCAM)*												
Health care related items:													
HCR.1	*Long-term care (social)*												
HCR.2	*Health promotion with multi-sectoral approach*												
Special reporting items to track Covid-19 spending within CHE:													
HC.COV.1	*Covid-19 related treatment costs*												
HC.COV.2	*Covid-19 related costs for testing and contact tracing*												
HC.COV.3	*Covid-19 related costs for vaccination*												
HC.COV.4	*Covid-19 related costs for medical goods*												
HC.COV.5	*Other Covid-19 related health care costs (incl. in CHE)*												
Special health care related items to track Covid-19 spending outside CHE:													
HCR.COV.1	*Health related Covid-19 spending (outside of CHE)*												
Special reporting items to track Covid-19 spending within the HKxHP table													
HK.COV.1	*Covid-19 related investment costs*												

Table 5.2. Special COVID-19 reporting items in the 2022 JHAQ template, HCxHP table

SHA 2011 — Health care **providers** (ICHA-HP)		HP.1	HP.1.1	HP.1.2	HP.1.3	HP.2	HP.2.1	HP.2.2	HP.2.9	HP.3	HP.3.1	
Health care **functions** (ICHA-HC) — *Millions of national currency*		**Hospitals**	General hospitals	Mental health hospitals	Specialised hospitals (other than mental health hospitals)	**Residential long-term care facilities**	Long-term nursing care facilities	Mental health and substance abuse facilities	Other residential long-term care facilities	**Providers of ambulatory health care**	Medical practices	
All HC	**All functions**											
Memorandum items:												
Reporting items:												
HC.RI.1	*Total pharmaceutical expenditure (TPE)*											
HC.RI.2	*Traditional, Complementary and Alternative Medicines (TCAM)*											
Health care related items:												
HCR.1	*Long-term care (social)*											
HCR.2	*Health promotion with multi-sectoral approach*											
Special reporting items to track Covid-19 spending within CHE:												
HC.COV.1	*Covid-19 related treatment costs*											
HC.COV.2	*Covid-19 related costs for testing and contact tracing*											
HC.COV.3	*Covid-19 related costs for vaccination*											
HC.COV.4	*Covid-19 related costs for medical goods*											
HC.COV.5	*Other Covid-19 related health care costs (incl. in CHE)*											
Special health care related items to track Covid-19 spending outside CEH:												
HCR.COV.1	*Health related Covid-19 spending (outside of CHE)*											
Special reporting items to track Covid-19 spending within the HKxHP table												
HK.COV.1	*Covid-19 related investment costs*											

6. List of tables used in the joint questionnaire

- A single data questionnaire file consisting of a front-page information sheet with the following six tables should be completed for each year:
  - Health Expenditure on Health Care Functions by Health Care Financing Schemes (HCxHF)
  - Health Expenditure on Health Care Functions by Health Care Providers (HCxHP)
  - Health Expenditure on Health Care Providers by Health Care Financing Schemes (HPxHF)
  - Health Expenditure by Health Care Financing Schemes by Revenues of Health Care Financing Schemes (HFxFS)
  - Health Expenditure on Health Care Providers by Factors of Health Care Provision (HPxFP)
  - Capital by Health Care Providers (HKxHP)
- The following section contains the full listing of the classifications used in the 2022 Joint OECD, Eurostat and WHO Health Accounts (SHA 2011) Questionnaire.

7. Classifications used in the joint SHA 2011 questionnaire

Health Care Functions (ICHA-HC)

HC.1+HC.2		**Curative and rehabilitative care**
HC.1		**Curative care**
HC.2		**Rehabilitative care**
	HC.1.1+HC.2.1	Inpatient curative and rehabilitative care
	HC.1.1	Inpatient curative care
	HC.2.1	Inpatient rehabilitative care
	HC.1.2+HC.2.2	Day curative and rehabilitative care
	HC.1.2	Day curative care
	HC.2.2	Day rehabilitative care
	HC.1.3+HC.2.3	Outpatient curative and rehabilitative care
	HC.1.3	Outpatient curative care
	HC.1.3.1	General outpatient curative care
	HC.1.3.2	Dental outpatient curative care
	HC.1.3.3	Specialised outpatient curative care
	HC.1.3.9	All other outpatient curative care
	HC.2.3	Outpatient rehabilitative care
	HC.1.4+HC.2.4	Home-based curative and rehabilitative care
	HC.1.4	Home-based curative care
	HC.2.4	Home-based rehabilitative care
HC.3		**Long-term care (health)**
	HC.3.1	Inpatient long-term care (health)
	HC.3.2	Day long-term care (health)
	HC.3.3	Outpatient long-term care (health)
	HC.3.4	Home-based long-term care (health)
HC.4		**Ancillary services (non-specified by function)**
	HC.4.1	Laboratory services
	HC.4.2	Imaging services
	HC.4.3	Patient transportation
HC.5		**Medical goods (non-specified by function)**
	HC.5.1	Pharmaceuticals and other medical non-durable goods
	HC.5.1.1	Prescribed medicines
	HC.5.1.2	Over-the-counter medicines
	HC.5.1.3	Other medical non-durable goods
	HC.5.2	Therapeutic appliances and other medical durable goods
HC.6		**Preventive care**
	HC.6.1	Information, education and counselling programmes
	HC.6.2	Immunisation programmes
	HC.6.3	Early disease detection programmes
	HC.6.4	Healthy condition monitoring programmes

	HC.6.5	Epidemiological surveillance and risk and disease control
	HC.6.6	Preparing for disaster and emergency response programmes
HC.7		**Governance and health system and financing administration**
	HC.7.1	Governance and health system administration
	HC.7.2	Administration of health financing
HC.0		**Other health care services *unknown***
All HC		**All functions**
Memorandum items:		
Reporting items:		
HC.RI.1		*Total pharmaceutical expenditure (TPE)*
HC.RI.2		*Traditional, Complementary and Alternative Medicines (TCAM)*
Health care related items:		
HCR.1		*Long-term care (social)*
HCR.2		*Health promotion with multi-sectoral approach*
Special reporting items to track COVID-19 spending within Current Health Expenditure:		
HC.COV.1		*COVID-19 related treatment costs*
HC.COV.2		*COVID-19 related costs for testing and contact tracing*
HC.COV.3		*COVID-19 related costs for vaccination*
HC.COV.4		*COVID-19 related medical goods*
HC.COV.5		*Other COVID-19 related health care costs (incl. in CHE)*
Special health care related items to track COVID-19 spending outside of Current Health Expenditure:		
HCR.COV.1		*Health related COVID-19 spending (outside of CHE)*
Special reporting items to track COVID-19 spending within the HKxHP table		
HK.COV.1		*COVID-19 related investment costs*

Health Care Providers (ICHA-HP)

HP.1		**Hospitals**
	HP.1.1	General hospitals
	HP.1.2	Mental health hospitals
	HP.1.3	Specialised hospitals (other than mental health hospitals)
HP.2		**Residential long-term care facilities**
	HP.2.1	Long-term nursing care facilities
	HP.2.2	Mental health and substance abuse facilities
	HP.2.9	Other residential long-term care facilities
HP.3		**Providers of ambulatory health care**
	HP.3.1	Medical practices
	HP.3.2	Dental practices
	HP.3.3	Other health care practitioners
	HP.3.4	Ambulatory health care centres
	HP.3.5	Providers of home health care services
HP.4		**Providers of ancillary services**
	HP.4.1	Providers of patient transportation and emergency rescue
	HP.4.2	Medical and diagnostic laboratories

	HP.4.9	Other providers of ancillary services
HP.5		**Retailers and other providers of medical goods**
	HP.5.1	Pharmacies
	HP.5.2	Retail sellers and other suppliers of durable medical goods and medical appliances
	HP.5.9	All other misc. sellers and other suppliers of pharmaceuticals and medical goods
HP.6		**Providers of preventive care**
HP.7		**Providers of health care system administration and financing**
	HP.7.1	Government health administration agencies
	HP.7.2	Social health insurance agencies
	HP.7.3	Private health insurance administration agencies
	HP.7.9	Other administration agencies
HP.8		**Rest of economy**
	HP.8.1	Households as providers of home health care
	HP.8.2	All other industries as secondary providers of health care
HP.9		**Rest of the world**
HP.0		**Providers *unknown***
All HP		**All providers**

Health Care Financing Schemes (ICHA-HF)

HF.1		**Government schemes and compulsory contributory health care financing schemes**
	HF.1.1	Government schemes
	HF.1.2/1.3	Compulsory contributory health insurance schemes/CMSA
	HF.1.2.1	Social health insurance schemes
	HF.1.2.2	Compulsory private insurance schemes
	HF.1.3	Compulsory Medical Savings Accounts (CMSA)
HF.2		**Voluntary health care payment schemes**
	HF.2.1	Voluntary health insurance schemes
	HF.2.2	NPISH financing schemes
	HF.2.3	Enterprise financing schemes
HF.3		**Household out-of-pocket payment**
	HF.3.1	Out-of-pocket excluding cost-sharing
	HF.3.2	Cost-sharing with third-party payers
HF.4		**Rest of the world financing schemes (non-resident)**
HF.0		**Financing schemes *unknown***
All HF		**All financing schemes**

Revenues of Health Care Financing Schemes (ICHA-FS)

FS.1		**Transfers from government domestic revenue**
	FS.1.1	Internal transfers and grants
	FS.1.2	Transfers by government on behalf of specific groups

	FS.1.3	Subsidies
	FS.1.4	Other transfers from government domestic revenue
FS.2		**Transfers distributed by government from foreign origin**
FS.3		**Social insurance contributions**
	FS.3.1	Social insurance contributions from employees
	FS.3.2	Social insurance contributions from employers
	FS.3.3	Social insurance contributions from self-employed
	FS.3.4	Other social insurance contributions
FS.4		**Compulsory prepayment (other than FS.3)**
	FS.4.1	Compulsory prepayment from individuals/households
	FS.4.2	Compulsory prepayment from employers
	FS.4.3	Other compulsory prepaid revenues
FS.5		**Voluntary prepayment**
	FS.5.1	Voluntary prepayment from individuals/households
	FS.5.2	Voluntary prepayment from employers
	FS.5.3	Other voluntary prepaid revenues
FS.6		**Other domestic revenues n.e.c.**
	FS.6.1	Other revenues from households n.e.c.
	FS.6.2	Other revenues from corporations n.e.c.
	FS.6.3	Other revenues from NPISH n.e.c.
FS.7		**Direct foreign transfers**
All FS		**All revenues of financing schemes**

Factors of Health Care Provision (ICHA-FP)

FP.1		**Compensation of employees**
	FP.1.1	Wages and salaries
	FP.1.2	Social contributions
	FP.1.3	All other costs related to employees
FP.2		**Self-employed professional remuneration**
FP.3		**Materials and services used**
	FP.3.1.	Health care services
	FP.3.2	Health care goods
	FP.3.3	Non-health care services
	FP.3.4	Non-health care goods
FP.4		**Consumption of fixed capital**
FP.5		**Other items of spending on inputs**
	FP.5.1	Taxes
	FP.5.2	Other items of spending
All FP		**All factors of provision**

Capital (HK)

HK.1.1		**Gross fixed capital formation**
	HK.1.1.1	Infrastructure
	HK.1.1.2	Machinery and equipment
	HK.1.1.3	Intellectual property products