An update on development of pilot UK Health Accounts

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Introduction

This article provides an update on work by ONS to develop Health Accounts for the United Kingdom. It also provides a description of methods used in compiling experimental total UK health expenditure figures for calendar years 1997–2001 and the experimental Health Account for the UK for the financial year 1999/2000, which are available on the National Statistics website at:

http://www.statistics.gov.uk/healthaccounts

This work was originally announced in the June 2001 issue of Economic Trends (Lee 2001) and in Health Statistics Quarterly 10 (Lee 2001). Previous updates along with some data appeared in the February 2002 issue of Economic Trends (Lee 2002), in Health Statistics Quarterly 13 (Lee 2002) and in an online release of experimental total UK health expenditure figures on 12 February 2002 (ONS 2002). Further updates will be placed on the above website.

The pilot UK Health Accounts are experimental in nature. ONS is keen to involve potential users at an early stage to ensure they are involved in the development and quality assurance, and become familiar with the new data. Comments on the development work described in this article should be sent to the e-mail address above.

Background

A UK Health Account is being developed on an experimental basis according to an internationally agreed framework of concepts, definitions, classifications and accounting rules, drawn up by the Organisation for Economic Co-operation and Development (OECD) in collaboration with the World Health Organisation and the European Commission. This framework is described in A System of Health Accounts (OECD 2000) and is consistent with the System of National Accounts (European Commission et al 1993), which sets out the definitions and classifications to be used in the compilation of economic aggregates. It defines total expenditure on health (Box 1) as well as three classifications for use in health expenditure analyses:

- **Source of financing classification.** This identifies whether the money is being spent, for example, by government, charities, insurance companies, or households.

- **Provider classification.** This identifies whether the health care is provided, for example, by hospitals, nursing care facilities, ambulatory care, or retailers.

- **Function (or purpose) classification.** This identifies what is being provided, for example, a good, a service (inpatient care, outpatient care, day care or home care and whether it's preventative, curative, rehabilitative or long-term nursing care), or health administration.
Box 1 The concept of health care

Activities of health care in a country comprise the sum of activities performed either by institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology, the goals of:

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

A System of Health Accounts, OECD 2000

Progress to date and further work planned

Development work has been focused on two areas: compiling estimates of total UK health expenditure, concentrating on the calendar years 1997 to 2001; and investigating how to disaggregate the total for a single, recent year using appropriate data sources and methods to populate the Health Accounts.

Since last year, improvements have been made to estimates of total UK health expenditure to bring them closer to the internationally standard definitions, and further work has been undertaken to disaggregate these components according to the Health Accounts classifications. The following text describes briefly sources and methods for each of the components of total health expenditure, highlighting where improvements have been made. Further detail is available on the National Statistics website.

1. Government expenditure on health

ONS produces estimates of government expenditure on health, the latest of which were published in UK National Accounts: The Blue Book 2002. Whereas these estimates include government expenditure on Education and Training of Health Personnel (E&T) and Research and Development (R&D), A System of Health Accounts (OECD 2000) recommends that these items are not included as health expenditure. Their importance to the health system is recognised in the Health Accounts framework as they are classified as health-related expenditure.

As for figures published in February 2002, the estimation of E&T is based on budgetary information supplied by the Department of Health for England. UK totals are calculated by assuming that the E&T per head spend in the UK is the same as that for England.

ONS conducts an annual survey of government expenditure on R&D, from which health administrations’ estimates of expenditure on R&D have been taken, also as for figures published last year.

Disaggregation by the Health Accounts classifications has been carried out according to information available in the first instance on activity costs and to budgetary information compiled by health administrations for financial reporting.

2. Household expenditure on health

ONS produces estimates of household expenditure on health, which includes employer’s expenditure on health. The latest such estimates were also published in the UK National Accounts: The Blue Book 2002.

Disaggregation by the Health Accounts classifications has been carried out according to information available in the more detailed household expenditure accounts available in Consumer Trends.

3. Long-term nursing care outside the NHS

Expenditure outside the NHS on long-term nursing care in the government and household expenditure figures described above, where it is estimated, is classified as social protection rather than health (long-term nursing care provided by the NHS is included in government expenditure on health). As can be seen in the international definition in Box 1, ‘caring for persons affected by chronic illness who require nursing care’ is part of health care.

The method used for producing estimates for publication in February 2002 has been maintained for these latest estimates. This method involves multiplying the numbers of persons resident in nursing homes by the marginal cost of nursing care in those homes, which is estimated as the difference in cost between the average nursing home place and the average residential care home place.

Payment for nursing care in nursing homes has been taken over by the NHS for self-funders in England from 1 October 2001. The cost of this care is included in government expenditure on health (figures as described above), and this has been reflected in the estimate of non-NHS nursing care. The timetable for further changes in funding arrangements for nursing care provision is that the NHS will bear these costs for all in Scotland from 1 July 2002, for all in Northern
Ireland from 7 October 2002, for self-funders in Wales from 1 December 2002, for those receiving Local Authority support in Wales and England from April 2003.

ONS is aware that there are questions over the international comparability of the estimates produced – what is deemed nursing care in the international definitions is not seen as nursing care in the UK. These are questions that all countries are facing, as each different nationality's legislation provides for different activities to be carried out by nurses under the banner of nursing care. Box 2 explains the costs that are included as health-care expenditure in Germany as an example of a country which includes as nursing care a wider range of activities than the UK. OECD is working on a long-term care project which will examine the comparability of long-term nursing care figures across the OECD group of countries, and is due to report in May 2003. This may include a clearer interpretation of the international definitions. ONS is also working closely with EU countries to establish a European interpretation of the international definitions on long term nursing care. Until this further guidance is available, ONS does not intend to change its methods for compiling estimates of long-term nursing care outside the NHS.

Box 2 Long-term nursing care in Germany

A special agency is responsible for determining whether a person has a long-term care requirement, and the level of dependency of people who have such a requirement. The level of dependency is rated according to a standard nationwide scale based on Activities of Daily Living (ADL). The ratings go from 1 (mild restrictions) to 3 (severe restrictions). The rating agency also states what setting is appropriate (in-patient, home care etc). The ‘Long-Term Care nursing scheme’ then pays a fixed amount according to the agency’s ratings, usually directly to the care provider, for services provided for an individual person. Some people (‘zero-level’ patients), who are not classified from 1–3 on the dependency scale, are still deemed to require some kind of care, and are covered by the ‘Social assistance scheme’. Finally, there is a special group of people with very high levels of dependency (in addition to level 3) who are eligible for an extra payment to cover the higher cost of the more intensive level of care.

All these costs are included as expenditure on health in the data Germany sends to the OECD, on the grounds that there is a legal requirement for the care to be provided or supervised by a qualified nurse.

No further disaggregation of nursing care is required to achieve compatibility with the Health Accounts classifications.

4. Expenditure on health by non-profit institutions serving households

Non-profit institutions serving households (NPISH) are charities (and similar relief and aid organisations), trade unions, some higher education institutions, friendly societies and religious organisations. They are financed by donations from the public, government and business, and provide goods or services to households free, or at prices that are not economically significant.

ONS has, as last year, conducted a sample survey of charities’ (including religious organisations) expenditure on health using the Caritas publication on the top 3,000 charities. This contains a considerable amount of information on the activities of charities, including income, expenditure and purpose of the charities listed.

It has so far not proved possible to disaggregate NPISH expenditure on health by the OECD Health Accounts functional and provider classifications.

5. Health expenditure outside health administrations

Some expenditure on health by government is administered outside of health administrations. In some cases, the expenditure originates from the health administrations, for example in the case of Local Authorities. In others, the origin of the expenditure is not the health administration, and therefore we need to ensure this is included in total UK health expenditure. The non-health administrations with known health expenditure are the Ministry of Defence (armed forces: army, navy, air force) and the Home Office and devolved administrations responsible for prisons. For the first time, ONS has estimated expenditure on health care by these administrations.

Primary health care (typically care provided by GPs, nurses, and so on) in the armed forces is currently devolved to each force (army, navy and airforce), with autonomy within each organisation for health-care budgets. Secondary health care (typically provided in hospital settings) in the armed forces is administered collectively, with estimates available from the Surgeon General’s Department for all secondary health-care except for the Medical Supplies Agency (MSA), which has provided its own data. Where time series have not been provided, changes in health expenditure have been assumed to move in line with changes in the number of the target population: total armed forces personnel.

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Administrative responsibility for prisons has been delegated to the constituent parts of the UK. Delivery of primary health services is undertaken in the main by medical staff employed by the prison service, while secondary health services are typically delivered by the NHS.

The relevant authorities with responsibility for prisons in the UK (the Home Office, the Scottish Prison Service and the Northern Ireland Prison Service) have each provided a single year estimate for the cost of health care in prisons that is not already included in NHS figures. In order to create a time series for 1997–2001, ONS has assumed that prison expenditure moves in line with the number of prison inmates. ONS is aware, however, that prison expenditure could also be affected by changes in productivity, economies of scale, inflation and other influences.

It has so far not proved possible to disaggregate armed forces’ and prisons’ expenditure on health by the OECD Health Accounts functional and provider classifications.

6. Provision of healthcare services in the home and of healthcare goods and services by employers

The provision of health-care services in the home includes, for example, nursing of elderly relatives or sick members of the household. There is no payment involved and as such this type of service has been ignored in compiling the total UK health expenditure figure.

The provision of health-care goods and services by employers to employees is entitled ‘occupational health-care’ in the international framework. It includes surveillance of employee health and therapeutic care that takes place on or off business premises, and has also been ignored in the compilation of total UK health expenditure.

It is recognised by many countries compiling Health Accounts, including the UK, that identifying and/or valuing these expenditures is difficult. In this early stage of development of Health Accounts, most countries are excluding these expenditures. ONS is not planning to examine either of these components in the current phase of development, unless specific user demand for them is identified.

Further work

There are three main areas in which ONS plans to conduct further development work on the pilot expenditure account, and progress will be documented on the National Statistics website. These are (a) investigation of other sources of information on health care financed by government and households, (b) disaggregation of health expenditure in prisons, by the armed forces and by NPISH, and (c) compilation on a calendar year basis. Comments on these proposals should be sent to the e-mail address at the beginning of the article.

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