GASTO SANITARIO PRIVADO

En España, el sector privado como agente de financiación del gasto sanitario representa casi el 30 por ciento del gasto sanitario total y alrededor del 2 por ciento del producto interior bruto. De ahí la importancia de disponer de un conocimiento acerca de este sector que permita responder a tres cuestiones básicas: ¿de dónde proviene el dinero?, ¿adónde va el dinero? y ¿qué tipo de bienes y servicios se compran?

La característica más específica de la metodología de la estimación del gasto privado en el marco del Sistema de Cuentas de Salud en España es que no hay estimación, al menos en las cifras agregadas, dado que las magnitudes de Contabilidad Nacional son la principal fuente de datos.

A nivel agregado, el gasto privado corriente es el resultado de sumar el gasto en consumo final de los hogares en salud, el gasto en consumo final de los hogares en servicios de seguro ligados a la sanidad, el gasto en consumo final de los hogares en cuidados de larga duración y el gasto en consumo final de las instituciones sin fin de lucro al servicio de los hogares —ISFLSH—. Si al gasto corriente se añade la formación bruta de capital de las instituciones privadas proveedoras de atención de la salud, se obtiene el gasto privado total.

Gasto sanitario privado = **(+)** Gasto en consumo final de los hogares

- » Salud
- » Servicios de seguro ligados a la sanidad
- » Cuidados de larga duración

(+) Gasto en consumo final de las instituciones sin fin de lucro al servicio de los hogares (ISFLSH)

(+) Formación bruta de capital

A partir de estas macromagnitudes, y siguiendo una metodología *top-down*, se desagrega el gasto total según función, proveedor y agente de financiación. Para ello, se utilizan varias fuentes de información, como son:

- Instituto Nacional de Estadística (INE). Contabilidad Nacional de España.
- Instituto Nacional de Estadística (INE). Encuesta de Presupuestos Familiares.
- Instituto de Mayores y Servicios Sociales (IMSERSO). Las personas mayores en España.

- Ministerio de Sanidad, Política Social e Igualdad. Estadística de Establecimientos Sanitarios con Régimen de Internado.
- Ministerio de Sanidad, Política Social e Igualdad. Estadística de Gasto Sanitario Público.
- Ministerio de Sanidad, Política Social e Igualdad. Dirección General de Farmacia y Productos Sanitarios.
- Ministerio de Economía y Hacienda. Dirección General de Seguros y Fondos de Pensiones.
- Comité Européen des Assurances (CEA). CEA Eco nº23 - Health Insurance in Europe in 2004.
- Cruz Roja Española. Memoria.

Es importante señalar que, previamente, hay que realizar un ajuste en las cifras de Contabilidad Nacional en lo que se refiere a los esquemas de seguro sanitario de los funcionarios públicos, ya que, aunque los servicios puedan ser prestados por aseguradoras privadas, se financian por el sector público. Mientras que Contabilidad Nacional lo incluye como gasto en consumo final de los hogares, el Sistema de Cuentas de Salud lo considera gasto de las administraciones públicas.

En el Anexo se describe, de manera detallada, en inglés, la metodología de estimación del gasto sanitario privado en España.

ANEXO

Private health expenditure - data sources and estimation methods

Country case study: Spain

María Luisa García Calatayud and Jorge J. Relaño Toledano

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"……National accounts …are the result of combining a complex mix of data from many sources, many of which require adjustment to put them into a national accounts database and which are further adjusted to improve coherence, often using non scientific methods."

"The addition of the word "statistics" (to the national accounts) implies acceptance of the notion of approximation, estimation and revision, things in which the national accountants excel, but which are anathema to company accountants.

François Lequiller and Derek Blades, *Understanding National Accounts*, OECD, 2006.

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1. GENERAL REMARKS

1. The private sector as health expenditure financing agent in Spain accounts for almost 30 per cent of total health expenditure. This justifies the need for a good knowledge of the sector that would allow us to answer the three basics questions that the Manual SCS considers: where the money comes from, where the money goes and what kind of services and goods are purchased.

2. For this task it is necessary to have a good methodology and reliable sources. On the one hand the methods and guidelines that Ravindra P. Rannan-Eliya[1] specifies give a good starting point to check and improve the different approaches each country employs in their estimations of private expenditure. On the other hand, the availability of reliable sources determines the actual possibilities of the different methods.

3. In our case, the importance of private health expenditure sector is not backed up by a good set of sources with the necessary information of the providers, functions and financial sources.

4. The quotation which opens this paper from François Lequiller and Derek Blades "Understanding national accounts" perhaps needs an explanation. We do not pretend to be national accountants since we know we are far from that, not only by reason of their knowledge of the economics aggregates and macroeconomics interrelations, but also because of the different extent of the research field that involves each one of the two subjects: national account and health accounts.

5. However, when we try to explain our estimation methods when reporting private health expenditure, the first quote, "*often using non scientific methods*", gives us a refreshing moral support that played down the importance of having used C methods[2] more than we would have liked.

6. The second quote *"... approximation, estimation and revision..."* justifies what we are going to do in this paper: a revision of several aspects of our methodology. In estimating the components of private health expenditure we lacked important sources of information and we are aware that our figures are an approximation and would need further improvements. Even at the time of writing this paper we still face a significant shortage of sources, but we have been able to improve the methods in some fields.

7. Consequently, the methodology we are going to present refers, mainly, to what will be our report of private expenditure in the next JHAQ2009. And still, we must point out that the figures entail "…*approximation* (better than the last one but worse than the next), *estimation* (we are not company accountants, obviously) and *revision* (the second one but not the last one)…"

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[1] Draft OECD Guidelines on improving the comparability and availability of private health expenditure. Ravi P. Rannan-Eliya

[2] A methods that are reliable and ideal, and are more appropriate. B methods that are less reliable, but are acceptable if A methods cannot be used. C methods that are non acceptable, except as a last resort.

Draft OECD guidelines for improving the comparability and availability of private health expenditure.

8. We want to give our most sincere thanks to our colleagues from the INE Directorate of National Accounts, mainly to Alfredo Cristobal Cristobal y Mª Carmen Ortega Pozas, for sharing their information with us and, what is more important, their wide knowledge; we also express our gratitude to our colleague Pilar Jimenez Rosado from the Instituto de Información Sanitaria of the Ministry of Health who was always ready to delve into the hospital statistics in order to find the details we needed. We also greatly appreciate the help of Suzanne Tiburtius in reviewing the English version of the paper.

9. Finally, we would like to point out that we feel that we have bared our "SHA soul" in this paper. This paper contains everything we do in order to estimate the private health expenditure in the framework of the very demanding SHA manual, both the scientific and non- scientific methods. We did hesitate when we were asked to write this paper (a lot of C or even further on the alphabet methods, that we are not very proud of) but now we think that our work can be helpful in understanding all the troubles and difficulties this task involves.

10. A brief summary of the main features of the Spanish health care system follows, before getting into a description of the methodology used to estimate the private health care expenditure.

2. OVERVIEW OF SPANISH HEALTH SYSTEM

11. Health care in Spain had a turning-point at the end of the '70s due to the enactment of the 1978 Spanish Constitution. Before that, public health care was a social benefit in kind, as part of a traditional Social Security scheme self-financed by the contributions of employers and employees.

12. On the one hand the Constitution gives health the status of a right, and health care therefore becomes a public service for all the country's citizens. On the other hand it defines the new region-based organization of the self-governing regions (Autonomous Communities (ACs)) and indicates the spheres of responsibility of each government level; health care and other essential public services with a high social content, as education or social care, are shared areas of responsibility between Central Government and the Autonomous Communities.

13. Following these legislative changes, in 1986 the General Health Act was enacted in order to regulate health care in Spain. Under this law, various public institutions and agencies have been incorporated within a National Health Service whose basic characteristics are universal coverage, devolution of the management to the regions and public funding.

14. In accordance with the process of political devolution, since 1981 the management of social security health care has gradually passed over to the ACs, that are responsible for provision and contracting of health services on their territories.

15. These historical reasons are behind the strong increase in health expenditure - especially public expenditure - from these years on, as Table 1 shows.

Table 1. Health expenditure and GDP in Spain

	1960	1970	1980	1990	2000	2006
Public health expenditure as % of GDP	0.9	2.3	4.2	5.1	5.2	6.0
Private health expenditure as % of GDP	0.6	1.2	1.1	1.4	2.0	2.4

2.1 Population coverage

16. As a result of this evolution, around 99.5% of the Spanish population (National Survey of Health, 2006) is covered by the National Health System (NHS). From these people, about 5% are civil, military or judicial servants which are covered by one of the three non-profit mutual funds existing, according to their department. The remaining 0.5% of the population consists of non-salaried high-income people who are not included in the Social Security scheme.

17. Besides this, around 14% of the population has also some private insurance coverage: 10% by contracting individual insurance policies and 4% through collective policies contracted by enterprises.

18. The regime of coverage of public mutual funds foresees the possibility for them to choose, on a yearly basis, between the NHS assistance and the one offered by some private companies that are contracted by the mutual funds with this purpose. The available figures show that about 30 per cent of the

private health insurance premiums come from these civil servants public funds.[3] These funds are accounted as public expenditure in the Spanish health accounts.

2.2 NHS Common Baskets of Services.

19. The NHS offers a comprehensive package of health services including in-patient and out-patient care, pharmaceuticals, health care transport, preventive and basic dental care and some other complementary benefits. All the included benefits are free at the point of use except for pharmaceuticals and some medical aids where co-payments are required.

20. ACs are empowered to widen the benefits provided; so, in some regions extra benefits are included, *e.g.* more comprehensive dental care or sex-change surgery. The funding of the benefits out of the Common Basket of Services of the NHS is assumed by each AC.

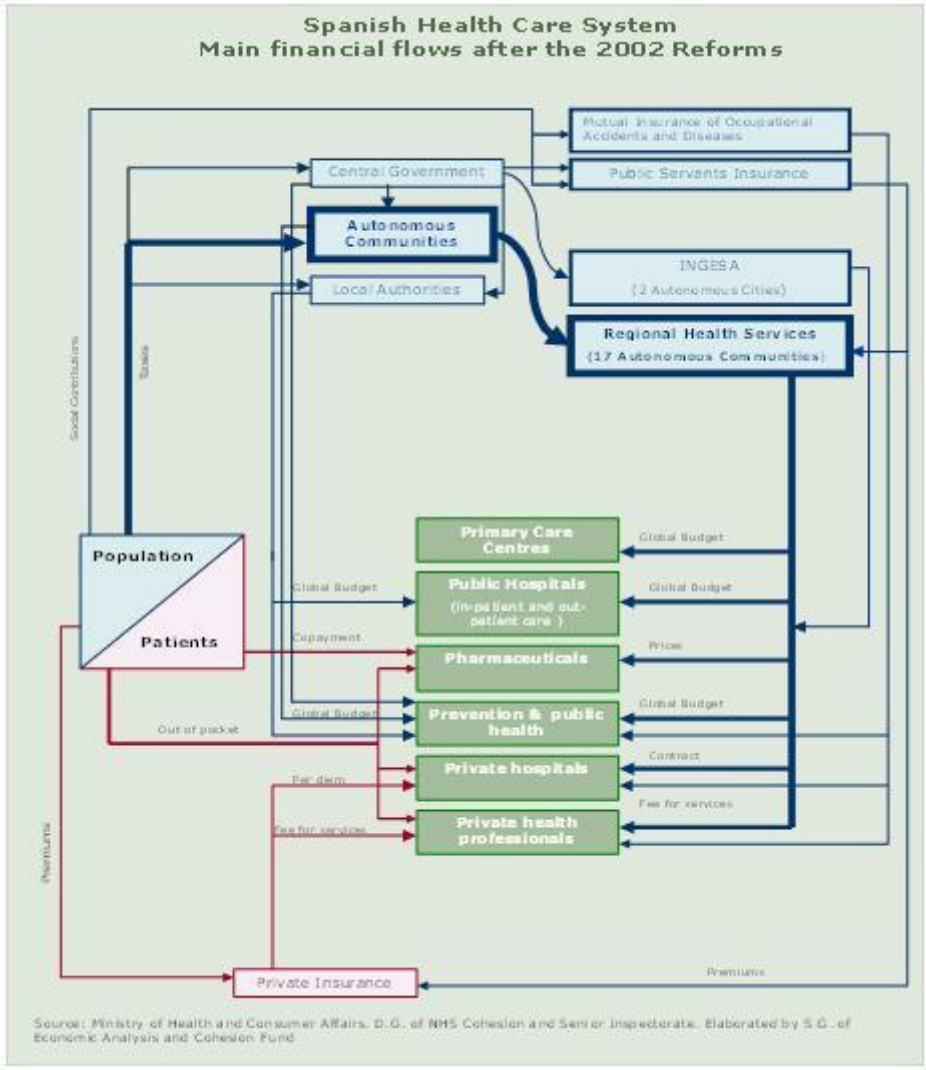
2.3 Funding of public expenditure

21. The funding model in force was established by the 21/2001 Act of Funding for Autonomous Communities and Cities, that was enacted in coincidence with the end of the devolution process.

22. The system of Communities' funding is not earmarked, that is to say there are no specific transfers for each devolved function, but a global basket of resources for the funding of their devolved powers as a whole. A General Fund is established by the Act 21/2001 that includes local taxation (transferred taxes) collected and managed by each AC and part of the general taxation (shared taxes) managed by the central government. A Sufficiency Fund intended to cover the gap between the regions needs and the resources provides by the General Fund is included in the General State Budget (GEB). Together with these funding sources, and also included in GEB, there are other minor funds, specifically earmarked for health care, that amount to no more than 2% of the public health care expenditure. Figure 1 shows the current general funding structure of the health care system in Spain.

[3] El seguro de salud. Estadística año 2006. ICEA. .

Figure 1. Funding of health care system in Spain

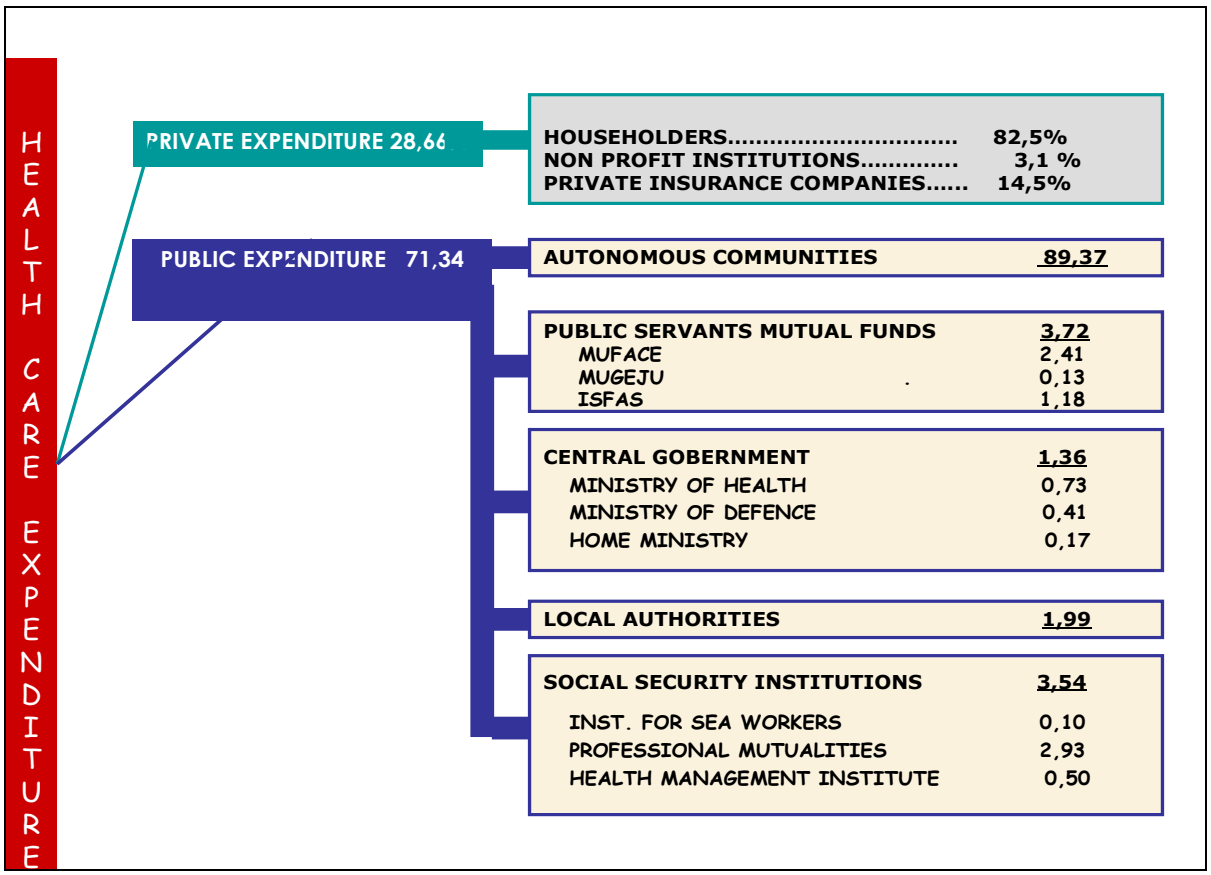


2.4 Health expenditure

23. From the late seventies on, structure of the Spanish health expenditure has remained fairly stable regarding the public/private share. In 2006, 71.2% of health care expenditure in Spain was financed from public sources and the rest from out-of-pocket payments and private prepaid plans.

24. Figure 2 shows the main actors in the Spanish health care system. The figures are not referred to last year, but are representative of the current participation of these actors in the health care expenditure, since from 2002 until present time the funding structure has remained very stable.

Figure 2. Main actors in Spanish health care system



25. Table 2 shows to what extent the two main sources of funding (HF.1 General government and HF.2 Private sector) contribute to finance the different functions of health care services.

Table 2. Private health expenditure: functions and funding structure

	HF.1	HF.2	TOTAL
HC.1-HC.2 Services of curative and rehabilitative care	71.7	28.3	100.0
HC.3 Services of long term nursing care	68.5	31.5	100.0
HC.4 Ancillary services	88.0	12.0	100.0
HC.5 Medical goods dispensed to out-patients	66.8	33.2	100.0
HC.6 Prevention and public health services	94.2	5.8	100.0
HC.7 Health administration and health insurance	47.3	52.7	100.0
Total expenditure HC.1-HC.9	**70.8**	**29.2**	**100.0**
HC.R.1 Capital formation	85.1	14.9	100.0
Total expenditure including HC.R.1	**71.2**	**28.8**	**100.0**

26. Central and local governments incur 93% of total public health expenditure and Social security schemes the remaining 7%. Nevertheless, it is necessary to point out that this item includes the expenditure

carried out by the civil servants' mutual funds. Around 70% of this mutual insurance scheme funding comes from central government transfers.

27. Moreover, health care in the Autonomous Cities of Ceuta and Melilla and health services offered to sea workers are still provided by entities that are formally part of the Social Security schemes, but its resources come from general taxation, via the Ministry of Health.

28. Indeed, only the healthcare services originate from professional contingencies (accidents in the workplaces and occupational diseases) are actually funded by security social contributions which amount to around 2.7 % of public expenditure on health.

3. PRIVATE HEALTH EXPENDITURE IN NATIONAL HEALTH EXPENDITURE CONTEXT IN SPAIN

29. Private expenditure in Spain accounts for almost 30 % of total health expenditure and around 2% of GDP. This share is nearly twice at present than in the nineties.

30. The economic growth of Spain along this period seems to be behind this evolution. In fact the Spanish regions with a higher preponderance of private insurance are among the wealthiest ones. This is the case of Madrid, Balearic Islands or Catalonia, where population contract this type of coverage four times over the national mean. Therefore is a logic assumption that Spanish people have used more and more private heath services and insurance as a complement of the benefits provided by the NHS.

31. Moreover, some fiscal and legislative measures had encouraged the subscription of private insurance policies. For instance, the 1998 Act of Personal Income Tax established a fiscal incentive to collective private insurance linked to labour market and enterprises.

32. On one hand, the premiums paid by the enterprise are no longer considered as payments in kind for the individual workers, so they have less income to declare in their tax declarations. From the employers' side, the total amount of these premiums is included among the costs of production and consequently treated as a profit reduction, tax-deductible in the Corporations' Tax.

33. Table 3 points to the great increase of collective insurance policies (75.55% in three years) as the main driver of the significant increase of the expenditure funded by health care insurers in the last years.

Table 3. Health insurance policies

	2003		2005		2006		2006/ 2003
	Number	%	Number	%	Number	%	variation
Individuals	3 081 729	47.82	3 013 794	43.15	2 933 054	41.16	-4.82
Collectives	1 280 230	19.87	1 936 724	27.73	2 247 495	31.54	75.55
Government (Mutual Funds)	2 081 868	32.31	2 033 245	29.11	1 942 686	27.26	-6.69
Total	**6 443 827**	**100.00**	**6 983 763**	**100.00**	**7 125 241**	**100.00**	**10.57**

3.1 Specific features of private health care

34. The Spanish Country Case for the OECD study "NHA for 13 Countries"[4] stated some remarkable differences between public and private structure of expenditure that are meaningful regarding the characteristics of the Spanish Health Care System.

[4] García Calatayud, Maria Luisa and Relaño Toledano, Jorge. National health accounts for 13 countries. OCDE 2004

35. As far as the public sector is concerned, there is a rough equilibrium between in-patient and out-patient modes of production, but out-patient curative care is widely preponderant in the private sector.

36. From the providers' point of view, as shown in Table 4, the expenditure of public hospitals is 2.6 times that of the ambulatory health care providers. However, that of the private sector is the reverse: the weight of hospital expenditure is only a fifth of that of ambulatory health care providers.

Table 4. Private health expenditure: providers and funding structure

	HF1	HF2	Total current expenditure
HP.1 Hospitals	51.2	9.0	38.8
HP.2 Nursing and residential care facilities	4.3	6.3	4.8
HP.3 Providers of ambulatory health care	20.1	50.3	28.9
HP.4 Providers of medical goods	20.5	28.0	22.7
HP.5 Provision and administration of public health programmes	1.2	0.5	1.0
HP.6 General health administration and insurance	2.2	6.0	3.4
HP.7 Other industries	0.5	0.0	0.4
HP.9 Rest of the world	0.0	0.0	0.0
Total expenditure	**100.0**	**100.0**	**100.0**

37. Hospitals provide 9% of the total private expenditure but, to have a wider view of the weight of private hospitals in the system, it is worth taking into account that 65 % of total services produced by private hospitals is publicly funded via contracts; so, the importance of the private hospital as producing sector is higher than it appears when reading Table 4. As far as the ambulatory care is concerned, this funding ratio is only 20 %.

38. The rationale behind these figures is historic: large general hospitals in Spain are mainly public ones whereas the private initiative has been more focused on middle size specialised clinics. So, private hospitals are, to some extent, complementary to the public network. We also have to highlight that advanced equipment and knowledge of public hospitals is highly valued by Spanish patients.

39. On the ambulatory care side, the NHS provides a generalist primary care based in health centres, on a territorial and population basis that ensures the already mentioned coverage of 99% of population; hence there is little room for private general practitioners in Spain. Consequently, the high share of ambulatory care in private expenditure comes from the private surgeries of specialists and dentists; as a whole, this amount to 78% of total private expenditure in ambulatory providers and to 81% of households' out of pocket expenditure in ambulatory care providers.

40. The expenditure in dentists' offices amounts up to 45% of ambulatory care, 22% of total out of pocket expenditure and 17% of total private expenditure. It means that dentists' offices are the greatest provider of ambulatory health care in the private sector. Therefore, the fact that orthodontics and dental curative services are not covered by the NHS is the main explanatory factor of the great weight of the out-patient care on private expenditure, both from the providers and the modes of production viewpoints.

41. Another meaningful difference between public and private functional structure is related to pharmaceuticals and therapeutic appliances. The first component – pharmaceuticals – has a similar share in public and private expenditure, around 22 % but, for therapeutic appliances the shares are 0.4% for public and 7 % for private. The reason is, as in dental care, the lack of public coverage for households' expenditure on glasses and hearing aids.

4. METHODOLOGICAL APPROACH

42. The most specific characteristic of the methodology involved in the Spanish estimation of private expenditure in SCS framework is that there is no estimation…… at least in the aggregate figures, since National Account (NA) magnitudes are the main source for our data.

43. We have not used the NA aggregates, as final household consumption expenditure, to check our estimates, as the OECD guidelines[5] suggest; we have used those macromagnitudes as the central point to our "top down" methodology and we started estimating when we needed to draw in the different components of total private health expenditure, according to the three dimensions of SHA: functions, providers and financing.

44. Between the three different approaches of estimating an aggregate of private expenditure – supply, demand and financing – the choice has been made with regard to the possibilities provided by available information.

1. Supply approach: Quantifying the production value of the agents that provide health services, and the production values of capital goods. Health private production remains a very difficult field to investigate; it is only available for specific sectors (hospital statistics).
2. Financing approach: Adding all the resources that the financing actors assign to the health expenditure. The main sources are the Household Budget Survey (unreliable and biased information) and the private health insurance schemes with available statistics from the regulator about premiums but very poor information about the indemnities.
3. Demand approach: Adding the goods and services consumed by the private sector and private investment. The National Accounts provide us with the best way of calculating an aggregate by means of the demand approach, mainly through household final consumption expenditure.

45. Box 1 shows the aggregate level of current private expenditure is the result of adding final household consumption expenditure in health (Division 6. Health of COICOP with some adjustments that we will explain below), final household consumption expenditure on insurance connected with health (class 12.5.3 Insurance of COICOP), final household consumption expenditure in long-term care (part of class 12.4 of COICOP) and non-profit institutions serving households' final consumption expenditure in health (Non-market human health services as products, and NPISH as industries from the input/output framework).

Box 1. Final consumption expenditure

Core concept : Final consumption expenditure

Private health expenditure = **(+)** Final household consumption expenditure

- Health (NA)
- Insurance connected with health (NA)
- Long term care (Surveys and NA)

(+) NPISHs final consumption expenditure (NA)

(+) Gross capital formation (Hospital statistics)

[5] Draft OECD Guidelines on improving the comparability and availability of private health expenditure.

46. So, our method of measuring the total private expenditure relies, mostly, on the NA figures. Our methodological approach is a top-down one, that aims to assign the total expenditure into the functional, provider and financing sources classifications and that can be shaped into the following steps:

1. Check if the borderlines of the private expenditure in NA estimates used in our equation are the same as SHA ones.
2. Make the necessary adjustments to reach the coherence between both (NA and SHA) borderlines:
   - Functional
   - Financing sources
3. Identify the global expenditure for the three financial sources: Out of pocket, Private Insurance schemes, and NPISH.
4. Estimate the composition of the aggregate expenditure of the three financial sources by an integrative approach, combining both providers and financing side perspective.

4.1 Checking the borderlines and making the adjustments

The financial boundaries of final household consumption expenditure

47. We include three elements in the final household consumption expenditure:

- Division 06 of COICOP: Health
- Class 12.5.3: Insurance connected with health.
- Estimate of part of group 12.4: Social protection.

48. The treatment that NA gives to the health insurance is that class 12.5.3 includes the service charge for the insurance, defined as "the difference between claims due, premiums earned and premium supplement".[6] The health services provided as indemnities for the private health insurers to the households are included as health final consumption expenditure in class 6.

49. Therefore we need to turn households' consumption expenditure into out of pocket expenditure, by means of eliminating the indemnities provided for insurers that NA include as household consumption. These indemnities added to the services charged for the insurers connected with health (Class 12.5.3) will give us the total amount of expenditure finance for the private health insurance schemes.

The boundaries of private health insurers as financing agent.

50. It is necessary to make another adjustment since national accounts include in the household expenditure some items that both the Spanish Statistics of Public Health Expenditure (EGSP) methodology and manual SHA, considers as public one. This expenditure refers to the civil servants' health insurance schemes, which are financed by the public sector, whereas the services are provided by private health insurance companies.

51. The civil servants can choose between the health assistance provided by their Regional Health Systems or by private health insurance companies, in which case, the administration pays collective premiums for the assistance to the insurers. Most of the civil servants choose the private companies. The

[6] COICOP. UN statistics division.

National Accounts consider these premiums as paid to the individual who spends it in buying the insurance. Therefore they are considered as household consumption expenditure, and not consumption expenditure of general government.

4.2 Functional borderlines

52. As our approach is a demand approach, we do not consider any amount not included either in final consumption expenditure or in gross capital formation. That means that we have not estimated any elements of intermediate consumption; so, there are no estimates for HC 6.5 Occupational health expenditure, and that becomes an important departure from the functional borderlines established for the manual SCS.

53. There is another departure, which applies to the gross capital formation, since the investments we include in our estimates only contain the investments in hospitals, and not in the other different health providers.

4.3 Identifying the global expenditure for the three financial schemes.

54. Once the above mentioned steps are completed, it is possible to identify, in accordance with the manual SHA, the aggregate expenditure financed for each one of the three agents: out of pocket, insurers and NPISH:

- Out of pocket:
  - Household final health consumption expenditure, minus the indemnities that insurance companies give to the policyholders.
  - Household final consumption expenditure in social protection related to long-term care.

  We assume that all the non-hospital long-term care is paid for by the households themselves.
- Health insurers**:**
  - Insurance connected with health (minus civil servants)
  - Indemnities that insurance companies give to the policyholder (minus public servants ones)
- NPISH
  - NPISH final health consumption expenditure

4.4 Estimating the composition of the three financial schemes aggregate expenditure.

55. The last step is to break down the aggregates of the three financial agents into the functional and providers SHA classification. We have used various sources, and in the next section we will describe, step by step, the methods and the respective sources used. The main sources have been:

- National Accounts. INE
- Hospital statistics. ESCRI (Ministry of Health)
- Household budget survey INE
- Health Insurance. Data 2003-2006. ICEA
- Directorate General for Assurance and Pension Schemes.(Ministry of Treasury)
- Dependent people white paper (Ministry of Labour and Social Affairs)

- Health insurance in Europe in 2004. CEA
- Prescriptions report (Ministry of Health and Consumers Affairs)
- Memoranda of several NPISH
- Expert opinions and meetings with sector representatives.
- Public Mutual Funds Economic memories
- Directorate General for Pharmacy (Ministry of Health)

5. FROM HOUSEHOLD FINAL CONSUMPTION EXPENDITURE TO OUT OF POCKET EXPENDITURE.

56. To eliminate the indemnities included in the health household expenditure we need to estimate them, not only in the total amount, but classified with the same details as the data from NA. We do not consider at this point the expenditure in long-term care included as social protection in NA, since private sector insurance is not active in this field.

57. Services charged for health insurers are defined (COICOP) as the difference between claims due, premiums earned and premium supplement. It is possible, knowing the premiums, to estimate the benefits paid out to policyholders, by deducting the insurance services from the total premiums, or knowing the claims ratio, raise it to claims, in the case where we do not know the total amount of the premiums.

58. National Accounts figures includes in the Class 12.5.3: "Insurance connected with health" not only the services charged for private health insurance but also for accident insurance.

59. Health care insurance private schemes in Spain include:[7]

- Individual insurance: 47% of total premiums
- Collective insurance (excluding public administration staff): 22.86% of total premiums
- Collective insurance (civil servants and other public employees such as judges and army personnel): 28.16% of total premiums
- Dental insurance: 1.51 % of total premiums

60. We know the average claim ratio included in NA estimates. For the health insurance we know both the premiums and the claims ratio, so we can estimate the health services paid out as benefits for the accidents services, for which we do not have the particular claim ratio. We are in contact with INE National Account experts in order to identify more precisely the premiums and claims ratios of this insurance scheme.

61. Once we know the amount of the benefits paid out for private insurance included in the Final Households Consumption Expenditure, the indemnities of public employees insurance as well as the remaining private insurance schemes , the calculation is as shown in Table 5. We will explain in the following sections the sources and methods used in the functional classification included in it.

[7] El seguro de Salud. Estadística año 2006. ICEA

Table 5. Private expenditure financial sources, 2006 (millions €)

	Household Final consumption expenditure (1)	Total Insurance claims and services (2)	Civil servant insurance scheme (3)	Insurance without Civil servant (4)=(2)-(3)	Out Of Pocket (5)=(1)-(2)
06.1	6.529	71	**45**	25	6.458
06.2	11.516	3.112	559	2.552	8.404
06.3	2.169	1.422	460	963	743
Total health 06	**20.214**	**75.534**	**1064**	**990.552**	**757.862**
15.3 Insurance connected with health	1.481	1.481	82	1399	0
TOTAL	**21.695**	**6.090**	**1.146**	**4.943**	**15.605**

62. Having estimated the total amount (not included LTC and capital formation) of the expenditure financed by these two financial schemes: €15.065 million out of pocket, €4.943 million from health insurance companies, and knowing the total amount of the third scheme, NPISH, that NA estimate as €610 million, we proceed in the next sections to explain the sources and methodology employed in the functional and providers classification of the three of them.

6. OUT OF POCKET EXPENDITURE: FUNCTIONAL CLASSIFICATION

63. The National Statistics Institute, through the National Accounts department, provides us with the household expenditure with the following details:

- 06.1 - Medical products, appliances and equipment
- 06.1.1 - Pharmaceutical products
- 06.1.2 - Other medical products
- 06.1.3 - Therapeutic appliances and equipment
- 06.2 - Outpatient services
- 06.2.1 - Medical services
- 06.2.2 - Dental services
- 06.2.3 - Paramedical services
- 06.3 - Hospital services

64. What we need, then, is to estimate, applying other sources and methods, the remaining functional breakdown and the provider classification.

6.1 Medical products, appliances and equipment

65. We can map the relationship between Coicop classification of group 06.1 - Medical products, appliances and equipment, and ICHA-HC group 5: HC.5 Medical goods dispensed to out-patients.

Table 6. COICOP group 06.1 and ICHA-HC group 5

COICOP	ICHA- HC
06.1.1 - Pharmaceutical products	HC.5.1.1 Prescribed medicines
	HC.5.1.2 Over-the-counter medicines
06.1.2 - Other medical products	HC.5.1.3 Other medical non-durables
06.1.3 - Therapeutic appliances and equipment	HC.5.2 Therapeutic appliances and other medical durables

66. In accordance with that map it is necessary to split up the expenditure on pharmaceutical products between those that have been prescribed, and the over the counter ones. SHA manual establishes that prescribed medicines are those that are "exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding and include branded and generic products".

67. In HC5.1.1 we just include, as private expenditure, the co-payment that NHS health care services and Public Mutual Funds (PMF) charge depending on the patient's different age and health status. Those co-payments are:

NHS …….. Retired people and their beneficiaries: No co-payment

NHS…… Non-retired people and their beneficiaries: 40% co-payment

PMF…… Both retired people and non- retired: 30% co-payment

Chronic and AIDS patients pay 10% with a maximum of 2, 24 €

The Directorate General for Pharmacy of the Ministry of Health and Consumer Affairs provided us the data of co-payments of NHS.

68. For estimation of the co-payment from the households covered by the Public Mutual Funds we have:

a) The total amount of publicly financed expenditure in prescribed medicines for this public scheme
b) The co-payment rates, both NHS and PMF
c) We know the composition of the total expenditure and co-payments in the NHS between chronically sick, active people and the retired
d) We assume that the performance of NHS and PMF groups of patients is similar

69. Then, applying to the total pharmaceutical expenditure of the Public Mutual Funds the structure of the NHS expenditure and co-payments we can estimate the co-payment of those agents.

HC.5.1.1 = NHS Co-payment (administrative register) + PFM co- payments (estimate)

HC.5.1.2 = COICOP 06.1.1 – HC.5.1.1

6.2 Out-patient services

70. Mapping COICOP *06.2 Out-patient services* into SHA *HC.1.3 Out-patient curative care*, allows us to find out where we need to split up the NA figures, to reach SHA functional classification

Table 7. Out-patient services and out-patient curative care

COICOP	SHA
06.2.1 Medical services	HC.1.3.1 Basic medical and diagnostic services
	HC.1.3.3 All other specialized health care
06.2.2 Dental services	HC.1.3.2 Out-patient dental care
06.2.3 Paramedical services	HC.1.3.9 All other out-patient care
	HC.4.1 Clinical laboratory
	HC.4.2 Diagnostic imaging
	HC.4.2 Patient transport and emergency rescue

71. We must point out that for out of pocket financial schemes we just include in HC1.3.1 the primary health care services and the diagnostic services that can be provided at this medical care level. We include all the services provided by specialists at H.C.1.3.3 *All other specialized health care.*

72. Our first assumption regarding ambulatory services is that all the out of pocket expenditure on medical services comes from services provided by specialists; therefore we have classified them under

HC.1.3.3. In fact, there is little room to include out of pocket primary care services taking into account that National Health Service and private health assurance cover this field efficiently.

73. At this point it is necessary to resort to the Household Budget Survey (HBS), to reach the necessary detail in the functional classification. A new HBS has been introduced in Spain from 2006, but we must point out that , until now, our SHA data rest on the old household budget survey, since the new one brings significant differences that would suppose a break in the series; therefore, there is a task ahead using the statistical techniques INE has designed to link them:

74. "Both surveys were designed for the main purpose of estimating the household consumption expenditure, as well as investigating other related variables. Nonetheless, there are relevant differences between the two as regards the understanding of each of the statistics, and many of their methodological features. The differences between the surveys make for a significant separation in the series of data on expenditure that was published up until the year 2005. In order to provide continuity for the series, it is necessary to apply statistical techniques that allow us to link the results obtained with both methodologies, that is, to obtain a single time series that allows us to observe the evolution of consumption expenditure in Spain throughout the period in which the data refers to the two surveys with different methodologies." (INE)[8]

75. Nevertheless, in this paper we would refer to the results of the new HBS, since it would be – once we have done the linkage – our source for implementing the following JQ. Now, let us point out the main characteristics of the survey and make out the actual possibilities of using it in our estimates.

76. The new Spanish Household Budget Survey, published annually, entered into force in January 2006, and one of the main differences with HBS base 1997 is the increase in the sample size: "In the survey base 1997, 8,000 households were interviewed each quarter, which implied, bearing in mind the design of the survey, an annual sample size of approximately 11,000 households. In the new survey, the size is similar to that usually used in the traditional basic family budget surveys (approximately 24,000 households)".

77. INE highlighted two other features of the new HBS because of "their importance and those which are related to specific needs of users: the estimate of expenditure as an instrument for obtaining private consumption in the National Accounts, and the estimate of the weightings structure from the expenditure necessary for calculating the CPI".[9]

78. Therefore we know that National Account household consumption expenditure was, obviously, kept in mind for the INE statisticians when they drew up the new HBS, and we can suppose that the new HBS has became one important source to the national accountants for their consumption estimations, in order for them to compare with other sources in the production side to reconcile demand and supply approach.

79. We must point out, too, that there are some features that involved departures between National Account consumption expenditure and expenditure from HBS:

- In relation to the territory:
  - National account includes, in the total household expenditure, all the consumption expenditure made by households resident in the country, whether this expenditure takes place in Spain or abroad. But, this expenditure is not functionally recorded, and it is added to the 12

[8] Technical note on the Household Budget Survey link system. INE

[9] Main features of the Household Budget Survey 2006. INE

Coicop division's figures as an import; expenditure of non residents (not functionally recorded either) is deducted. According to these rules, the expenditure in each COICOP division does not include the expenditure households realize abroad; it just includes the consumption carried out on home territory.

- Household Budget survey refers to all resident expenditure abroad and at home.

- In relation to the household:
  - The household sector in National Accounts includes individuals or groups of individuals whose principal function is consumption, and also persons living permanently in institutions who have little or no autonomy of action or decision in economic matters (*e.g.* members of religious orders living in monasteries, long-term patients in hospitals, prisoners serving long sentences, old persons living permanently in retirement homes).
  - Household sector in HBS refers only to the individual households.
- In relation to the private health insurance schemes
  - As we have already mentioned, the NA group 6 of household expenditure includes, functionally desegregated, the health claims, while the insurance services are in group 12.
  - HBS includes as insurance the total amount of premiums.

80. When comparing the figures of both sources, NA and HBS, one must bear in mind those departures. The first one we assume that it is not very important, since the total amount of final consumption expenditure of residents in the rest of the world account for 1.9% of the total household expenditure, the health expenditure being 3.6% of that total.

81. The second one can be considered as more significant, but we do not have the means to quantify it. As far as the third one is concerned, as explained in paragraph 4.1, we have already deducted to the NA final consumption figures the estimated expenditure provided for private insurance companies.

82. So, let us compare the total amounts and the composition of the health expenditure for the year 2006 (two digits level):

Table 8. Household Budget Survey and National Account Consumption Expenditure 2006

	HBS		NA		NA Adjusted	
	Millions €	%	Millions €	%	Millions €	%
06.1	5.511	41.1	6.529	32.3	6.458	41.4
06.2	7.337	54.7	11.516	57.0	8.404	53.9
06.3	569	4.2	2.169	10.7	743	4.8
Total 06	13.417	100.0	20.214	100.0	15.605	100.0

83. The difference between the HSB and NA adjusted households expenditure aggregates stands at 14% of the total amount of the expenditure; this ratio is the same average one that is stated in the OECD Guidelines: "The average level of consumption per capita in the household survey was only 86% of the total estimated in the national account, and the discrepancy was greater in OECD economies…"[10]

[10] Draft OECD Guidelines on improving the comparability and availability of private health expenditure

84. At the two digit desegregation level there is an important concordance in the percent ratios of each one of them. So, we can presume that we are doing things well.

85. We do not need the HBS at this level, because we use NA data. What we need is to disaggregate NA figures to reach SHA functional classification, as stated in Table 7 above, and there things do not match so nicely. The most significant feature is the difference between dental and medical services in both schemes: 43.7% against 25% of total expenditure in the case of dental services and 7.3% against 21.7% in the case of medical services.

86. As long as we do not have more information about these differences and pending results of further investigations, we stick to our methodological rules: NA first; so we take their figures as valid.

87. Finally, we need to count - not having another possible source- with HBS expenditure structure to disaggregate 06.2.3 *Paramedical services* into those items that SHA classification established: Clinical laboratory, Diagnostic imaging, other medical care, and transport. For the last one, there is no reference, since HBS 06.2.3.3 *Other non-hospital services*, that includes SHA HC.4.2 *Patient transport and emergency rescue*, have no estimates, due to the lack of representation of the questionnaire answers.

Table 9. Ancillary services expenditure structure in HBS

06.2.3.1 Clinical laboratory and diagnostic imaging	13.6
06.2.3.2 Non hospital auxiliary medical services	86.4
06.2.3.3 Other non-hospital services	-
	100.0

88. Applying these coefficients to the total NA adjusted 06.2.3, we get the HC.1.3.9 *All other out-patient care* and HC.4.1 *Clinical laboratory* and HC.4.2 *Diagnostic imaging*, but with the problem that the coefficient of the last two comes together. So, we would need to rely on other sources to disaggregate them.

89. At this point we are aware that the source we rely on to carry on with the functional breakdown is not as appropriate as it should be; we just have these necessary details for the public expenditure, as a whole, and for the health insurance scheme of public servants. Therefore, we have applied the last one, as the least bad.

Table 10. Public servants expenditure structure

HC.4.1 Clinical laboratory	48.1
HC.4.2 Diagnostic imaging	51.9
	100.0

6.3 Hospital services and modes of production

90. The COICOP definition of Hospital services states: Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day-care and home-based hospital treatments are included, as are hospices for terminally ill persons. This group does not cover

the services of facilities, such as surgeries, clinics and dispensaries, devoted exclusively to out-patient care.[11]

91. It is necessary, then, to split the expenditure in hospital services that NA provides into the three modes of production that SHA establish.

Table 11. Expenditure in hospital services

COICOP	SHA
06.3 Hospital Services	HC.1.1 In-patient curative care
	HC.1.2 Day cases of curative care
	HC.1.4 Services of curative home care

92. The Ministry of Health through the Health Information Institute produce the Spanish Hospital Statistic (ESCRI), that give us information about the activity of the hospitals (both public and private) in great detail, and some expenditure data with less detail.

93. The classification of hospitals is based on two criteria:

1. Health care purpose: General acute care, other acute, long-term care and mental care.
2. Functional dependence: Public hospitals (National Health Services, and other public ones) and private hospitals (Profit institutions, and non-profit institutions).

94. All the information in the ESCRI can be reached under these classifications, but it is important to point out that the economic information refers, only, to sales and purchases and it is not possible, with that source, to link activity with costs at the necessary level. But, at least we have good information about the activity of the hospitals that allow us to draw on the activity structure of the different hospitals (acute, long-term care, mental care in public and private sectors) according to the three modes of production: in patient, day care and home care. Table 12 shows the number of medical consultations according to the classifications above:

Table 12. Hospital medical consultations, 2006

	National Health Service	Other Publics	Private with profit	Non- profit private	**TOTAL**
Day care	**1.638.405**	**221.667**	**223.105**	**301.831**	**2.385.008**
Geriatric	50.366	97.328	147.271	208.841	**503.806**
Mental care	282.612	59.369	45.352	8.848	**396.181**
Other	1.305.427	64.970	30.482	84.142	**1.485.021**
Home care	**389.670**	**23.040**	**30.162**	**52.504**	**495.376**

95. As far as cost information of the different modes of production is concerned, we count on two different sources:

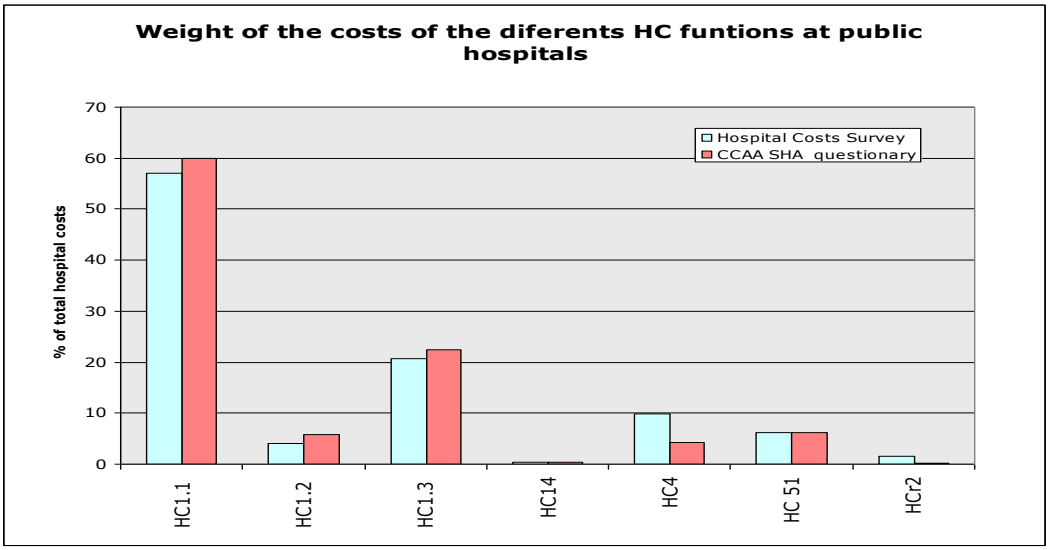
1. The Public Hospital Costs Survey. This survey has been developed over the past 10 years in the framework of the study of Spanish GRD. The sample refers to 17 hospitals and recently, for the results of 2007, has been extended to 35 with the aim of obtaining more representative outcomes. The methodology of the survey and the subsequent analysis gives relevant economic information about the ambulatory activity performed in the public hospitals.

[11] Classifications of Expenditure According to Purpose: COICOP. United Nations Statistics Division.

2. A questionnaire filled out by the Autonomous Communities that provided us with the expenditure structure of the different SHA functions and modes of production.

96. Figure 3 shows the results of the two sources. The only significant difference between them refers to the HC4, Ancillary services. A possible reason for this discrepancy could be the different methods they have to assign administration and services costs.

Figure 3. Cost of HC functions at public hospitals



97. For the moment we have chosen the first source, since the methodology of assigning costs is clearly stated and also, because not all the CCAA have answered the questionnaire.

98. With that tool it has been possible to quantify the expenditure of the different modes of production to fill out the SHA classifications for the public funded hospitals:

Table 13. Expenditure by modes of production in public hospitals, 2006

	Public hospitals	
	Million €	%
In-patient	13.937	92.04
Day care	1.107	7.31
Home care	98	0.65
	15.142	100.00

99. We need a link between those public expenditure estimations and their respective activity, and private hospital activity. We have calculated a ratio referring day care and home care consultations to hospital inpatient admissions, which can give us a measure of the weight of this ambulatory activity in the four different kinds of hospital that ESCRI classify.

Table 14. Activity ratios at public and private hospitals

	National Health services	Other public hospitals	**Public hospitals**	Non-profit private hospitals	Private profit hospital	**Private hospitals**
Day care consultations / hospital inpatient admissions	0,54	0,55	**0,54**	0,14	**0,27**	0,10
Home care consultation/ hospital inpatient admissions	0,13	0,06	**0,12**	2,67	**0,05**	0,05

100. Now, the only way we have to reach an estimate in this field is to assume that in-patient, home care and day care costs structure in the private sector is the same that those in public one. And the expenditure of the private hospital activity can be derived, by triangulation, from public hospital activities and costs ratios.

7. OUT OF POCKET EXPENDITURE: PROVIDER CLASSIFICATION.

101. There is a direct concordance between some of the items in the functional classification with some in the provider side. For others items sometimes it has been possible to get estimates for the different providers; otherwise it has been necessary to give data aggregate without splitting up into the several providers.

7.1 Providers of medical products, appliances and equipment

102. Table 15 shows the cross-classification of expenditure on health reported under the Medical goods dispensed to out-patients function HC5 with the health care provider industry classifications.

Table 15. Cross-classification, HC5 and health care provider industry classifications

ICHA-HC	ICHA-HP
HC.5.1.1 Prescribed medicines	HP.4.1 Dispensing chemists
HC.5.1.2 Over-the-counter medicines	HP.4.1 Dispensing chemists
HC.5.1.3 Other medical non-durables	HP.4.1 Dispensing chemists HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods
HC.5.2 Therapeutic appliances and other medical durables	HP.4.2 Retail sale and other suppliers of optical glasses and other vision products
	HP.4.3 Retail sale and other suppliers of hearing aids
	HP.4.4 Retail sale and other medical appliance suppliers

103. As far as HC 5.1.1 and HC 5.1.2 are concerned, there is an immediate concordance between the functional and the providers' classification.

104. HC.5.1.3 – Other medical non-durables – comprises "a wide range of medical non-durables such as bandages, elastic stockings, incontinence articles, condoms and other mechanical contraceptive devices".[12] Those products can be provided not only by a dispensing chemist but also by other providers included in HP.4.9; as we do not know the amount of that provision we assume that all the expenditure has been made through the dispensing chemists which, in fact, are the major distribution institutions.

105. For the Therapeutic appliances and other medical durables – HC.5.2 – the answer to the lack of comprehensive sources has been, up to now, to assume that the major provider, HP.4.2 - Retail sale and other suppliers of optical glasses and other vision products - is the global provider. In our defence we must point out that, in Spain, retail providers of glasses and hearing aids are, quite often, the same. But even then, we have no additional arguments for HP.4.4.

106. Trying to get a more accurate estimate we have been investigating the different possible sources of information both in the production side and in the sales, both domestic and abroad, for these products.

[12] A System of Health Account. Version 1. OECD, 2000.

107. The commercial statistics do not provide us with data in the necessary detail. And it is only in Statistics on the production of manufactured goods[13] - based on the product classification, the Prodcom List, which consists of about 4.500 headings relating to manufactured products - that we have found data of the products included in HC.5.2 Therapeutic appliances and other medical durables.

Table 16. Production of manufactured goods

PRODCOM CODE	Concept	Thousand $	%
334011-014	Total Glasses	**221.895**	**80.84**
331018	Total hearing aids	**28.069**	**10.23**
354311-12	Total invalid carriages	**24.535**	**8.94**
	TOTAL	**274.499**	**100.00**

108. The next step will be, if possible, to count foreign trade statistics with similar level of desegregation, but by the moment, we do not have any results.

7.2 Providers of ambulatory services.

109. Table 17 shows the cross-classification of expenditure on health reported under the out-patient services function HC 13 with the Health care provider industry classifications.

Table 17. Cross-classification, out-patient services and health care provider industry classifications

COICOP	ICHA-HC	ICHA-HP
06.2.1 Medical services	HC.1.3.3 All other specialized health care	HP.1.1 Hospitals
		HP.1.3.1 Offices of physicians
06.2.2 Dental services	HC.1.3.2 Out- patient dental care	HP.3.2 Offices of dentists

110. As stated above, we have assumed that all the out of pocket expenditure on medical services comes from services provided by specialists. Therefore the first step has been to estimate how much of these services have been provided in hospital specialized out- patient wards.

111. From the Public Hospital costs survey mentioned in section 6.3, we know that the expenditure in medical consultations and emergencies without admission to hospitals (HC.1.3.3-HP.1) represents 40 per cent of the total in-patient hospital costs.

112. From the ESCRI, hospital statistics, we have good information about the activity of the hospitals that allow us to draw on the activity structure of the different hospitals. In this case we have chosen, as the most suitable indicator, the ratio that refers to the number of medical external consultations / hospital stays; which can give us a measure of the weight of this ambulatory activity in the four different kinds of hospital that ESCRI classify.

Table 18. Activity ambulatory ratios at public and private hospitals

	NHS	Other publics	Total	Private no profit	Private for profit	Total
Medical consultations / hospital stays	2,2	1,3	2,024	0,7	1,1	0,919

[13] Prodcom List. EUROSTAT

113. Now, the only way we have to reach an estimate in this field is to assume that the cost structure referring to medical consultation and hospital stay costs in the private sector are the same as those in public one. Therefore we can take the 40 per cent aforementioned and, by triangulation from public hospital activities and costs ratios to the private for-profit hospital activity, estimate the expenditure of medical services provided by HP.1.1.

114. Then, the difference between total medical services and those estimated as provided in the hospital wards, refers to the services provided at the offices of physicians.

7.3 Providers of hospital services

115. As mentioned in section 6.3, the Hospital Statistic (ESCRI) provides us with information about the activity of the hospitals (both public and private) in great detail, and the total expenditure data according with the two aforementioned classification criteria: Health care purpose and legal dependence.

116. In accordance with the purpose they establish four kinds of hospitals:

1. General acute care
2. Other specialized acute care
3. Long-term care
4. Mental care.

- for which we can have their total expenditure breakdown according to the functional dependence of the hospitals:

1. National Health System
2. Other public
3. Private for profit
4. Private non-profit

117. ESCRI refers to the functional dependence of the hospitals according to the nature of the entities on which it depends; since that classification does not match with the SHA financing approach (public system hospitals buy services from private hospitals) it is necessary to refine the expenditure data that classification offers us. The ESCRI also provides us with the information about the services sold to the NHS by private hospitals, so we can reach the information at the level we need:

Table 19. Expenditure structure of private for profit hospitals

	% expenditure (2006)
General acute care	72.4
Other acute	22.5
Long care	3.1
Mental care	2.0
Private for profit hospitals total expenditure	100

118. And applying this percentage structure to the hospital expenditure we estimate the expenditure provider's classification.

8. PRIVATE INSURANCE EXPENDITURE: FUNCTIONAL AND PROVIDER CLASSIFICATION

119. As stated above, we have deducted from the NA figures of Household final consumption expenditure, both in the COICOP class 06 and 0.12, the expenditure related to the public employees mutual funds, since we consider it as publicly funded. We have deducted, as well, the premiums - claims and insurance services – collected by the private health insurance companies; in this way we identify the amount founded both by out of pocket and insurance companies as financial agents.

120. The data of premiums and claims for the health private insurance companies relies on two different sources:

1. The Ministry of the Treasury acts as regulatory agency, through the Directorate of Insurance and Pension Plans.

2. ICEA, industry association, yearly collects and reports premiums and claims data. Does not provide data on the distribution of claims expenditure by functions and provider.

121. There is a slight difference between both sources; ICEA data are referred to 47 companies, which represent around 95 % of total estimated premiums. The Directorate of Insurance and Pension Plans (DIPP), as a regulatory agency, collects data from the whole sector. We have elaborated our estimates from the last one. Nevertheless yearly statistics published by ICEA provide us with a good source for acquiring knowledge of the composition of the industry business.

122. The different types of provision of private health insurance in Spain takes two main basic forms:

1. Health care assistance insurances, that account for 85.27 % of total premiums.
2. Sickness insurances that includes: a) expenditure reimbursement (9.37%) and b) sickness benefits and indemnities (5.36%).

123. Both the health care assistance assurance and the expenditure reimbursement one are considered as services provision assurances and, therefore, its expenditure clearly fits into the core SHA functions. From the point of view of benefits paid, they account for 96.6 % of total claims whereas sickness benefits and indemnities stand for the remainder 3.4%.[14]

[14] El seguro de salud. Estadística año 2006. ICEA

Table 20. Structure of the different types of health insurances

Types of insurances	Premiums	Benefits paid	People insured
1. Health care assistance insurances	85.27	88.25	78.38
2. Sickness insurances	14.73	11.75	21.62
2.1 expenditure reimbursement	9.37	8.38	7.57
2.2 sickness benefits and indemnities	5.36	3.37	14.05
Services provision insurances (1) + (2.1)	94.64	96.63	85.95
Total (1) + (2)	100.00	100.00	100.00

124. We know that sickness benefits and indemnities insurances expenditure include benefits that SHA framework classifies as related functions, not to be included in the core functional expenditure classification, but also that some indemnities – hospitalization and surgery ones – should be included. So, we have included the total amount of both kinds of sickness assurance expenditure, but being aware that this point needs a revision.

125. To classify the figure of claims expenditure by functions we have two options:

1. CEA [15] - European insurance and reinsurance federation – that provides yearly tables of the breakdown of the benefits paid by type of healthcare expenditure with the detail shown in Table 21. However, the latest figures for Spain refer to 2004.

Table 21. CEA breakdown of benefits paid by type of healthcare expenditure

Hospitals
Non-hospital care
Doctors
Laboratories
Dentists
Auxiliaries
Other care
Transport costs
Medical items for non-hospital care
Pharmaceuticals
Optical, orthopaedic
Other items
Others

2. The functional expenditure structure of the health insurers when providing services to the public mutual funds, that we know with great detail.

126. Therefore, the estimation strategy in this case has been to use both data sources with a different target. We used CEA 2004 expenditure structure to estimate the composition of the different functions at the level shown in Table 21, and the public mutual fund data to go deep in the functional classification and to reach, as well, some of the provider details. To complete the necessary classification regarding both modes of production and hospital providers we have based our estimates in ESCRI and data from hospital costs.

[15] The European health insurance market in 2006. CEA. Insurers of Europe

9. NON PROFIT INSTITUTIONS SERVING HOUSEHOLDS: FUNCTIONAL AND PROVIDER CLASSIFICATION

127. As stated earlier, the absolute level of expenditure for the NPISH comes from input output framework - Non market human health services as products, and NPISH as industries. We do not count on comprehensive surveys to face the distribution of the NA expenditure data.

128. As direct source we just have the hospital statistics – ESCRI – which gives us the expenditure of non-profit hospitals. But these figures must be refined since an important number of those hospitals do not match with the definition of non profit institution according to the 50% criterion. As stated at SEC95, if the NPI - or a local kind-of-activity unit - sales cover more than 50% of the production costs, they must be regarded as market producers.

129. ESCRI provided us with the necessary information– sales and expenditures – according to the four kinds of hospitals already mentioned; therefore it has been possible to estimate the expenditure of NPI hospitals that should be included as expenditure due to non market producers.

130. For the rest of the expenditure of non profit institutions, the information and data necessary to allocate it to the different functions and providers comes from the study of the memoranda of a few of the most important NPISH – Red Cross and Cáritas Española between the most significant. We have also resorted to expert opinions and meetings with sector representatives, which provided us with some indicators.

10. COMMENTS ON "GUIDELINES FOR IMPROVING THE COMPARABILITY AND AVAILABILITY OF PRIVATE HEALTH EXPENDITURE"

- From a formal point of view we found the structure of the guidelines very friendly, and it is easy to get information about a particular subject.

- From a technical point of view, we agree that is necessary to achieve a better consistency and comparability in private expenditure estimates. These guidelines become a good starting point to check and improve the different approaches each country employs in their estimations of private expenditure.

- When writing our paper about the methodology used in our estimates it has been very useful to contrast our methods with the different options the guidelines set out.

- As our methodology rest on National Account figures, as first step to estimate the absolute expenditure level, we feel somehow ashamed since all the guidelines mark as C methods almost every attempt of estimating through that source.

- The NA basis as way of estimating private HC in Spain, has been kept since the middle of the nineties, what offer a coherent long time series that has somehow configured the image we have about de Spanish Health Care System.

- The point is that there are, at least, two different kind of national institutions involved in the task of estimating health care expenditure: National Institutes of Statistics and Health Administration bodies. The resources, the sources, the expert background and their experience and, finally, the degree of concern are quite different.

- There is in Spain a legal commandment for the Ministry of Health, the Autonomous Communities and other health administration bodies, to produce Health Accounts on public expenditure that includes a clear structure of classifications and agents. This statistic operation is regularly contemplated in the four-year National Statistics Plan and it is yearly regulated in its annual application plan. There is no prevision at all about estimating the private expenditure. So, it could be not easy for the Institutions involved, to assign resources, both personal and monetary ones, intended to calculate what the NA experts have already done when estimating final households' consumption expenditure.

- Without doubt, the detail level SHA requires is far from the desegregation of macroeconomics NA data; and it is there where health accounts experts could go deeper into the functions and providers classifications by using health surveys, documents and their own knowledge as well as or all other information they could get, about the health care sector management.

- We completely agree with the introduction point three regarding the problem of comparability between countries due to the omission of some elements of private expenditure owing to a lack of appropriate data or methods.

- It is not possible to complete for the private expenditure the demanding SHA manual classifications with methods and estimates as good as public expenditure one. Therefore, the table functions-providers, as addition of the both financing schemes could entails, at some desegregation levels, misleading figures.

- It seems necessary to draw a desegregation level at which private expenditure estimates becomes reliable. At this level the consolidation of both financing schemes will lead to consistent expenditure figures. And as far as public estimate is concerned the wider provider- functions and modes of production breakdowns can be kept.

- We found that it would be necessary to lay emphasis on the health benefits of traffic and other accident insurance. It is not clearly mentioned either in the Manual or in the guidelines.

- It would be interesting to mention the different borders of Household's Budget surveys and final household consumption, and the possible expenditure included in the last one, that do not match with the SHA financing scheme.