Health care expenditure

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2 Metadata update	
2.1 Date of last update	19.09.2023

3 Statistical presentation

3.1 Data description

Health care expenditure quantifies the economic resources dedicated to health functions, excluding capital investment. Healthcare expenditure concerns itself primarily with healthcare goods and services that are consumed by resident units, irrespective of where that consumption takes place (it may be in the rest of the world) or who is paying for it. As such, exports of healthcare goods and services (to nonresident units) are excluded, whereas imports of healthcare goods and services for final use are included.
Health care expenditure data provide information on expenditure in the functionally defined area of health distinct by provider category (e.g. hospitals, general practitioners), function category (e.g. services
of curative care, rehabilitative care, clinical laboratory, patient transport, prescribed medicines) and financing scheme (e.g. social security, private insurance company, household). For the collection of the data on health care expenditure the System of Health Accounts (SHA) and its related set of International Classification for the Health Accounts (ICHA) is used.
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.
The System of Health Accounts - SHA 2011 is a statistical reference manual giving a comprehensive description of the financial flows in health care.
It provides a set of revised classifications of health care functions, providers of health care goods and services and financing schemes.
The SHA is currently used as a basis for a joint data collection by OECD, Eurostat and WHO on health care expenditure. 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.

3.2 Classification system

Healthcare expenditure is recorded in relation to the international classification for health accounts (ICHA) defining:
• healthcare expenditure by financing schemes (ICHA-HF) — which classifies the types of financing arrangements through which people obtain health services; health care financing schemes include direct payments by households for services and goods and third-party financing arrangements;
• healthcare expenditure by function (ICHA-HC) — which details the split in healthcare expenditure following the purpose of healthcare activities — such as, curative care, rehabilitative care, long-term care, or preventive care;
• healthcare expenditure by provider (ICHA-HP) — which classifies units contributing to the provision of healthcare goods and services — such as hospitals, residential facilities, ambulatory health care services, ancillary services or retailers of medical goods.

3.3 Sector coverage

1. Household individual consumption on health, including the collective consumption with two exceptions:
i. Occupational health care (intermediate consumption within establishments) minus an estimated share of occupational health in health providers' and other medical industries net administration;
ii."Remunerated" unpaid household production in the form of transfer payments (social benefits in cash) for home care of sick, disabled and elderly persons provided by family members. SHA 2011 Manual recommends following the standard System of National Account (SNA) rules for drawing the production boundary of health care services, albeit with two notable exceptions:
- Occupational health care is included in the national totals of health care spending. In SNA, this item is recorded as ancillary services and part of intermediate production of enterprises and
- Part of the cash transfers to private households for care givers of home care for the sick and disabled are treated as the paid household production of health care.
2. Health care financing schemes: HF1 Government schemes and compulsory contributory health care financing schemes; HF2 -voluntary health care payment schemes;
HF3 - Household out-of-pocket payment; HF4 - rest of the world financing schemes.
3. NACE rev. 2, section Q, human health and social work activities.

3.4 Statistical concepts and definitions

SHA concept is the consumption of health care goods and services.
Health care statistics describe the process of providing and financing health care in countries by referring to health care goods and services, its providers and financing. For the collection of the data on health
care expenditure the System of Health Accounts (SHA) and its related set of International Classification for the Health Accounts (ICHA) is used. 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).
Data are presented in 3 summary (one-dimensional) tables and 3 cross-classification tables (2-dimensional tables).
Summary tables provide data on:
• Current expenditure by provider (ICHA-HP)
• Current expenditure by function (ICHA-HC)

• Current expenditure by financing scheme (ICHA-HF)
Cross-classification tables refer to:
• HC x HP: Health care expenditure by function and provider: data on which type of health care goods and services are supplied by which health care provider;
• HC x HF: Health care expenditure by function and by financing scheme: data on how are the different types of services and goods financed;
• HP x HF: Health care expenditure by provider and by financing scheme: data on from which health care provider and under which particular financing scheme are the services and goods purchased.
The classifications and definitions presented in the SHA 2011 manual are to be followed. Additional guidelines and material useful for compilers are also available at this address.

3.5 Statistical unit

Commission Regulation 2021/1901 concerns the collection of data on "current expenditure on healthcare" which is defined as the "final consumption expenditure of resident units on health care goods and services".
There is a very close relationship between the concept of "final consumption expenditure" as defined in the System of Health Accounts (SHA) and in National Account and, as a consequence, also between the underlying economic transactions as recorded in the two accounting frameworks.
In National Accounts there are two types of statistical units: institutional units and local kind-of-activity units (KAU). A local KAU groups all the parts of an institutional unit in its capacity as producer which are located in a single site. A local KAU belongs to one and only one institutional unit.
SHA uses the same two types of units for data compilation.
Local KAUs operating as providers of healthcare goods and services to resident units are statistical units in SHA.
Also transactions by institutional units are recorded in SHA, in which framework institutional units are also referred to as "financing agents". More precisely, SHA financing agents are institutional units that manage one or more financing schemes. The transactions are executed by the financing agents, according to the rules of the financing schemes.
Financing agents serve as key statistical units in producing national health accounts. While financing schemes are the key units for analysing how the consumption of health care goods and services is financed, the data concerning the relevant transactions are collected either from the financing agents that operate the different financing schemes or from the providers.
The concept of "healthcare financing schemes" in SHA is an application and extension of the concept of "social protection schemes" defined by the European System of Social PROtection Statistics (ESSPROS): "a distinct body of rules, supported by one or more institutional units, governing the provision of social protection benefits and their financing ...". The social protection scheme is the statistical unit in ESSPROS. It is an analytical unit that allows describing the complete structure of the social protection financing system: expenditure and receipts.
According to SHA Manual 2011, "the key concepts for describing the structure of the health care financing system are based on measuring: (a) the expenditure of health care financing schemes, under which goods and services are purchased directly from health care providers, on the one hand, and (b) the types of revenues of health care financing schemes, on the other hand.
Commission Regulation 2021/1901 limits its scope to the collection of data on the expenditure of health care financing schemes.

3.6 Statistical population

SHA focuses on the consumption of health care goods and services by the resident population irrespective of where this takes place. This implies the inclusion of imports (from non-resident providers) and the exclusion of exports (health care goods and services provided to non-residents).

3.7 Reference area

The data aims at providing a complete overview of expenditure on health care goods and services consumption of services and goods by the resident population on the national territory of the Slovak Republic.

3.8 Time coverage

1997 - 2020

3.9 Base period

Not applicable.

4 Unit of measure

Data are expressed in million euro.

5 Reference period

Health expenditure and financing data pertain to the calendar year (1 January to 31 December).

6 Institutional mandate

6.1 Legal acts and other agreements

At international level:
Health care expenditure are compiled in accordance with the methodology of the System of Health Accounts (SHA 2011) and on the basis of the current Commission Regulation (EU) 2021/1901 of 29 October 2021 implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council as regards statistics on health care expenditures and financing.
At national level:
The Act on State Statistics of the National Council of the Slovak Republic no. 540/2001 regulates the conditions for obtaining statistical information needed to assess socio-economic development, the position and competence of bodies performing state statistics, the role of public authorities in the field of state statistics, rights and obligations of reporting units, protection of confidential statistical data from misuse, provision and publication of statistical data, ensuring comparability of statistical information and fulfilment of agreements in the field of state statistics, by which is the Slovak Republic bound. Statistical surveys are governed by the Decree of the Program of Statistical surveys for a three-year period, which is compiled by the SO SR in cooperation with ministries and state organizations. The program contains a description and scope of surveys, including surveys carried out by other central authorities and ministries. Basic information on the compilation of the program of state statistical surveys for the relevant year, the number of conducted surveys in the relevant year and the evaluation of the administrative burden of

respondents are contained in the annual reports on the implementation of the program of state statistical surveys.

6.2 Data sharing

Data are collected through the joint health accounts questionnaire (JHAQ) that countries submit to Eurostat during the annual data collection exercise. The joint health accounts questionnaire (JHAQ) is coordinated in agreement with the World Health Organisation (WHO) and the Organization of Economic Co-operation and Development (OECD).
Health care expenditure are compiled in accordance with the methodology of the System of Health Accounts (SHA 2011) and on the basis of the current Commission Regulation (EU) 2021/1901 of 29 October 2021 implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council as regards statistics on health care expenditures and financing.
The published data are used to compare healthcare expenditures not only within the European Union, but also in OECD and WHO countries.

7 Confidentiality

7.1 Confidentiality - policy

Regulation (EC) No 223/2009 on European Statistics (recital 24 and article 20 (4) of 11 March 2009 OJ EC L 87, page 164) establishes a need to set common principles and guidelines to ensure the confidentiality of used data for the production of European statistics, and it provides access to such confidential data with due account for technical development and the requirements of users in a democratic society. The European Statistics Code of Practice provides additional conditions that statistical offices must comply with in the field of protection of confidential statistical data (Principle 5).
The SO SR is responsible for the protection of confidential data obtained and guarantees their use exclusively for statistical purposes. In accordance with the Act on State Statistics no. 54/2001 Coll. §2g and §30, the SO SR may not publish confidential statistical data, but only information that has been created by summarizing confidential data, which does not allow direct or indirect identification of the reporting unit.
The Directive on the Protection of Confidential Statistical Data at the Statistical Office of the Slovak Republic (No. SME-1/2015) is available on the internal website of the SO SR, which regulates specific methods and parameter values used in protecting confidential statistical data of individual statistical surveys.

7.2 Confidentiality - data treatment

Confidential statistical data is defined as data relating to an individual statistical unit, which enables direct or indirect identification and was obtained for statistical purposes according to the law. The SO SR provides or publishes statistical data and information without direct identifiers in such a form that the data provided by the applicant cannot be directly or indirectly identified in them, this means it applies active protection for all reporting units.
In ensuring the protection of confidential statistical data in tables with aggregated data, the SO SR applies in all cases the rule of the minimum frequency for n=3, that means each cell of the table must contain an aggregation of data for at least 3 reporting units.

8 Release policy

8.1 Release calendar

Not applicable.

8.2 Release calendar access

Not applicable.

8.3 User access

Confidential statistical data is defined as data relating to an individual statistical unit, which enables direct or indirect identification and was obtained for statistical purposes according to the law. The SO SR provides or publishes statistical data and information without direct identifiers in such a form that the data provided by the applicant cannot be directly or indirectly identified in them, this means it applies active protection for all reporting units.
In ensuring the protection of confidential statistical data in tables with aggregated data, the SO SR applies in all cases the rule of the minimum frequency for n=3, that means each cell of the table must contain an aggregation of data for at least 3 reporting units.

9 Frequency of dissemination

Data are published annually.

10 Accessibility and clarity

10.1 News release

Not applicable.

10.2 Publications

SHA data are published of the Statistical office of the Slovak Republic's yearly publication "Statistical Yearbook of the Slovak Republic".

10.3 On-line database

Data are published as open data and are accessible on the Statistical office of the Slovak Republic ´s website - the three core tables:

- Expenditure on health care by health care providers and functions of care;
- Expenditure on health care by financing schemes and functions of care;
- Expenditure on health care by financing schemes and health care providers:

Data can also be obtained at the health-databases of OECD, EUROSTAT and WHO.

10.4 Micro-data access

Not available.

10.5 Other

All data available in the DataCube database are provided free of charge and are not subject to any registration. In addition, the data are also available via the STATdat database, which contains reports (tables) of data from the DataCube database that can then be exported to various data formats.

10.6 Documentation on methodology

Health care expenditure are compiled in accordance with the methodology of the System of Health Accounts (SHA 2011).

10.7 Quality documentation

The Statistical Office of the Slovak Republic is holder of certificate that confirms that the office meets the requirements of the international standard ISO 9001:2015 in organizing, obtaining, processing and providing official statistics according to applicable standards. At the same time, it provides evidence that the established quality management system creates suitable conditions for further improving the quality of services provided to users and develops the office towards greater efficiency.
A quality report is drawn up based on Eurostat's quality requirements. The main parts of the report are focused on relevance, accuracy and reliability, topicality and timeliness, accessibility and comprehensibility, comparability and coherence.

11 Quality management

11.1 Quality assurance

Authorities responsible for SHA data collection are working to ensure that the statistical practices used to compile national health accounts are in compliance with SHA methodological requirements and that good practices in the field are being followed, according to the methodology underlined in the SHA 2011 Manual and European Statistics Code of Practice respecting professional independence of the statistical authorities. Procedures are in place to plan and monitor the quality of the health care expenditure statistical production process.

11.2 Quality assessment

The quality of SHA figures from Statistical office of the Slovak Republic can be considered to be quite high.

12 Relevance

12.1 User needs

Data of the health care expenditure has a significant impact on policy makers, academic research and media.
Main groups of users:

- Eurostat, European Council, European Parliament and other european insitutions,
- International organisations - OECD, WHO etc.
- Ministry of Health of the Slovak Republic,
- Ministry of Finance of the Slovak Republic,
- Research institutions use SHA data for research projects and studies,
- Students
- and general public, including media like newspapers, magazines, independent journalists.

12.2 User satisfaction

Feedback from main users is incorporated in the compilation of SHA figures if feasible and possible.

12.3 Completeness

Regarding the Commission Regulation, the data is almost complete.

13 Accuracy and reliability

13.1 Overall accuracy

Overall accuracy of the Slovak Republic SHA data can be considered to be quite good.
Brief description of sources is outlined under 18.1. Source data.

13.2 Sampling error

Not relevant for SHA indicators.

13.3 Non-sampling error

Not relevant for SHA indicators.

14 Timeliness and punctuality

14.1 Timeliness

Member States are required to transmit their data to Eurostat in compliance with the Commission Regulation 2021/1901 transmission deadlines.
Data and reference metadata for the reference year T should be transmitted to Eurostat by 30 April T+2.

14.2 Punctuality

Usually, all required data (data and metadata) are submitted on time via eDamis.

15 Coherence and comparability

15.1 Comparability - geographical

Not applicable at national level.

15.2 Comparability - over time

Breaks in time series result from methodological changes.

15.3 Coherence - cross domain

SHA and ESSPROS are based on different underlying concepts. SHA is based on final consumption whereas ESSPROS is based related LTC and takes into account also the social aspects of LTC. A full coherence between these different approaches for Slovakia is not and therefore data cannot be mapped from one approach to the other.

15.4 Coherence - internal

The data are internally consistent.

16 Cost and burden

Not relevant for SHA indicators.

17 Data revision

17.1 Data revision - policy

The revision policy is an important tool for improving the quality of statistical data. It provides the basic rules and general procedures applied in revisions in the SO SR.
For the purposes of this regulation, any change in the statistical value of data stored in the relevant databases and/or published on the website is considered a revision of statistical data.
The reasons for the revisions are changes in current legislation, adjustment of methodological definitions and procedures, revisions of classifications and code lists, implementation of new statisticalmathematical methods, availability of more accurate data as well as the errors in the sources and calculated data. The aim of the revisions is to achieve or maintain consistency in the content of statistical data.
The basic rules and general procedures applied in revisions at the SO SR are regulated by the SME-1/2020 Directive – Revision Policy of the Statistical Office of the Slovak Republic and the revision calendar of the SO SR (updated every year).
Published data can have the following levels of quality:

- **Flash estimate** – estimation of the relevant indicator on the basis of available current information, or extrapolation of development trends,
- **Adjusted estimate** – data that is obtained on the basis of the results of short-term statistical surveys and the use of available administrative data sources,
- **Preliminary data** – data that is compiled from verified and revised sources used to compile the adjusted estimate or data available at the date of the first publication. It can be compiled in a smaller range of indicators,
- **Semi-definitive data** – data revised on the basis of updated statistical surveys or available long-term surveys and administrative sources, as well as additional information,
- **Definitive data** – data that is compiled from verified and revised statistical surveys, administrative sources and data obtained on the basis of specified statistical – mathematical methods and other additional information. The definitive data changes only in the case of special revisions, otherwise these data are unchanged.

In terms of content, the reason for revision is considered to be:

- Incorporation of better quality data on the basis of a more complete source,
- Clarification of data due to the update of seasonal factors and changes in the reference period,
- Specification based on updated methodology (in concepts, definitions and classifications) and changes in statistical methods,
- Corrections in source data and calculations.

In terms of time schedule, revisions can be divided into these types:

- **Routine revisions** are the revisions without major methodological changes. These are usually major data corrections, including data obtained from new sources. They are carried out periodically at precisely defined dates, due to the updating of monthly and quarterly data, until the next publication of the data,

- **Annual revisions** are revisions that are made when all monthly, quarterly data are available and more detailed results from annual surveys are already available,
- **Special and major revisions** are revisions of definitive data due to significant methodological changes resulting from the revision of methodologies, from changes in the procedures of statistical – mathematical methods of calculation or corrections of data. Special revision may result (e.g. by changing the definition) in disruption of time comparability of the data.

17.2 Data revision - practice

The general revision policy of the health care expenditure:
We revise data - for relevant reasons:
- the changes of the methodology for calculation;
- the changes of the sources for data;
- the changes in our accounting practice etc.

18 Statistical processing

18.1 Source data

Health care expenditure are aggregated data compiled according to the SHA 2011 methodology, based on a combination of several data sources – statistical surveys, administrative data sources as well as alternative data sources.

18.2 Frequency of data collection

Annual.

18.3 Data collection

Data are collected through the joint health accounts questionnaire (JHAQ) that countries submit to Eurostat during the annual data collection exercise. There is a voluntary deadline to send the JHAQ questionnaire for the calendar year T by the 31st of March T+2. The joint health accounts questionnaire (JHAQ) is coordinated in agreement with the World Health Organisation (WHO) and the Organization of Economic Co-operation and Development (OECD). These three international organisations are known collectively as the International Health Accounts Team (IHAT). Countries submit data to Eurostat on the basis of Commission Regulation (EU) 2021/1901 of 29 October 2021 implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council as regards statistics on healthcare expenditure and financing.

18.4 Data validation

The
The 2019 JHAQ includes a number of features which allow national data correspondents to perform various quality checks before submitting the data. The embedded programmes allow the verification of:
1- Consistency of the data between tables, This step checks if the marginal totals reported in each table of the JHAQ are consistent across all tables. For example, for each function (HC), the total across all financing schemes (HF) in the HCxHF table has to be equal to the total across all providers (HP) in the HCxHP table, i.e. the values in the column “All HF” in the HCxHF table have to be equal to the values in the column “All HP” in the HCxHP table. Any detected differences are flagged up in the corresponding row or column in the relevant tables and all inconsistencies are

listed in the “Report” worksheet by variable code together with the amount by which the respective variable differs between the two compared tables. A positive value indicates that the first listed table has a higher value for the same variable, and vice versa.
2- Consistency of the data within tables,
Any detected inconsistencies are listed by variable code together with an indication of which total is not equal to the sum of its subcomponents as well as the numerical difference. A positive figure indicates that the total is greater than the reported sub-components, and vice versa.
- The presence of negative values,
Entries in the tables cannot be negative as they refer to the consumption of goods and services. If an individual data table is checked for internal consistency, the negative values check is performed for the relevant table and then any negative values are highlighted red and crossed out.
- The presence of atypical entries,
The atypical entries check provides information whether the data tables contain values in cells which are – if at all – only reported by very few countries and are thus atypical for health accounting. If an individual data table is checked for internal consistency, the atypical entries check is performed for the relevant table. In the data tables, any cell containing an atypical entry will be highlighted for national data providers. Should any atypical entries be identified, compilers should scrutinize in detail the transactions that led to entries in those cells and assess whether the accounting rules of SHA have been correctly applied. If they come to the conclusion that the transactions are recorded in the correct categories of the ICHA classifications, then the corresponding atypical entries represent unique – and correctly accounted for – features of the country’s health system. In this case a short description of the nature of the transactions should be included in the accompanying Metadata file under “II.3. Atypical entries”. If, on the other hand, compilers come to the conclusion that the transactions are not recorded correctly, then they need to make adjustments in the concerned tables. In case the transactions recorded in a cell do not belong to the boundaries of SHA (e.g. they refer to intermediate consumption) the value of the respective cell should be deleted (and all cells that are affected by this change adjusted accordingly). In case the transactions are misreported and another category of the ICHA classification is more appropriate, the value of the cell should be transferred to the correct cell of the table.
3- The growth rates against the previous year and the magnitude of revisions as compared to previously submitted data. Results are grouped into three different categories:
- Breaks in series (the current questionnaire shows no data for an item that is not null in the other file)
- Newly reported (the current questionnaire contains data for an item that is empty in the other file)

- Differences (all other types of differences)
The questionnaire JHAQ includes a number of features which allow national data correspondents to perform various quality checks before submitting the data.
The embedded programmes allow the verification of:
1- **Consistency of the data between tables**, This step checks if the marginal totals reported in each table of the JHAQ are consistent across all tables. For example, for each function (HC), the total across all financing schemes (HF) in the HCxHF table has to be equal to the total across all providers (HP) in the HCxHP table, i.e. the values in the column “All HF” in the HCxHF table have to be equal to the values in the column “All HP” in the HCxHP table. Any detected differences are flagged up in the corresponding row or column in the relevant tables and all inconsistencies are listed in the “Report” worksheet by variable code together with the amount by which the respective variable differs between the two compared tables. A positive value indicates that the first listed table has a higher value for the same variable, and vice versa.
2- **Consistency of the data within tables**,

Any detected inconsistencies are listed by variable code together with an indication of which total is not equal to the sum of its subcomponents as well as the numerical difference. A positive figure indicates that the total is greater than the reported sub-components, and vice versa.
- *The presence of negative values*,
Entries in the tables cannot be negative as they refer to the consumption of goods and services. If an individual data table is checked for internal consistency, the negative values check is performed for the relevant table and then any negative values are highlighted red and crossed out.
- *The presence of atypical entries*,
The atypical entries check provides information whether the data tables contain values in cells which are – if at all – only reported by very few countries and are thus atypical for health accounting. If an individual data table is checked for internal consistency, the atypical entries check is performed for the relevant table. In the data tables, any cell containing an atypical entry will be highlighted for national data providers. Should any atypical entries be identified, compilers should scrutinize in detail the transactions that led to entries in those cells and assess whether the accounting rules of SHA have been correctly applied. If they come to the conclusion that the transactions are recorded in the correct categories of the ICHA classifications, then the corresponding atypical entries represent unique – and correctly accounted for – features of the country's health system. In this case a short description of the nature of the transactions should be included in the accompanying Metadata file under "II.3. Atypical entries". If, on the other hand, compilers come to the conclusion that the transactions are not recorded correctly, then they need to make adjustments in the concerned tables. In case the transactions recorded in a cell do not belong to the boundaries of SHA (e.g. they refer to intermediate consumption) the value of the respective cell should be deleted (and all cells that are affected by this change adjusted accordingly). In case the transactions are misreported and another category of the ICHA classification is more appropriate, the value of the cell should be transferred to the correct cell of the table.
3- **The growth rates against the previous year and the magnitude of revisions as compared to previously submitted data**. Results are grouped into three different categories:
- *Breaks in series* (the current questionnaire shows no data for an item that is not null in the other file)
- *Newly reported* (the current questionnaire contains data for an item that is empty in the other file)

- *Differences* (all other types of differences)

18.5 Data compilation

Several methods are normally used for estimations:
- **Balancing item/Residual method**: For example, if data are available from the financing side, which permit accurate estimation of the flows to a provider or function, then an acceptable estimation method is to subtract these expenditure flows from the total revenues, and derive the expenditure flows from the unmeasured financing scheme as a residual.
- **Pro-rating/Utilisation key**: Typically in the absence of direct spending data, a utilisation key linked to the proportion of resources used can be constructed in order to distribute e.g. aggregate provider spending across functions. For every key a fraction of total utilisation within the cost-unit is assigned: fractions in the key must add up to 100% of all care delivered by the cost-unit. Examples of utilisation keys are admissions, bed-days, contacts, staffing, etc.
- **Interpolation/Extrapolation**: In the absence of data for the period in question, missing values can be estimated using known data points.
- **Other**.

18.6 Adjustment

Not relevant for this domain.

19 Comment