# Accounting guidelines for COVID-19 related activities under the 2021 joint OECD, EUROSTAT and WHO health accounts (SHA 2011) data collection

# 1. Introduction

The Joint Health Accounts Questionnaire (JHAQ) data collection has been developed by Eurostat, the OECD and WHO to collect data on health care expenditure and financing. The JHAQ is based on the methodology of a System of Health Accounts 2011 (SHA 2011)[1].

Following the COVID-19 pandemic, the need for a full picture of the impact of the COVID-19 crisis on total health expenditures and of the spending implications of COVID-19 on the health sector has been expressed.

The guidance provided in this document is a help in the classification of the related COVID-19 expenditures with the aim to identify all health expenses incurred by the COVID-19 crisis and to ensure to the maximum extent possible a harmonised approach across EU Member States and countries participating to the Joint Health Accounts data collection.

# 2. Accounting guidelines for the JHAQ for COVID-19 related activities

- While the COVID-19 pandemic may have a significant impact on health spending in 2020, the pandemic does not change the fundamental accounting principles on which the *System of Health Accounts 2011* (SHA 2011) is based. The key principles for a spending item or activity to be considered under *Current Health Expenditure (CHE)* are:[2]
    - The primary intent of the activity is to improve, maintain or prevent the deterioration of the health status of the individuals, groups of the population or the population as a whole as well as to mitigate the consequence of ill health;
    - Qualified medical or health care knowledge and skills are needed in carrying out this function, or it can be executed under the supervision of those with such knowledge, or the function is governance and health system administration and its financing;
    - The consumption is for the final use of health care goods and services of residents;
    - There is a transaction of health care goods and services.
- COVID-19 is one of many health conditions that health systems treated in 2020. Nevertheless, given the importance of tackling the pandemic and ensuring comprehensive and internationally comparable health spending data, some accounting guidelines for the most frequent activities and transactions related to the pandemic are considered useful.
- When examining COVID-19 emergency budgets, a lot of the spending in the area of health (e.g. the purchase of ventilators and ICU beds, grants for R&D into vaccine

[1] OECD, Eurostat and World Health Organization (2017), A System of Health Accounts 2011: Revised edition: https://ec.europa.eu/eurostat/documents/3859598/7985806/KS-05-19-103-EN-N.pdf/60aa44b0-2738-4c4d-be4b-48b6590be1b0

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

research) does not meet the criterion of final consumption of health care goods and services and therefore falls outside of “current health expenditure”. As such, the SHA framework does not measure the *total* resources mobilised in a country to fight the pandemic or the total costs of the pandemic response. However, it can play an important role to better understand the impact of COVID-19 on health systems and contribute to a better measurement of overall pandemic response costs. Chapter 3 introduces some special COVID-19 reporting items that allow for an identification of some of these response costs.

## Guidelines

- Table 1.1 discusses activities related to the COVID-19 pandemic response, giving recommendations as to how these should best be accounted within the SHA 2011 framework. The list is not exhaustive and compilers are invited to draw on these guidelines to treat related activities in a consistent way. Like any other disease, activities to treat and prevent COVID-19 are allocated across different health care functions if they qualify as current health expenditure (according to the principles set out above). If they do not, they may be considered as investments (to be recorded in the capital account table).

- The recommendations follow Chapter 5 of the SHA 2011 Manual but also draw on the “Supplementary guidelines” for how to account for preventive activities.[3] A number of boundary issues are apparent. This particularly concerns some preventive activities where determining whether health or another domain, such as employment or public safety, is the primary purpose. Some specific areas are discussed further:

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

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

- Spending on **compliance with COVID-19 public health and safety regulations.** In general, enterprise spending on *compliance* with safety at work regulations are not

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

included under HC.6.[4] It is proposed that costs for work place adaptations (e.g. installation of plexi-glass screens, floor markings, etc.) to ensure COVID-19 compliant working conditions are not included under current health expenditure. Expenditure for facemasks might also be interpreted as compliance costs since many countries have introduced obligations to wear masks in the work place but they should be considered as occupational health care in SHA. In line with the guidance above, it is recommended that the costs are included only if the masks fulfil the criteria to be considered as a health product. The same goes for the accounting of costs for hand sanitizers.

- Related to the above are the **costs of businesses who** might provide facemasks and hand sanitizers to their **clients**. It is recommended to exclude these costs from current health expenditure for two reasons. First, it can be argued that the health motive of these initiatives are secondary only as a means to be able generate business – the main motivation. Secondly, expenses for these services are not for final use but are considered intermediate consumption in the production for non-health output. The one exemption described in SHA where intermediate consumption should be included under CHE only refers to employers (when providing occupational health care for their staff) but not to businesses.[5]

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

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

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

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

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

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

***of health systems, the accounting recommendations for HP in Table 4.1 are only indicative***.

- In a number of countries, **transfers from government to health providers** (mainly private) have been made to compensate for lost revenues. Since current health expenditure measures the final consumption of health care goods and services, such income support measures are excluded. The exception is when transfers can be considered as subsidies. This is the case, for example, when hospitals receive payments to keep treatment capacity available for COVID-19 patients and have to postpone elective activity for this purpose. This is considered as a ‘subsidy on production’ and included under current health expenditure. Financial transfers to health providers with the purpose to replace foregone income (due to lower utilisation) are not subsidies but income support.

**Table 1.1. Summary of SHA accounting recommendations for COVID-19 related activity**

| | Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|---|
| Public health/Admin functions | Dissemination of information on COVID-19 of how to change health behaviour to minimise the risk of infection via different media outlets | HC61<br>HP6 | HC.COV.5 | Clear purpose is information and education about health risk |
| | Production and dissemination of daily updates of data on tests, positive cases, hospitalization rates, mortality, etc.<br>Risk analysis and epidemiological operative investigation. | HC65<br>HP6 | HC.COV.5 | Key function of epidemiological surveillance |
| | Emergency response (preparation and coordination); creation of multi-agency emergency task forces discussing and a wide range of policy option and planning policy response | HC66<br>HP6/HP7 | HC.COV.5 | |
| | Legislative changes pertaining to public health and health care organization related to COVID-19 | HC71<br>HP7 | HC.COV.5 | Key function of health administration and governance (could be HC72 if related to health financing) |
| | Specific training of human resources related to COVID-19 (prevention, intensive care, etc.) | Intermediate consumption (for HC11, HC13, HC6 etc.<br>HP1, HP3 etc). | HC.COV.1; HC.COV.2; HC.COV.3, etc | (intermediate consumption, only accounted in costs for services provided at a price not economically significant) HC according to the purpose of the training |
| | Enforcement costs of lock-down/social distancing/mask wearing regulation; costs of police and other staff to monitor lock-down, check exemptions and issue fines | Outside Current Health Expenditure (CHE) | | In line with the guidelines on accounting for preventive care[7] enforcement costs are outside of the core SHA framework if implemented by non-health staff; also practical considerations |

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

| | Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|---|
| | Costs associated with quarantining suspected cases outside of their home. This can include costs for lodging, food and travel | HC6 or outside CHE or HK<br>Maybe HP82 if HC6 | HC.COV.1; HC.COV.2 or outside | Depends. For dedicated quarantine centres with health staff and medical observation -HC.6 .Investment costs for converting structures into quarantine centres –HK. Lodging costs in hotels without health staff should be considered as enforcement costs of social distancing regulation – outside CHE. Any incidental health service of testing HC1 and HC6. |
| Testing | PCR and other molecular diagnostic tests (to detect acute Sars-Cov-2 infection) in ambulatory setting as part of outpatient contact for patients with symptoms | HC13<br>HP3 (other HP possible) | HC.COV.2 | Part of a curative treatment; HC63 is to be used for people before symptoms appear; HC41 requires independent contact |
| | PCR and other molecular diagnostic tests in hospital or LTC facility for inpatients with COVID-19 symptoms | HC11<br>HP1, HP2 | HC.COV.2 | Part of treatment episode |
| | Systematic PCR tests (or other molecular diagnostic tests) in hospital or LTC facility for patients without COVID-19 symptoms | HC63<br>Different HP | HC.COV.2 | This should be considered as early disease detection if costs can be identified separately. HC63 typically requires the definition of a population group at risk – in the case of COVID-19 the argument can be made that nearly everyone is at risk. |
| | Systematic PCR tests (or other molecular diagnostic tests) in other setting (car park, airport etc.) carried out by public health authorities (generally for people without symptoms) | HC63<br>HP6 or HP82 (or other) | HC.COV.2 | Early disease detection; tests will typically be carried out by trained staff from public health offices so HP6 is most appropriate provider, but HP82 may also be justified in some instances. |
| | Systematic PCR test (or other molecular diagnostic tests) of employees (health staff or other) | HC63<br>HP depending on who carries out testing (HP6 if public health office; HP1-HP5 if health facility); HP82 for antigen test for non-health providers also possible | HC.COV.2 | This is part of occupational health care. Typically occupational health care is under HC64 but since it is disease-specific it should go under HC63 |
| | PCR test (or other molecular diagnostic tests) in laboratories (as independent contact) if part of programme (for patients without symptoms) | HC63<br>HP4 | HC.COV.2 | Part of a programme; if this test series is part of a study (with a more limited number of participants) to better understand the infection rates it could go under HC65 |
| | PCR test (or other molecular diagnostic tests) in laboratories (as independent contact) based on own initiative (without programme covering costs) – e.g. used as attestations to travel | HC41 (HC63)<br>HP4 | HC.COV.2 | According to the Manual should be HC41 as this is not part of a systematic programme, and purpose may be difficult to establish. May be difficult to distinguish from HC63. |

| | Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|---|
| | Serological test (to detect possible immunity) if part of systematic programme to assess evolution of pandemic | HC65<br>HP4, additional non-health providers possible if involved in organisation of serological tests (HP82) | HC.COV.2 | Part of epidemiological studies |
| | Serological test based on own initiative | HC41 (HC65) | HC.COV.2 | Not part of programme, so HC41 may be most appropriate but may be difficult to distinguish from HC65. |
| | Point of entry screening – temperature control at borders | HC63<br>HP6 or HP82 (if e.g. done by border police | HC.COV.5 | The purpose is early disease detection (although this particular activity is not mentioned in the Manual) |
| Tracing | Costs of developing tracer application for mobile phones | Capital Account | HK.COV.1 | Not final consumption of health care |
| | Costs of tracing the contacts of infected cases (mainly staff costs) - typically part of local public health office but could also be done by other (non-health) authorities or outsourced to private companies | HC65<br>HP6, HP7, HP82 (and maybe other) | HC.COV.2 | This is part of epidemiological surveillance. Countries use a wide range of providers since public health offices have been frequently overwhelmed with this task. |
| Treatment | Teleconsultations with GP for patients with COVID-19 symptoms | HC131<br>HP3 | HC.COV.1 | Outpatient care and not home-based care |
| | Physical consultation with GP for patients with COVID-19 symptoms | HC131<br>HP3 | HC.COV.1 | No difference in accounting to patients with other diseases |
| | Hospital treatment for severe COVID-19 cases | HC11<br>HP1 | HC.COV.1 | No difference in accounting to patients with other diseases |
| | Treatment of COVID-19 cases in LTC nursing home | HC11<br>HP2 (can also involve HP3 for visiting doctors) | HC.COV.1 | COVID-19 is not related to LTC dependency so it should be accounted for as HC11 if possible |
| | Home-based care for patients with COVID-19 symptoms | HC14<br>HP3 | HC.COV.1 | Only when there is physical presence of health staff in patient's home |
| | Patient transportation for severe COVID-19 cases | HC43<br>HP4 | HC.COV.1 | No difference in accounting to patients with other diseases |
| | Medication | HC51<br>HP5 | HC.COV.4 | If provided outside of hospitals or other institutional setting. HC11 if part of inpatient curative treatment |
| | Treatment of sequelae of COVID-19 after patient's remission (fibrosis, heart diseases, kidney diseases) | HC1 / HC2/ HC3<br>Many different HP possible | HC.COV.1 | No difference in accounting to patients with other diseases |
| Protective equipment | Government purchase to stock certified medical face masks, visors, and other personal protective equipment to build up strategic reserve | Part of the Capital formation but no category in HKxHP table | | In SNA this is a "change in inventories"; at the time when these stocks are depleted and handed out to the public they should be recorded as HC513; they are treated as intermediate consumption if given to health providers. |

| Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|
| Acquisition of personal protective equipment of health providers for staff use (particularly for "front-line" health workers) | Intermediate consumption | | Not for final use; these costs are an input into the production of health services (included implicitly in different HC and HP) |
| Purchase of personal protective equipment by population if this equipment qualifies as medical non-durable goods (e.g. medical face masks, surgical masks, FFP2, N95). In most countries, this goods needs to be certified. The purchase of face masks out of clothing, plastic face shields etc. is outside of SHA | HC513<br>HP5 (but also other HP possible, eg. HP82) | HC.COV.4 | By convention, this should be considered as HC513 instead of HC6 if self-initiated purchase (see p.98 SHA 2011). Medical non-durables can be disseminated by a wide range of providers are possible. The use of re-appropriated non-medical goods is outside the scope of SHA.<br>Since there is a link between HC513 and COICOP 6.1.2 it may be easiest to makes decision on inclusion and exclusion in SHA based on the accounting in COICOP. |
| Self-manufactured personal protective equipment | Outside SHA | | No transaction, not certified |
| Purchase of alcohol-based hand sanitizers (or similar product that qualify as medical non-durable good) for final use | HC513 | HC.COV.4 | By convention, this should be considered as HC513 if self-initiated purchase. Might be challenging to identify. Several HP possible. Purchase of regular soap outside of SHA.<br>Use link between HC513 and COICOP 6.1.2 to make decision to include or exclude in case of doubt |
| Purchase of certified personal protective equipment by employers (non-health) for their staff (if it qualifies as health product). | HC66 | HC.COV.5 | Thus is intermediate consumption but can be interpreted as occupational health care and hence included in CHE and HC.6. There is no ideal subcategory in HC6 on the 2nd digit level. HC66 seems the most appropriate. |
| Purchase of non-personal protective equipment (boards dividing offices) by employers (non-health) to enable return to normal office work | Outside SHA | | Cost of compliance. Main purpose is the resume of economic activity |
| Reinforcement of nosocomial infection prevention | Intermediate consumption | | Input costs in production of health output (included implicitly in different HC) |
| Businesses handing out face masks and or hand sanitizer is to clients (in supermarkets, cinemas etc.) | Outside SHA | | This transaction is interpreted as compliance costs for businesses with the main motivation to resume business and making sales (with health care being secondary). This transaction can also be interpreted as intermediate consumption and hence outside of the scope of SHA. |

| | Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|---|
| Vaccines | Government contribution to international vaccine R&D initiative | Outside CHE | | Not directly related to domestic health care |
| | Government R&D grant to pharmaceutical manufacturer | Part of Capital Account but no category in HKxHP table | | Should be recorded as Memorandum item in the Capital Account (see chapter 11 of SHA 2011 manual on the recording of R&D) |
| | Early government purchasing agreement with manufacturers. A number of governments have concluded deals with manufacturers that give them the right to purchase a set amount of vaccine in case a vaccine proves to be safe and effective and will be authorized. | Excluded – Costs for vaccination will be recorded when campaigns are rolled out. (Costs may be adjusted to take into account purchase agreements) | | In case the contract foresees a financial flow for the option to purchase vaccines later; this can be interpreted as and advance payment and part of the final price. To be recorded in period of vaccination, |
| | Cost of vaccination (once vaccine is available) including costs of vaccine, service charge for doctors or nurse and distribution costs. | HC62 different HP possible | HC.COV.3 | Should include all costs components; a wide variety of providers possible |
| | Acquisition and storing of vaccines as strategic reserves | Part of the Capital Account but no category in HKxHP table | | In SNA, this is a “change in inventories”; at the time when these stocks are depleted and the population is vaccinated this will be recorded under HC62. |
| Infrastructure | Purchase of intensive care beds, ventilators and other equipment with service life of over 1 year; either by hospitals themselves or by governments that transfer it to health providers. | Capital Account | HK.COV.1 | Clear example of acquisition of assets. |
| | (Temporary) increase of treatment capacity, e.g. mobile hospitals, hospitals beds, ventilators by using reserve capacity (in stocks) | Capital Account (only costs of installation) | HK.COV.1 | These existing assets have already been accounted for when they have been acquired. The only transactions recordable in the current period are the installation and maintenance costs associated with making the assets fit for use.<br>To be considered as capital good, expected service life needs to be at least one year. (if less, it is a cost component captured under CHE) |
| | (Temporary) increase of laboratory capacity for tests | Capital Account | HK.COV.1 | The building of new laboratories and the acquisition of analytical equipment are GFCF |
| Other | Bonus payments to health and LTC staff. A number of countries have decided to pay bonuses to front-line health care staff | HC1, HC2, HC3 etc. (depends on the worker receiving bonus)] Different HP possible | HC.COV1-3 | Part of the costs of service provision. Bonus needs to be allocated to year to when bonus was earned |

| Activity | Accounting recommendation | COVID-19 memorandum item | Rationale |
|---|---|---|---|
| Payments by government to (private) health care providers in exchange to keep space available for the treatment of COVID-19 patients. | HC11,HC13 etc. | HC.COV.1-3 | These are "subsidies on production" and by definition not part of final consumption. However, as discussed on p.46 of SHA 2011 they should be included in Current Health Expenditure. To be recorded in the year to which subsidies refer to (not necessarily the year they are paid).<br>General income support that covers all self-employed (incl. health professionals) should not be considered here. These are non-health specific economic support. |
| Payments by government to (private) health care providers to balance reduced provider income as a result of postponed treatment or reduced activity. | Outside CHE | HCR.COV.1 | These are current transfers and not subsidies. These payments are outside of SHA as they are not part of final consumption.<br>General income support that covers all self-employed (incl. health professionals) is also not included under SHA. These are non-health specific economic support. |
| Payment of unemployment benefits or short-term work benefits to health professional who have been made redundant due to reduced health care activity during COVID-19 by their employers. | Outside CHE | | These transactions are not related to the final consumption of health care |
| Deferred payment of social contributions (i.e. employers get a temporary break from paying social contributions and pay them in later accounting period) | Relevant for HFxFS | | If HFxFS is based on accrual principle then deferral has no effect. |
| Assistance in kind from abroad. Donations of face masks, ventilators, hospital beds to domestic governments from foreign governments or international donors | Depends | | If these goods are used in the production of health care services, they are part of the intermediate consumption (raising the output and consumption of domestic health care). If face masks are distributed to directly to people HC513 (probably HF11xFS2/7). If capital goods part of Capital Account. |
| Purchase of thermometer or pulse oximeters | HC52<br>HP5 | HC.COV.4 | Final consumption |

# 3. Special COVID-19 spending reporting items

- The COVID-19 pandemic has highlighted the importance of having timely health spending data available to policy makers. Hence, all countries are strongly encouraged to submit preliminary health spending data for *t-1* (2020) as part of the 2021 JHAQ data collection. The accounting recommendations discussed in the last section (Chapter 2) can help data compilers in deciding which COVID-19 related transactions should fall within the core SHA framework defining the limits of Current Health Expenditure and how to allocate them across functions and providers.

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

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

- These items are

  *a.* HC.COV.1: Spending for COVID-19 related treatment

  b. HC.COV.2: Spending for COVID-19 testing and contract tracing

  c. HC.COV.3: Spending for vaccination against SARS-CoV-2

  d. HC.COV.4: Spending for COVID-19 medical goods

  e. HC.COV.5: Other COVID-19 related health spending n.e.c

  f. HCR.COV.1: COVID-19 provider support (income replacement)

  g. HK.COV.1: COVID-19 related investments

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

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

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

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

- *HC.COV.5: **Other COVID-19 related spending*** refers to all other COVID-19 related costs –within the SHA boundary of current health expenditure- not classified in any other category HC.COV.1-4, such as the organisation and co-ordination of the pandemic emergency response and other costs.

- *HCR.COV.1: **COVID-19 provider support*** refers to transfers to health provider due to COVID-19 to compensate for loss in revenues which cannot be considered subsidies (generally, subsidies should be included under current health expenditure). These items can be particularly relevant in countries with activity-based financing with a large number of private health providers. Unemployment benefits to salaried or self-employed health care staff should be excluded. Payments from "furlough schemes" should also be excluded.

- *HK.COV.1: **COVID-19 related investment*** should refer to the acquisition minus disposal of infrastructure capacity to treat COVID-19 patients. This includes the acquisition of medical equipment (e.g. ventilators, beds) and construction of medical facilities. It should also include costs related to the development of mobile tracing apps and any other IT infrastructure or software costs. Only "response costs" to COVID-19 should be recorded under this reporting item. "Planned" health capacity increases that predate COVID-19 (but became operational in 2020) should not be considered. Only costs that refer to Gross Fixed Capital Formation (HKxHP table) should be recorded here. This means that a change in the stock of pharmaceuticals and vaccines are not included.

- While it is clear that comprehensive reporting of all these reporting items will be challenging, it may be possible for some of the items and may be limited to certain financing schemes or providers. Table 3.1 and Table 3.2 display how the memorandum items would be embedded in the existing template.

**Table 3.1. Special COVID-19 reporting items in the 2021 JHAQ template, HCxHF table**

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

**Table 3.2. Special COVID-19 reporting items in the 2021 JHAQ template, HCxHP table**

| SHA 2011 — Health care functions (ICHA-HC) / Health care providers (ICHA-HP), Millions of national currency | | HP.1 Hospitals | HP.1.1 General hospitals | HP.1.2 Mental health hospitals | HP.1.3 Specialised hospitals (other than mental health hospitals) | HP.2 Residential long-term care facilities | HP.2.1 Long-term nursing care facilities | HP.2.2 Mental health and substance abuse facilities | HP.2.9 Other residential long-term care facilities | HP.3 Providers of ambulatory health care | HP.3.1 Medical practices | HP.3.2 Dental practices | HP.3.3 Other health care practitioners |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Memorandum items:*** | | | | | | | | | | | | | |
| *Reporting items:* | | | | | | | | | | | | | |
| ***HC.RI.1*** | *Total pharmaceutical expenditure (TPE)* | | | | | | | | | | | | |
| ***HC.RI.2*** | *Traditional, Complementary and Alternative Medicines (TCAM)* | | | | | | | | | | | | |
| *Health care related items:* | | | | | | | | | | | | | |
| ***HCR.1*** | *Long-term care (social)* | | | | | | | | | | | | |
| ***HCR.2*** | *Health promotion with multi-sectoral approach* | | | | | | | | | | | | |
| ***Special reporting items to track Covid-19 spending within CHE:*** | | | | | | | | | | | | | |
| ***HC.COV.1*** | *Covid-19 related treatment costs* | | | | | | | | | | | | |
| ***HC.COV.2*** | *Covid-19 related costs for testing and contact tracing* | | | | | | | | | | | | |
| ***HC.COV.3*** | *Covid-19 related costs for vaccination* | | | | | | | | | | | | |
| ***HC.COV.4*** | *Covid-19 related costs for medical goods* | | | | | | | | | | | | |
| ***HC.COV.5*** | *Other Covid-19 related health care costs (incl. in CHE)* | | | | | | | | | | | | |
| ***Special health care related items to track Covid-19 spending outside CEH:*** | | | | | | | | | | | | | |
| ***HCR.COV.1*** | *Covid-19 related provider support* | | | | | | | | | | | | |
| ***Special reporting items to track Covid-19 spending within the HKxHP table*** | | | | | | | | | | | | | |
| ***HK.COV.1*** | *Covid-19 related investment costs* | | | | | | | | | | | | |