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French comments on the discussion paper on unit 10: Classification of financial schemes (HF)

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French comments on the discussion paper presented at the 8-9th October OECD meeting about unit 10: Classification of financial schemes (HF)

Definition of the Group 1 in the ICHA-HF Classification

Two proposals are offered in the input paper:
- Option (A): Group I includes only the "compulsory social protection schemes";
- Option (B): Group I includes all the "government and compulsory health insurance", even if no inter-personal redistribution is involved.

In the French system, there is no compulsory private insurance. Basic insurance is public (mainly Social Security and a small part financed by central government) and complementary insurance is private (voluntary private health insurance, with individual or group contracts, and a majority of age-related premiums).
We understand that the present classification does not correspond to the health system of some countries and that some private insurance need to be included in the Group I. But, from our point of view:
- The Group I « compulsory social protection schemes » must remain consistent in terms of risk-pooling. So the private insurances in the Group 1 must be « social insurances », i.e. insurances with non-risk related premiums.
- We consider that Medical saving accounts (MSA) can not be considered as insurance, because it is simply saving and it does not imply risk-pooling between households. So MSA, compulsory or not, should be part of out-of-pocket payment.
- One of the goals of SHA 2 compared to SHA 1 is to enhance the comparability with other types of accounts, including ESSPROS. In option A, the definition of Group 1 would correspond to the definition of social protection, so health care expenditure financed by Group 1 would be consistent with health care expenditure in ESSPROS.

Therefore we strongly support the option A.

We also think that several users of SHA data may need to continue making a distinction between publicly managed and privately managed insurances (as in the current ICHA-HF classification). As SHA data are disseminated at the 2-digit level, we propose to have 3 sub-categories in the Group 1, namely:
- HF.1.1 « general government programmes »

- HF.1.2 « compulsory public health insurance » (including NHI and compulsory social health insurance),
- HF.1.3 « compulsory private social health insurance (with non-risk related premiums) ».

Non-market health providers

The present Joint health accounts questionnaire (JHAQ) is based on 3 tables (HC*HF, HC*HP and HP*HF) which have to be consistent. It implies that for each provider the sum of the health productions (in ICHA-HC classification) must be equal to the sum of payments from all financers (in ICHA-HF classification). For market producers, there is no problem. But for non-market producers, there can be a difference between these two aggregates. According to the rules of national accounts for non-market producers, the total production (ICHA-HC side) is indeed equal to the expenditures made by the producer to pay inputs used in the production (salaries, intermediate consumption). If the non-market producer shows a deficit, the production in the ICHA-HC side (expenditures) is not equal to the receipts in the ICHA-HF side.
This situation is not only theoretical: French public hospitals are in deficit since 2005, and the deficit for 2007 is about 1 billion euros.

This problem can be treated in different ways (as for deficit in FS):
- In the ICHA-HF classification, a balancing item « deficit/surplus of non-market producers » could be created.
- If the deficit is relatively small compared to the total production, one can assume it will be compensated by a benefit in some other year; so, one can assume the deficit will be financed by the same structure of financing flows (ICHA-HF) as the existing flows of the year.
- If the deficit is big, it will probably be compensated by a specific financing flow (for instance, transfers from central or local government). When this specific flow occurs, it can be included in the appropriate item of the ICHA-HF classification. When this flow has still not occurred, then health accountants may have to make an assumption about who will finance the deficit (In the French case, in 2008 JHAQ, we assumed the deficit will be financed by Social Security = HF.1.2).

The SHA Manuel should provide guidance in that case.

Definition of voluntary private health insurance

In the definition proposed by OECD, the method for fund-raising is « non-income related premium (often risk-related) ». That is in line with the paper of Vittorio Mapelli[1], where it is noticed that voluntary insurance scheme do not imply intentional income redistribution, which sounds logical from a theoretical point of view.
But, in France, among our “mutuelles” (individual voluntary private non-profit health insurance), there are some which do have income related premiums. This is the case of several insurances for public servants, for instance MGEN (mutuelle générale de l'éducation nationale, which is the biggest ”mutuelle”).
We want also to point out that in the French system, for fiscal reasons, voluntary private health insurance premiums are mostly not directly risk-related (otherwise, they would have to pay a specific additional tax). So, most of the premiums are age-related, but premiums do not increase with age as much as risks do.

[1] Mapelli V., « Comment on the interim report on the work on refinement of the SHA framework for health financing », 2008. Available on the SHA revision EDG.

So, it would be more convenient for France if the definition is slightly changed, for instance:
« Method for fund-raising: *mostly* non-income related premium (often *directly or indirectly* risk-related) ».

<u>Questions asked in the document</u>

Point n°41, page 15. We consider National health insurance (NHI) should not be distinguished from compulsory social health insurance (CSHI). The main characteristics are common: both are compulsory and financed by taxes or social contributions.

Point n°48, page 17. There is a need for distinction between private insurances with risk related premiums and with non-risk related premiums. This is important, for instance, to analyse risk-pooling and access to health care. As far as we understood, in option A, compulsory insurances with non risk related premiums should be in Group 1, and compulsory insurances with risk related premiums should be in Group 2.

Point n°53, page 18. In HF.2 (Group 2), there should be a distinction between compulsory private insurance and voluntary private insurance. Within the voluntary private health insurance:
- Group versus individual: we have not precise data in France, but we could make estimations
- Community-rated versus risk-rated is an interesting distinction, but we would appreciate further explanations about what is meant with "community".
- Primary versus non-primary: in France, all private insurances would be non-primary. How to deal with insurances that supplement the public insurance (for instance in Canada, they pay for dental care that are not publicly reimbursed)?
- The current distinction between private social and private non-social insurance (5th bullet point) is not adequate (we do not manage to apply it in the French case).

Point n°62, page 20. MSA (mandatory or not) should be considered as out-of-pocket expenditure, because it is not insurance but saving, and it does not imply risk pooling.

Point n°67, page 20. The distinction between different types of out-of-pocket (OOP) expenditure is difficult in France. We do not have much data for that, and it is not really relevant to make a distinction between OOP related to compulsory health protection schemes and OOP related to voluntary health insurance schemes because French voluntary private insurances complement the basic compulsory insurance.
As an example: the principal activity of private voluntary insurance is to reimburse the public cost-sharing, totally or partially (depending on the type of contract). If the public cost-sharing is partially reimbursed, then the corresponding OOP is actually related to both compulsory and voluntary insurance…

Point n°77, page 22: In France, corporations finance only "prevention and public health programs" (HC.6): mainly occupational health care, and prevention of accidents at work. So we are not really concerned by that point.