

Revision of the

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United States Comments on the Proposal for Unit 7

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United States Comments on the Proposal Unit 7 Functional Classification of Health Expenditures

by

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General Comments on Functional Classification of Health Expenditures

1. The proposal for Unit 7 was a very comprehensive revision of the functional classification contained in SHA 1. We agree with broadening of the categories and attempts to provide comparable aggregated data.

Comments on Main Criteria for a revision of ICHA-HC

2. When developing a measurement framework for the health care system care should be taken that the purpose is to provide clear objective data for policy makers. The system should not advocate any position on whom or how individuals are covered. In this proposal, the functional classification also seemed to be taking a very broad picture on what is included in health care. We need to be careful to set up very clear boundaries on what is considered health care or nearly every activity in the economy could be included.

3. Another point raised in the proposal “data availability should not direct the classification” is true to a certain degree. However, having a classification system that cannot be completed does not add anything to an understanding of how health care spending is distributed through a system. If there is a goal that needs to be attained for data then steps should be developed that could aid in the development in these new data sources with emphasis on how this data would be useful for all countries. Collecting data for comparability purposes is a good goal, but we must realize that there are limited resources for development of data in most countries.

Comments on Functions of Care & Treatment

4. The categories included in HC1 are an interesting approach but we are not sure of the usefulness of this type of data and the ability to provide data on these grounds. There would be problem establishing the differences between HC1.1 Acute &Emergency Care and HC1.2 Chronic Disease Management. These categorizations are based on a progression of care for a disease and not the functions preformed. The same types of services and goods may be needed for both categories. For example, an asthma patient with an acute episode, the condition is chronic but the treatment would be acute.

5. Most health care expenditure measurement systems are based on the establishment where the care is provided, such as a hospital, physicians' office, out-patient care center, dental office, nursing home and at the patient's place of residence. This may be primarily due to the convenience of collecting the data; it is relatively simple to survey a hospital or the office of a physician. However the question from a policy viewpoint: Are these the groupings where decisions are or need to be made? A functional classification system is one way to examine expenditures that may provide insight into the "goals and purposes of health care" (SHA manual). For that reason, the functional classification system should start at the highest level such as outlined in the proposed guidelines, HC1 Health Care & treatment, HC2 Public Health and Prevention and HC3 Stewardship and Government. At this level, there could be consensus across most countries and comparable statistics could be reported.

6. At the levels below HC1 Health Care & Treatment, countries would differ, but at a minimum it would be helpful to have categories that distinguish between care provided to treat an illness (acute or chronic) (HC1.1) and providing a full range of support mechanisms for persons with health related impairments, disabilities and handicaps (HC1.2.). This type of analysis would continue, creating levels that would provide information at the broad level that is comparable among the most member countries and then providing details that are meaningful for analytical purposes.

Comments on Functions of Public Health and Prevention

7. SNA 1.0 classifies Prevention and Public Health Services under the rubric of “Collective Health Services” along with Health Administration and Health Insurance.

The proposed definition of HC.2 makes no operative distinction between individual services and collective services in terms of economic accounting. Since these categories are not mutually exclusive or exhaustive, it will be nearly impossible to gather this data in a manner that is “neutral of mode of production”.

Internationally accepted principles and conventions for national economic accounting codified in the System of National Accounts (SNA) make clear the distinction between individual services and collective services. The distinction between the acquisition of individual services and collective services (in this case public health services) is the key to determining which government activities should be defined as public health activity - as opposed to government provision of personal health care services.

The SNA defines a collective (public) service by three characteristics:

- (a) Collective services can be delivered simultaneously to every member of the community or of particular sections of the community such as those in a particular region or a locality;
- (b) The use of such services is usually passive and does not require the explicit agreement or active participation of all the individuals concerned;
- (c) The provision of a collective service to one individual does not reduce the amount available to others in the same community or section of the community. There is no rivalry in acquisition.

This distinction is important for determining what is **public** about public health services. Governments can, and frequently do, provide personal health care services to individuals or groups of individuals; however, these goods and services, although **publicly provided**, do not constitute public health services.

8. H.C.2 Public Health and Prevention is defined as encompassing six kinds of activity that constitute Public Health Care and Prevention. The operative phrase in paragraph 8 b. is:

“...through organized community effort for (1) the sanitation of the environment, (2) the control of communicable infections, (3) the education on the individual in personal hygiene, (4) the organization of medical and nursing services for the early diagnosis and prevention of disease, (5) and for the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity” [numbering added].

Contrast these activities with the activities of H.C.6 Prevention and Public Health in SNA 1.0.

Function H.C.6 Prevention and Public Health is further broken down into the following subcategories:

- HC.6.1 Maternal and child health; family planning and counseling
- HC.6.2 School health services
- HC.6.3 Prevention of communicable diseases
- HC.6.4 Prevention of non-communicable diseases
- HC.6.5 Occupational health care
- HC 6.9 All other miscellaneous public health services.

SHA 1.0 provides a full description of the activities that are included in and excluded from each of these HC.6 two-digit categories. Without reproducing the entire description of each category here, it is sufficient to note that these definitions identify those health care services that are directed at populations (prevention of diseases) or segments of populations (maternal and child health and occupational health care). By characterizing both population-based health services and health care services delivered to segments of populations, SHA 1.0 blurs the theoretical economic distinction between public services and individual services described above.

Yet the proposal goes much further in blurring in distinction between collective and individual services. The H.C.2 definition of Public Health and Prevention also expands the production boundary of public health by including social services and sanitation of the environment. Both of these activities were explicitly excluded from public health in SHA 1.0 (see page 121, H.C.6 Prevention and Public Health).

For additional discussion of measuring public health see:

Sensenig, Arthur L. MA; Refining Estimates of Public Health Spending as Measured in National Health Expenditures Accounts: The United States Experience. *Journal of Public Health Management & Practice*. 13(2):103-114, March/April 2007.

9. Insuring everyone with a standard of living adequate for the maintenance of health, could be construed as the totality of human endeavor, or at least most human activity that is measured as economic activity. Provision of food, shelter, clothing, and other human needs are required to maintain a standard of living, but not all of these activities could or should be considered health care.

10. In the proposal HC2.2.1 the “valuation of regulations and enforcement to protect public health, ensuring the quality of personal and population-based health services” is extremely ambiguous. Does this mean that national health accountants need to calculate “value” in terms of utility gained by creating and enforcing regulations; or does this mean that the cost of creating and enforcing regulations is to be included as a health care cost? The cost and value of creating and enforcing regulations are two entirely different concepts.

11. The term “valuation” in the proposed HC.2.2.2 Disease Surveillance and Control, and HC2.2.3 Information and Awareness present the identical problem. In national economic accounting non-market goods and services are measured as the sum of the costs of producing the output, since there are no observable transaction prices. Absent a transaction price, measuring the value of a good or service entails pricing the utility (or sum of utilities) that society obtains from the non-market good or service.

Comments on Annex 3. Definition of the Resource formation classes

12. In Annex 3. Definition of the Resource formation class, item 41 should not be limited to research and development of a public health agenda. All non-commercial research, the cost of medical research that is not an intermediate output to some final health care good or service, should be included Resource Formation. This research might be considered a “public good” since there is no ownership right on the part of the institutional unit performing the research, and there is “no rivalry in acquisition” as the knowledge gained passes immediately into the public domain. However, the research need not be limited to research on public health care, as non-commercial research aimed at improving personal health care is also a cost to society.

13. Also in Annex 3 item 40, *Human Resources* is problematic because it measures human capacity – the capacity to provide health care – as a stock. To be included in the cost of health care the concept must be a flow of expenditures, in the same fashion as Gross Capital Formation (investment) is measured. The cost of educating health care providers is certainly germane to the measurement of the cost of health care. However this cost should not be measured in terms of human capital, as that would result in a plethora of issues such as how much the capital (embodied education) is worth, how fast it depreciates, whether or not there are “capital gains”, etc.