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Comment
Unit 2

French comments on the draft versions of unit 2 of the SHA manual

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French comments on the draft versions of unit 2 of the SHA manual

Unit 2: Global boundaries of health care

We are pretty much in line with this paper. In particular, we find that figure 1 is a very good illustration of the place of the « core accounting framework » of SHA in the overall health system.

The definition at point 6 is a good one. Nevertheless, as mentioned in an intervention at the 8-9th October OECD meeting, the word «principal» should be added, because several activities not connected to health have as secondary purpose to improve the health status:

« ...the boundary is defined by the sum of activities performed either by institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology, the *principal* purpose of improving, maintaining and preventing the deterioration of the health status of persons. »

Concerning the list of boundary problems at point 19, we agree with point (c) and (d):

- «paid transactions including home care and including paid services by households [and not to include unpaid household activities] »: for consistency with national accounts, this is the best option. As proposed at page 41, non-paid household production of health could be added as a memorandum item. ,
- «the consumption value of medical goods at purchaser's prices [and not to distinguish between trade margins of distribution and production of medical goods]. »: as proposed at page 35, ail intermediate activities of production should be excluded from the core boundaries of SHA 2.

Concerning point (b), we agree with the fact that it is desirable to provide information on imports of health care in the core framework, and also on export in an extended framework. But by now, we face a huge problem of lack of data, and several other countries seem to have the same problem. The question whether to include gross capital formation or not is a difficult one. As it is indicated at page 28 of the paper (footnote n°5), a problem is that in some countries, the price for services does not include consumption of fix capital (CFC), whereas is other countries (like in France) cost of CFC is included in prices.

The current health expenditure (CHE) is lower in the first case, and it is difficult for countries in the second to evaluate CFC and subtract it from CHE. Two solutions could be possible:

- if international comparisons are made using CHE, countries where the price for services does not include CFC should add CFC to CHE.

- if international comparisons are made using total health expenditure (THE) as it is done now, countries should deal investments in a different way. In countries where the price for services does not include CFC, THE should be defined as the sum of CHE and the *gross* fixed capital formation (GFCF). In countries where the price for services includes CFC, THE should be defined as the sum of CHE and the *net* fixed capital formation (GFCF less CFC).

In annexe 2, the borderline problem of long-term care (LTC) is mentioned. That problem has already been debated several times. From our point of view, the current treatment of LTC in SHA 1 is convenient. Other solutions could also be acceptable, but two points are important:

- to have somehow information on LTC in SHA 2 ,
- to define the distinction between health and social with the « type of care » approach, as it is done for other borderline issues. For instance, distinctions based on mode of financing or on the qualification of the persons providing care could not lead to internationally comparable data.