

Revision of the

# System of Health Accounts

ORGANISATION  
FOR ECONOMIC  
CO-OPERATION  
AND DEVELOPMENT



World Health  
Organization

Comment  
Unit 5

## Belgian remarks on the proposals of SHA revision Units (draft version)

Author ..... Dirk MOENS  
Affiliation ..... FOD Sociale Zekerheid, Belgium  
Submitted on ..... 04/02/2009  
Document code ..... 05103

*The opinions expressed and arguments employed herein do not necessarily reflect the official views of the **Organisation for Economic Co-operation and Development** or of the governments of its member countries, those of the **World Health Organization** or those of **EUROSTAT** or the **European Commission**.*









## FOD SOCIALE ZEKERHEID

### Directie-generaal Beleidsondersteuning

Multilaterale Relaties

tel.: +322528 63 26

fax: +32 (0)2 528 69 67

vragen naar: Dirk Moens

e-mail: Dirk.Moens@minsoc.fed.be

uw brief van  
uw kenmerk

ons kenmerk  
datum 5 februari 2009

bijlage(n)

Betreft: Belgian remarks on the proposals of SHA revision Units (draft version)

Dear all,

As producers of the Belgian health accounts, we support the general agreement that SHA 1.0 needs further improving. It has proved a valuable tool in analysing health care in countries and an asset in international comparison. A further improving is therefore desirable. However, it is not advisable to develop and extend for the simple sake of developing and extending. There needs to be an equilibrium in the balance between improvement attained and effort needed. The effort produced in many countries in the development of health accounts is not to be neglected, neither in view of the human resources assigned, nor in financial efforts.

In a general way, we think that the analytical framework opened by SHA has to be seen in view of the real value added it brings to the existing (accounting) frameworks **to the users**, otherwise an effort of separate methodology and production is not worth it, and could be replaced by further refining or improving (even moderately) the existing tools.

If some ideas go in the direction of developing SHA to an all embracing accounting tool, we are not convinced that the main intended user, the policy maker, will find sufficient value added by some 'new' dimensions, accounts, dimensions, classifications, etc. compared with what is available or could be obtained by (even moderate) improvements and refining existing tools.

As we have stated during the meeting of the Health accounts expert group of the OECD in last October, we think that some of the proposals of the IHAT-team for the different units need to be treated in combination as they are interlinked. The proposals for unit 5 are in their essence influenced by decisions (not proposals) under other units of the revision process (unit 1, unit 2).

The proposal clearly states several aims and objectives, which have not been subject to general consensus at this stage. It is clear that the ultimate aim of SHA will also influence choices and options for other units than only those related to the scope of SHA. Other 'units' are clearly also interlinked (e.g. units 9 and 10).

Questions still arise in our mind whether SHA (after the revision) is intended to measure

- consumption or production
- health care or health sector (e.g. inclusion of pharmaceutical industry,..)
- productivity
- etc...

and are not resolved yet. Therefore we take as a starting point of our reflections the SHA 1.0. All what goes further than that is speculative at this time (and we have recently seen to what speculation can lead). In our view, the SHA-aim still is mainly limited to **expenditure**.

It is also important to note that in our opinion a 'satellite account' does not necessarily have to follow scrupulously the definitions and terminology of its 'mother' system. Otherwise stated, in our view SHA does not have to follow exactly definitions and categorisation of SNA in terms of 'institutions', 'sectors', etc... We would like to illustrate this by an example: in Belgian social security, the occupational hazards insurance is mainly executed/operated by private insurance companies. In SNA the services rendered by these insurance companies **in social security** are following the accounting rules classified as 'financial services' in the private sector, as their main 'product' are financial services and not social security. For analytical purposes, it is important and relevant to the policy maker to see the organisation of the system, and therefore it is not because an insurance company 'belongs' to the financial sector that is hat to be seen in all reporting and analytical systems as such.

### **Units 1 and 5**

SHA 1.0 aims at measuring consumption of goods and services by the individuals.

Even when the definition refers to the **goods and services delivered** (which could be understood as 'production'), by its practical restriction (by e.g. excluding 'exports' and 'imports' of these goods and services, by limiting to certain services and goods) the extend of coverage is limited to what is being delivered on the national territory to residents on the national territory. This covers only the 'turnover'- side.

SNA is a tool aiming to measure value added (production) of goods and services by an economy. It has therefore developed a methodology for these purposes, which takes into account the production costs.

SHA is meant to be a 'satellite' account of SNA. First of all, it is necessary to define the concept of a 'satellite account'. Several understandings exist. In essence, a satellite account aims at describing an item, covered by national accounts, in a different way (other dimensions, other delimitations, etc..).

In paragraph 2 of the document, it is stated that the aim of the revision of the methodology SHA 1.0 wants to 'borrow' some of the methodology of SNA and to use for those reasons a 'sequence of accounts similar to those used in SNA in order to **report the generation, distribution and use of income** of institutional sectors (in casu the health sector as defined by SHA).

This is a implicit extension of the aims of SHA. We wonder whether this can be considered, as the boundaries and scope of SHA 2.0 are still under elaboration in unit 1 of the revision process, and that there is to our knowledge still no consensus on the exact objectives of SHA in the future.

That this is an important modification, implied by the proposal, is clearly illustrated under the bullets of paragraph 2:

- generation of value added
- reporting on productivity
- estimation of financial surplus/deficit

These reformulated objectives go far beyond the objective of SHA 1.0 mentioned above, and need therefore to be subject to a prior approval because of their essential implications on the accounting framework. Need it to be said that Belgium sees serious conceptual problems:

- 'productivity' of health and long term care: this needs an expression of quantification of the output of the health and long term care sector (SHA definition), in order to compare to an input. We agree with the French comments that productivity in this sector relates closely to aspects of quality. If I might use a caricature: if we think of a productivity measure in the sense of 'numbers of patients treated', is a physician has many patient contacts (e.g. of the type 'hello-goodbye', is he more 'productive' than his colleague who sees a limited number of patients, but whom he thoroughly examines?
- Deficit/surplus estimations: we disagree that this can give an indication of long-term sustainability of health care. It might be a useful measure on a micro-economic level to see the survival possibilities of an economic entity (where income/receipts and costs are clearly measured). In the case of SHA, this would need at least an quantification of the financing (income) side, and also an understanding of the concepts of surplus and deficit. In my view, on a macro-economic level in health care this makes no sense because for e.g. cross-subsidiating out of other activities of the actors . It's a concept which as far as my knowledge of SNA reaches, doesn't exist at that level.

We can agree with paragraph 5, but think that therefore e.g. the use of 'sequences of accounts' are to be seen as a part of a kind of 'users guide' of 'practical guide' of SHA, and not as a part of the definitional framework. It is to be seen as an 'instrument' and not as an 'objective'

Paragraph 8 states that the revision process aims at **‘developing the health care sector as an institutional sector of SNA**. This would lead us away from the benefits of the actual SHA. It could indicate an intention to make SHA a part of SNA. We think the discussions should then take place at another level if this should be the final objective. It would then be a spill of resources to continue the discussions in our groups, but to be efficient, discussions should then rapidly be transferred to SNA working groups. It is clear that Belgium opposes to this, because we would then lose a lot of the richness of SHA.

Many of our discussion turn around how to come from existing institutional sectors to the ‘health and long term care’ by eliminating non-health and long term care activities from these existing sectors on the one side, and on how to ‘extract’ health and long term care out of other institutional sectors in order to be able to account for them. In our view, aiming at a new ‘health and long term care’ institutional sector does not change anything to these problems. In our opinion, actual SHA has the merit of bringing a framework in which this can be done. Turning SHA into a part of the problem would be a step backwards.

**As SNA has limitations in its possibilities to hand solutions to make these ‘redistributions’, we are convinced that turning the question in the other direction, will not lead to a solution also. In other words, in that case, SHA will have no ‘value added’ at all.**

Paragraph 12 i.. The first sentence in its statement that ‘the sum of consumed goods and services, broken down by provider would represent the value of the output of the producers can only be true if these providers/producers have no other activities other than health and long term care. (e.g. bookshops in hospitals): in our view the ‘isolation’ problem remains.

Paragraph 12 iv, v, vi: we don’t see where this should lead to, other than observing that SNA-data and methods can be an instrument/source of information in the compilation of SHA.

Paragraph 16: we think this is only a part of the truth. We would complement the statement by adding that comparability will only be reached if these common definitions are applied in a common understanding (meaning that definitions alone are never enough).

Paragraph 21 iii. It would be useful to think of the group of countries who ‘currently compile’ their SHA not based/starting on SNA. (Belgium is in the case, and probably others). We are not convinced that for the countries mentioned in the document, the compilation of **SHA** would be so straightforward compared to their actual methods (see also French remarks). **SHA is about isolating activities, not institutional sectors only.**

To conclude we would like to remind you that in our view, the best way to discredit an instrument, is to use it for a purpose it has never been intended for. And this leads us to the problem mentioned in the introductory paragraphs of this document. We are convinced that some of the ‘units’ for revision should be taken as a sequence, and not in parallel, and unit 5 is one of those (together with unit 1 and 2).

## **Unit 2**

One of the problems actually facing SHA is the delimitation between 'health care' and 'social care' in the area of long term care. One could oversimplify this problem by the question 'When is being old becoming an illness?'

Our basic conviction is that a clear cut, comparable solution is difficult, maybe impossible. One could imagine many solutions by e.g. keys, but as long as both types of care are provided in the same institutional surroundings (between the same walls of the same 'home'), it remains hard to distinguish: is it by personnel qualification?, by the type of beds?,...) In our understanding, the problem is most difficult to resolve in what is commonly referred to as 'homes for elderly persons' (not specialised in specific nursing care or revalidative care). In our country, information on ADL and IADL for people residing in these types of institutions is available for the last health interview survey only (subjective reporting). In many other countries however, institutionalised persons are not covered by surveys of the HIS-type, and it is therefore the question whether results can be considered comparable or equally robust.

Therefore, we remain, for the time being, more inclined to a SHA with a 'dual layer' SHA-health care *stricto sensu*, and a SHA-health and long term care (but including institutionalised long term care).

Another theme addressed by the proposals of unit 2 is the question on 'consumption of capital'. We think this leads us away from the health expenditure, and leads us closer to a concept of 'health costing', by bringing in a number of balance sheet items: investment, disinvestment, depreciation, etc... However interesting from a macro-economic analytical view, we believe it of lesser interest to the policy makers. The interest of valuating correctly this, will depend on the methods used by countries to construct their SHA and the valuation methods they use for the 'final products'.

Often, the pricing mechanism of medical acts and health products include a provision for 'consumption of capital goods' and introducing this concept would need a revision for the valuation methods used (for those countries who do not compile their SHA out of a factor costing methodology) in order to avoid double counting. It is to be underlined that cost and expenditure are different concepts.

It can also be argued that, in order to be compatible with the rest of SHA, this item should then be ventilated by financing agent, by function and by provider. We doubt whether this is feasible.

If information on investment can be considered useful, it could be retained as a separate item

The discussion document on Unit 2 proposes also in annex 1 an overview of borderline questions. In most cases, we agree with the recommendations of Eurostat, with some exceptions:

- housing adaptation: we agree that this can be considered as an investment. However, we don't agree with the argument that it is merely 'improving standards of living'. It is hard to

imagine that a household would make this investment without need. However, we would propose retaining the amounts of population wide support programs in this domain (a bit alike prevention programs: can also be considered as an investment without immediate health effect). For the part financed by household, we would leave it out (similar to personal prevention expenditure).

In annex 2 is introduced a reflection on the 'medical goods production'. Our opinion on this point is clear, this is not part of 'health care expenditure' (final consumption), and therefore to be excluded from SHA. However it is possible that some might use the (SNA) information in order to construct their SHA (as an element of intermediate consumption, with all imaginable corrections).

### **Unit 9 and 10: Financing sources and Financing agents**

In our view, also the classifications between Financing sources and the HF-classifications are interlinked. Where the HF-classification permits to analyse the financing structures of the health systems, a link with an underlying 'Financing sources' permits to identify the financing of that intermediate layer of financing 'agents' or agencies. Figure 1 is a clear and correct representation of this difference.

In our view, the analysis of the 'Financial sources' should permit to identify the mechanisms behind the finances of the intermediate agents and agencies: general taxation, earmarked taxes, social contributions (eventually earmarked also), insurance premiums and household financial assets. The question arises whether a further drilling down brings in relevant information, as ultimately every financing finds its origin in the private households. We ask ourselves if an 'institutionalised' analysis (in 'households', 'enterprises', 'government' brings in a better understanding: we doubt it.

An analysis as proposed can permit to understand the financing of the health expenditure, which in our view still is one of the objects of SHA. (An example of how this could be organised can be found in the ESSPROS-methodology (Eurostat)) **It is in fact the limitations of SNA in this field, that are at the origins of the SHA 'sattelite accounts'**. If there is an understanding problem, returning to the 'institutional' concepts of SNA (and the mechanisms used to delimit or attribute them), will not resolve it. One could also argue that SNA already permits to establish a 'proxy' subdivision of the institutional origins of financing health care.

If finances exceed or do not cover the total current expenditure, is in our opinion not the fundamental problem for SHA, as it is only looking at the expenditure side and is no 'closed' accounting system (which would have to be extended with e.g. balance sheets, etc. in order to allow a full analysis of the financing of the health care system).

If the present manual uses indeed a terminology which can lead to difficulties in interpretation, vocabulary can be improved (e.g. HF1 'Government' vs. HF2 'private sector'). Our preference goes more to a classic 'public/private' split, preferably following option B, as we do not feel that a split 'private'/'public' is depending on the redistributive character of a scheme. It is also not the 'collective vs individual' arrangement which will define in our view the public/private split. It is the fact whether the system is operated following public law or private law which will have to

determine the split. The 'compulsory/voluntary' split is better suited as a subdivision (2<sup>nd</sup> level) of the larger 'public/private' split. For an example, we refer to organisation of the Belgian social security insurance on occupational hazards (see above). It is in that sense obvious for us that (in opposition to National accounting) this scheme is a 'public' scheme as the fundamentals of the system are not ruled by private law.

These thoughts are certainly not exhaustive, and do not cover all proposals and units, and event those looked at are most probably not covered exhaustively. But we wished to submit these results of a limited brainstorming to the discussion.

Kind regards

Dirk MOENS  
*Attaché*  
FOD Sociale Zekerheid  
Dienst Internationale relaties