

Revision of the

# System of Health Accounts

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World Health  
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Comment  
Unit 9&10

## Comments on Units 9 and 10 of the SHA manual: The accounting of health financing”

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Raymond Rossel, 26 May 2009

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## REVISION OF THE "SYSTEM OF HEALTH ACCOUNTS" SHA

# Comments on Unit 9 and 10 on the accounting of health financing

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Considerable progress has been made on the new concepts needed for an appropriate analysis framework for health financing. Bringing together in one unit the two classifications HF and FS/IS is a positive step, although this unit is in its present shape too long. Long comments and links to SHA 1.0 can be dropped later when the main options are decided. Explanations and arguments will then be easier and shorter.

The main advantage of this new chapter on the financing of health care is that it is definitely oriented toward health policy, bringing transparency and interface with the social protection schemes and reconciling health accounts with the institutional sectors of the national accounts. Basically the system of two classifications is sufficiently adequate for the quantitative description of raising/collecting revenues, pooling resources and purchasing services for health care.

One general point would perhaps need some consideration. The purchasing agent or the payer is not always easy to identify. Government or compulsory social and private insurance may for instance pay for purchasing long term care in different ways: directly to a nursing home as a global subsidy, for the service (fees) or to households as additional cash benefits in order to cover long term care expenditure. It could be stated that these are all to be considered in HF1 Government programmes and compulsory health insurance, although legally the household may remain responsible for payments. (See also specific remark above). Here as well, the health policy perspective is the most important aspect to consider. See also a specific comment below on cost-sharing and third party payments.

### Specific comments

Paragraph 32, p. 11, two last points: The tables with 3 dimensions are not properly presented (HPxHFxfinancing agents, Table 1 p.18) and (HCxHFxfinancing agents, Table 2 p.19). These are tables for each item of HP and HC classifications, which should remain optional. Proposal: do not mention these tables.

Paragraph 92, p.31: Question for debate, risk related vs non risk related premium as a criteria for sub categories for compulsory schemes. This question would concern a priori three categories of compulsory schemes (HF.1.2.1, HF.1.2.2, HF 1.3). It could be assumed that any compulsory scheme is basically and to a certain extent financed with premium unrelated to individual risk. In contrast, any voluntary scheme is basically or to a certain extent characterized with risk related premium to individuals or groups of population. In my opinion, this additional characteristic in HF classification is complicated and probably useless.

Paragraph 98, p. 32, Question for debate, second point: A state subsidy has always some function of risk sharing or pooling. It can be for instance a subsidy to hospitals (HF1.1 General Government health programs). It can be a specific scheme under HF1.2., for instance a subsidy scheme or sub system aiming to promote voluntary health private insurance. Subsidies can also be treated under the classification for accounting for revenue raising (IS). As an example, subsidies for premium reduction in compulsory or voluntary health insurance schemes can be mentioned. In this case it would appear in the table HFxIS.

Paragraph 101, p. 32, Question for debate, Sub-categories for voluntary private insurance: the second option, Annex 4, p. 87 would be the most relevant.

HF.2.1.1. Employer and group voluntary health insurance;

HF.2.1.2. Individual voluntary health insurance;

HF.2.1.3. Community based voluntary health insurance;

Paragraph 102, p. 33, Questions for debate, Sub-category for community-based health insurance under HF2 Voluntary private insurance schemes is probably a good solution.

Paragraph 106, p.33, This paragraph is not clear. Is this interpretation correct?

Households' out of pocket should exclude all **cost sharing** expenditure, independently from who is paying. Whether the service is paid for by the patient or by the scheme makes no difference in cost sharing. The payment as a criterion is not practicable in cost sharing expenditure. In Switzerland it is impossible and also not very important to distinguish between "third party paying" and "third party guarantying" in the compulsory health insurance scheme. The total of cost sharing is the most meaningful financing flow.

This interpretation does not apparently correspond to paragraph 112, p. 34 with an example in the French Social Security Scheme.

Paragraph 118 and 119, p 35 the question seems unclear to me.

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I would simply state that a private insurance bought by the employer is not an enterprise program but the financing of a voluntary private insurance schemes by corporations (See IS). If the insurance belongs to the employer or is run by the employer (pooling) only for their employees, then it belongs to this category.

Pages 42-44, Table 7 Draft classification for Institutional sectors/units for health systems

IS.2 and IS.3 : such detailed information may not be needed.

Paragraph 152

#### **Answers to “Questions for discussion”**

- 1) A classification of financing agents (institutional units) for ICHA-HF would be two steps backward ignoring the positive experience gained under SHA 1.0.
- 2) Schemes vs Sub-systems: Schemes is the adequate word for public and compulsory regimes covering health expenditure with good interface with the European system of social protection statistics (ESSPROS) but since we have a “system of health accounts”, sub-systems is intellectually more pleasant and adapted to include households.
- 3) The main categories of ICHA-HF are appropriate.
- 4) A distinction between National Health Insurance and compulsory medical saving accounts is clearly needed since social solidarity and redistribution is basically different.
- 5) Option A is preferred for ICHA-HF
- 6) Option B is preferred for accounting of revenue-raising. From a health policy oriented point of view, a classification of “financing sources” or “financing agents” is more appropriate than a stricto sensu institutional sectors and units. For European countries, the ESSPROS is already partly fulfilling the same goal.
- 7) The classification of institutional units for health system could be appropriate if this option is taken. Detailed information on corporations in IS.2 and IS.3 is not needed.
- 8) Yes, this classification would be a good starting point if this option is adopted. The practicability of this classification has not been checked. Data availability is not sufficient at the present time nor is it likely to be in the next few years.
- 9-10) The tables provide sufficient information.
- 11-13) The proposed tools are sufficient.