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Comment
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French comments on OECD proposal for the Units 9 and 10 of the SHA manual: The accounting of health financing”

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**French comments on OECD proposal for the units 9 and 10
of the SHA manual : The accounting of health financing”**

The paper proposed by OECD is very comprehensive. We appreciate that, among the classifications and tables proposed, there is a clear distinction between what would be mandatory for international comparisons, and what would be optional and for national purposes. We also appreciate to have a discussion on both FS and HF units in the same paper.

We support the overall orientation of the paper of defining the HF-classification as a classification of health financing schemes (or financing sub-systems). From our point of view, the main arguments for this orientation are:

- It enables to better describe the health care systems than the definition of the present SHA Manual (see for instance the example of Netherlands at paragraph 34).
- Several countries seem to already deviate from the present SHA Manual and use the “classification of schemes” approach when providing data for the Joint health accounts questionnaire
- It will enhance comparability with ESSPROS
- The information provided by SHA will be different from the information provided by national accounts, but the two will be complementary and, if needed, it will be possible to explain the differences between the two approaches with a HF*IS*HC table, like in table 2.

Answers to the questions listed at paragraph 208.

1) “This paper proposes to define ICHA-HF as a Classification of Health Financing Schemes (or Classification of Health Financing Sub-systems).”

We support the proposition of the paper

2) “Should ICHA-HF be defined as a Classification of Financing Schemes or Classification of Financing Sub-systems?”

We don't really give preference to one option or the other. The word “scheme” would show the consistency with ESSPROS, but it may not be adequate for out-of-pocket expenditure.

3) “Are the main proposed categories of ICHA-HF appropriate? Are there any financial arrangements of countries that cannot be brought under any of these categories?”

The categories seem appropriate. For France, in the present HF classification, it is difficult to deal with “Couverture maladie universelle complémentaire” (CMUc), which is a specific central government programme for poor people. The CMUc is managed by public social insurance (“Social security”) for most of the beneficiaries, but for few of them it is managed by private insurances. With the proposed classification, it will be much easier to describe the health care expenditure financed by CMUc.

4) “How the draft definitions of the ICHA-HF categories could be improved? Are the following categories needed? : National Health Insurance; Compulsory Medical Saving Accounts”

The distinction between National health insurance and compulsory social health insurance is not relevant for France. Social security system is made of different schemes. Historically, these schemes were all based on professional status (e.g. general scheme for employees, scheme for farmers, scheme for self-employed etc.) so they were all compulsory social health insurance. Now, every person living in France is covered: if one is not covered because of professional status, one is covered by the general scheme for employees (Cnamts). Therefore, Cnamts should rather be considered now as a National Health Insurance. But in our data it would be difficult to distinguish health care expenditure financed by Cnamts from the expenditure financed by the other schemes. So we prefer not to distinguish National health insurance from compulsory social health insurance.

Compulsory Medical Saving Accounts must be presented as a separate category (and not included under compulsory private insurance).

Other points concerning HF-classification:

a) Sub-categories of voluntary private insurance (paragraph 101):

The basic information needed is the distinction between primary coverage and non-primary coverage. Within non-primary insurance, the following subcategories are interesting:

- “Employer and group insurance” / “individual insurance” / community based
- “Community-rated” versus “risk-rated”.

The present distinction between social and non-social insurance, with the present definition, should be avoided in SHA2.

b) Community-based health insurance (paragraph 105): a specific category for community-based health insurance seems preferable.

c) Voluntary private insurance / Method for fund-raising

In the definition of voluntary private insurance, the method for fund-raising is “non-income related premium (often risk-related)”. As we mentioned in our comments on the paper presented at the 8-9th October 2008 OECD meeting, 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) », or if our specific national situation is explained. Actually, 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”). This is also the case for some employer group insurance, where the premium increases with the salary.

d) Explanation of “voluntary” versus “compulsory”.

Further explanation might be needed, as in ESSPROS: “Compulsory schemes are social protection schemes where membership is made compulsory *by the government*”. For instance, an employer can decide to have a group insurance for all its employees: this is considered as a

voluntary insurance, although for each employee the participation in the insurance can be imposed by the employer.

e) Enterprise health programmes (paragraph 119)

We would prefer option B: If a separate fund exists, then it should be considered as voluntary health insurance (the enterprise appears in the financing side of that insurance) and if the benefits are directly provided by the enterprise it is an enterprise health programme.

5) “Which option for grouping the ICHA-HF categories into HF.1 and HF.2 is preferred?”

Concerning the choice between option A (paragraph 127) and option B (paragraph 129), we prefer option A: it is useful to isolate HF3 “out-of-pocket payments” from pre-paid schemes, especially when studying access to the health care system.

As we expressed in our comments on the paper presented at the 8-9th October 2008 OECD meeting, we consider “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.”

But, if it is decided that the distinction between HF1 and HF2 corresponds to the distinction between mandatory and voluntary, then the users of the SHA data must be able to find out, within mandatory private insurance, what corresponds to insurances with risk-related premiums and what corresponds to insurances with non risk-related premiums. Therefore, to the question at paragraph 92, our answer is that there is a need for sub-categories within compulsory private insurance.

6) “Which option for the classifications for accounting revenue-raising is preferred? (Option A or Option B)?”

We would prefer option B (a new classification for financing agents is developed). It seems difficult to build a general classification, as proposed in option A, which is really relevant for both “purchasing agents” and “revenue-collecting agencies”. For instance, the relevant degree of detail may not be the same: for FS classification, there is a need to stay at an aggregate level.

7) “Are the main proposed categories of the Classification of Institutional Units for Health System appropriate? Do the draft definitions provide an appropriate starting point?”

Maybe there should be more explanations on how to deal with employer social contributions. The paragraph 142 explains that IS/FS1 includes contributions paid “on behalf of employees of the government”. Should the same be applied to employer social contributions paid by social security funds (IS.1.4), Insurance corporations (IS3) and households (IS4)?

8) “Are the main proposed categories of the Classification of the type of revenues appropriate? Do the draft definitions provide an appropriate starting point?”

The draft definitions are a good starting point, but there are some problems.

The most important is: how to deal with earmarked taxes? In France, it can be CSG (generalized social contribution), taxes on consumption (tobacco, alcohol) etc. These earmarked taxes can not be included in R1 “non-earmarked revenues of government” nor in R2 “social insurance contributions”.

From our point of view, the item R.2.3 should correspond only to self-employed contributions; contributions paid by jobless and retired persons should either be included in R.2.4 (as in ESSPROS classification) or be a separate item. To enhance consistency with ESSPROS, R.2.1

could correspond to employer contributions and R.2.2 to employee contributions; so R.2.2 to R.2.4 would correspond to contributions paid by the protected persons.
Grants should appear further in the classification, just before "other revenue".

9 and 10. The information seems globally sufficient.

In the T-tables (HF*IS, HF*R etc.) it could be useful to mark in grey the cells that should remain empty (For instance, HF.3*IS.1, HF.3*IS.2, HF.3*IS.5 and HF.3*IS.6).