

Revision of the

System of Health Accounts

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Comment Unit 2,3 and 8

Polish comments on proposals for the units 2, 3 and 8 of the SHA 2.0 manual

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General remarks

We have an impression that the authors of draft of unit 3 attempt to adjust SHA to the methodology and concepts of SNA at any cost. We believe that compatibility to some extent between SHA and SNA is needed but because SHA concerns specific area of health care so the main purpose of the SHA should be the best analysis of this area with its characteristics. SHA 1.0 provides valuable information and in itself has a great value. Implementation of a large amount of SNA methodologies and concepts (Price and volume, inputs, output and outcome, direct volume measures, deflation, indices, quality adjustments) and a significant increase of the area of account (Non health products, (Un) paid household production, Cost of illness, Non-monetary health data, Production account) may lead to confusion and lack of comparability of data in time and data between countries. Concepts and measurements of SNA are often inconsistent and conflicting with similar terms used in SHA (eg accrual vs. cash accounting). Revision, which aims to SHA 2.0 is trying to make too big qualitative leap forward. Proposed objectives of revision are very wide, which we believe can lead to loss of many positive features of SHA1.0. We think that the first question that should be answered is: "what should be measured" and then it should be specified which methods of reaching the goal are appropriate and clearly indicated the methods that are recommended.

Polish comments on Eurostat proposal for the unit 2 of the SHA manual “Global Boundaries Of Health Care”

Specific remarks

Figure at page 6

Intermediate consumption is placed next to “core”, however occupational medicine is included into SHA and from SNA point of view it is not the final consumption, but intermediate consumption. Some comments should be added.

Point 5: “The provision to individuals implies an economic flow from providers to consumers”. What does “economic flow” mean? If services or goods, the flow is really from providers to consumers. However at the same time we have financial flow from agent to provider.

Point 11, last sentence: “Transactions usually take place between actors as individuals, providers, corporations, and financing agents which are the economic units of health systems” is not clear, i.e. providers are mixed with financing agents.

Point 36 – see remarks to Unit 3

Annex 1

- Alternative medicine - It will be difficult to distinguish services provided by health professionals and no-health professionals. In our opinion only the first group should be included into SHA.
- We suggest to you change the order of two last columns: main arguments should be put after recommendations

Annex 2

1. Current health expenditure versus Total health expenditure. We support proposed solution.
2. SHA restricted to a Consumption approach versus SHA as a system integrating Consumption and Provision approaches.
In our opinion the proposal is not compliant with the general rule of not-including export into SHA (which is mentioned many times). It can lead to lack of international comparability or force some countries to workout the account in defiance with methodology. Such solution could be accepted as “the last resort”, in case of no other possibilities.
3. Medical goods production versus final use approach of medical goods, Production of medical goods versus trade margins of medical goods versus turnover approach
We agree with the proposal to limit the providers and provision of products to viewpoint of the consumers. However in our opinion adding the words „(domestic and

foreign)” needs reconsideration, because it suggests including export of goods and services.

4. Nursing care versus Long term care (social care)

We agree with the proposal to keep the situation as it is, i.e.:

- define LTC with a functional approach

- LTC including ADL but excluding IADL

5. Home production for own final use

We support the first proposal to include only remunerated household production in SHA, because estimation of the all household production in the SHA framework would be extremely difficult, even impossible, as in the given example of chicken soup for the sick member of household. In case when whole family consume this soup, what value should be included into SHA?

Additionally, we add some cogitation concerning residents and non-residents that you might find useful:

In answer to the proposition concerning definition of the residence of individual person in “one and only one economic territory”, expressed in point 3.6 Territorial boundary – p. 13, it can be well-funded to mention detailed regulations of the Council Regulation (EEC) No. 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community. The Council Regulation, especially these articles included in the Title II of regulation: “Determination of the legislation applicable”, can be very helpful when defining the legislation of the country applicable to given user of social services, including health care goods and services as well as defining the country responsible for covering expenditures on health care goods and services. Regulation 1408/71, together with regulation 574/72, specifies in which cases (not uncommonly very particular: seasonal workers, official representatives, students) an individual person, who utilizes health care services and goods abroad, is subjected to the legislation of a given EU member state. Such a strict classification, despite of its complexity, allows statisticians to decide to which country a specific health care expenditure should be referred/attributed. It also specifies the way in which flows of funds between health care funders of different member states should be organized. The important weakness of the considered regulation is its limited area of application. Since it is a law document of the European Community, and it was designed, among many other things, in order to solve the problem of health care expenditures attribution, it can be applied only to the financial transfers made between different EU member states. However, it can serve as a starting point for a discussion on attribution of the health care expenditures (also issue of health care goods and services imports tracking) to the health care system of a given country when the cross-border health care is analyzed.

Polish comments on OECD proposal for the unit 3 of the SHA manual “Key concepts and definition in Health accounts”

Specific remarks

Provision and consumption

Figure 1 (p. 6) does not appear to be quite clear from an economic point of view. Are concepts of Provision and Consumption parallel to Supply and Demand? For example, demand may be greater than consumption, and this situation can often be found in health care. Is there assumption that supply = demand in methodology of Health Account?

Accrual versus cash accounting

In Poland, Health Account is compiled from the side of Financing Agents and expenditure is recorded in cash. The use of accrual accounting in this case is extremely difficult. We believe that cash accounting gives a better view of flow of funds than accrual accounting because recording of actual expenditure in real time is more practical and safer than reckoning of sums that will be transferred in the future. This is also consistent with the first paragraph of Part 1: “Health accounts are a systematic description of **financial flows** related to health. In their current form, the primary purpose of these accounts is to capture three elements of these financial flows, namely: Who is **spending funds** on health? How much are they spending? What are they spending these funds on? “

Export

The approach that we use (recording of expenditure from side of agents) will not allow us also to directly estimate the volume of export of services. The export of health services does not fall within the scope of SHA, but revision proposes to include export (Unit 2, p.31) and mentions it a couple of times and recommends separate estimation of exports as a memorandum item “for clarity and reconciliation with the production account”. Does that mean that in our situation we have to additionally estimate exports of health goods and services?

Gross capital formation

We wanted to ask why the category HP.4 "retailers of medical goods" has been excluded from the definition of Gross capital formation?

Research and Development

We support the position that Research and Development should be included into classification of Gross capital formation.

Polish comments on Eurostat proposal for the unit 8 of the SHA manual “Classification of Health Care Providers”

Specific remarks

Classification of economic units

As Figure 1. exhibits (Possible classification of economic units...) - p. 4, health care providers are attributed to cost-sharing. In fact, such reference is not always an obvious fact. At least this attribution requires additional comments. Health care providers can only participate, together with corporations (and purchasing/financing agents – what is not stated in the Figure 1.), in the process of cost-sharing payments administration (including: collection, evidence and reporting) or sometimes impose some additional payments (e.g. balance billing) but never share a part of payment with patients/health care users, irrespectively of the kind of payment: co-payment (a flat fee or charge per service), coinsurance (set as percentage of total cost of service), deductible (payment that cover a fixed amount of money before insurance coverage become active) and balance billing (an extra payment imposed by provider in addition to payment obtained from the third-party payer). One can recommend to make a connection between the co-financing dimension (4.1) and purchasing agents by means of cost-sharing. It is a matter of fact that purchasing agent are, within their principal activity, primarily engaged in the process of cost-sharing administration as well as they share the cost of health care goods and services utilization (e.g. deductible).

In the footnote No. 9, which stands for a comments to criteria for classification of economic units in SHA – bottom of p. 4, a new distinction is made between the rest of the economy (HP.7) and providers of health related functions (M1(HP)). However, the proposed classification seems to be a vague concept. It can be supposed that, in a great number of countries around the world, there are health care settings that can be referred to the both mentioned points of the economic units classification. How, by the way of example, to classify institution which provides health related functions and, at the same time, provides health care as the secondary activity? Probably a fourth point of the classification is needed or some further adjustments have to be done.

Consumption and Delivery

In the point 2.5.5 – p. 12 it is stated: “Consumptions of services mirror the delivery of health care”. According to the common understanding, such declaration indicates the equivalence between consumption and delivery of health care goods/services. Of course it is not true, especially when the arguments presented in the next section of unit 8, namely 2.6 Boundary issues, and some conclusions from the Unit 2, concerning export for non-resident individuals are taken into account. Therefore, an indicated sentence should be excluded or modified.

Classification of providers

First level classification starts with 10 and goes on. In our opinion it can be confusing and is not compatible with rest of classifications (HC,HF). It would be more convenient to start with one digit ex. 1,2, etc.

Dispensing chemists

In the point HP*16.1 – p. 41 “Dispensing chemists” it is written that “pharmacies in hospitals serving mainly out-patients are part of establishments classified under HP*10 Hospitals. However, the case of pharmacies in hospitals should be deeply elaborated. Let’s consider the HP classification in the following cases:

- pharmacies in hospitals which are included in the organizational structure of the hospitals and serve the medical needs of the in-patients cured in the hospital – it can be advised to classify under HP*10 Hospitals.
- pharmacies in hospitals which are excluded from the organizational structure (owned by a private corporation/entity) of the hospitals and serve the medical needs of both: the in-patients cured in the hospital as well as two different groups of out-patients: “internal out-patients” (those cured within the outpatient health care which stands for the secondary activity of the hospital) and “external clients” (not cured in hospital) – a very good question is how those pharmacies should be classified: under HP*10 “Hospitals”, HP*16.1 “Dispensing chemists” or in the other way?
- as it is in the second case, but pharmacies in hospital are included in the organizational structure of the hospital and are not owned by a private corporation - it can be advised to classify under HP*10 Hospitals.

Other remarks

- on the page 2 (point 3) the questions should be asked as follow: “What **is** the organizational structure which **is** characteristic...” or “What **are** the organizational structures which **are** characteristic...”. The author have to choose between singular or plural.