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Comment Unit 11

Classification by beneficiary/ recipient characteristics

French Comment on the WHO Proposal

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**French comments on WHO paper on the unit 11 of the SHA manual
Classification by beneficiary/recipient characteristics**

Here are some comments and questions about the paper by WHO for unit 11.

A general comment is that we consider that expenditure by patient characteristics should be only on a voluntary basis in SHA2 questionnaires. Furthermore, in the case of expenditure by regions, we doubt there is a real interest for that topic in international comparisons; so we consider this part of the unit 11 as some advice for countries which would need to split expenditure by regions for national purposes.

Scope of health expenditures considered in distributional analyses

We support the proposal of paragraph 26: “this document proposes that all standard distributional analyses of expenditures by beneficiary be restricted in scope to direct personal and collective service health expenditures (HC.1 – HC.7).” If this kind of analysis is made in the existing SHA framework, it is conceptually more satisfactory to analyse expenditure by patient characteristics in the scope of current health expenditure than for only personal health care goods and services. But for collective health care services (HC.6 and HC.7), there will be a need for very clear guidance to have comparable data across countries. For instance, for prevention expenditure (HC.6), there can be several methods which can lead to very different results: allocation on an equal per capita basis at total level, allocation on an equal per capita basis for each prevention program among the targeted persons (the results then depending on the level of detail available to define a prevention program). For instance, for an information campaign to discourage smoking, how should the expenditure be allocated among diseases? For health administration and health insurance (HC.7), expenditure can be allocated on an equal per capita basis, or proportionally to the personal health care (HC.1-HC.5 expenditure).

In paragraph 3, there is a reference to the “work of the OECD/Eurostat project on expenditures by disease, age and gender”. But in the list of characteristics presented at paragraph 30, age and gender on the one side, and type of disease or illness on the other side, are presented

separately. Does it mean that the idea of expenditures by disease, age and gender is abandoned? If not, then there is a need for clarification.

Age and gender

In the paper, when considering personal health care goods and services, it is supposed that expenditure is linked to one person. But some personal expenditure can be linked to several persons. The simplest example is expenditure linked to pregnancy or delivery: should that be linked to the baby or to the mother? Another (minor) example is health care for fertility problems, when both the man and the woman are concerned. So there should be clear guidelines for these cases; these guidelines should not only be conceptually satisfactory, but should also take account of the data availability problems.

Socioeconomic status

The paper proposes three approaches: income, expenditure and consumption. It mentions that all these approaches will require use of household survey data.

In the French case, we are able to produce some information by quintiles or deciles of income (or income adjusted for size of household, using "OECD-modified equivalence scale"). But I doubt we can produce information by quintiles of expenditure or consumption, because we have no household survey providing reliable data both on health consumption and overall consumption (resp. expenditure). For instance our household budget survey provides reliable data for overall consumption, but not for health expenditure because of lack of information concerning health expenditure financed through (public or private) third-party-payment arrangements.

Geographical region

In the French case, one would need to use estimates (and sometimes rough estimates) to allocate expenditure by regions. But it would be impossible to build the regional accounts mentioned at paragraph 56, because of lack of data.

Methodological approaches

Paragraph 59: We support the position that "SHA-based beneficiary analyses must generally adopt what is known as a top-down approach".

Paragraph 64: We consider SHA2 should stay at the "basic approach" proposed in the paper, i.e. "analysis of spending by one dimension of beneficiary characteristics and one ICHA dimension". The ultimate objective mentioned in the paper ("estimating a triaxial distribution of spending by provider, function and financing scheme") would need much more information than what is available now, and probably than what will be available in the coming years.