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Comment
Unit 8

Classification of Health providers

Revision of the
System of Health Accounts

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Classification of Health providers

Classification proposal:

Roughly, we agree on the proposed classification, however, some remarks:

- In our view, the proposal document balances on the edge of what the value added of a 'satellite account' can be to an accounting system, in casu SNA. In that sense that we think that paragraph 27 could be questioned in its assumption that aggregating SHA economic units can lead to SNA industries etc. A first question is whether this is absolutely necessary, and a second remark is that this might be the case on a theoretical base, but in practice? We remain convinced that the main value added of SHA is that it permits to overcome the limitations of a number of classifications and to analyse activities rather than institutions. An absolute correspondence (equality) between totals is therefore not necessary.

Another more general remark we would like to make, results from the proposal of the classification for 'provision related providers' (education, research, pharmaceutical industry). It seems to us that there might be an implicit risk that the scope of the health accounts is enlarged and goes much further than the initial aim at the basis of SHA 1.0: to measure consumption of health and long term care services. Different practices in different countries may then lead to lack and loss of comparability.

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These categories, if seen in terms of measuring the final consumption, are in an large part intermediate consumption and investment and need therefore to be eliminated, except if they are and in so far that they are, providers of 'finally consumed' services and goods. National methodologies will have to resolve the problems linked to the separation between final and intermediate consumption for those countries where this is necessary in view of the construction method of their health accounts.

If the aim is not or no longer to measure only health consumption, (first of all there should therefore be an agreement on this modification of the final aim of the health accounts) this will lead analytically to a very different measure (differently) the importance of the medical and pharmaceutical sector in the economy which goes far beyond health care consumption within the countries. Is this not already done in SNA (with its classifications of activities and products)?

If so, we then have the (unresolved) question for ourselves of what would be the 'policy utility' of SHA, other that blowing up totals and making economical sectors appear more important. (e.g. if 'medical research' is to be included, what with the education costs of the researchers – especially the non-medical researchers)?

It will be clear that our preference is to keep the 'health provision related' providers out of the scope and leave them 'health related - below the line' (voluntary for those who wish) for all activities not directly being final consumption of health goods and services.

Finally, it is also obvious that the scope covered by the providers classification has to correspond with the scope covered by the functional classification, as they are to be crossed at a given time.

Specific remarks

- _Concepts of classification:_ We do not fully understand paragraph 4 on the comparability not being the main intention of HP-classification. In our view classifications (and the criteria behind it), are just useful for enhancing comparability and are meant to permit comparability and understanding and comparability should be (at least) one of the most important priorities of classifications. Classifications and their criteria just permit overcoming comparability issues emerging when just referring to 'vocabulary habits' for national concepts. Comparability is to be pursued not only for the functional classification (HC), but also for the classifications in the other dimensions, otherwise the tool loses much of its analytical powers based on comparability.

  By reaching for comparability in the providers classification (HP), and especially by the classification criteria behind it, SHA just overcomes the comparability problems of SNA; ISIC, etc…linked to for example, the use of the 'majority' rules in such systems.

  Some punctual remarks:

- classification categories 10.1 and 10.2: in our opinion, this distinction is unclear. University hospitals offer basically the same kind of medical services as general hospitals. On the other hand, it is not to be excluded that in some general hospitals who are not connected to a university, medical education is delivered. Therefore, we would propose that, if the distinction is to be made, it would be made at the 4th digit level (10.1 General hospitals, subdivided in 10.11 – university hospitals and 10.12 – Other general hospitals)
- from a definitional point of view, it seems illogical to us to use the term one wants to define in its definition: it is obvious that a 'university hospital' will belong to the university hospital category (second part of the definition)

- *Coding (figure 2) – annex II:*
  - In the paper, the first level classification coding uses a two digit 'x0' classification. However this is mostly a convention problem, we wonder whether this is efficient. We think of it as more 'natural' to start with '1, 2, etc…' on the first digit level.
  - For the categories 10 to 16, we think it is more logical to start with 11, etc.. to be more in line with the conceptual proposals for the 3rd digit level. 'x.0' numbering is often used for software versions, but is it useful compared to habits in accounting?
  - If the subcategory 30 'health administration…' exists, it seems to correspond to a kind of global denominator for the categories 30.1, etc..; A similar 'globalising' name for the proposals 10,11, etc.. lacks. We would propose something in the direction of 'formalises care provision'. 20 'Households would then become something like 'informal care provision' (again we would prefer to number these globalising items as 1, 2, …)

- *Boundary:* In view of paragraph 31, our opinion remains that the SHA-scope is to be limited to the final consumption of health services and goods.

Other issues related to HP:

- mode of production: we agree with the remarks on the actual integration of this dimension in the functional classification (SHA 1.0). We agree that this is probably not the most indicated way to integrate the mode of production and that is more linked to the providers than to the functions of care, if 'mode of production' is to be integrated.
- private/public ownership: we find this from a (Belgian) policy point of view an irrelevant criterion.

May it also be clear that these have not the ambition to be an exhaustive answer to every remark the proposal can lead, but that it only gives an overview of those which struck us most. It is therefore clear that these and other points can need further discussion.