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Advancing The Debate On International Spending Comparisons
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The Commentary by Dale Rublee and Markus Schneider is both a constructive addition to the important debate on international comparative data and a good example of a misleading interpretation of new comparative data. Given the widespread interest in international health system comparisons and the almost complete lack of interest in the underlying conceptual bases of the data, it is important to have alternative methodological formulations of the underlying data. It is also important that these formulations be conceptually sound and not based on one-sided a priori political motivations. The article by Daniel Waldo and Sally Sonnefeld in the Summer 1991 issue of Health Affairs provides a good example of a careful critique of a one-sided attempt to adjust international data inappropriately.¹

The problem with the Rublee/Schneider Commentary is rather different. The authors assert that their bottom-to-top approach to developing a series of health expenditures leads to better comparative information than the data developed by the Organization for Economic Cooperation and Development (OECD). By excluding research and development, construction, and administrative costs, components they assert are difficult to measure, and adding together in a bottom-to-top approach hospital spending, physician spending, dental expenditures, long-term care expenditures, and so forth, the authors argue that they have constructed a better comparative data series than the OECD’s top-to-bottom approach. They also “consulted with authorities in all countries.”

Defining health components. Their arguments are unfortunately spurious and misleading. In fact, if a country’s accounting system is comprehensive and consistent, then either the OECD or the Rublee/Schneider approach should lead to the same magnitudes. The real problem is that there are no standardized, internationally-accepted definitions of health care components. Individual countries all use their own definitions of hospital services, long-term care services, and so forth, in their administrative reporting systems. To define hospital services to “include acute care, psychiatric care, and long-term hospital care, drugs used in hospitals,
and the services of physicians provided in hospitals” or long-term care services as “including services in nursing homes and home care” is tautological. How are hospitals, nursing homes, and home care defined? Defining hospital services as services performed in hospitals is not very helpful. Are retirement homes and home-based social services included in long-term care? This circular and imprecise definitional approach does not in any way assure that individual countries’ administrative reporting systems are using the same definitions, especially since there are no standard definitions and the boundaries between medical and social services are notoriously imprecise.

As discussed at length in our Spring 1991 DataWatch, the OECD expenditure data are based on a standardized concept, that of national income and product accounts. These data are a mixture of macroeconomic satellite health accounts and a basis for integrating micro data sets. There are, as we point out, boundary issues concerning long-term care. In fact, while the OECD data set arbitrates perhaps on the low side of this gray area, there appears to be an upward bias in the Rublee/Schneider approach. While Rublee and Schneider stick to the reported data, the OECD approach pushes countries to modify their definitions to be consistent with the Classification of Functions of Government definitions that underlie national income and product accounts. In contrast to Rublee’s and Schneider’s assertions, the OECD does not simply accept the data supplied by individual countries. These data are made to conform to the underlying standardized concept. These data are verified by the appropriate statistical authorities of all the OECD countries on an ongoing basis, and changes are made only so long as recommended changes are consonant with the basic standardized definitional concept. The claim that a bottom-up approach based on circular definitions from administrative reporting systems using different definitions can provide better comparative data is simply wrong.

**Price deflators.** There are other troublesome areas. As the authors point out, price deflators are one of the most difficult areas in international comparisons. Yet, little information is provided about the specific composition of the price deflators used in their analysis. We would argue that input price measures of the type that the OECD is trying to develop are superior to the medical care component of the consumer price index (MCI?). The MCPI hardly reflects actual prices paid for the bulk of medical care by most U.S. third-party payers or the public systems in most other countries. The point here is that this is a difficult area, and one must be extremely careful to define precisely the indices used.

**Measurement difficulty.** Another problem concerns the authors’ assertion that their concept of health expenditures is a better measure for
making comparisons due to the difficulty of measuring research and development, construction, and administration. In our view, measurement difficulty is not a sufficient condition for asserting that one approach is superior to another. In fact, we would argue that the measurement difficulties here are not intractable and that total national health expenditures including administrative costs are a better measure of the performance of health systems. Measuring private health expenditures in many countries is also an area of measurement difficulty; why not also exclude these from the underlying comparisons? The point here is that there are always trade-offs and issues of data reliability. While one must make trade-offs concerning reliability versus completeness, it is not at all clear that data problems preclude development and use of the more complete concept of total national health expenditures.

**Conclusion.** After all is said and done, the data developed by Rublee and Schneider provide the same overall comparative picture as those developed by the OECD. The U.S. health care system is the most expensive in the world. The OECD data provide a similar story of increases in gross domestic product (GDP) shares and nominal spending, while real spending increases are heavily dependent on the price deflators chosen. Are Americans to take heart because based on the Rublee/Schneider definition of health spending, U.S. per capita spending in 1988 exceeds Germany by only 68 percent and Canada by 34 percent instead of the OECD’s 71 and 3.5 percent? Might not the more complete OECD data be more meaningful from a health policy perspective?

Rublee and Schneider have contributed positively to this debate by attempting to develop disaggregate information on health care spending components. This is a problematic area. Such disaggregate information is extremely hard to obtain and make consistent with measures of availability and use (a problem not of concern to Rublee and Schneider). We hope that responsible international organizations will begin to devote the resources to further develop comparative disaggregate data as well as the institutional information so desperately needed to move the current debate beyond the aggregate comparisons currently possible.

**NOTES**