

Revision of the

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## Comments on the proposal for the Unit 7 of the new SHA Manual

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# Comments on the proposal for the Unit 7 of the new SHA Manual

by

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## 1. Main purpose of ICHA-HC:

According to the proposal:

- “the classes retained should correspond to final consumption”;
- “categories should reflect the purpose of care”;
- “Categories should not be oriented according to the institutional or societal arrangements to make services accessible to the public”;

In general conceptual terms, the main purpose of ICHA-HC hasn't changed. The current SHA Manual already highlights that “The functions of health care refer to the final consumption of goods and services” (see in §3.6 of SHA Manual version 1.0). However a neutral position about the mode of production classification is being introduced that is, in other words the classification implies that the providers or the provision approach are dropped.

The crucial question here is to assess the “importance” of data (expenditure on health) split by mode of production. This means that if the provider approach is dropped a lot of information is lost and we need to assess cost/benefit of losing that information in terms of the analysis of the National Health Systems having or not available the information of expenditure on health by mode of production.

On one hand, the main purpose of SHA should meet the main data needs of its main users. And the main purpose ensures this goal. On the other hand, the SHA data should be a tool to measure the development and to analyse the national health policies performance and as such should reflect obligatorily the providers' point of view. The expenditure on health by mode of production reflects the organization of

the providers and enables the analysis and planning of the provision of the health care goods and services.

The ideal solution can pass to keep the classification of the mode of production and by compiling an additional table on expenditure of health by providers and mode of production. Therefore we propose that the modes of production are kept.

For operational reasons we also have to consider for many cases the availability of the information split by functions that is provided by providers: This mean hat providers have implemented a specific system of information that should be mapped to the functions. For SHA 1 this had already been more or less achieved and although SHA1 had lots of problems we think that this change requires new systems of information that are not implemented. Therefore we think that the implementation of such classification as proposed will be more feasible the more harmonized with the existing systems of information would.

## **2. ICHA-HC Categories:**

The proposal presented by WHO for the unit 7 of the new SHA Manual introduce a great revision in ICHA-HC classification.

- Services of Curative Care and Services of Rehabilitative Care are replaced for Acute and Emergency Care and Chronic Disease Management
- Ancillary Services to health care and Medical goods dispensed to the out-patients (Pharmaceuticals and other medical non-durable + Therapeutic Appliances and other medical durable) are included in Acute and Emergency Care, Chronic Disease Management and Long Term Care

The definitions of the new ICHA-HC categories need to be better described and some ambiguous situations should be clarified. The classification must be objective and mutually exclusive and concerning the functional classification no doubts should be raised to the compilers.

- According to the new classification the expenditure on pharmaceuticals, other medical non-durable, therapeutic appliances and other medical durable is included in one episode of acute, emergency, chronic or long term care.

- In the case of the pharmaceuticals dispensed to out-patients by pharmacies: how we can separate de pharmaceuticals dispensed to acute patient or to chronic patient?
- The Over-the-counter medicines are included in the total of medication (HC.1.1.4)?

In this case we suppose that these medicines are exclusively administrated to acute patient.

- The therapeutic appliances and other medical durable are only dispensed to chronic patient? For instance, if a person breaks a leg probably you need to buy crutches. This person is not a chronic patient but the crutches are classified under the therapeutic appliances and other medical durable. Where should we record the expenditure on crutches?

- In the case of the health services provided by the general or specialist practitioners in private offices how to separate the expenditure between acute patient and chronic patient?

- We would like to stress that some chronic diseases also have acute episodes. Therefore we envisage difficulties in doing so.

For practical reasons the main problem would be to separate expenditure on health at the second level of the functional classification, between acute and emergency care and chronic disease management. It only will be possible if the data sources provide information according to the type of diseases or patients.

### **3. Annex 1. Transition path from ICHA-HC.1 to ICHA-HC.2**

We disagree with the direct correspondence between:

#### **HC.1.3/HC.2 Outpatient and rehabilitative = Acute care**

Outpatient and rehabilitative care should also take into consideration the chronic patients

#### **HC.1.4/HC.2 Home care = Chronic Disease Management**

Home care should also take into consideration the acute patients

We also would like to see the medicines and the other medical durable goods dispensed to out-patients isolated in one position of the first level of the functional classification. It is important for policy reasons to have these medical goods isolated on a first level.