

Revision of the

System of Health Accounts

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Comment Unit 7

OECD comments to Unit 7

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OECD COMMENTS to UNIT 7

Background

Received country feedback has raised a number of issues regarding the proposed revision of the ICHA-HC Functional Classification. At the OECD meeting in October 2000 and at the subsequent WHO regional meetings country representatives have expressed reservations to the proposal.

The proposed revision represents a major revision of the classification, which, while welcomed in its conceptual approach, would appear unfeasible in practice. It also appears to out of step, in some respects, with some of the guiding principles of the revision process (outlined in the Framework and PoW documents), namely:

- to ensure backward comparability of data based on the current classification and those based on the revised one.
- a solid statistical framework that is comprehensive, consistent and appropriately linked to other statistical systems, in particular to the System of National Accounts.

While it is acknowledged that there are a number of problems with the current classification(s) - and these have been well documented - such a radical change would appear unnecessary based on the advances made over recent years in current reporting and the wishes of a number of countries. As part of the feedback to the draft PoW, the following was included in the final POW:

“The second group of general comments on the Draft Programme of Work addressed the reasons for revising. Some respondents expressed the view that the current system of health accounts methodology is working quite well and thus no or minimal change is required. We recognise both the strengths and weaknesses of the current methodology. Our focus is on improving the weaker points but not on changing the whole system.”

Some of the main issues raised with the proposal are briefly summarised below:

1. Acute/Chronic/Long Term

Many comments point to the definitional and data difficulties in reporting what is essentially a classification of stages of disease.

2. Incorporation of mode of production

One of the objectives raised in the proposal paper is the separation of mode of production from function. The proposal put forward is that this should be under the provider classification. However, the corresponding input paper on HP revision, although stating this again, does not provide a concrete proposal on how to achieve this. Would this mean a further mode of production category for each HP.1 and HP.3 sub-category?

Moreover, despite the conceptual issues raised of mixing mode of production in functions there appears to be little enthusiasm for removing it, rather the opposite.

One of the arguments for removing the mode of production has been the difficulties of countries to report expenditures by mode of production. However, results from the 2008 JHAQ suggest that the vast majority of countries are able to do this at an in-patient/out-patient level and increasingly for day-care and home-care.

3. Reporting of strong policy relevant variables

In addition to the policy importance of in-patient vs. out-patient, another frequently requested and important variable is pharmaceutical spending. The proposed classification does not allow for an easy extraction of such expenditure. This can only be done by summing across sub-categories of acute/chronic, etc. Given the difficulties raised in separating according to these categories in many cases these will be left blank and thus vital information will not be easily provided by the tables.

4. Personal prevention

From a practical point of view, this is likely to pose problems for many countries in being able to separate prevention activities from curative treatment. However, the reporting of prevention activities under the current system is weak and there have been a push from some countries to include prevention undertaken at the primary care level and some have been able to provide data (in some cases rather onerously), so there could be a case.

5. Links to existing statistical systems

SHA.1.0 included a correspondence table between ICHA-HC and COFOG, COICOP. This should be maintained, if not strengthened in any revision to meet the revision objective.

6. Separate reporting of cost structure

An additional point that we would raise is the possible confusion over what are 'functions' for final consumption and what are supporting activities in providing an inpatient treatment – medication, diagnostic services, hotel costs etc. It is clear that there is a request for this information, as has been shown in the inclusion of memorandum items in the JHAQ. However, a separate classification of the *function in the cost structure of providers* is needed and was highlighted in SHA 1.0.

Proposed next steps

From the proposal it should be stated that there are some areas that have received general support and that that should be carried forward, namely:

- A top level separation into “Care and Treatment”, “Prevention and Public Health” and “Stewardship and governance”. Whether these need to be explicitly assigned HC codes is another question.
- The proposed treatment of prevention into personal and collective, albeit with the difficulties raised above. The split into personal/collective prevention should be examined, since this has been a highlighted weakness in SHA.1.0. However, the inclusion of a separate medical goods category may cause too many problems, unless clearly defined as particular preventive goods – nicotine patches, (lipid-regulators), etc.
- The renaming and sub-division of Stewardship and Governance category, subject to clear definitions.
- The support for a separate Resource Formation classification covering Gross Capital Formation, Human Capital and R&D requires further investigation.

Taking these changes into mind we are suggesting a return to the SHA 1.0 ICHA-HC classification as a starting point and then adopting a “minimal change” approach which is contained in Annex 1 (with a mapping to SHA.1.0.) and Annex 2 (a mapping from SHA.1.0 to SHA.2.0).

The main basic criteria for the original classification of health care services in SHA 1.0 was adopted from the Australian Health Data Committee model of “type of episode of care” and the subsequent division into Curative, Rehabilitative and Long-term care.

Returning to these sources reveals a current classification of hospital-type care according to the following types of care:

Value	Meaning
1.0	Acute care (Admitted care)
2.0	Rehabilitation care (Admitted care)
2.1	Rehabilitation care delivered in a designated unit (optional)
2.2	Rehabilitation care according to a designated program (optional)
2.3	Rehabilitation care is the principal clinical intent (optional)
3.0	Palliative care
3.1	Palliative care delivered in a designated unit (optional)
3.2	Palliative care according to a designated program (optional)
3.3	Palliative care is the principal clinical intent (optional)
4.0	Geriatric evaluation and management
5.0	Psychogeriatric care
6.0	Maintenance care

- 7.0 Newborn care
- 8.0 Other admitted patient care
- 9.0 Organ procurement - posthumous (Other care)
- 10.0 Hospital boarder (Other care)

Full details and definitions can be found at:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/270174>

Combining some of these categories of care would leave us primarily with the same groups as SHA.1.0 (below) although accompanied by stricter definitions, particularly in the case of Long-term nursing care (see separate note on LTC):

- **Curative care**
- **Rehabilitative care**
- **Long-term nursing care**

As stated, these categories refer to hospital-admitted or in-patient care. Therefore a number of issues need to be addressed:

- 1. Can these groupings equally apply to the other modes of production: day care, out-patient and home care?*
 - 2. Are these groupings any more preferable regarding the feasibility of countries to report them, i.e. the current SHA.1.0 split or the proposed WHO Acute/Chronic care split? (For example, in the current 2008 JHAQ, 7 out of 20 countries did not provide a split in-patient care into C&R. For the 13 remaining countries, curative in-patient accounts for 27% of current health expenditure while rehabilitative in-patient is 2%. Is this a true reflection of the curative/rehabilitative split? Furthermore, even if the classification splits C & R, should the collection continue to allow countries to report both together?)*
 - 3. Should the Functional Classification start from the Mode of production viewpoint or from this type of episode of care perspective? If we have a separate category of Preventive care, then does it make more sense to start from the Curative/Rehabilitative, etc viewpoint?*
 - 4. A split of curative in-patient care into medical and surgical types is put forward as a suggestion to give a link to a possible product breakdown of in-patient care (re. proposed framework on PPPs). Is this a possible approach to pursue?*
 - 5. Where should traditional medicine be included – as an optional sub-category of curative out-patient care for example? Or also in other areas e.g. medical goods, etc? Or as a separate category in its own right? (The proposal shows both options)*
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On the rest of the proposed classification in Annex 1, some further questions arise (among many others!);

- 6. Should there be a separate classification for 'Resource Formation' covering GCF and R&D (and Education & Training) or should these remain part of the functional classification as health-related functions?*
 - 7. To avoid confusion on what is Public Health Expenditure, should 'Prevention and Public Health' be called just 'Prevention'?*
 - 8. Should Medical goods be split into a 'cleaner' pharmaceuticals only category? Previous reporting of pharmaceuticals included 'other non-durables'?*
 - 9. Is the breakdown of Therapeutic appliances to the 3 digit level warranted when the 2nd – digit covers less than 3% of current spending on average? Does it belong in a detailed product classification?*
 - 10. Do the proposed collective prevention categories (from WHO) extend the boundary to include expenditure previously reported under HC.R.4 and HC.R.5?*
 - 11. The classification contains a proposal to split the previous category of Ancillary services to include Diagnostic and laboratory test with out-patient care, leaving Transport as a separate category. A lot of emphasis has been placed on transport through the regional networks and input documents. Could this provide a basis for meeting what is highlighted as an important policy need? Do the other ancillary services belong under out-patient care?*
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The classification proposed merely sets out a possible approach. In developing it further, there will be a need to work through, in detail, the definitions and issues such as the exhaustiveness and mutual exclusiveness of the classification. This includes whether all categories should include an 'other' sub-category.

Additionally, links to other classifications such as COFOG and COICOP need to be explored at some stage. Finally, the question arises as to whether a classification such as this should be submitted in its own right to the UN Social and Economic Classifications Expert Group for review.

Annex 1. Proposed revision of ICHA-HC: mapping SHA.2.0 to SHA.1.0¹

SHA.2.0	ICHA-HC →	SHA.1.0
HC.1	CURATIVE CARE	HC.1
HC.1.1	In-patient curative care	HC.1.1
HC.1.1.1	In-patient curative care - medical cases	-
HC.1.1.2	In-patient curative care - surgical cases	-
HC.1.2	Day cases of curative care	HC.1.2
HC.1.3	Out-patient curative care	HC.1.3*/HC.4.1/HC.4.2
HC.1.3.1	Basic medical and diagnostic services	HC.1.3.1*
HC.1.3.2	Specialised health care	HC.1.3.3
HC.1.3.3	Out-patient dental care	HC.1.3.2
HC.1.3.4	<i>Imaging and pathology services</i>	HC.4.1/HC.4.2
HC.1.3.9	All other out-patient care (incl.TCAM - see HC.8)	HC.1.3.9
HC.1.4	Home care: curative	HC.1.4
HC.2	REHABILITATIVE CARE	HC.2
HC.2.1	In-patient rehabilitative care	HC.2.1
HC.2.2	Day cases of rehabilitative care	HC.2.2
HC.2.3	Out-patient rehabilitative care	HC.2.3
HC.2.4	Home care; rehabilitative	HC.2.4
HC.3	LONG-TERM NURSING CARE	HC.3
HC.3.1	In-patient long-term nursing care	HC.3.1
HC.3.2	Day cases of long-term care	HC.3.2
HC.3.3	Out-patient long-term care	-
HC.3.4	Home care: long-term nursing care	HC.3.3
HC.4	PATIENT TRANSPORT	HC.4.3
HC.4.1	Patient transport and emergency rescue	-
HC.4.2	Other patient transport ?	-
HC.5	MEDICAL GOODS dispensed to out-patients	HC.5
HC.5.1	Pharmaceuticals	HC.5.1
HC.5.1.1	Prescribed medicines	HC.5.1.1
HC.5.1.2	Over-the-counter medicines	HC.5.1.2
HC.5.2	Other medical non-durables	HC.5.1.3
HC.5.3	Therapeutic appliances and other medical durables	HC.5.2
HC.6	PREVENTION (AND PUBLIC HEALTH)	HC.6/HC.1.3.1*/HC.R.4*/HC.R.5
HC.6.1	Individual Services	-
HC.6.1.1	Counselling and Risk Assessment	-
HC.6.1.2	Screening and Check-Ups:	-
HC.6.1.3	Family planning and contraception.	-
HC.6.1.4	Immunisation and vaccines	-
HC.6.1.5	<i>Preventive medical goods</i>	-
HC.6.2	Collective Services	-
HC.6.2.1	Regulation	-
HC.6.2.2	Disease Surveillance & Control	-
HC.6.2.3	Information and awareness	-
HC.7	STEWARDSHIP AND GOVERNANCE	HC.7
HC.7.1	Health Programme administration	-
HC.7.2	System financial administration	-
HC.8	TCAM	-
HC.9	Other health functions n.e.c	HC.9
HC.1-9	CURRENT HEALTH EXPENDITURE	HC.1-9
HC.1-9 +GCF	TOTAL HEALTH EXPENDITURE	HC.1-9 +HC.R.1
<i>Health Related</i>		
HC.R.1	HEALTH RELATED SOCIAL CARE	HC.R.6
HC.R.1.1	Long term social care	HC.R.6.1
HC.R.1.9	Other social care	HC.R.6.9
HC.R.2	Education and training	HC.R.2
HC.R.3	Food, hygiene & drinking water control (cf. HC.7.2)	HC.R.4*
HC.R.4	Environmental health (cf. HC.7.2)	HC.R.5*
<i>Other aggregates</i>		
HC.3+HC.R.1	Total Long-term care	HC.3+HC.R.6.1
<i>Memorandum items</i>		
M.1(HC)	Total pharmaceuticals (incl. in-patient, etc)	M.2(HC)
M.2(HC)	Total imaging and pathology services (incl. in-patient, etc)	M.3(HC)*

¹ * denotes possible boundary difference.

Annex 2. Proposed revision of ICHA-HC: mapping of SHA.2.0 from SHA.1.0²

SHA.1.0	ICHA-HC →	SHA.2.0
HC.1	Services of curative care	HC.1
HC.1.1	In-patient curative care	HC.1.1
HC.1.2	Day cases of curative care	HC.1.2
HC.1.3	Out-patient curative care	HC.1.3*
HC.1.3.1	Basic medical and diagnostic services	HC.1.3.1*
HC.1.3.2	Out-patient dental care	HC.1.3.3
HC.1.3.3	All other specialised health care	HC.1.3.2
HC.1.3.9	All other out-patient curative care	HC.1.3.9
HC.1.4	Services of curative home care	HC.1.4
HC.2	Services of rehabilitative care	HC.2
HC.2.1	In-patient rehabilitative care	HC.2.1
HC.2.2	Day cases of rehabilitative care	HC.2.2
HC.2.3	Out-patient rehabilitative care	HC.2.3
HC.2.4	Services of rehabilitative home care	HC.2.4
HC.3	Services of long-term nursing care	HC.3
HC.3.1	In-patient long-term nursing care	HC.3.1
HC.3.2	Day cases of long-term nursing care	HC.3.2
HC.3.3	Long-term nursing care: home care	HC.3.4
HC.4	Ancillary services to health care	-
HC.4.1	Clinical laboratory	HC.1.3.4*
HC.4.2	Diagnostic imaging	HC.1.3.4*
HC.4.3	Patient transport and emergency rescue	HC.4
HC.4.9	All other miscellaneous ancillary services	-
HC.5	Medical goods dispensed to out-patients	HC.5
HC.5.1	Pharmaceuticals and other medical non-durables	HC.5.1
HC.5.1.1	Prescribed medicines	HC.5.1.1
HC.5.1.2	Over-the-counter medicines	HC.5.1.2
HC.5.1.3	Other medical non-durables	HC.5.2
HC.5.2	Therapeutic appliances and other medical durables	HC.5.3
HC.5.2.1	Glasses and other vision products	-
HC.5.2.2	Orthopaedic appliances and other prosthetics	-
HC.5.2.3	Hearing aids	-
HC.5.2.4	Medico-technical devices, including wheelchairs	-
HC.5.2.9	All other miscellaneous medical durables	-
HC.6	Prevention and public health services	HC.6*
HC.6.1	Maternal and child health; family planning and counselling	-
HC.6.2	School health services	-
HC.6.3	Prevention of communicable diseases	-
HC.6.4	Prevention of non-communicable diseases	-
HC.6.5	Occupational health care	-
HC.6.9	All other miscellaneous public health services	-
HC.7	Health administration and health insurance	HC.7*
HC.7.1	General government administration of health	-
HC.7.1.1	General government administration of health (except social security)	-
HC.7.1.2	Administration, operation and support activities of social security	-
HC.7.2	Health administration and health insurance: private	-
HC.7.2.1	Health administration and health insurance: social insurance	-
HC.7.2.2	Health administration and health insurance: other private	-
HC.9	Not specified by kind	HC.9
	Current health care expenditure HC.1-HC.9	HC.1-9
HC.R.1	Capital formation of health care provider institutions	-
	Total expenditure HC.1-HC.9; HC.R.1	HC.1-9 +GCF
HC.R.2	Education and training of health personnel	HC.R.2
HC.R.3	Research and development in health	-
HC.R.4	Food, hygiene and drinking water control	HC.R.3
HC.R.5	Environmental health	HC.R.4
HC.R.6	Administration and provision of social services in kind to assist living with disease and impairment	HC.R.1
HC.R.6.1	Social services of LTC (LTC other than HC.3)	HC.R.1.1
HC.R.6.9	All other services classified under HC.R.6	HC.R.1.9
HC.R.7	Administration and provision of health related cash-benefits	-
Memorandum items:		
M.1(HC)	Other (Non-health care/health-related) goods and services	
M.2(HC)	Total pharmaceuticals and other medical non-durables (including in-patient and other ways of provision)	M.1(HC)*
M.3(HC)	Total of ancillary services (including in-patient)	M.2(HC)*

² * denotes possible boundary difference.