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Comment
Unit 7

French comments on the draft versions of unit 7 of the SHA manual

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French comments on the draft versions of unit 7 of the SHA manual

Unit 7: Functional Classification of Health Expenditure

The revised HC classification should satisfy some important criteria: homogeneity inside a class and heterogeneity between classes, international comparability, possible transition from HC in SHA1 to HC in SHA2...

The proposed HC classification seems to be based on an "episode of treatment" approach, which is very interesting. But the implementation of that classification seems to raise several theoretical and practical issues.

The first breakdown in the classification is a distinction between "HC1-Health care and treatment" and "HC2-public health and prevention". That distinction generates conceptual problems in the definition of boundaries.

For instance, in the paper, antibiotics are mentioned as an example of "HC.2.1.2 Prophylaxis", but antibiotics are also used to care illnesses. Another example is the treatment of cholesterol: should it be considered as the treatment of a disease, or as a treatment of a risk factor to prevent for instance heart-diseases? The distinction between treatment and prevention also raises technical problems. In France, we made a study to isolate in personal health care the part that could be considered as prevention goods or activities¹.

For that study, we had to use a methodology close to the one used by the present OECD working group on expenditure by age, gender and disease (actually, in our study, we estimated at the same time prevention and expenditure by disease). So we had to use several data sources, including surveys (for instance to isolate prevention activities among medical examinations). As we mentioned at the 2007 OECD meeting, it is not feasible to implement that methodology every year (because of the amount of work that it represents); it is not useful either because a lot the surveys we used are only renewed every 4 or 5 years.

So, we propose that the HC classification in SHA 2 continues to include in the prevention category only the collective programs of prevention, and that prevention activities made on an individual basis (like prevention activities in ordinary medical examinations) continues to be

¹ See for instance the presentation made at the 2007 OECD meeting of health accounts experts by Thomas Renaud, or the short English version of that study, available at:
<http://www.irdes.fr/EspaceAnqlais/Publications/IrdesPublications/QES111.pdf>

aggregated with treatments (HC1, HC2, HC4 and HC5 in present classification). But to have information on the global prevention expenditure, it could be possible to add a memorandum item that countries could fill on a voluntary basis, every 4 or 5 years, as it is planned for expenditure by age, gender and disease.

The second breakdown in the classification is a distinction between "HC.1.1 acute and emergency care" and "HC.1.2 chronic disease management". This generates also conceptual and technical problems. For instance: how to consider the treatment of an acute episode of chronic disease? Is there an internationally accepted list of chronic diseases? From a practical point of view, we won't have data to isolate "chronic disease management" among several health expenditure, for instance medical examinations and transportation.

Another problem of the definition of the first and second digit level is that one has to add several items to get basic information. For instance, total medical goods expenditure is the sum of HC.1.1.4, HC.1.2.4, HC.2.1.2.

If the distinction between acute care and chronic diseases is an important issue, we suggest that the HC classification in SHA 2 puts in the first digit level the type of care and goods (more or less like in the present classification) and only at a second or third digit level the distinction between acute care and chronic disease. Other important distinction should be present in the next HC classification, like the distinction between inpatient care and ambulatory care.