

Revision of the

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## Comment Unit 8

### Comments concerning the Proposal Unit 8 (ICHA-HP CLASSIFICATION OF HEALTH CARE PROVIDERS)

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Comments concerning the Proposal Unit 8 - ICHA-HP CLASSIFICATION OF HEALTH CARE PROVIDERS.

- a) I am a little bit confused with classifying and treatment of economic units providing health care services where this is not their principal activity. The text of the unit 8 does not seem to be clear to me enough as in the sence describe in the following lines.

The problem can be illustrated on the treatment of social care establishments classified by NACE codes 87 and 88. In the text you mention that only those with principal activity of health care should be included in health care providers HP\*.1. On the other hand when describing Residential providers on pages 34-35 the definition explicitly says that social services prevail in these establishments. Is it necessary/worthwhile having these categories of providers in HP\*.1 if most of them should be classified as non-health care providers?

Figure 2 on page 8 does not provide a clear message whether there is direct link between SHA version 2.0 and NACE, i.e. whether all establishments classified with code NACE 87 are linked to the respective categories of HP\*.11.

It should be at least much clearer from the SHA 2.0 how the units belonging to NACE 87 and 88 should be classified - if based on the criterion of principal activity (some of them would then belong to HP\*.11 and the rest of them under HP\*.50) or whether all of them in health care providers.

The application of principal activity criterion implies that each individual institution is evaluated concerning its principal activity and this process and following results might be different in different countries (based on different data sources and methodologies).

The same problem concerns HP\*.13.4 (Integrated care providers) and HP\*.13.5 (Social care providers) as most of the providers do not provide health care as their primary activity. If we use the criterion of primary activity these groups of providers inhibit understanding of provision of health and social services and the link to SNA because only small part of the institutions should be included in health care providers and the rest in other institutions (rest of economy).

Concluding, there are two options:

1) Following the NACE and keeping general consistency of SHA with NACE/SNA we would consider "Providers of health and social services" altogether and only focus on more detailed/adjusted structure of this industry for the purposes of SHA;

2) Primary activity is strictly followed which means that some categories of health care providers may be excluded from the proposed classification (e.g. HP\*.13.5, and probably HP\*.11.2-9,...) as they are not supposed to provide health care services as primary activity. --- If we decide on this approach I would propose to add an additional group of "Provision related producers" HP\*.4 which includes a category of social care establishments following structure of NACE 87 and 88 sections.

One more implication related to this issue. If we classify part of the residential establishments into "provision related producers" what would be the estimate of expenditure on health care services in these institutions? Is it only pure health services? Ancillary services such as accommodation and food costs should be excluded although these costs are taken into account in residential establishments which are "health care providers".

- b) There seem to be another example of inconsistency in SHA 2.0 concerning considering principal activity as a criterion. This can be demonstrated with the example of classifying of hospitals. One should classify (following instructions) army, veterans and police hospitals under HP\*.10.1. But military and prison health services not provided in separate health care establishment should be classified under HP\*.10.9. This example demonstrates that criterion of principal activity is suppressed as these services are provided as a secondary activity of military or prison institution. These services need not usually be provided in a separate economic unit and thus following the recommendation of SHA these services should be included under HP\*.50 in my understanding of the instructions. I agree that these hospitals are included under hospitals HP\*10.0 but the more explanation/justification is needed for this solution.
- c) We (in the Czech Republic) still can not find a solution for classifying bed care institutes providing rehabilitative, follow-up or balneology care which could be classified under HP\*.10 or under HP\*.11. These institutes do not usually provide acute care but the share of medical care is not negligible. In SHA 1.0 these institutes used to be classified und HP.1.2 or HP.1.3:
- "Balneologic institutes" provide in-patient and out-patient treatment at a spa that prevalently employs local curative sources and climatic conditions. In this case the situation is even more complicated by the fact that the provision of hotel services is usually not necessary/linked to spa services which can be provided in a separate building. So that beds are usually not directly linked to provision of health care;
  - "Institute for TB & respiratory diseases" determined for patients with pulmonary and extra-pulmonary respiratory diseases whose health state requires long-term bed care. (Average length of stay - ALOS - is about 40 days);

- "Rehabilitation institute" provides complex long-term rehabilitation bed care to patients with specified locomotory disorders or with disorders of other specified functions. (ALOS is 35 days);
- "Psychiatric institute" provides bed care to persons with mental disorders. It may also provide ordered compulsory (or protective) treatment, out-patient psychiatric care and psychotherapy and also other specialised diagnostic and curative care. (ALOS is 80 days.)

Some supporting or illustrating indicators might also be helpful for classifying the providers in SHA v 2.0, e.g. ratio of medical and nursing personnel, average length of stay, physician to bed ratio, ...

The problem with these establishments comes from disparity between classification of functions HC and classification of providers HP. HC considers acute, rehabilitative and long-term care whereas HP considers only hospitals and residential/nursing care providers in SHA v.1. Thus providers of predominantly rehabilitative care should be classified either as hospitals or LTC providers which might cause comparability problems between countries. We would prefer having more clearer statements on how the establishments providing prevalently post-acute, rehabilitative, follow-up, balneologic care should be treated.

d) Specific comments with the page reference:

Page 35: HP\*.11.3: We are not sure whether assisted-living facilities should be treated as residential care providers. The reason is that the grade of autonomy of persons living there is very high and that the provision of nursing/social services might be treated as home care services and other services like rent may not be taken into account as part of health care services.

Page 38: The first paragraph of the HP\*.12.9 subchapter seems to belong somewhere else in the text. It is not clear whether family planning centres belongs to HP\*.12.2 or HP\*.12.9 because they are mentioned in both categories of providers.

Page 42: As retail sellers of medical goods are not usually treated as health care establishments the data in the structure requested, i.e. HP\*.16.2, HP\*.16.3 and HP\*.16.9 can hardly be gained in reality. The situation is even more complicated as the NACE does not provide enough detailed classification and description and medical goods retailer can be included not only under the code 47.74 but also under 32.50 or 47.78 codes.

Page 43: HP\*.30.1: It is not clear where public institutions providing services to the ministry of health should be classified. This group of institutes covers e.g. statistical institutes of ministry of health or institutes administering health

registries. It is also not clear whether health departments of regional or municipal governments should be included - these are not economic units but they provide health administration.

Page 43: The description of HP\*.30.3 belongs to HP\*.30.2 and description of HP\*.30.4 belongs to HP\*.30.3. The description of NPISH and other administrative units is missing.

Page 45: There is a difference between SHA v1 and v2 in treating laboratories. Laboratories are treated as related producers now. If imaging and laboratory services are treated as health care services we have economic units providing health services (i.e. these laboratories) but not considering them as health providers. If the payment to such laboratory comes from physician/hospital asking for the test I can understand that the provider of health service could be the physician/hospital. But usually the laboratories are paid by third parties and thus they should be considered as health providers in my understanding. The services of laboratories are in this relation similar to services provided by ambulances/medical transport and in my understanding should be treated in the same way. My question is who is the provider of these laboratory services?

Paragraphs 56 and 72 say something about "unknown" providers, i.e. providers which can not be classified into a specific group of providers. It should be clear whether there is only one such group HP.nsk (par. 56) or more HP.x.9 (par. 72). If paragraph 72 applies then distinction must be done as there are already defined HP.x.9 categories which are reserved for "specific" health care providers (e.g. HP\*.11.9 for group homes ...).

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