

Input Document
Unit 7

ICHA-HC Functional Classification of Health Care

Summary

The United States (US) offers its recommendations on Unit 7 based on three years of research on the feasibility of producing functional estimates in the US National Health Expenditure Accounts. The US suggests that the ICHA-HC Functional Classification system include more aggregated categories that are applicable across all OECD nations. These would allow for greater cross country comparisons in spite of data limitations and differences across health systems. Additionally, proposals that might lead to more universally applicable, useful, and accurate estimates are put forth. These include a quest for greater clarification between or merging of HC.1 (curative care) and HC.2 (rehabilitative care), as well as merging the concepts of Outpatient and Day cases. Also discussed are implementations of new categories or concepts through the use of satellite accounts or supplemental tables.

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In October 2007, a paper was presented at the OECD Meeting of Health Accounts Experts on attempts by the US to implement the ICHA-HC Functional Classification of Health Care. This study revealed that extensive conceptual issues and data gaps exist between the SHA functional categories and the US health data system. Other OECD member countries may face similar conceptual and data-related roadblocks that inhibit the completion of estimates of health care spending by function. In the interest of creating a functional accounting system that can be used as a basis for comparison between other countries, it might be advantageous to develop an aggregated list of functional categories that summarize the current, more comprehensive breakout. Countries with extensive data systems would still provide detailed breakouts of health care spending by function; however, aggregated categories would allow for higher-level cross-country comparisons with those countries that have fewer or less compatible data resources. The comparability of health data across countries is important and the OECD should be supported in their endeavors to find meaningful measurements of health spending. This input document provides recommendations that may improve the accuracy and usefulness of the functional estimates.

Key Issues

This document offers the following suggestions for discussion, based on the key issues outlined in the Invitation to Submit Input Documents for Unit 7. IHCA Functional Classification of Health Care.

Key Issue 1: The construction of classes independently of mode of production

Aggregated functional categories, including the construction of classes independently of mode of production, would enable countries with more limited data sources to be able to participate in cross-country comparisons. In general, this could make the functional estimates more inclusive and universally applicable, which should be a priority of the international health accounting system. The functional framework should be structured in such a way that it can be employed by more nations (even those with fragmented health financing and data collection systems) and it can incorporate a wider range of data availability and capabilities. Successful compliance with the current framework is closely linked to two factors: a country's ability to access universal claims data and that country's ability to adjust data at the event level to estimate health spending across multiple dimensions. While it is admirable to establish a system designed to provide users with a great level of detail, an assessment of universal applicability is needed to ensure that data is available to create the estimates and allow for comparability across countries. We will delve further into this issue in Key Issue 2.

The System of National Accounts (SNA93) states that the creation of satellite accounts or systems allows for

“(b) The use of complementary or alternative concepts, including the use of complementary and alternative classification accounting frameworks, when needed to introduce additional dimensions to the conceptual framework of national accounts.”ⁱ

In this case, a system of aggregate functional breakouts could be prepared that would allow for more comprehensive cross-country comparisons. Additional satellites could be

developed that would provide useful breakouts for comparisons across countries with similar systems or abilities to provide the measures.

Key Issue 2: Disaggregation of HC.1 into the various products of the hospitals

Disaggregation of functional categories into the various products of hospitals is acceptable, as long as aggregated functional categories are also included. However, definitional ambiguities currently make disaggregation of functional categories prohibitively complicated. For example, the disaggregation of classes HC.1, 2, or 3 (curative care, rehabilitative care, and long-term care, respectively) into products of the hospital may be problematic, as the definitional line between HC.1 and HC.2 is difficult to draw in nations whose health delivery and data systems do not differentiate between acute and rehabilitative care (see Key Issue 3). Spending may be allocated arbitrarily or less precisely to either of these classes, which would impact the comparability of disaggregated hospital spending estimates across OECD countries. Therefore, the classification and disaggregation of products associated with hospital care should be those that can be clearly defined and are universally applicable across all OECD health care delivery systems.

Pharmaceuticals and medical equipment expenditures provide another example where the inclusion of more aggregated measures may prove useful and policy-relevant. The current SHA functional classification system only accounts for HC.5 (Medical goods dispensed to outpatients). A valuable extension of the current classification system would be to create supplemental tables that would expand the pharmaceuticals and medical equipment categories to include total spending as well as spending disaggregated by mode of production. Although U.S. data are not currently capable of this kind of analysis, the concept is worth exploring due to its policy relevance.

Key Issue 3: Review of HC. 2 as a class of its own or possibly merge with another

The definitional line between curative and rehabilitative care is difficult to distinguish. An episode of curative care is defined in the SHA as “one in which the principal medical intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury or to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, ” while rehabilitative care “comprises services where the emphasis lies on improving the functional levels of the persons served and where the functional limitations are either due to a recent event of illness or injury or of a recurrent nature.” There are a variety of episodes of care that may be loosely defined by either one of these categories. For example, a hip replacement surgery may be intended to both relieve/reduce the symptoms of an injury, while also improving the functional levels of the patient. The categories rehabilitative and curative care should be collapsed into one category and long-term custodial care into another category.

Key Issue 4: HC. 4 to be analyzed regardless of mode-of-production (presently accounts only for outpatient care)

Currently, the SHA does not explicitly state that HC 4 was intended to account for only outpatient care. Congruent to our discussion in Key Issue 2, examining the total spending on ancillary services to health care within a provider category and then disaggregating total ancillary services spending by mode of production in supplemental tables would make a worthwhile addition to a functional analysis.

Key Issue 5: HC. 5 to be analyzed regardless of mode-of-production (presently accounts only for outpatient care). Consider the inclusion of traditional, alternative and complementary medical goods in the framework.

See discussion in Key Issue 2, paragraphs 2 and 3. Traditional, alternative, and complementary medical goods may be included in the framework, so long as aggregate categories are still included to permit as many countries to submit comparable estimates as possible.

Key Issue 6: HC.R.1 to be accounted in a separate classification as it is not a genuine health function.

Capital spending is a key indicator that reflects the changing capacity of a health system. So while these estimates are important to the overall accounting scheme, we should distinguish them from the actual delivery of care. Therefore, it is appropriate to include two aggregate health spending measurements – one that accounts for spending on direct health care services and products delivered in a given year and another that includes both direct care spending and spending on capital (capacity).

Additional Key Issues/Comments

Key Issue 7: The addition of an aggregated mode of production that encompasses Day cases and Out-patient cases

For some countries, it may be difficult to make a distinction between Day cases and Outpatient cases. Both are episodes of care where the patient does not stay overnight; however, some health systems may consider admitted patients that do not spend the night (ex. Ambulatory surgery) to be outpatients, while others distinguish them as day cases. Therefore, we recommend the inclusion of an additional functional category entitled “Outpatient and Day cases” that aggregates the current Day case and Outpatient case categories. This will allow for comparability of spending data across more countries.

Key Issue 8: The Episode as the Unit of Analysis: An Assessment of Policy Relevance

The current unit of analysis in the functional framework (the episode) presents a number of conceptual and data-related challenges both in constructing estimates and in providing policymakers with understandable and useful data. According to the current definition, an episode includes every service rendered to limit the severity, duration, and effects of disease or injury (SHA Manual p.115). This definition may be subject to interpretation as to when episodes begin and end, which may lead to inconsistent allocation of spending across national estimates and/or conceptual ambiguity. Both of these issues potentially reduce the policy relevance of the estimates. One solution is to add a clear temporal boundary to the definition of an episode for each service (e.g. limiting an inpatient hospital episode to a single hospital stay.) The choice of temporal boundary should ideally be tailored to permit as many countries as possible to provide estimates, as well as to provide policymakers with a more concrete concept by which analyze and compare spending estimates.

ⁱ System of National Accounts. XXI Satellite Analysis and Accounts. Paragraph 21.4b.