ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

World Health Organization

Comment
Unit 8

Comments from WHO regional consultation

Revision of the
System of Health Accounts

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Submitted on 28/07/2009
Document code .... SHA-REV- 08204

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Unit 8 comments from WHO regional consultation

The World Health Organization has conducted regional three days consultations with separate sessions devoted to each of the Units in the SHA revision. National experts in health accounting and health financing policy have been invited from member states in the respective regions. Because comments represent the views of different regions, they may vary or even contradict each other.

Regional Office for Africa, Nairobi 15-17 April 2009

The consultation meeting underlines the importance to keep Household as proposed.

Suggested changes are:

Traditional healers should be classified in new category (digit 2)

Create a special subcategory (digit3) for independent traditional midwife under "other care providers".

Hospitals should be broken down in only "general hospital" and "specialized hospital" and leave countries include national specificities. For example private/public/faith bacsed might be a split practiced in several countries. "Mental health hospitals" and "Out patient mental health centers" should be classified respectively under "Specialized hospital" and "Medical care centers". No main categories are needed. But there were intense discussions about the classifications of hospitals and whether the proposed classification is compatible with the African context of university hospitals and district hospitals. There is an interest in being able to distinct between not only the level of specialty, but also geographical catchment area. It calls for being careful in defining the categories, and naming them.

There is for the AFRO region no need to have a sub category called "Social care providers". In the region they always work in health facilities, not as independent providers.

Suggested deletions are:

Laboratories for scientific research should be kept as "provision related producers" (HP 42), but the following items are suggested to be removed:

"Medical and diagnostic laboratories » from « provision related producers" and leave it at "health care producers" (HP 12.6).

"Market research" (HP 41.2) from "provision related producers"

"Industries" (HP 42)from "provision related producers"

"Wholesale retailer" (HP 44) from "provision related producers"

"Reinsurance" (HP 45) from "provision related producers"

Regional Office for South-East Asia and Regional Office for the Western Pacific, Seoul 6-8 May 2009

SHA should clearly describe criteria and present examples; describe which rules/criteria are followed. ISIC focuses not only on health but also on social care – there is a need to have a definition to separate the providers of health (main activity) versus providers of social care (main activity) but with health as secondary activity; can "rest of economy" still be used?

Although there is a risk to lose the details/in-depth of providers information, there are advantages in using additional criteria for HP classification, i.e. to go beyond ISIC.

The meeting had a long discussion of whether there should be a private/public ownership split in the classification. Most of the represented countries have this incorporated in their national classifications and it was agreed that guidance on this is useful in an international standard because if many countries use it, common definitions and basic classifications of private/public is useful. However, the meeting strongly recommended to keep the classification as simple and minimal as possible, which argues for keeping it outside the actual classification.

There is a need to permit flexibility in the HP classification structure to allow for countries to add additional characteristics, most importantly primary, secondary and tertiary levels of care.

There is an overlap, or at least an ambiguity in the proposed "Provision related producers" of pharmaceutical industry and research, and a need to clarify/distinguish scientific from market research. Its recommended to either include a complete classification of research and development institutions, or exclude incomplete categories. Generally the need for inclusion of pharmaceutical industry as a provider is disputable.

In HP 12 and 13 it is unclear what the different "other providers" mean (12.9 could in principle be 13, and what is 13.9 in relation to 12.9?)

It is recognized by the meeting that there is an improved comprehensiveness and completeness compared to the current HP classification, but also "new" inconsistencies introduced, e.g. between HP 12 and HP 13.

Confusion about the class households, and what that really means given that non-reimbursed household provision is excluded by the boundary criteria. A special explanation delineating this class from the "provider of home care" is also needed.

The Regional Office for the Eastern Mediterranean and the Regional Office for Europe, Geneva 26-28 May 2009

The region supports following the ISIC classification and stresses that the organizational structures are more important than functions in the provider classification, which should be reflected.

The new classification is useful in the sense that nothing from the current HP is lost but more categories were added. Regarding the level of care it is best reflected in the functional classification and not in the HP provider classification. But it's also suggested to classify providers into central, regional and municipal levels.

There is a need for more careful explanations and improved definitions of what is meant by many of the classes, in addition to the need of examples;

- How do we distinguish between hospital and medical care center?
- What should be included or excluded under HP 44 to avoid duplication?
- Regional and municipal government entities are very often not only financing agents, they administrate health services and other activities. Do we have to assign it under HP30.9 (other administrative units)? Do we need to create independent subcategory under HP30?

Suggestions;

- A shortage in SHA 1 is the lack of a public/private split of providers. Since many countries introduce this themselves in the classification, it would be very useful with a common definition.
- Add a new category under HP16 - Other retailers of medical equipment
- SHA2 proposes to put blood and organ banks under pharmaceutical industry. The meeting recommends to put it in the same category as it was in SHA1, under other providers of ambulatory health care.
- Its suggested to look at what names are used for the HP provider classification in regions outside Europe.
- HP 14.1 public health centers, and 14.2 other preventive care units: in the annex other classifications are provided for the same HP categories (14.1 provision and administration of health promotion and control programs, 14.2 specialist providers of occupational health care). This should be corrected or explained.

Regional Office for the Americas, Cuernavaca 17-19 June 2009

There is no need to have a one-to-one relation between the new HP and the ISIC economic units and NACE Classification because the ISIC and the NACE are accountable for the aggregate economic activities of a country, whereas the old and the new HP respond to more specific interests of the health sector. But the meeting recognizes the importance of reaching harmonization among classifications whenever possible. An Appendix that includes the ISIC and NACE Classifications, together with their corresponding HPs is recommended, and the goods and services they produce included based on the CCP products classification.

The proposed classification of providers includes various classes that are actually functions. This was subject to criticism throughout the meeting. The HP classification must correspond to institutional structures that truly represent a provider of health care goods and services. In this sense, it is possible to take the ISIC as reference, or otherwise, take it as a basis to identify organizational structures. Next, the goods and services (outcomes) produced by these institutions should be considered followed then by the functions. That is the purpose (or it is in

the process of development) of the functional classification. HP classification should exclude functions.

The chapter includes a section of criteria for the classification of economic units, but it is not sufficiently clear or precise to be used as the basis for the definition of each institutional structure within the HP classification.

With the present classification of providers the benefits are the following:

- University hospitals are included
- Dialysis centers and units are included, which is very important because of the incidence of diabetes.
- It includes transportation providers.

The following is lost with the proposal:

- The denomination Mental Hospitals is inferior to that of Mental Health and Substance Abuse Hospitals.
- It uses denominations that do not belong to an institutional structure, such as: practices and personnel
- Proposal 2 of the new classification includes industry, wholesalers, manufacturing, medical facilities, medical equipment, and so on, which in case they are included would generate double accounting because these values are within the final goods and services. What must be included are the final health care providers and final services plus the management/administrations of health care and social security.
- The new proposal denominates specialized and general offices in the two digit level. A better option is to have the medical office denomination with two digits and the specialized and general office with three digits since often times there is information only regarding offices in general and there would be no way to segregate them in general and specialized. This could be part of a further research study, but in the meantime, the possibility of having them included together is preferred.
- The new version, option 1, excludes laboratories and diagnostic centers. We strongly recommend keeping them because of the important weight they have in out-patient care.
- Dental practice represents a function and so we advise to use dental centers.
- “Out-patient Care Providers” is preferred to “Out-patient Medical Care Providers” since non-medical providers are also included.
- This chapter defines “Other Health Care Providers” as non-medical health facilities; however, this is not always the case since many of the services pointed out as examples

are provided by physicians: chiropractors, optometrists, mental health specialists, physical therapists, and so on.

- In SHA 1 and in the new version 1, providers of medical education such as universities and other medical education centers, are excluded.
- The following order is recommended: Hospitals, Outpatient Center and Day Care.

Further comments and observations

- With regards to providers of preventive program, we consider that these programs are included within the benefits of health care units, so they cannot be treated separately. Additionally, there is no specific or separate budget line to identify the service or function of out-patient care delivered by these facilities, hence this classification is not useful.
- The chapter mixes concepts of the SNA and the SHA. It is quite clear that one of the objectives of the methodological revision is to bring both systems of accounts into harmonization, but there should be no mixture or confusion of concepts. Development of compatibilities, contact points and means to migrate data are required.
- When pondering upon the role of households in the three activities: consumption, provision and financing, this section is overworked. Chapter 8 refers to the function of households as providers, but this is poorly developed. Indeed, it would be convenient to consider opening the role of households as paid providers by identifying those medical offices and medical and non-medical practices carried out informally within the household. Likewise, it would be interesting to offer guidelines for a study on non-paid household work in order to provide methodological support to separate research projects.

  The meeting considers that for the time being this should not be incorporated as part of the accounts because of the lack of information and estimation difficulties.

- The chapter is written more as food for thought than as an explanatory document. It is an intermediate product between a reflection and a manual, and is actually full of questions. This is very valuable because it opens up the opportunity to express our opinions on a very preliminary version. However, the next version should be written in a manual style and the questions or gray areas placed as footnotes for further discussion.
- Harmonization of the terminology used is recommended: Facilities (hospitals, centers, providers) and practices (dental, general medicine, transportation of patients), are providers. Transform these into institutional structures: providers, and clearly establish the difference between provider and function. A provider is an organizational unit or facility; the purpose of the benefit is a function.
- The term “primary care providers” was proposed to be removed: there are no primary care providers since this is a strategy involving several kinds of providers and also several kinds of functions.