

## Input Document Unit 8

# Inputs to the Revision of the ICHA-HP (Unit 8)

### Summary

This paper discusses weaknesses and issues confronted in the current version of the ICHA-HP scheme that could hopefully be resolved in the second System of Health Accounts or SHA2. The specific issues tackled include: determining the appropriate object of classification when applying the ICHA-HP; need for more comprehensive and consistent treatment of providers of health related services and providers of traditional/ alternative medicine services; simplification of the categories for hospitals and ambulatory care providers; and need for improved definition of private households as providers of home care.

Overall, this paper suggests (1) simplifying the ICHA-HP scheme; and (2) improving documentation in the SHA manual. The ICHA-HP scheme should be simplified and have countries build in the additional detail according to their needs and (statistical and data) capacities. Simplification will reduce inapplicable and inconsistent categories. Additionally, the chances of compliance with the standardized classes will be higher if these are not too complicated. Some of the issues could be resolved with better documentation of the ICHA-HP scheme in the SHA manual – including among others, more explanations of concepts and clear statements of definitions.

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# **UNIT 8 - ICHA CLASSIFICATION OF HEALTH CARE PROVIDERS**

## **Inputs to the Revision of the ICHA-HP (Unit 8)**

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## **Introduction**

### ***Comment on the general approach underlying ICHA-HP***

The provider classification of health care industries in SHA1 was formulated using the approach in the System of National Accounts or SNA that involved (1) to identify the classes or groupings of production units according to their principal economic activity and (2) to follow the International Standard for Industrial Classification or ISIC for classifying economic activities or industries. The SHA2 will be emphasizing closer link and compatibility with other international statistical and classification standards. The approach taken in SHA1 for the formulation of the health provider classification, the International Classification of Health Accounts-Health Providers or the ICHA-HP, as described above should be continued and followed in SHA2 as this has already promoted to a great extent link to other international standards.

An important input to the construction of the ICHA-HP scheme is the definition of the range of types of economic activities or functions included in the health accounts boundary. The definition of the scope of included functions is important because these, in turn, identify the production units included in the health provider branch. Any significant changes in the range of functions included in the health accounts boundary between SHA1 and SHA2 should be examined carefully for possible implications on the provider classification scheme.

While the main criteria used to draw up the existing classification of health providers is the type of health care and health related services produced/provided from principal or secondary activity, other criteria seems to have also been applied, including other characteristic properties of providers. For example, as in the SNA, the distinction between economic units operating domestically and internationally is made, and all health providers located outside of a country are treated separately as part of the rest-of-the-world or ROW providers (HP.9 ROW). Another example, an attempt was made to separate out providers of traditional and other alternative medicine services in the extended ICHA-HP classification presented in the National Health Accounts Producer's Guide or the PG. These additional criteria, on top of the principal economic activity criteria, have contributed to making the current provider classification scheme more informative. On the other hand, the use of additional criteria may have also introduced problems such as inconsistencies among the classes or categories.

### ***Possible areas for revision in the ICHA-HP***

A number of weaknesses in the ICHA-HP classification have been encountered, several of which had manifested in actual application or practice. (The weaknesses referred to are both conceptual as well as practical ones, i.e. the latter being deficiencies in the SHA and/or PG

manuals.) This paper attempts to discuss a number of these weaknesses or issues, providing suggestions where the writer can.

Conceptual issues discussed include: (1) determining the appropriate object of classification in the ICHA-HP, which the manuals do not explain adequately; and (2) how the health care function split between core and related health services should be handled in the provider classification.

Difficulties encountered in actual practice and discussed cover (1) missing or unclear definitions of provider categories, and (2) missing or inconsistent categories. Another difficulty discussed is insufficient guidance and instructions in the SHA1 and the PG about some aspects of measurement.

Other difficulties encountered and discussed relate to having to rearrange, regroup and work around the existing provider categories to suit and fit country contexts. That is, categories needed to be modified to reflect the country health care system structure, to answer data need of policymaking and to suit the data situation. The issue here is to find a compromise between the extent or the level at which categories are standardized across countries (i.e. the minimum categories needed for international comparability), and the extent to which countries are allowed to specify more detailed categorization according to their own needs and capacities.

The weaknesses or issues are discussed in the succeeding sections referring to the particular portions of the ICHA-HP that need attention. The discussions are organized from the more general to the more specific issues. Some of the weaknesses and issues pointed out in this paper could hopefully be resolved in SHA2.

## **Object of classification in ICHA-HP**

A brief review of some System of National Accounts (SNA) concepts and approaches with regard to classifying economic transactions and transactors is presented, since the SNA is the basic guide in the formulation of the ICHA-HP classification scheme.

The SNA framework maintains a classification system that includes classification of transactors and transactions. The economic transaction of relevance to this paper is the production of goods and services. For identifying flows in the SNA pertaining to the production of goods and services, the relevant transactors or reference units are economic units capable to owning assets and incurring liabilities on their own behalf – and these are called “institutional units.” In addition to being the center of legal responsibilities, institutional units are centers of decision for all economic activities. The institutional units are grouped into sectors including among others non-financial corporations (principally engaged in production of market goods and non-financial services), financial corporations (engaged in production of financial services) and general government (engaged in the production of services and in regulation.) Aside from

the grouping of institutional units by sector, the institutional units are also grouped by economic activity in the SNA. This grouping requires more homogeneous units that can be identified with a principal economic activity. Institutional units engaged in more than one production activity are further disaggregated into smaller production units which can then be identified with a principal economic activity and these smaller units with homogeneous products are called establishments. It is the establishments which are then classified according to the ISIC.

However, what may be considered homogeneous as far as the SNA is concerned may not be so for health accounts purposes. In health accounts the different health goods and services are considered as distinct products. And we do find health provider establishments producing mixes or combinations of health services rather than a homogeneous set. As stated in SHA1, the ideal object of classification for ICHA-HP would be production units or establishments producing a homogeneous range of services – thus, establishments would be well-defined and internationally comparable. However, in reality establishments may not necessarily be ideal, with some producing mixes or combinations of services rather than producing a homogeneous set. SHA1 does not provide complete instructions on how to deal with the less than ideal situation, i.e. how to handle the assignment of establishments to ICHA-HP categories when they produce a mix of health services. More specifically, the issue of interest is how to treat the production of health related services (HC.R) when these are carried out as secondary activities in establishments that are primarily producing core health care services (HC). Should the “sub-unit” in charge of the (secondary) production of health related services be treated as a production unit separate from the main establishment unit? How to determine operationally (for this latter situation) the appropriate “production units” to be used as objects of classification for purposes of the ICHA-HP classification needs to be clarified in SHA2. This particular issue arises from the fact that in the health care functions classification the functions are split into core and health-related, and that the two sets of expenditures need to be kept distinct in NHA estimation to be able to construct the different expenditure aggregates, e.g. Total Health Expenditures or THE versus the National Health Expenditures or NHE.

From a health functions perspective production activities may be grouped broadly into those that produce three categories of products – core health services (HC), health-related services (HC.R) and non-health products. Some establishments will be producing a homogeneous group of products and some will be producing a combination of these products. To illustrate the problem in the ICHA-HP classification and its use, establishments with different combinations of activities will be classified according to health provider categories, as shown in the table below. (Only the types of establishments included in the NHA are listed in the table below.)

Type of establishment (by combination of economic activities – principal and secondary activities)	Health Provider Classification		
	HP.1 to HP.6 Core health functions (principal)	HP.7 Core health functions (secondary)	Health related functions (principal & secondary)
<i>Establishments with homogeneous group of activities</i>			
(A) Principal activity – core health function	X		
(B) Principal activity – health related function			X
<i>Establishments with combination of activities</i>			
(C) Principal activity – core health function; Secondary activity – health related function	X (?)		X (?)
(D) Principal activity – non-health Secondary activity – core health function		X	
(E) Principal activity – non-health Secondary activity – health related function			X

In general, most types of establishments may be classified under only one HP category. The problem encountered is in the (C) establishments that produce core health services as primary activity and, at the same, also produce health related services as secondary activity – these establishments fall under two HP categories. How this may be resolved and the issues involved are discussed further in the next section.

### **Providers of core versus related health services**

If the existing broad grouping for health care functions which distinguishes between “core” health care functions (coded HC) and health related functions (coded HC.R) is kept in SHA2, how should this split be handled in the provider classification?

The SHA1 presently makes no reference to health related functions in the provider classification. The extended ICHA-HP classification in the PG inserted the category HP.8, Institutions providing health-related services, to fill the gap mentioned, but did not establish the definitions for this set of providers. If the approach adopted in the PG (i.e., inserting HP.8 in ICHA-HP) is adopted in SHA2, then SHA2 needs to define what this category of providers constitute. The code for this category, HP.8, may also have to be changed in SHA2 to distinctly reflect its intended contents and possible code would be HP.R parallel to the health functions code for health related services, HC.R.

What will clearly be classified under HP.8/HP.R would be, as indicated in the previous table, establishments (B) with health related functions as principal activity (e.g., health research institutions) and establishments (E) with non-health production as principal activity but with health related activity as secondary activity (e.g., health research in universities.) And as shown in the same table, the introduction of HP.8/HP.R has resulted to the problem about how to classify establishments (C).

Two approaches can be taken regarding establishment (C): first, classify the entire (C) establishment based only on principal activity; or, alternatively, treat the units carrying out health-related activities within the (C) establishment (e.g., research unit) as separate production units – a practice applied in the SNA to create homogeneous production units.

The two approaches suggested for classifying the (C) establishments each have implications on how the NHA table would look like and the what information these would show. The differences are illustrated using the financing agent by health provider (FA x HP) and health provider by health care function (HP x HC) tables reporting NHE. The illustrative tables show where expenditures of the (C) establishments of, say, the National Government would be reported. These establishments would have expenditures consisting of core health expenditures (HCX<sup>c</sup>) and health-related expenditures (HC.RX<sup>c</sup>). The acronyms in the illustrative tables are as follows: NG national government, LG local government, and NHE national health expenditures (core plus health-related expenditures.) The tables are presented for each approach.

- FIRST APPROACH (classify C-establishment based only on principal activity and the establishment in its entirety becomes the sole object of classification)

FA x HP

Health provider	Financing Agent		
	NG	LG	Other
HP.1-HP.7	HCX <sup>c</sup> + HC.RX <sup>c</sup>		
HP.8/ HP.R			
NHE			

HP x HC

Health Function	Health provider	
	HP.1-HP.7	HP.8/ HP.R
HC	HCX <sup>c</sup>	
HC.R	HC.RX <sup>c</sup>	
NHE		

- SECOND APPROACH (unit carrying out health related activities in C-establishment is treated as a separate production unit and is an object of classification in addition to the original establishment)

FA x HP

Health provider	Financing Agent		
	NG	LG	Other
HP.1-HP.7	HCX <sup>c</sup>		
HP.8/ HP.R	HC.RX <sup>c</sup>		
NHE			

HP x HC

Health Function	Health provider	
	HP.1-HP.7	HP.8/ HP.R
HC	HCX <sup>c</sup>	
HC.R		HC.RX <sup>c</sup>
NHE		

Comparing the tabulations for the two approaches, the main difference is that in the first approach health related expenditures of C-establishments will not be reported under the HP.8/HP.R category – which of course is a direct result of how health-related activities is treated in the first approach.

Comparing the FA x HP tables, in the first approach the core and health-related expenditures are not distinguishable when the table is reporting the NHE. Another FA x HP table needs to be produced that would report only the THE to be able to show expenditures for the core health functions. In the second approach, the core versus health-related expenditures split is directly available from the FA x HP table reporting the NHE.

Comparing the HP x HC tables, the first approach would report health-related expenditures made by different types of health providers. The second approach would report all health-related expenditures under HP.8/HP.R, since all units carrying out health-related activities have been assumed to be independent production units and directly classified to this category.

The first approach provides information on health-related activities expenditures of other health providers in the HP x HC table, but in this approach the core versus health-related distinction is lost when the HC dimension is not included in the table (e.g., in the FA x HP table.) The second approach allows for consistency of the health providers classification with the health functions classification (i.e., the core versus health-related split), particularly in the reporting of expenditures in NHA tables that do not include the health function (HC) dimension. But the information on health-related activities expenditures of other health providers is lost in the second approach.

Both approaches have advantages and disadvantages. For practical purposes, being able to maintain the core versus health-related split in the second approach in any NHA table is important because of the need to construct the different expenditure aggregates (i.e., THE, etc.) But an issue in the second approach is whether it is appropriate to treat a subunit of an establishment that is carrying out health-related activities as a separate production unit for HP classification purposes.

## **Providers of traditional and other alternative medicine services and goods**

There are two main issues for this category of providers including: (1) the lack of reference to traditional/alternative medicine goods even in the PG; and (2) the need to establish definitions and to harmonize the treatment of the providers of traditional/alternative medicine services which differ in the SHA1 and the PG.

### ***Goods***

While the SHA1 and PG versions of the ICHA-HP include categories under which the services component of traditional medicine can be reported, there is presently no provider category under which the goods component of traditional medicine care can be reported. There is a complete lack of reference in ICHA-HP to traditional medicine goods and related supplies. This component needs to be defined in SHA2 (if these are determined to be included in the health accounts boundary) in the discussion of health care functions, Unit 5, so these can be referred to in Unit 8.

The providers involved in the retail trade of these goods are in fact providers already listed in ICHA-HP, i.e. HP.4.1 Dispensing chemists and HP.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods. The definitions of these providers just need to be revised to include reference to the retail sale of traditional/alternative medicine goods and supplies. In many Asian countries there are shops that specialize solely in the retail sale of Chinese traditional medicine goods and these can be covered by HP.4.9, given revised definitions.

### ***Services***

The categories representing providers of traditional medicine services, HP.1.4 and HP.3.9.3, in the extended ICHA-HP in the PG are categories not in the original scheme in SHA1. Instead, in SHA1 traditional medicine hospitals are included in HP.1.3 Specialty hospitals, and ambulatory health service providers that may be considered as traditional/oriental (e.g. acupuncturists' offices and practitioners of Chinese medicine) are listed among the providers in HP3.3 Offices of other health practitioners. The distinction between traditional versus Western medicine services, however, is not made in SHA1 and therefore no definition for traditional/alternative medicine is given. The definition given in the PG is very brief, basically just an entry in the general Glossary for "traditional practitioners and faith healers."

There are two aspects of the providers of traditional medicine services that need to be addressed in the revision. First, better definitions should be established. And second, the appropriate place in the ICHA-HP classification of these traditional medicine service providers should be resolved, since these are different in SHA1 and the PG. The treatment in SHA1 is logically more appropriate, especially in view of the succeeding suggestions below to simplify and reduce the number of categories for hospitals (HP.1) and for providers of ambulatory care

(HP.3). Following the logic of SHA1 and the using the simplified set of categories, countries can expand on the simplified categories, as needed, by including hospitals of non-allopathic systems as a subcategory of Specialty hospitals and including alternative/traditional practitioners as a subcategory of Offices of other health practitioners.

### **Retail sale and other providers of medical goods (HP.4.1 and HP.4.9)**

It is difficult to determine the different providers from whom pharmaceuticals are purchased by households. More specifically, households are not able to report precisely how much of such expenditures are made in pharmacies HP4.1 versus other outlets HP.4.9. Often all of such household expenditures are simply reported as purchases from pharmacies HP.4.1. There is an assortment of drug outlets in developing countries including ambulant vendors (e.g., sellers of anti-malarial drugs in Africa) to small neighborhood stores to grocery stores, and purchases of medicines and other health goods from these outlets could be significant.

It is suggested that the scope of HP.4.1 be redefined and expanded to cover not only dispensing chemists but also all other types of drug retail outlets (to reflect what is already generally being done in practice.) And to let countries decide what subgroups to introduce under HP.4.1, e.g. HP.4.1.1 Dispensing chemists and HP.4.1.2 other retailers.

### **Hospitals (HP.1)**

Hospitals can be categorized in many ways using different criteria, including size (number of beds), ownership/legal status, regional aspects and specialization. Countries have their own systems of classification that are used for different purposes such as planning, policymaking and regulation/licensing. Considering that hospitals will be classified in different countries in a variety of ways for different own purposes, it is best to keep the number of standardized categories in the ICHA-HP to a minimum. And to let the countries decide about the additional dimensions or breakdowns to adopt in their health accounts.

The existing second digit classification for hospitals, which is based on specialization, is sufficient for purposes of setting the minimum set of standardized categories that countries should report on. The current number of second level categories could be reduced further to just two: (1) general hospitals, and (2) specialty hospitals. The two hospital categories HP.1.2 Mental health and substance abuse hospitals and HP.1.4 Hospitals of non-allopathic systems (in PG) are categories of specialty hospitals and can be reported there. In many countries these latter types of specialized hospitals do not exist, but in those countries where these do exist subcategories can be created for these.

The additional breakdown in the reporting of hospital expenditures that a country may wish to generate could involve using a combination of criteria. As an example, at the start of the work on the revised NHA in the Philippines, hospitals in the country were initially classified using five criteria including (1) specialty, (2) government/private split, (3) government agency operating the hospital (if government), (4) regional aspects (e.g., regional, provincial, city, district, municipality hospitals), and (5) size and level of complexity (e.g., primary, secondary and tertiary). The resulting classification included categories with codes up to the 5 digit level (see Table 1.) Note the fact that government and private hospitals were classified based on different sets of criteria.

Table 1. Classification of Philippine Hospitals

ICHA Code	Philippine Code	Description
HP.1	HP.1	Hospitals
HP.1.1	HP.1.1	General hospitals
	HP.1.1.1	Public general hospitals
	HP.1.1.1.1	DOH hospitals
	HP.1.1.1.1.1	Medical centers (e.g., JRRM, TMC, EAMC, ARMC, etc.)
	HP.1.1.1.1.2	Regional hospitals
	HP.1.1.1.1.3	District hospitals (DOH retained hospitals)
	HP.1.1.1.1.4	Extension hospitals
	HP.1.1.1.1.5	Research hospitals (e.g., RITM, Schistosomiasis Research Hospital)
	HP.1.1.1.2	Local Government Units (LGU) hospitals
	HP.1.1.1.2.1	Provincial hospitals
	HP.1.1.1.2.2	City hospitals
	HP.1.1.1.2.3	District hospitals
	HP.1.1.1.2.4	Municipal hospitals
	HP.1.1.1.3	Other government hospitals (e.g, PGH, Veterans Hospital, AFP Hospital, etc.)
	HP.1.1.2	Private general hospitals, sanitaria and other similar institutions
	HP.1.1.2.1	Infirmery
	HP.1.1.2.2	Birthing homes (Well Family Clinics)
	HP.1.1.2.3	Primary care hospitals
	HP.1.1.2.4	Secondary care hospitals
	HP.1.1.2.5	Tertiary care hospitals

HP.1.2	HP.1.2	Mental health and substance abuse hospitals
	HP.1.2.1	Public mental health and substance abuse hospitals (NCMH, Mental Hospitals in Davao and Bicol, etc.)
	HP.1.2.2	Private mental health and substance abuse hospitals (Sunrise Hill, etc.)
HP.1.3	HP.1.3	Specialty/special hospitals (other than mental health and substance abuse)
	HP.1.3.1	Public specialty/special hospitals (e.g., Lung, Kidney, Heart, PCMC, Orthopedic, Fabella, SLH, NCH)
	HP.1.3.2	Private specialty/special hospitals (other than mental health and substance abuse)

The detailed classification of hospitals in Table 1 was done as part of an exercise to completely map the country's hospital system, but it could not be used in the same level of detail in the country's national health accounts or NHA because of data constraints. The breakdown for hospital expenditures eventually used in the NHA in the provider classification was reduced to the following (Table 2):

Table 2. Classification of Hospitals Used in the 2005 Revised NHA of the Philippines

ICHA Code	Philippine Code	Description
HP.1	HP.1	Hospitals
HP.1.1	HP.1.1	General hospitals
	HP.1.1.1	Public general hospital
HP.1.2	HP.1.2	Mental health and substance abuse hospitals
	HP.1.2.1	Public mental health and substance abuse hospitals (NCMH, Mental Hospitals in Davao and Bicol, etc.)
HP.1.3	HP.1.3	Specialty/special hospitals (other than mental health and substance abuse)
	HP.1.3.1	Public specialty/special hospitals (e.g., Lung, Kidney, Heart,

		PCMC, Orthopedic, Fabella, SLH, NCH)
	HP.1.1.2, HP.1.2.2, HP.1.3.2	Private hospitals of all types

The government-private split for hospitals is important in developing countries because government hospitals remain to be a significant provider of health services in these countries. It is important to track resources allocated to public hospitals because these are mainly the providers of inpatient care of the low-income households and of residents of many remote places in the country.

In general, the expenditure detail or breakdowns that may be important in some countries may not be important in others. The creation of additional categories or subcategories for hospitals must be left to be determined by the individual countries.

### **Private households as providers of home care (HP.7.2)**

The home production of health care (HP.7.2) is important particularly in developing countries as it constitutes the substitute for services provided in nursing and residential care facilities (HP.2) found in developed countries. In SHA 2 private households as providers need to be defined more clearly and additional guidance provided about the measurement specifically of unpaid home production. The instructions in SHA1 simply points health accountants in the direction of SNA methodologies.

### **Providers of ambulatory health care (HP.3)**

As with hospitals, there exists a wide diversity of ambulatory health care providers within a country, and even greater diversity across countries. They vary in terms of organizational arrangements and the combination of health services provided. This makes setting the minimum standardized categories a challenge. The breakdown or the categories for providers of ambulatory care in the ICHA-HP can be improved – by rethinking about the usefulness and practicality of the level of detail that are currently in the standardized categories.

First, many of the single-activity or single-function providers, such as some of those listed under HP.3.4 Outpatient care centers and HP.3.9 Other providers of ambulatory care, do not exist (and if they do, not in significant numbers) in many developing countries because these are generally integrated with other types of providers. For example, ambulance services and blood banks are services provided mainly by hospitals. Ambulatory surgery services are

generally provided in offices of physicians, multi-specialty centers, integrated care centers and hospital outpatient department. Most dialysis centers are operated by and are part of hospitals and multi-specialty centers.

Second, when more subgroups are introduced into a classification scheme the distinction between any two subgroups diminishes. For example, the difference between HP.3.4.5 All other out-patient multi-specialty and cooperative service centers versus HP.3.4.9 All other out-patient community and other integrated care centers is not clear, which makes assigning of expenditures to either of these two categories difficult.

Based on developing country experience, standardization of ambulatory health care providers would be useful and practical up to the second digit level classification and the categories at this level already existing in the current version of ICHA-HP are sufficient. The option to formulate subgroups (if any are desired) should be left to the countries to decide.

### **Some conclusions**

Overall, the ICHA-HP as a scheme should be simplified and have countries build in the additional detail according to their needs and (statistical and data) capacities. Simplification will reduce inapplicable and inconsistent categories. The chances of compliance with the standardized classes will be higher if these are not too complicated. At the same time, countries will have greater flexibility about the level of detail and what detail to introduce and, thus, make the NHA more useful for country purposes.

Other suggestions made in this paper are about improving the SHA manual in terms of the documentation of the ICHA-HP scheme and its application – including among others, more explanations of concepts, clearer statement of definitions and better guidance on methodological (e.g., measurement) aspects.