Revision of the System of Health Accounts

Input Document
Unit 7

ICHA-HC
Functional Classification of Health Care

Summary

The Canadian Institute for Health Information (CIHI) believes that the construction of classes regardless of mode of production would provide for improved international comparability. It recommends that the categories of curative care and rehabilitative care be merged. It also suggests a partial disaggregation of HC.1 in hospitals, for those products that both fully match the definition of curative care and are clearly identifiable across countries. The inclusion under HC.R.6 (social care) of help with ADL and AIDL, indistinctly, would be CIHI's preferred option with respect to data availability in Canada. While alternative and complimentary goods may be included in the revised SHA, CIHI recommends that they be identified separately from traditional medical goods. It also recommends that overlapping functions between environmental safety and health (such as monitoring drinking water safety) not be included in HC.6 (prevention and public health) and that personal preventive services be left under HC.1 if existing databases do not allow to fully distinguish them from curative services. CIHI proposes some issues for consideration in the discussion of HC.7 (health administration). It recommends that HC.R.1 (capital formation) be retained in the IHCA-HC, but suggests improved guidelines and clarification of concepts for this function.

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Key issue 1: Construction of classes independently of modes of production

Canadian data sources do always allow for the reporting of health expenditures by mode of production. For example, the Canadian MIS Database (CMDB) at the Canadian Institute for Health Information (CIHI) contains financial and statistical information by functional centre in hospitals collected according to a standardized framework (known as the MIS Standards). In this framework, a functional centre is a subdivision of the hospital used to record the budget and actual direct expenses; statistics; and/or revenues, if any, which pertain to the function or activity being carried out. Expenditures of each functional centre, including an allocation of hospital overhead costs, are mapped to the various functional categories of the ICHA-HC. Within each functional centre, based on the MIS Standards, a distinction is made between four types of service recipients: inpatient, resident, clients, and referred-in. The information on service recipients is used to map expenditures of Canadian hospitals to the modes of production in the ICHA-HC. Clients are officially accepted by the hospital (or registered) but not formally admitted and do not stay overnight. Services provided to clients in many functional centres comprise both day care and out-patient care indistinctly. When a distinction cannot be made between day care and out-patient care in CMDB, the entire expenditure is reported by default under out-patient care in the ICHA-HC. Another administrative database at CIHI, the National Physician Database (NPDB), contains information on payments made directly to private practice physicians by the provincial medical care insurance plans. However, for many services in the NPDB, the mode of production cannot be determined and the entire expenditure is reported by default under out-patient care in the ICHA-HC. This has the effect of overestimating the expenditure for out-patient care. Because of similar lack of details in their databases, other countries may also overestimate expenditure for one or more modes of production and underestimate expenditure for other modes. The construction of functional classes independently of modes of production is desirable as it would result in improved comparability across countries, although the comparisons would be made for larger aggregates.

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

Expenditures of various functional centres in Canadian hospitals are mapped to HC.1. In the Canadian context, the easiest disaggregation of HC. 1 would therefore be by functional centre. The functional centres correspond to the core activities carried out in the hospitals. Some functional centres, such as “Emergency”, “Intensive Care Nursing Unit, “Operating Room” and “Radiation Oncology” provide services that fully match the definition of curative care in the ICHA-HC. However, other functional centres may provide a mix of curative and rehabilitative care, or long-term care. When expenditure on rehabilitative or long-term care cannot be identified separately from expenditure on curative care, the entire expenditure on the functional centre is reported by default as curative care.

We would recommend a partial disaggregation of HC.1 that would only include products that fully match the definition of curative care and are clearly identifiable in most countries. This would allow for valuable international comparisons. For example, products for consideration may include the functional or activity centres listed in the above paragraph.

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

The Canadian national databases allow for some distinction between curative and rehabilitative care only in hospitals. Expenditures of three functional centres in hospitals (1. Rehabilitation Nursing/Resident Unit, 2. Rehabilitation Specialty Day/Night Care, and 3. Rehabilitation Specialty Clinic) are mapped to HC.2. However, for other functional centres in hospitals, expenditures on rehabilitative care cannot be identified separately from expenditure on curative care and the entire expenditure of the functional centre is reported by default as curative care. For providers of ambulatory care, such as private practice physicians, it is not possible to distinguish, in the databases, between curative and rehabilitative care and, again, the default allocation is curative care. Because the distinction between curative and rehabilitative care is often not possible, it would be preferable to merge the two categories.

Key issue 4: Definition of HC.3 to reflect the health – social care distinction (based on OECD advances)

The National Health Expenditure Database (NHEX) maintained by CIHI reports expenditures on "Other Institutions" and "Home Care", defined to include only care provided by health practitioners, similarly to the definition of HC.3 in the SHA manual.

For both categories "Other Institutions" and "Home Care", the distinction between public sector expenditure on home care and public sector expenditure on social services is established from the provincial/territorial public accounts in consultation with the jurisdictions. Generally, expenditures reported in the public accounts under Ministries of Health are deemed to be for health care.

While NHEX has historically tracked public sector expenditures on home care as reported in the public accounts, in the last few years it also collected data on expenditures by provincial/territorial governments for home support (defined to include help with both ADL and IADL, indistinctly) in seven jurisdictions that include more than 70% of Canadian population. One proposed option in the revision of the SHA is the inclusion under HC.3 of help with ADL. Since the data sources on expenditures for home support do not generally distinguish between ADL and IADL, the inclusion of ADL along with IADL under HC.R.6 would be the preferred option for Canada with respect to availability of data. This option is also said to be supported by the revision of SNA according to NACE. However, if there is a need to distinguish between ADL and IADL, we would consider using information from surveys in doing so (such as the Canadian Community Health Survey).

Besides the still incomplete data on public sector expenditures on home support, NHEX does not collect any data on long-term social care.

Key issue 5: HC.4 to be analyzed regardless of mode-of-production (presently accounts only for out-patient care)

The Canadian MIS Database includes the functional centres "Clinical Laboratory" "Diagnostic Imaging" and "External Patient/Resident/Client Transport". Within each functional centre, a distinction is made between four types of service recipients: inpatient, resident, clients, and referred-in. Expenditure for clients is mapped to HC.4 which is intended to account only for out-patient care. However, as already indicated under Key issue 1, clients comprise both day cases and out-patient cases indistinctly. This results in an overestimation of the expenditure for HC.4. Other countries may also face similar problems in the disaggregation by mode of production. The analysis of HC.4 regardless of mode-of-production, while providing for a more comprehensive picture of ancillary services, should also provide for improved international comparability.

Key issue 6: HC.5 to be analyzed regardless of mode-of-production (presently accounts only for out-patient care). Consider the inclusion of traditional, alternative and complementary medical goods in the framework

The analysis of HC.5 regardless of mode-of-production, while providing for a more comprehensive picture of expenditures of medical goods, should also provide for improved international comparability. For example, in Canada, an increasing number of drug therapies are being administered outside of the hospital setting, thereby shifting drug costs from hospital care, including in-patient care, to care in the community. Since the extent of the shift in drug cost from an in-patient care to out-patient care may vary between countries, the inclusion of drug expenditure for in-patients in the analysis should improve international comparability.

Alternative and complementary medical goods may be included in the revised SHA, but they should be identified separately from traditional medical goods.

Similar to the functional category Pharmaceutical and Other Medical Non-Durables in the OECD system of health accounts, the Drugs category in NHEX is intended to measure final consumption, outside an institutional setting, of drugs purchased by consumers or third-party payers on their behalf, generally from retail outlets. Drugs in hospitals are considered as inputs (intermediate consumption) to the production of health care in hospitals. Consequently, drugs paid through hospital budgets are not identified separately in NHEX but are classified as hospital expenditure. Similarly, drugs purchased by residential care facilities for their residents are classified as institutional expenditure. All expenses of physicians' and dentists' practices, including drugs, are considered to be expenditure for physicians' and dentists' services. Some drug expenditure is also included in the NHEX category of public health (for example, vaccines). While the above hierarchy of classification is essential in allocating overlapping categories of expenditure, it also reflects data availability. For example, data on expenditure by provincial/territorial governments are usually extracted from provincial/territorial government public accounts. In the accounts, it is generally not possible to isolate drug spending from other categories of expenditure within program areas (for

example, hospitals, public health). While there exist other possible data sources, the use of a single data source for the different categories of provincial government health expenditure—such as the provincial/territorial public accounts—has the major advantage of minimizing the risk of double counting.

The revised SHA should provide explicit guidelines with regard to the reporting of drug expenditure in offices of providers of ambulatory health care and in public health.

Key issue 7: HC.6 to be redefined: inclusion of genuine public health services (currently below the line as some environmental interventions like testing potability of water for drinking) and explicit accounting of personal prevention services (e.g. immunization which is currently reported as curative health care in HC.1)

Monitoring drinking water quality is an overlapping function between environmental safety and health and so are numerous services such as testing water used for recreational activities, testing for air quality, testing sites for chemical, radiological and biological contamination, etc. Our preference would be leave such services below the line because of their mixed nature. The relative scarcity of expenditure data pertaining to this multiplicity of services in some countries would be an additional reason to leave them below the line.

Personal preventive services such as immunization can be reported explicitly (as a sub-category of either HC.1 or HC.6, but preferably as a class of personal care on its own, separate from HC.1 and HC.6) only to the extent that the expenditures for these services can be identified. In Canada, the National Physician Database (NPDB), contains information on payments made directly to private practice physicians by the provincial medical care insurance plans. However, it is not possible to distinguish the payments for immunization in all provinces. In some provinces, immunizations are treated as separate services while in others, they are included in visit fees.

If existing databases do not allow for a full distinction between personal prevention services and curative services, our recommendation would be to leave personal prevention services in HC.1.

Key issue 8: HC.7 to be discussed as it is not a genuine health function, but only support health functions

We would encourage a discussion of HC.7. Some considerations that might be taken into account are as follow:

- Health administration is an essential part of the systems of delivery and financing of health care. Proper delivery and financing of health care can hardly be done without a minimum of planning, management, handling of claims, etc.

- Administrative expenditures within hospitals, nursing homes, offices of physicians, etc., are not reported in HC. 7, but are included in the various functional categories as of cost of production of health care. If HC.7 is to be removed from the functional classification of health care and consequently from the definition and measure of health expenditure, it would also seem appropriate to remove the administrative component of the other functional categories.

- In the public sector, some types of administrative activities carried out at the facility level in some countries (and excluded from HC.7), may be carried at a higher level in other countries and included in HC.7. For example, regional health boards, within Canadian provinces, may carry out some administrative activities that are performed at the hospital level in some other countries.

Key issue 9: HC.R.1 to be discussed in a separate classification as it is not a genuine health function.

Capital formation should be retained in the IHCA-FC as it is an important indicator of change in the physical capacity of the health system.

Capital expenditures may be counted in full at the time the expenditure is made (full-cost accounting) or as an amortized stream of expenditure over the useful life of the capital investment (accrual method). The revised SHA should provide some guidelines on the preferable method.

It is unclear why the definition of capital formation (HC.R.1) in the SHA manual excludes capital spending of “Retail sale and other providers of medical goods”. This should be clarified.