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Proposals for the SHA classification: ICHA- HP

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Proposals for the SHA classification: ICHA-HP

1. The OECD SHA manual classifies oriental (traditional) medicine clinics as “Offices of other health practitioners” (HP.3.3), which comprises establishments of independent health practitioners (other than physicians and dentists). In East Asian countries including Korea, however, oriental medical services and herbal medicine have played a far greater role than in many other western countries. In Korea, for example, students who want to enter oriental medicine schools need to score as high a score in the entrance examination as those who enter western medical schools.

- Oriental medicine doctors’ clinics should not be classified as “Offices of other health practitioners”, but as “Offices of Physicians”(HP.3.1), and, if necessary, an additional three-digit items such as “HP 3.1.1 Offices of Physicians” and “HP 3.1.2 Offices of oriental medicine physicians” could be created.

2. The definitions and explanations for both “Provision and administration of public health programs” (HP.5) and “General health administration and insurance” (HP.6) are not very clear in the OECD SHA manual. Factors of both function and provider are mixed. “Provision and administration of public health programs” or “General health administration and insurance” are not names for providers, but for functions.

- Current ICHA-HP items HP.5 and HP.6 are proposed to be replaced, for example, by ‘HP.5 Government Organization’ and ‘HP.6 Other Non-private Organization including Social Security Organization’, respectively.

3. Under the current SHA classification, “Rest of the economy” (HP.7) contains only providers that provide health care as secondary activity. Therefore, providers of health related functions do not belong to it, and a new category has been prepared outside of the current provider classification in practice. In this concept the economy is divided for 3 main categories; Providers with a primary activity of providing health services or distributing health care goods (HP.1-6), Rest of the economy (HP.7) and Providers of health related functions (M1(HP)). This classification principle has some limits.

Firstly, providers cannot be categorized consistently based on their primary activity. For example, a research institute providing prevention will be categorized under the Rest of Economy(HP.7), but a similar research institute that does only research will be included in the Providers of health related functions (M1(HP)). Where does the institute belong that performs both prevention and research?

Secondly, the term “health-related” is originally for the functional classification. It was used to fix the boundary for health expenditure by sorting out the “health-related” from the “core” functions. It would cause confusion to add such concept as ‘providers of health-related function’ for provider classification.

Thirdly, it does not make sense to put research institutes outside the table of providers, while putting households inside.

- In this respect, it is proposed that 'HP.7 Other industries' is renamed as ‘HP.7 Other providers’, which includes as its sub-items, as an example, ‘HP.7.1 Worksites’, ‘HP.7.2 Households’, ‘HP.7.3 Education and training institution’, ‘HP.7.4 Research institutions’, ‘HP.7.5 NGOs, NPOs etc.’ and ‘HP.7.9 Others’, removing the category for Providers of health related functions (M1(HP)).