

Revision of the

System of Health Accounts

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Comment
Unit 7

Functional Classification of Health Expenditure

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Danish Comments for the Unit 7 Proposal Presented by the WHO at the Meeting for Health Accounts Experts in Paris the 8 -9 October 2008

The proposal presented by WHO at the meeting for health accounts experts in Paris the 8 – 9 October 2009 regarding the functional classification of health expenditure takes a modern approach to the health accounting. The overall division between curative and rehabilitative care, prevention and stewardship reflects the general challenge that health policy makers face every day: how to create satisfactory link between prevention, curative care and health management. Hence, on a theoretical level the overall division makes great sense.

We do however expect that some of the suggestions made in the paper will be difficult or unwise to implement:

- *Neutral Mode of Production:* In the input paper it is suggested that the functional categories should not reflect the mode of production but only the actual purpose of care. Hence the mode of production should be reflected in the HP-classification and not in the HC-classification.

We do not agree with this. The mode of production may not reflect the actual *purpose* of care *per se* but in-patient and out-patient services *do* differ in nature. For this reason the distinction should be made in the HC category. Furthermore if the in-patient/out-patient distinction be moved to the HP-classification we would not be able to cross the mode of production with the producers. It is, for example, very important from a Danish point of view to be able to cross “Out-patient curative care” and “General Hospital” (HC1.3 X HP1.1 in the current SHA). We would very much regret to see this possibility disappear.

- *The proposed HC1 category:* In the input paper it is suggested that the HC1 category is divided into Acute and Emergency Care, Chronic Disease Management and Long Term Care. The problem with this division is that it represents stages of disease rather than different functions. What starts out as acute may end as chronic disease management. Hence the division is not functional – it just reflects different stages in the disease.
- *Medical Expenditures:* Medical expenditures are scattered across different accounts (HC1.1.4; HC1.2.4; HC1.3.1 and HC2.1.2) in order to link medical expenses to Acute and Emergency Care, Chronic Disease Management, Long Term Care and Prophylaxis. This is very hard to do in practise.

Consider for example medicine for high blood pressure: it has an acute curative function since it cures high blood pressure (hence expenses should be accounted for on HC1.1.4), but it also has a preventive function since it prevents strokes (hence it should be accounted for in HC2.1.2)

Furthermore, from a Danish point of view it is important that the HC classification provides an *overall* picture of medical expenses, expenses for transportation and expenses for accommodation as it is the case in SHA 1.0 (HC5.1 for medical goods HC4.3 for transportation etc.)

The arguments above also apply to the split that has been suggested for expenses for transportation (suggested to be split between HC1.1.5 and HC1.2.7) and for the split that has been suggested for expenses for accommodation services (suggested to be split between HC1.1.7 and HC1.2.8)

- *Link to SHA 1.0:* A guiding principle in the revision process is to create a new manual that is closely linked to the current one. From a Danish point of view the HC-revision proposed by the WHO is difficult to link to the current HC-classification. This means loss of time-series data.