

Revision of the

# System of Health Accounts

ORGANISATION  
FOR ECONOMIC  
CO-OPERATION  
AND DEVELOPMENT



World Health  
Organization

## Comment Unit 11

# Classification by beneficiary/ recipient characteristics

## German Comment on the WHO Proposal

Author ..... Manuela Nöthen  
Affiliation ..... Statistisches Bundesamt, Germany  
Submitted on ..... 22-06-2009  
Document code ..... SHA-REV-11202

*The opinions expressed and arguments employed herein do not necessarily reflect the official views of the **Organisation for Economic Co-operation and Development** or of the governments of its member countries, those of the **World Health Organization** or those of **EUROSTAT** or the **European Commission**.*



## Classification by beneficiary/ recipient characteristics

- German comment on the WHO Proposal -

### Methodological approach

The Federal Statistical Office agrees in many points with the proposal outlined by WHO. This is especially true for the methodological aspects which most widely coincide with the findings of the OECD project ***Estimating Health Expenditures by Disease, Age and Gender under the SHA***

*Framework.* Among others, these refer to the following main aspects:

Scope of disease	→	general Cost of Illness study
Demarcation of costs	→	direct medical costs
Methods	→	prevalence-based method
Direction of approach	→	top-down approach
Definition of health care	→	broad definition of Health Expenditure (a concentration on Personal Health Expenditure like discussed by the Belgium colleagues is another possible option).

### Overall conclusions

On the one hand, a reporting on Health Expenditures by beneficiary characteristics such as age, gender, disease, socioeconomic status, geographic region and other demographic groups (like race or ethnicity) is important and desirable. To incorporate this whole set of dimensions into the classification scheme of the SHA would be a comfortable solution. On the other hand, the experiences of the mentioned OECD project and of the national Cost of Illness (COI) Accounts indicate that this is difficult to realize for different reasons:

- 1) Data situation/quality of results: As outlined in the OECD project for most participating countries a realization of COI Accounts by disease, age, gender and one additional dimension of the SHA at one's own choice is feasible and provides meaningful results. A multi-dimensional accounting system that considers additionally socioeconomic status, geographical region or other demographic groups would require additional data sources. Depending on the particular situation of each country more or less data sources which contain the desired information and coincidentally may be linked to the SHA are necessary. These very often are not available. Especially data sources which fit to the number of cost units reflecting the appropriate distribution are not present. To solve this problem by using e.g. the same data source/distribution for several cost units would be accompanied by substantial loss of quality of results. This methodological problem is an inherent characteristic of such accounting systems: With growing number of dimensions usually the number of required data sources for the calculation increases overproportionally. Independently, each additional

dimension reduces the cell frequency which might also limit its informational value.

- 2) Costs/benefit: A multi-dimensional accounting system that considers additionally socioeconomic status, geographical region or other demographic groups does not always make sense or is of prior interest. This is especially true for geographical region, if no comparable classification is used. Compared with the benefit of implementing additional dimensions the efforts seem to be out of proportion. Especially in view of the alternative to realize such analysis much more easier outside of the SHA.
- 3) Technical limits: To add new variables (also depending on the number of additional categories) to the existing system in Germany would certainly go to the limits of the technical scope and manageability of the accounting system. The consequence might be a changeover of the whole system, affecting the used software and the computation procedures.

### **Comment on single notes**

40. through 42. If one compares the current German list of diseases with the GBD and the IHSMT, IHSMT would capture the most information, especially because it uses ICD codes par for par and does not sum up specific ICD codes converting them into particular disease groups. Nevertheless both classifications have the disadvantage that they have not been constructed originally for COI purposes. Maybe it would make sense to use a very short list for a worldwide reporting and use more detailed lists for particular groups of (similar) countries. However it is felt that the ICD classification to be used would benefit from further discussion.

### **Consequences**

The OECD project has shown that a realization of Cost of Illness studies by disease, age, gender and one additional dimension of the SHA at one's own choice is feasible and provides meaningful results. From the German point of view these variables should be considered as core data set. An additional consideration of socioeconomic status, geographic region and other demographic groups in one single accounting system is desirable but for most countries hardly to achieve because of missing data sources, technical limits and enormous efforts.

We would like to support the proposal of the Belgium colleagues to do additional analysis separately outside of the SHA. Here, it would be possible to use elements of the SHA, e.g. the Total Health Expenditures (or the Personal Health Expenditures) as demarcation and starting point for analysis.