

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

Author ..... Dirk MOENS  
Affiliation ..... FODSociale Zekerheid  
Submitted on ..... 16-06-2009  
Document code ..... 11201

*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.*



**Directie-generaal Beleidsondersteuning**  
Domein Multilaterale relaties

Uw brief van :  
Uw kenmerk :  
Ons kenmerk :  
Datum : 10/6/2009  
Bijlage(n) :

Betreft :

## Unit 11.

### Classification by beneficiary/recipient characteristics

#### On the utility of the exercise:

From a policy viewpoint, it is evident that health expenditure data need further analysis than a purely macro-economic summation of financial information. Health policy will only be efficiently supported if additional information is available. Therefore, exercises aiming to bring in new dimensions are interesting and needed. But, these dimensions are not included in the actually used classifications and data sources used for the construction of SHA. The question arises whether this is necessary (the most optimal way to do it).

#### On the integration in SHA:

The question arises thus whether such a multi-dimensional framework needs to be integrated in the existing SHA framework. In reviewing the proposals and description of the presented document, we feel that the proposal itself already states that this is very hard, maybe impossible to do within the full, consistent and closed framework of SHA. (e.g. by pointing out the data availability problem).

In an accounting framework, 'squared balances' need to be equal, which means that at the end, the grant total needs to be accounted for by each classification dimension. We feel that it is not feasible to do with the SHA totals of expenditure.

It is clear that the objectives of the present proposed unit require 'crossing' SHA data with other databases and linking them together. Different questions arise:

- Has this to be done within the SHA framework, or are these kind of analytical exercises not better and more efficiently performed outside the SHA-framework (however using SHA data, amongst other sources)
- How will these linkages be made?
- Are adequate sources available?
- Is sufficient information available?
- Are all items covered by SHA bringing value added if classified by these proposed dimensions? (in other terms: are all dimensions and dimension items relevant for all types of expenditure?)
- And others

Some questions:

#### Expenditure by age and sex

- Is it 'useful' to classify e.g. prevention and public health expenditure by age and sex?
- Such classification needs demographic information, but also consumption information or patterns (by age and sex). Is this available? Is basic information available?
- On which level is the distinction to be made? For all functions? For all providers?
- What with different age/sex patterns for different medical acts? (e.g. gynaecologists are unlikely to perform many medical acts on men – but are these acts distinguishable?)

#### Socio-economic 'spread' of expenditure

- How are consumption patterns to be measured?

#### Expenditure by disease

- morbidity information is necessary, as well in ambulatory care as in institutionalised care. Is this information sufficiently available?
- If specific diseases are to be picked out, on what grounds? Which diseases are of sufficient interest (everywhere)? (different public health challenges in the different parts of the world)

#### Geographical spread of expenditure

- on which geographical distinction? Purely administrative (cities, counties, provinces). National data on e.g. hospital expenditure have proved in Belgium that within one region/province large differences can exist? Which conclusions can then be drawn?

It must be clear that in our opinion, these questions still have insufficient answers, and that therefore exercises are better left outside the SHA scope. We are against mixing underlying basic information with analytical tools.

If sufficient international interest would arise, it would be more efficient in our opinion to dedicate specific working groups to these analytical exercises, bringing together the specialists in the different fields of

knowledge necessary to make qualitatively sound analyses. Integrating everything in one overriding system will make this system impossible to handle and even to feed.

Finally, but not least, we ask ourselves whether at this moment in time, there is sufficient interest in all of these exercises in order to justify that they are integrated in the (common) part of SHA. We think this is not the case.

Furthermore, we would like to make a practical observation: the WHO-proposal starts from ICD-10 classification, where a number of countries still use ICD-9 in their national information systems. In this line, we would like to mention that our experts fear that the rapid revision periodicity of ICD-classification can be harmful for the efficiency of this kind of work. Investment burden in information systems and formation of professional in the use of profoundly renewed classifications are not to be underestimated