PART I

Chapter 6

Classification of Health Care Providers (ICHA-HP)

Introduction

Health care providers encompass organisations and actors that deliver health care goods and services as their primary activity, as well as those for which health care provision is only one among a number of activities. They vary in their legal, accounting, organisational and operating structures. However, despite the huge differences that exist in the way health care provision is organised, there is a set of common approaches and technologies that all health care systems share and that helps to structure them. The classification of health care providers (ICHA-HP) therefore serves the purpose of classifying all organisations that contribute to the provision of health care goods and services, by arranging country-specific provider units into common, internationally applicable categories.

The principal activity exercised is the basic criterion for classifying health care providers. This does not mean, however, that providers classified under the same category perform exactly the same set of activities. Hospitals, which are major health care providers, usually offer not only inpatient health care services, but, depending on specific country arrangements, may also provide outpatient care, rehabilitation, long-term care services and so on. For the purpose of international comparisons, the value added of the ICHA-HP classification lies in two advantages: first, its connection with the functional classification, which gives an insight into the variety of country-specific settings for the provision of health care services, and second, its combination with the financing classification, which sheds light on the variety of health care funding mechanisms that exist across countries.

This chapter introduces the classification of health care providers (ICHA-HP) and describes its main elements. It traces health care expenditure by provider categories to address the question: *What is the organisational structure that is characteristic of the provision of health care within a country?* Together with the classification of health care functions (ICHA-HC) and the classification of financing schemes (ICHA-HF), the HP classification shapes the accounting space of the core health care expenditure accounts.

Concept of the classification of health care providers

Objectives

The main objective of the classification of health care providers is to be comprehensive and complete, which means capturing all the organisations and actors involved in the provision of health care goods and services. Second, all providers should be structured by their main characteristics into categories that enable linkages with the related structures of health care functions (HC) and health care financing (HF). And third, the classification should be described in a way that will help both data compilers and data users to match national organisations and actors with HP categories.

The classification of health care providers introduced by SHA 1.0 used the North American Industry Classification System (NAICS) as a starting point.[1] The provider

classification under SHA 2011 follows that of SHA 1.0, though there are certain modifications that have been driven by countries' experiences with SHA implementation, on the one hand, and the recommendations of the International Standard Industrial Classification (ISIC Rev. 4), on the other. Both factors reflect trends in health care provision, contribute to greater comparability with other national and international classifications, and preserve continuity with the previous SHA version.

The universe of health care providers

Comprehensiveness with respect to the classification of health care providers means that all organisations in the field of interest should be covered, while completeness means that all activities in the field of interest should be compiled, irrespective of the type of organisation. Therefore, since many organisations within the domestic economy can provide some form of health care, the classification of health care providers must be able to capture all of them, regardless of whether health care is their primary or secondary activity.

Primary providers are those whose principal activity is to deliver health care goods and services as defined in the core functional classification (ICHA-HC). Typical primary providers are offices of general and specialised physicians, units of emergency ambulance services, acute and psychiatric hospitals, health centres, laboratories, nursing care facilities, pharmacies and so on. Within the ICHA-HP classification, primary health care providers are grouped under six categories (HP.1-HP.6).[2] *Secondary providers* are those that deliver health care services in addition to their principal activities, which might be partially or not at all related to health. Examples of secondary providers include: residential care institutions, whose main activities might be provision of accommodation, with other social services in addition to nursing supervision provided as secondary activities; supermarkets that sell over-the-counter pharmaceuticals; and health care facilities/professionals that provide health care services to a restricted group of the population, such as in the case of in-house occupational medicine services for employees, or prison health services (HP.8.2).

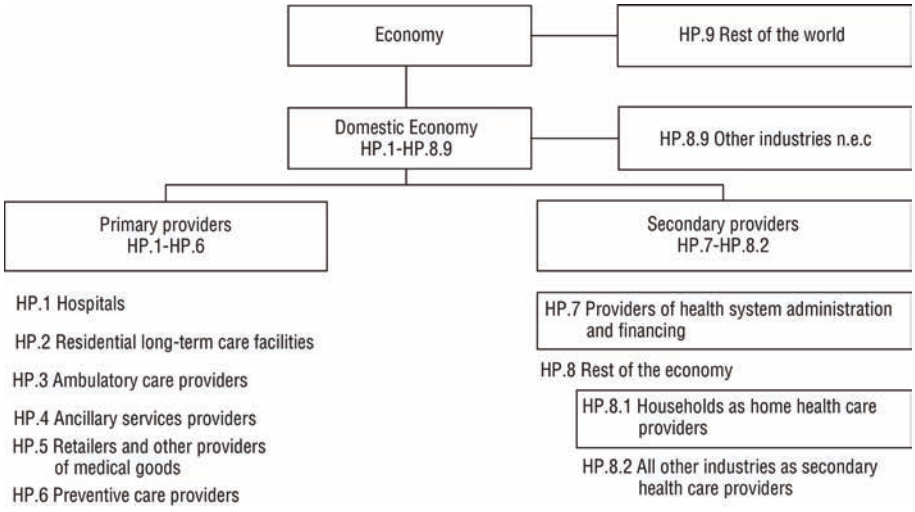
There are two special categories of secondary providers, namely: *i*) providers of health care system administration and financing (HP.7), and *ii*) households as providers of home health care (HP.8.1). The former plays an important role in the governance and management of health care systems by carrying out a type of collective service related to the provision and financing of health care (for example, activities of the Ministry of Health),[3] while the latter often provides home health care services directly to family members. The scope of activities under both of these categories is defined by the functional classification and fits within the health care boundary under the proposed criteria and circumstances (see Chapters 4 and 5). Within the ICHA-HP classification, all secondary health care providers that deliver goods and services directly to consumers (either individuals or population groups) for the purpose of its final consumption are recoded under two categories (HP.7 and HP.8, except item HP.8.9).

In order to complete the picture, any industries that perform health-related activities but are not involved in the provision of health care goods and services directly to patients (either as primary or secondary activities) can be recorded under the category HP.8.9 Other industries *n.e.c.* There are two reasons for introducing this subcategory, which comprises industries that are outside of the universe of health care providers. First, it allows the classification of establishments that are involved in the provision of health care-related activities as defined by the functional classification, *i.e.* long-term social care and health

promotion with a multi-sectoral approach. Second, it enables the linking of the HP classification with the classifications of the extended accounts, the capital account in particular. Consequently, industries involved in the provision of medical equipment or in health research and development or in the education and training of health care professionals can be recorded under HP.8.9 Other industries *n.e.c.*[4]

Figure 6.1 presents an overview of primary and secondary providers as encompassed by the ICHA-HP.

Figure 6.1. **Overview of primary and secondary providers encompassed by ICHA-HP**



Source: IHAT for SHA 2011.

SHA focuses on the final consumption (see Chapter 3) of health care goods and services by residents. This approach has consequences for both data compilation and the provider classification itself. First, it delimits the universe of health care providers to those that deliver final health care goods and services directly to consumers. As a result, producers of intermediate health products, such as fluids for dialysis, which are further transformed or used in the provision of health care services, are not taken into consideration (unless they also deliver some products directly to patients, for example, for the purpose of home dialysis). Second, the health care goods and services consumed by non-residents should be excluded and those consumed abroad by residents should be included.[5] Therefore, if it is the case that a medical goods retailer or health professional is solely servicing non-residents, then they should not be considered part of the health provider universe. On the other hand, health care providers abroad who service patients resident in the country in question should be included. As a result, in addition to domestic health care providers, the classification also includes an entry for all health care providers abroad, recorded under the category *rest of the world* (HP.9).

The structure of health care providers

The categories of the provider classification must be *mutually exclusive*. Consequently, the HP classification tries to structure health care providers into meaningful, homogeneous groups of providers within categories and at the same time to ensure

heterogeneity between categories. The criterion *type of health care activity* is relevant when providers are grouped into certain categories of the HP classification. When classifying an actor or organisation, the first question should be: does the economic unit provide health care? If the answer is yes, the next step is the identification of its main characteristics. This can be derived from the activities that it performs and the legal requirements for the provision of these activities. Examples are national standards for performing inpatient services as hospitals. Most countries keep registers of various health care providers because of the special conditions which these units must fulfil to provide quality health care. These conditions are usually related to requirements on medical professionals and on the equipment and technology involved, but also consider other factors such as sanitation regimes. The registers are one of the main information sources used to structure primary providers into categories of SHA.

In general, a precondition for grouping national health care providers into primary and secondary providers is an ability to distinguish between the health and non–health activities that they perform; a functional approach is then used to quantify those falling within the SHA health care boundary. With respect to the health care activities performed, the operational rules that follow NACE Rev. 2 (Eurostat, 2008a) and ISIC Rev. 4 (UN, 2008a) are that:

- An organisation with health care outputs for which more than 50% of the value added results from health care activities is to be classified and allocated – based on the type of the principal health care activity – into one of the HP.1-HP.6 categories;
- Those with less than 50% output of health care activities are to be classified under HP.8.2 All other industries as secondary providers of health care.

In the case that value added is not available, the ISIC/NACE proposes that other criteria related to output or input be used as a substitute for value added:

- Substitutes based on output, such as the production value or the turnover that is attributable to the goods or services associated with each activity. Examples are the revenue shares of hospitals from the sale of inpatient and outpatient services.
- Substitutes based on input, such as wages and salaries or hours worked that are attributable to the different activities; or employment according to the proportion of people engaged in the different activities of the unit. Examples are staff ratios of labour working in inpatient and outpatient departments.

Regarding the inclusion or exclusion of certain activities, reference is made to the classification of health care functions (ICHA-HC). It delimits the type of health care goods and services included in the health care boundary for the purpose of international data comparison. Under the functional classification, these health care goods and services are structured into aggregated groups of functions. Some of them, such as curative and rehabilitative services, can be directly allocated to individuals, while others, such as preventive programmes or health care system administration, are allocated to society at large. Individual health care functions are subsequently classified by mode of provision (inpatient, day care, outpatient and home care). The mode of provision underlines the technical and managerial organisation of health care provision. Together, the types of function and their mode of provision, by referring to certain characteristics of the health care goods and services delivered, offer guidance for the structure of the HP classification and for grouping the various national health care providers into more homogeneous categories. For example, providers like hospitals and long-term nursing care facilities

provide services in the inpatient mode as their principal activity, but they differ due to the level of care intensiveness (acute versus nursing care), the medical personnel employed (specialised physicians versus nurses) and the level of technological support (operating theatre versus nursing room).

The interrelation between the functional classification and the provider classification requires that the latter should be complete, in the sense that all functions included are to be covered by providers. This implies, for example, that long-term nursing home care, which can be provided either by a nurse, or in some cases by family members, has to be exhibited in the providers' classification. Therefore, although the principal activity attributed to households would be consumption rather than health care provision, households are identified as a special category of secondary providers of health care goods and services (HP.8.1). Another example is the function consisting of the governance, management and administration of the health care system. Although the primary purpose of these activities is not the provision of health care goods and services directly to the patients, its role in pursuing these goals cannot be neglected. Respectively, providers such as Ministries of Health and Health Insurance Funds are captured under the provider classification as secondary health care providers, as their principal activities are related to administration and/or financing health care activities in the system as a whole (HP.7).

Table 6.1. **Classification of actors/organisations in health care provision and health system dimensions**

		Provision of health care goods and services				Provision of health-related services
Health system dimensions	Activities within the functional classification	As principal activity		As secondary activity		Other industries
		HP.1-HP.6	HP.7	HP.8.1	HP.8.2	HP.8.9
Provision						
Modes of provision: • *Inpatient* • *Day care* • *Outpatient* • *Home care*	Curative services Rehabilitative services Long-term nursing care services	Hospitals HP.1 Residential long-term care facilities HP.2 Ambulatory health care providers HP.3		Households as home health care providers HP.8.1	All other industries as secondary providers of health care HP.8.2	
	Ancillary services	Ancillary services providers HP.4				
	Medical goods	Retailers HP.5				
	Preventive care services	Preventive care providers HP.6				
Governance/ administration	Governance management and health care system administration		Principal activity of Providers of health care system administration and financing HP.7			
Health-related provision	• Long-term social care, • Multi-sectoral prevention					Principal activity of other industries *n.e.c.* under category "rest of economy" HP.8.9

Source: IHAT for SHA 2011.

In practice, all industries with principal activities other than health care can be classified as secondary providers in the ICHA-HP, so long as they do provide some health care goods and services directly to individuals or population groups. Included are social care facilities with some elements of medical care provision, prison health care facilities and research institutes involved in health promotion campaigns (HP.8.2). However, in contrast, even if the principal activity of a research institute is related to health, *i.e.* study and research on the development of new-generation antibiotics, and is thus important for the purpose of resource generation for health care in the future, this activity lies outside the core health care accounts, as it does not fall within the consumption boundaries. Table 6.1 shows the relation between different functions and health care providers, both primary and secondary, with, in addition, reference to the dimensions of health systems.

Description and guidelines for compilers

In the following section of this chapter, the main changes in the HP classification of SHA 2011 as compared to SHA 1.0 are highlighted. Furthermore, specific issues relevant for compilation are outlined.

Changes from SHA 1.0

For almost all provider categories at both the first-digit level and second-digit level, the HP classification of SHA 2011 keeps continuity with that of SHA 1.0. The majority of categories are retained, although partly under different codes.

a. Under HP.1 Hospitals, the structure of the classification has been kept the same as SHA 1.0. The subcategory Mental and substance abuse hospitals has been renamed into HP.1.2 Mental health hospitals.

b. Under HP.2 Residential long-term care facilities, the two subcategories Community care facilities for the elderly and All other residential care activities have been replaced by the category Other residential long-term care facilities. This is reserved for special residential facilities not elsewhere classified, as for example geriatric rehabilitation clinics. The reason is that in general only a part of residential care facilities can be qualified as health care establishments. Often the expenditure share for long-term health care in these residential care facilities is less than 50 per cent, in which case these facilities have to be classified under HP.8.2 All other industries as secondary providers of health care. As a result, the category HP.2 Residential long-term care facilities consists of three sub-categories: long-term nursing care facilities, Mental health and substance abuse facilities and Other residential long-term care facilities.

c. Under HP.3 *Providers of ambulatory health care*, the SHA 1.0 subcategory *Offices of physicians* is split into *General medicine* and *Medical specialists*, following the revision of the NACE.[6] As most countries have implemented some form of primary care system, it would be useful to show this explicitly in health accounts. The HP classification offers a breakdown of medical practices into *Offices of general medical practice, Offices of medical specialists* and *Offices of mental medical specialists* at the three-digit level.

d. Under HP.4 *Providers of ancillary services* have been separated from HP.3 because of the special characteristics of their services. Providers of ancillary services comprise organisations that provide specific ancillary services (*e.g.* blood tests) directly to outpatients (with or without medical prescription or supervision of health professionals)

that are not covered by hospitals, nursing care facilities, ambulatory care providers or other providers. The HP.4 category is further broken down into *Providers of patient transportation and emergency rescue, Providers of medical and diagnostic laboratories* and *Other providers of ancillary services*.

e. The categories under HP.5 *Retailers and other providers of medical goods* have been restricted to three categories: *pharmacies, retail sellers and other suppliers of durable medical goods and appliances* and *all other miscellaneous retail sellers and other suppliers of pharmaceuticals and medical goods*. This means that retail sellers of hearing aids, vision products and orthopaedic prostheses that were classified separately in SHA 1.0 are captured now by a single class, because the breakdown by products is available by the functional classification.

f. The category HP.6 *Providers of preventive care* is retained as in SHA 1.0. It encompasses all providers such as Institutes of Public Health and of Occupational Medicine or Sanitary agencies for water control whose primary activity concerns various types of health preventive services. Note, however, that the total value of health care preventive programmes (targeting both individuals and population groups) can be captured only by the functional classification HC.6 *Preventive health care,* which may encompass, as well, some activities of other providers, such as *Providers of ambulatory care* (HP.3).

- The category HP.7 P*roviders of health care system administration and financing* follows SHA 1.0 in that the structure of the subcategories at the second-digit level refers to the institutional structure of the financing agents, and not to the structure of the financing schemes (Chapter 7).

g. The category HP.8 *Rest of economy* comprises *Households as providers of home health care* (HP.8.1) and *All other industries as secondary providers of health care (HP.8.2)* as well as the separate subcategory *Other industries n.e.c.* (HP.8.9). Under the HP.8.2 subcategory, all secondary providers of health care are included except HP.7 and HP.8.1. Establishments of in-house occupational health care providers are no longer separated from all other industries as secondary providers of health care thus recorded under (HP.8.2). The subcategory HP.8.9 *Other industries n.e.c.* – is reserved for all industries not providing health care as primary or secondary activities. Although this category comprises industries with activities that go beyond the SHA health care boundary, it can be used to link the health care provider classification with health care-related functions.

h. The category HP.9 *Rest of world* has been kept the same as in SHA 1.0, although in SHA 2011 it is explicitly recommended that both the health care providers as well as establishments outside the health care boundary (as with HP.8.9) be recorded under this item. This is to identify and cross-classify with functional classification all foreign units with activities related either to health care goods and services or health-related functions.

Specific compilation issues

University hospitals. The experience from the compilation of hospital expenditure data by SHA 1.0 shows that most countries allocate hospital expenditures to general hospitals at the second-digit level. University and teaching hospitals are usually classified as general hospitals, except those which provide highly specialised services dedicated to patients with specific diseases or health conditions. In some countries, these specialised university hospitals constitute the so-called third level of inpatient/hospital care. Countries might

wish to separate university hospitals for the purpose of further analysis of expenditures on education and research, which are often closely connected to expenses for treatment, or due to the medical high-technology involved, by adding such categories at the third-digit level.

Independent doctors working in hospitals. One particular issue in the provision of services in hospitals concerns individual doctors performing a specific service to patients in the hospital framework as subcontractors (integrated as offices in hospitals). In SHA 2011, offices of self-employed doctors working in hospitals are recorded under hospitals in the same way as services of employed doctors. Only if the provision is clearly independent of the hospital's activities (*i.e.* the physician rents a room or equipment for his own outpatient practice) should it be separately accounted as a provider of ambulatory care.

Long-term care providers. Here SHA 2011 is closely related to SHA 1.0. Providers of long-term care encompass establishments that are primarily engaged in the provision of residential care with medical or nursing care in combination with personal care as the dominant activities (as defined under the HC classification). Providers of long-term care should be classified either as *Residential long-term care facilities* (HP.2) or as *Providers of home health care services* (HP.3.5) if provided at home. Institutions with dominant social care services that provide health care only to a limited extent are classified under HP.8.2 *All other industries as secondary providers of health care*, *e.g.* residential care homes for the elderly, or providers of meals-on-wheels (providers of IADL services), if these organisations also provide some nursing and/or personal care.

Health care providers with less extensive medical knowledge. In ambulatory care, a wide variety of informal and less-than-fully-qualified health care providers might exist in many countries. SHA 2011 recommends that these categories should be recorded in line with their qualifications according to the ISCO 08 rules. In SHA 2011, HP.3.3 *Other health care practitioners* offers the possibility of including paramedical practitioners that provide different forms of traditional medicine. This item, however, should be restricted to providers with a certain level of medical education and/or skills (*e.g.* similar or equal to the level of nurses, midwives and physiotherapists; see ISCO 08: 3221 Nursing associate professionals, 3222 Midwifery associate professionals, 3230 Traditional and complementary medicine associate professionals, 3255 Physiotherapy technicians and assistants, 3259 Health associate professionals not elsewhere classified[7]).

Public versus *private ownership*. The ICHA-HP classification of SHA 2011 does not distinguish between public and private ownership and the legal status of establishments. A separation according to ownership (with application of SNA rules) might be useful for monitoring the efficiency and quality of health care provision of public vs. private owners of health care settings; it is thus primarily suggested for national purposes.[8]

Statistical units. The statistical unit is the entity from which the recommended items of data are collected. Different types of statistical units meet different needs, but each unit is a specific entity, which is defined in such a way that it can be recognised and identified and not confused with any other unit. It may be an identifiable legal or physical entity or, as for example in the case of the unit of homogeneous production, a statistical construct.[9] However, one has to be sure that all health care activities, especially those provided as secondary activities, are covered in the health accounts. As a consequence, one has to investigate whether establishments not classified by ISIC/NACE as corresponding to health care providers do deliver any health care goods or services, as defined by the functional

Table 6.2. **Classification of health care providers**

Code	Description	SHA 1.0 codes
HP.1	**Hospitals**	**HP.1.0**
HP.1.1	General hospitals	HP.1.1
HP.1.2	Mental health hospitals	HP.1.2
HP.1.3	Specialised hospitals (other than mental health hospitals)	HP.1.3
HP.2	**Residential long-term care facilities**	**HP.2**
HP.2.1	Long-term nursing care facilities	HP.2.1
HP.2.2	Mental health and substance abuse facilities	HP.2.2
HP.2.9	Other residential long-term care facilities	HP.2.3, 2.9
HP.3	**Providers of ambulatory health care**	**HP.3**
HP.3.1	Medical practices	HP.3.1
HP.3.1.1	Offices of general medical practitioners	HP.3.1
HP.3.1.2	Offices of mental medical specialists	HP.3.1
HP.3.1.3	Offices of medical specialists (other than mental medical specialists)	HP.3.1
HP.3.2	Dental practice	HP.3.2
HP.3.3	Other health care practitioners	HP.3.3
HP.3.4	Ambulatory health care centres	HP.3.4
HP.3.4.1	Family planning centres	HP.3.4.1
HP.3.4.2	Ambulatory mental health and substance abuse centres	HP.3.4.2
HP.3.4.3	Free-standing ambulatory surgery centres	HP.3.4.3
HP.3.4.4	Dialysis care centres	HP.3.4.4
HP.3.4.9	All other ambulatory centres	HP.3.4.5, 3.4.9
HP.3.5	Providers of home health care services	HP.3.6
HP.4	**Providers of ancillary services**	
HP.4.1	Providers of patient transportation and emergency rescue	HP.3.9.1
HP.4.2	Medical and diagnostic laboratories	HP.3.5, 3.9.2
HP.4.9	Other providers of ancillary services	HP.3.9.9
HP.5	**Retailers and other providers of medical goods**	**HP.4**
HP.5.1	Pharmacies	HP.4.1
HP.5.2	Retail sellers and other suppliers of durable medical goods and medical appliances	HP.4.2, 4.3, 4.4
HP.5.9	All other miscellaneous sellers and other suppliers of pharmaceuticals and medical goods	HP.4.9
HP.6	**Providers of preventive care**	**HP.5**
HP.7	**Providers of health care system administration and financing**	**HP.6**
HP.7.1	Government health administration agencies	HP.6.1
HP.7.2	Social health insurance agencies	HP.6.2
HP.7.3	Private health insurance administration agencies	HP.6.3, 6.4
HP.7.9	Other administration agencies	HP.6.9
HP.8	**Rest of economy**	**HP.7**
HP.8.1	Households as providers of home health care	HP.7.2
HP.8.2	All other industries as secondary providers of health care	HP.2.3, 2.9, 7.1, 7.9
HP.8.9	Other industries *n.e.c.*	
HP.9	**Rest of the world**	HP.9

Source: IHAT for SHA 2011.

classification. Examples are pharmaceuticals distributed by supermarkets or medical care delivered in residential facilities by employed health professionals. In both cases, the statistical units would be single establishments, parts of larger enterprises (a pharmacy within a drugstore chain or a nursing unit in a home for the elderly), that provide goods and services directly to consumers, and thus recorded as HP.8.2 *All other industries as secondary providers of health care*. In general, the classification of health care providers follows the ISIC/NACE approach as far as possible.[10] In practical terms, the situation with data availability may vary from country to country, and between groups of providers

depending on institutional structures and the legal framework for activities in the health care sector. This might also be determined by the level of development of statistical systems, traditions, national priorities in data collection or the resources available.

Household own accounts. The own-account provision of home health care services by members of the household for their own final consumption is excluded from measured production in conventional national accounting practice.[11] In contrast to SNA, SHA explicitly recognises in specific cases that the work devoted to the home care of household members has an economic value, which is measured in monetary terms. Cash allowances granted to households for home health care, such as nursing allowances, are considered as "paid" household provision.[12]

Explanatory notes to the ICHA-HP classification of health care providers

HP.1 Hospitals

Hospitals comprise licensed establishments that are primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialised accommodation services required by inpatients. Hospitals provide inpatient health services, many of which can be delivered only by using specialised facilities and professional knowledge as well as advanced medical technology and equipment, which form a significant and integral part of the provision process. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home health care services as secondary activities. The tasks of hospitals may vary by country and are usually defined by legal requirements. In some countries, health care facilities need in addition a minimum size (such as a number of beds and medical staff to guarantee 24-hour access) in order to be registered as a hospital. SHA 2011 distinguishes between general hospitals, mental health hospitals and specialised hospitals other than mental health hospitals depending both on the scope of medical treatments provided and the specificity of diseases or medical conditions of inpatients.

HP.1.1 General hospitals

This category encompasses licensed establishments that are primarily engaged in providing general diagnostic and medical treatment (both surgical and non-surgical) to inpatients *with a wide variety of medical conditions*. These establishments may provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services or operating room services for a variety of procedures and/or pharmacy services, that are usually used by internal patients (intermediate outputs within the hospital treatment) but also by outside patients.

Illustrative examples

- General acute care hospitals;
- Community, county and regional hospitals (other than specialised hospitals);
- Army, veterans, prison and police hospitals if settled in a separate establishment[13] (other than specialised hospitals, *e.g.* forensic hospitals);
- Teaching hospitals, university hospitals (other than specialised hospitals);

- Company general hospitals (*e.g.* hospitals owned by oil companies) if set up as a separate independent establishment;
- General hospitals of private non-profit organisations (such as the Red Cross or Red Crescent) (other than specialised hospitals).

Note: Included are integrated community health care centres providing both inpatient and outpatient services but which are primarily engaged in inpatient services.

Cross-references

- University hospitals comprise licensed tertiary hospitals that are engaged in academic medical education, clinical research and patient care as teaching hospitals. In case there are specialised university hospitals where activities relate to certain types of treatment or disease, they should be recorded respectively under HP.1.2 *Mental health hospitals* or HP.1.3 *Specialised Hospitals (other than mental health hospitals);*
- Forensic hospitals should be classified under HP.1.2 *Mental health hospitals*.

HP.1.2 Mental health hospitals

This item comprises licensed establishments that are primarily engaged in providing diagnostic and medical treatment and monitoring services to inpatients who suffer from severe mental illness or substance abuse disorders. The treatment often requires an extended stay in an inpatient setting, including intensive pharmaceutical treatment. Depending on the specificity of the hospital's various therapies, psychiatric, psychological or physical therapies are available at the facilities as well as other types of services including educational and vocational services in order to ensure comprehensive treatment, leading at the end to patient recovery. To fulfil the complexity of these tasks, mental health hospitals usually provide services other than inpatient services, such as outpatient mental health care, clinical laboratory tests, diagnostic X-rays and electroencephalography services, which are often available for both internal and outside inpatients but also for outpatients. Mental health hospitals exclude community-based psychiatric inpatient units of general hospitals.

Illustrative examples

- Psychiatric hospitals;
- Forensic hospitals;
- Substance abuse hospitals.

Cross-references

- Establishments that are primarily engaged in providing treatment for mental health and substance abuse illnesses on an outpatient basis are classified under HP.3.1.2 *Offices of mental medical specialists* or HP.3.4.2 *Ambulatory mental health and substance abuse centres*;
- Establishments referred to as hospitals that are primarily engaged in providing residential care for persons diagnosed with mental retardation or engaged in providing inpatient services of mental health and substance abuse illness with the emphasis on longer stay/care and counselling rather than on medical treatment are classified under HP.2.2 *Mental health and substance abuse facilities*.

HP.1.3 Specialised hospitals (other than mental health hospitals)

This item comprises licensed establishments that are primarily engaged in providing diagnostic and medical treatment as well as monitoring services to inpatients *with a specific type of disease or medical condition*.

Illustrative examples

- Specialised hospitals or university hospitals with a focus on specific disciplines (oncology, gastroenterological, paediatric, orthopaedic, cardiology, etc.);
- Specialised emergency centres;
- Maternity clinics;
- Orthopaedic hospitals;
- Specialised sanatoriums (primarily engaged in medical post-acute, rehabilitative and preventive services);
- Thermal health care centres and spa hospitals that focus on medical rehabilitation;
- Specialised hospitals for infectious disease (tuberculosis hospitals; hospitals for tropical diseases);
- Aesthetic clinics; and
- Traditional, Complementary and Alternative Medicine (TCAM) hospitals or inpatient centres/clinics (*e.g.* hospitals specialising in Oriental medicine).

Cross-references

- Establishments licensed as hospitals that are primarily engaged in providing diagnostic and therapeutic inpatient services for a variety of medical conditions, both surgical and non-surgical, are classified under HP.1.1 *General hospitals*;
- Mental health hospitals, hospitals providing inpatient acute care for the mentally ill, are to be classified under HP.1.2 *Mental health hospitals;*
- Establishments referred to as hospitals but primarily engaged in providing inpatient long-term nursing and rehabilitative services to persons requiring convalescence are classified under HP.2.1 *Long-term nursing care facilities*;
- Facilities specialising in the long-term care of persons diagnosed with mental retardation or mental health problems or in substance abuse programmes are classified under HP.2.2 *Mental health and substance abuse facilities*.

HP.2 Residential long-term care facilities

The category of *Residential long-term care facilities* comprises establishments that are primarily engaged in providing residential long-term care that combines nursing, supervisory or other types of care as required by the residents. In these establishments, a significant part of the production process and the care provided is a mix of health and social services, with the health services being largely at the level of nursing care, in combination with personal care services. The medical components of care are, however, much less intensive than those provided in hospitals.

HP.2.1 Long-term nursing care facilities

This subcategory comprises establishments that are primarily engaged in providing inpatient nursing and rehabilitative services for long-term care patients. The care is

generally provided for an extended period of time to individuals requiring nursing care. These establishments have a permanent core staff of registered or licensed practical nurses that, along with other staff, provide nursing care in combination with personal care. They provide predominantly long-term care, but also occasionally acute health care and nursing care in conjunction with accommodation and other types of social support, such as assistance with day-to-day living tasks and assistance towards independent living. Included are various establishments that provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile persons placed in an inpatient institution. The exact classification in the corresponding types of institutions (skilled nursing care facilities, residential mental retardation facilities, other residential long-term care facilities) depends on the country-specific division of labour in the care process, especially in long-term care and rehabilitation.

Illustrative examples

- Convalescent homes or convalescent hospitals (other than mental health and substance abuse facilities);
- Homes for the elderly with nursing care;
- Inpatient care hospices;
- Palliative care establishments for the terminally ill;
- Nursing homes;
- Rest homes with nursing care;
- Skilled nursing facilities (*e.g.* in the United States);
- Teaching nursing homes.

Cross-references

- Institutions where nursing care interventions are more of an incidental character or are performed by non-permanent staff such as visiting nurses are probably social care institutions and should be classified as HP.8.2 *All other industries as secondary providers of health care*. This should also apply to organisations with a physician acting as director, for example, in a home for handicapped persons, where medical and nursing health care services account for only a small share of the institution's overall activity. Another example of this type of institution is residential homes for the elderly with visiting nurses. Nurses visiting these institutions should be reported separately as a corresponding category of ambulatory health care, in this case, *Other health care practitioners* HP.3.3;
- Hostels with only limited medical assistance, such as supervision of compliance with medication, should be classified under HP.8.2 *All other industries as secondary providers of health care*.

HP.2.2 Mental health and substance abuse facilities

This item comprises establishments (*e.g.* group homes, intermediate care facilities) that are primarily engaged in providing, in an inpatient setting, domiciliary services for persons diagnosed with mental retardation. These facilities provide mental health care, though the focus is on room and board, protective supervision and counselling. Residential mental health and substance abuse facilities comprise establishments that

are primarily engaged in providing residential care and treatment for patients with mental health and substance abuse illnesses. Although health care services may be available at these establishments, they are incidental to the counselling, mental rehabilitation and support.

Illustrative examples

- Residential mental retardation facilities;
- Mental health and substance abuse facilities;
- Alcoholism or drug addiction rehabilitation facilities (other than licensed hospitals);
- Mental health convalescent homes or hospitals;
- Day and night care institutions providing, for a limited time, long-term nursing, including personal care for persons with mental illness such as dementia, etc.

Cross-references

- Hostels with only limited medical assistance, such as supervision of compliance with medication or continuing-care retirement communities and homes for the elderly without nursing or health care are classified under HP.8.2 *All other industries as secondary providers of health care*;
- Day-care centres with curative or rehabilitative care focusing on individuals other than those diagnosed with mental retardation are classified under HP.3.4.9 *All other ambulatory centres;*
- Establishments that are primarily engaged in providing residential nursing and rehabilitative services for individuals other than those diagnosed with mental retardation, for example, for oncology rehabilitation or geriatric rehabilitation, are classified under HP.2.1 *Long-term nursing care facilities* or HP 2.9 *Other residential long-term care facilities*.

HP.2.9 Other residential long-term care facilities

This category includes the provision of residential and health care services in organisations classified neither as long-term nursing care facilities HP.2.1, nor as mental health and substance abuse facilities HP.2.2. This includes specialised non-mental residential facilities, as, for example, geriatric rehabilitation facilities that do not fulfil the criteria for geriatric hospitals.

HP.3 Providers of ambulatory health care

This item comprises establishments that are primarily engaged in providing health care services directly to outpatients who do not require inpatient services. This includes both offices of general medical practitioners and medical specialists and establishments specialising in the treatment of day-cases and in the delivery of home care services. Health practitioners in ambulatory health care primarily provide services to patients who visit the health professional's office, or the practitioners visit the patients at home. Consequently, these establishments do not usually provide inpatient services. This item has five subcategories, including: medical practices, dental practices, other health care practitioners, ambulatory health care centres and providers of home health care services.

HP.3.1 Medical practices

This subcategory comprises both offices of general medical practitioners and offices of medical specialists (other than dental practice) in which medical practitioners holding the degree of a doctor of medicine (Code 2210 ISCO-08, ISCED-97 level 5 and 6) are primarily engaged in the independent practice of general or specialised medicine, including psychiatry, cardiology, osteopathy, homeopathy, surgery and others. This group also includes the practices of TCAM professionals with a corresponding medical education. These practitioners can operate as individual practitioners or in a group practice in their own or rented offices (*e.g.* centres, clinics) or independently in the facilities of others, such as hospitals or health maintenance organisations (HMO)-type medical centres.

HP.3.1.1 Offices of general medical practitioners. This item comprises establishments of health practitioners who hold the degree of a doctor of medicine or a corresponding qualification and are primarily engaged in the independent practice of general medicine. Although in some countries "general practice" and "family medicine" may be considered as medical specialisations, these occupations should always be classified here.

Illustrative examples

- General/family practitioners in private offices;
- Physician walk-in offices/centres;
- Paediatricians providing general medicine in private offices (general practitioner for children and adolescents);
- District medical doctors; family medical practitioners; medical doctors (general); medical officers (general); resident medical officers specialising in general practice; physicians (general); primary health care physicians;
- Independent practising general practitioners and general paediatricians within the public system.

Note: The role of a paediatrician varies considerably across countries; therefore their appropriate classification under offices of general medicine – primary care physicians – or specialists has to be decided by the country.

Cross-references

- Free-standing medical centres that are primarily engaged in providing emergency health care for accident or catastrophe victims and free-standing ambulatory surgical centres are classified under HP.3.4.3 *Free-standing ambulatory surgery centres*,
- Offices of psychotherapists and psychoanalysts without a degree of medical doctor are to be recorded under HP.3.3 *Other health care practitioners*.

HP.3.1.2 Offices of mental medical specialists. This item comprises establishments of independent mental health practitioners holding the degree of a doctor of medicine with a specialisation in mental medicine or a corresponding qualification.

Illustrative examples

- Practices of independent psychiatrists;
- Offices of medical doctors of mental health;

- Offices of mental health physicians;
- Offices of mental health paediatricians;
- Offices of psychoanalysts (medical doctors);
- Offices of psychotherapists (medical doctors).

Cross-references

- Providers of ambulatory mental health services in combination with other health and social professions have to be classified under HP.3.4.2 *Ambulatory mental health and substance abuse centres*.

HP.3.1.3 Offices of medical specialists (other than mental medical specialists). This item comprises establishments of health practitioners holding a degree of medical doctor with a specialisation other than general medicine or mental health (equivalent to ISCO-08 Code 2212).

Illustrative examples

- Offices of surgeons, aesthetic surgeons, anaesthetists, cardiologists, dermatologists, emergency medicine specialists, gynaecologists, endocrinologists, ENT (ear, nose, throat), gastroenterologists, infection specialists, nephrologists, obstetricians, ophthalmologists, orthopaedists, pathologists, paediatricians for specialised care (*e.g.* oncological treatment), pathologists, preventive medicine specialists, radiologists and radiotherapists, rheumatologists, specialist physicians (internal medicine), urologists, offices of medical specialists practicing TCAM, etc.;
- Establishments that are known as medical clinics other than multi-specialist centres, which are primarily engaged in the treatment of outpatients (Korea, Japan);
- Self-employed and independent specialists who rent a room or equipment for the purpose of their own outpatient practices on-site in hospitals or residential long-term care facilities.

Cross-references

- Paediatricians and other physicians working in primary care are classified under HP.3.1.1 *Offices of general medical practitioners*;
- Offices of nephrologists with dialysis units are classified under HP.3.4.4 *Dialysis care centres;*
- Offices of surgeons who operate with colleagues and anaesthetists as well as other medical staff and are primarily engaged in providing surgical services (*e.g.* orthoscopic and cataract surgery) in specialised facilities are to be reported under HP.3.4.3 *Free-standing ambulatory surgery centres;*
- Offices of midwives, physiotherapists and other paramedical practitioners are included under HP.3.3 *Other health care practitioners*;
- Doctors of dental medicine with a specialisation (*e.g.* dentist surgery) are to be recorded under HP.3.2 *Dental practices*.

HP.3.2 Dental practices

This subcategory comprises independent establishments of health practitioners who hold a university-level degree in dental medicine or a qualification at a corresponding level

(Code 2261, ISCO-08) and are primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (*e.g.* centres, clinics) and either provide comprehensive preventive, reconstructive or emergency care or specialise in a single field of dentistry. They can provide dental practice activities of a general or specialised nature, *e.g.* dentistry, endodontics, paediatric dentistry, oral pathology and orthodontic activities.

Illustrative examples

- Dental practitioners; dentists; endodontists;
- Dental surgeons; oral and maxillofacial surgeons;
- Oral pathologists; orthodontists; paedodontists; periodontists; and prosthodontists.

Cross-references

- Dental laboratories that deliver services directly to patients and are primarily engaged in making dentures, artificial teeth and orthodontic appliances for dentists are classified under HP.4.2 *Medical and diagnostic laboratories* (including dental laboratories);
- Establishments of dental hygienists who are primarily engaged in cleaning teeth and gums or establishments of denturists primarily engaged in taking impressions for and fitting dentures are classified under HP.3.3 *Other health care practitioners*; *e.g.* denturists in the Netherlands and dental prosthetists in Australia are allowed to provide full dentures.

HP.3.3 Other health care practitioners

This subcategory comprises the group of paramedical and other independent health practitioners (other than medical professions: general or specialist physicians, and dentists), such as chiropractors, optometrists, psychotherapists, physical, occupational, and speech therapists and audiologist establishments who are primarily engaged in providing care to outpatients. These practitioners operate as individual or group practices in their own offices (for example, centres and clinics) or independently in the facilities of others, such as hospitals or HMO medical centres. Some form of legal registration and licensing (implying a minimum of public control over the contents of the care provided) is regarded as a necessary condition in order to be reported as a paramedical practitioner in many countries.

Illustrative examples

- Nurses and midwifes offices;
- Offices of acupuncturists (other than physicians);
- Chiropractors (other than physicians);
- Physiotherapists and physical therapists;
- Occupational and speech therapists;
- Audiologists;
- Offices of dental hygienists;
- Offices of denturists;
- Offices of dieticians;
- Offices of homeopaths (other than physicians);

- Offices of inhalation or respiratory therapists;
- Offices of naturopaths (other than physicians);
- Offices of podiatrists;
- Practitioners with a less extensive understanding of Chinese medicine and other forms of traditional medicine based on relatively short periods of formal education and training (Code 3230 ISCO-08); in countries where these forms of medicine have been an integral part of medical practice for a long time, formal licensing may not be required as criteria for recognition as health practitioner; oriental (traditional) medicine clinics (Korea).

Cross-references

- The independent medical practice (general physician, mental or other specialist) is classified, respectively, under HP.3.1.1 *Offices of general medical practitioners*, HP.3.1.2 *Offices of mental medical specialists* or HP.3.1.3 *Offices of medical specialists (other than mental medical specialists)*;
- The independent practice of dentistry is classified under HP.3.2 *Dental practices*;
- The independent practice of home health care services is classified under HP.3.5 *Providers of home health care services*.

HP.3.4 Ambulatory health care centres

This item comprises establishments that are engaged in providing a wide range of outpatient services by a team of medical and paramedical staff, often along with support staff, that usually bring together several specialities and/or serve specific functions of primary and secondary care. These establishments generally treat patients who do not require inpatient treatment. They differ from HP.3.1.3 *Offices of medical specialists* by their multi-specialisations, the complexity of the medical-technical equipment used and the range of types of health professionals involved.

HP.3.4.1 Family planning centres . This subcategory comprises establishments with medical staff who are primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counselling, voluntary sterilisation and therapeutic and medically indicated termination of pregnancy.

Illustrative examples

- Pregnancy counselling centres;
- Birth control clinics;
- Childbirth preparation classes; and
- Fertility clinics.

Cross-references

- Centres involved in providing collective preventive programmes and campaigns against the transmission of HIV (including maternity health) are classified under HP.6 *Providers of preventive care*.

HP.3.4.2 Ambulatory mental health and substance abuse centres. This item comprises establishments with medical staff that are primarily engaged in providing outpatient

services related to the diagnosis and treatment of mental health disorders, alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide counselling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programmes, if necessary.

Illustrative examples

- Outpatient alcoholism treatment centres and clinics (other than hospitals and mental health facilities);
- Outpatient detoxification centres and clinics (other than hospitals and mental health facilities);
- Outpatient drug addiction treatment centres and clinics (other than hospitals and mental health facilities);
- Outpatient mental health centres and clinics (other than hospitals and mental health facilities);
- Outpatient substance abuse treatment centres and clinics (other than hospitals and mental health facilities).

Cross-references

- Hospitals primarily engaged in the inpatient treatment of mental health and substance abuse illnesses with an emphasis on medical treatment and monitoring are classified under HP.1.2 *Mental health hospitals*;
- Establishments primarily engaged in the inpatient treatment of mental health and substance abuse illness with an emphasis on residential care and counselling rather than medical treatment are classified under HP.2.2 *Mental health and substance abuse facilities*;
- Practices of mental health specialists are to be recorded under HP.3.1.2 *Office of mental health specialists.*

HP.3.4.3 Free-standing ambulatory surgery centres . This subcategory comprises specialised establishments with physicians and other medical staff who are primarily engaged in providing surgical services (*e.g.* orthoscopic and cataract surgery) on an outpatient basis. Outpatient surgical establishments have specialised facilities, such as operating and recovery rooms, and specialised equipment, such as anaesthetic or X-ray equipment.

Cross-references

- Physician walk-in centres are classified under HP.3.1.1. *Offices of general medical practitioners;*
- Hospitals that also perform ambulatory surgery and emergency room services are classified under HP.1 *Hospitals*.

HP.3.4.4 Dialysis care centres . This subcategory comprises establishments with medical staff who are primarily engaged in providing outpatient kidney or renal dialysis services.

HP.3.4.9 All other ambulatory centres . This subcategory comprises establishments that are engaged in providing a wide range of outpatient services, by a medical and paramedical

staff, and often support staff too, usually bringing together several specialities and/or serving specific functions of primary care and/or secondary care, *e.g.* centres or clinics of health practitioners with different degrees from more than one speciality practising within the same establishment (*i.e.* physician and dentist) are included in this item.

Illustrative examples

- Outpatient community centres and clinics;
- Chemotherapy and radiotherapy centres;
- Multi-speciality outpatient polyclinics;
- Multi-speciality HMO medical centres and clinics;
- Outsourced call centres staffed with trained call advisors or experienced nurses who are trained to answer clinical questions (*e.g.* England and United States);
- Multi-specialised TCAM providers not elsewhere classified.

Note: HMO-type medical centres comprise establishments with physicians and other medical staff primarily engaged in providing a range of outpatient health care services to HMO subscribers, with a focus generally on primary health care.

Cross-references

- Offices of medical practitioners who are primarily engaged in the independent practice of their profession are classified under HP.3.1.1 *Offices of medical practitioners*, HP.3.1.2 *Offices of mental medical specialists*, or HP.3.1.3 *Offices of medical specialists (other than mental medical specialists)* and HP.3.2 *Dental practices*; and HP.3.3 *Other health care practitioners*;
- Centres of hospitals that also perform ambulatory surgery and emergency room services are classified under HP.1.1 *General hospitals* if they are fully integrated.

Note: Mixed health and social care. In some health care systems "*integrated care*" refers to the inclusion of social care elements. It can be classified under HP.3.4.9 *All other ambulatory centres* if medical ambulatory care dominates, or otherwise under HP.8.2 *All other industries as secondary providers of health care,* if social care dominates. However, there is no common definition across countries. Countries might add categories at the third-digit level if necessary.

HP.3.5 Providers of home health care services

This subcategory comprises establishments that are primarily engaged in providing skilled nursing services in patients' homes, along with a range of the following: personal care services: medical social services, support in medications, use of medical equipment and supplies, counselling; 24-hour home care; occupational and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. The services of home nursing care providers are often substitutive for inpatient long-term services delivered by HP.2 *Residential long-term care facilities* or outpatient services provided by *HP.3.3 Other health care practitioners*.

Illustrative examples

- Community nurses and domiciliary nursing care (including child day care in the case of sickness);
- Home health care agencies;

- In-home hospice care services;
- Visiting nurse associations.

Cross-references

- Excluded are non-medical or non-paramedical providers offering help and support at home, and thus predominately engaged in providing services related to instrumental activities of daily living (IADL) such as help in cleaning, shopping, etc. These non-health care activities are outside the health care boundary, and respective providers that deliver only IADL services are captured under *HP.8.9 Other industries n.e.c.*

HP.4 Providers of ancillary services

This category comprises establishments that provide specific ancillary type of services directly to outpatients under the supervision of health professionals and not covered within the episode of treatment by hospitals, nursing care facilities, ambulatory care providers or other providers. Included are providers of patient transportation and emergency rescue, medical and diagnostic laboratories, dental laboratories and other providers of ancillary services. These specialised providers may charge patients directly for their services rendered or may provide these ancillary services as benefits-in-kind under special service contracts.

HP.4.1 Providers of patient transportation and emergency rescue

This subcategory comprises establishments that are primarily engaged in providing the transportation of patients by ground or air in the case of emergencies at patients' homes or outside (on the street) as well as in the case of illness as a component of the treatment process (*e.g.* transferring patients between health care providers, transportation of patients to dialysis or chemotherapy). The ambulance vehicles are usually equipped with lifesaving equipment operated by medically trained personnel. Transportation of patients might be carried out by different types of providers. The transportation in specially-equipped vehicles or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care is often delivered by ambulance services such as the Red Cross or Red Crescent, but also in some regions by fire brigades or private suppliers, depending on national regulations. In this case, the department of fire brigades that is responsible for ambulance services is considered as a primary provider.

Illustrative examples

- Ambulance services for patients with or without emergency rescue;
- Establishments primarily engaged in providing specialised patient transportation that is not rescue service along with health care *e.g.* transport services for dialysis or chemotherapy;
- Patient transportation (by ground and air) related to specific medical services like transplantology;
- Patient transportation by conventional vehicles specially adjusted for a medical purpose;
- Ambulance services provided in peacetime or non-disaster situations by the army, police or fire brigade.

Note: Transportation of body organs/fluids or other medical products is excluded as it is treated as intermediate output within the whole episode of treatment.

Cross-references

- Transportation in conventional vehicles by non-specialised providers, such as by taxis when this is authorised and the costs are reimbursed by health insurance (*e.g.* for transportations of patients undergoing renal dialysis or chemotherapy), is classified under HP.8.2 *All other industries as secondary providers of health care*.

HP.4.2 Medical and diagnostic laboratories

This item comprises establishments that are primarily engaged in providing analytic or diagnostic services, including body fluid analysis or genetic testing, directly to outpatients with or without referral from health care practitioners.

Illustrative examples

- Diagnostic imaging centres;
- Dental X-ray or medical X-ray laboratories;
- Medical/clinical laboratories;
- Medical pathology laboratories;[14]
- Medical forensic laboratories;
- Genome data banks.

Note: Excluded are any providers of diagnostic services, forensic laboratories, genome data centres or blood and organ banks that deliver their services only as intermediate outputs to other health care providers within an episode of medical treatment.

Cross-references

- Establishments such as optical and orthopaedic laboratories that are primarily engaged in making lenses to prescription or making orthopaedic or prosthetic appliances to prescription are classified under HP.5 *Retailers and other providers of medical goods*;
- Establishments, such as dental laboratories making dentures, artificial teeth and orthodontic appliances to prescription usually provide their services directly to dental practices and not to patients. In this case the value of their services should be included under HP.3.2 *Dental practices*. But there are exemptions: *e.g.* in the Netherlands denturists and in Australia prosthetists are allowed to provide full dentures; they may also work in independent practices. In the latter case, they should be classified under HP.3.3 *Other health care practitioners*.

HP.4.9 Other providers of ancillary services

This subcategory comprises other providers of ancillary services not explicitly listed above.

Illustrative examples

- Hearing testing services (except by offices of audiologists);
- Pacemaker monitoring services;
- Physical fitness evaluation services (except by offices of health practitioners).

HP.5 Retailers and other providers of medical goods

This item comprises specialised establishments whose primary activity is the retail sale of medical goods to the general public for individual or household consumption or utilisation. Establishments whose primary activity is the manufacture of medical goods, such as making lenses, orthopaedic or prosthetic appliances for direct sale to the general public for individual or household use, are also included, as is fitting and repair done in combination with sale. This category is made up of three subcategories.

Note: Due to special medical safety and quality regulations, retailers of over-the-counter medical products and other providers of medical goods are subject to licensing and/or pharmaceutical authorisation in order to be eligible to provide their activities. Non-health care products such as cosmetics, dietetic products and natural products are excluded from health expenditures.

HP.5.1 Pharmacies

This subcategory comprises establishments that are primarily engaged in the retail sale of pharmaceuticals (including both manufactured products and those prepared by on-site pharmacists) to the population for prescribed and non-prescribed medicines. Pharmacies operate under strict jurisdiction/licences of national pharmaceutical supervision. Usually, either the owner of a pharmacy or its employees must be a registered pharmacist, chemist or pharmacy doctor.

Illustrative examples

- Dispensing chemists;
- Community pharmacies;
- Independent pharmacies in supermarkets; and
- Pharmacies in hospitals that mainly serve outpatients.

Cross-references

- Pharmacies integrated in hospitals that mainly serve inpatients are part of establishments classified under HP.1;
- Specialised dispensaries where the continuous monitoring of compliance and treatment plays an important role (such as for diabetes patients) are classified under HP.3.4 *Ambulatory health care centres (e.g.* HP.3.4.4 *Dialysis care centres,* HP.3.4.9 *All other ambulatory centres*);
- Dispensed medicines in doctors' offices are recorded under HP.3.1 *Medical practices;*
- Over-the-counter medicine sales in supermarkets are to be classified as HP.8.2. *All other industries as secondary providers of health care.*

HP.5.2 Retail sellers and other suppliers of durable medical goods and medical appliances

This item comprises establishments that are primarily engaged in the retail sale of durable medical goods and medical appliances such as hearing aids, optical glasses, other vision products and prostheses to the general public for individual or household use. This

includes the fitting and repair provided in combination with sales of durable products, for example, in the case of hearing aids, cleaning, adjustment and the provision of batteries. Also included are establishments that are primarily engaged in the manufacture of medical appliances as prostheses, where the distribution to the general public, the fitting and the repair is usually done in combination with the manufacture of medical appliances.

Illustrative examples

- Retail sellers of glasses and vision products;
- Retail sellers of hearing aids;
- Suppliers of wheelchairs;
- Providers of orthopaedic shoes, artificial limbs and other prosthetic devices;
- Medical supply stores.

Note: Examples of specialised professions of suppliers of vision products are opticians, ophthalmic opticians, optometrists and orthoptists. Professions of suppliers of hearing aids include audiologists, hearing aid technicians. Usually, hearing health care professionals are an integral part of the selection and delivery of appropriate hearing instruments. The supply of prostheses involves professions like medical and dental prosthetic technicians, orthodontic technicians and orthopaedic appliance makers.

HP.5.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods

This subcategory includes all other principal activity retail suppliers of medical goods to the general public for individual or household consumption or utilisation not elsewhere classified.

Illustrative examples

- Cartridges, sale of fluids (*e.g.* for home dialysis);
- All other suppliers of medical goods *n.e.c.* delivering medical goods directly to consumers;
- Electronic shopping and mail-order houses specialising in medical goods.

HP.6 Providers of preventive care

This category comprises organisations that primarily provide collective preventive programmes and campaigns/public health programmes for specific groups of individuals or the population-at-large, such as health promotion and protection agencies or public health institutes as well as specialised establishments providing primary preventive care as their principal activity. This includes the promotion of healthy living conditions and lifestyles in schools by special outside health care professionals, agencies or organisations (see also HP.8.2).

Illustrative examples

- Institutes of Occupational Medicines;
- Local occupational health and safety networks/centres;
- Public health institutes/departments (in case of major prevention activities);
- Epidemiological surveillance and disease control centres;

- Institutes administering health registers related to disease control programmes;
- Institutes for communicable diseases;
- Health promotion agencies;
- Centres of public health education with activities involving the promotion of healthy lifestyles, healthy food and diets;
- Local health authorities operating preventive health programmes.

Cross references

- Preventive programmes provided in schools by employed health professionals are classified under HP.8.2 *All other industries as secondary providers of health care*;
- The provision of individual preventive screenings such as mammography are recorded under *e.g.* HP.3.1 *Medical practices* or HP.4.2 *Medical and diagnostic laboratories*. If services are provided to inpatients this has to be classified under HP.1 *Hospitals*;
- Provision of occupational medicine could be recorded under *Providers of ambulatory health care e.g.* HP.3.1.3 *Offices of medical specialists (other than mental health specialists)* if outsourced by enterprises to special medical providers, or under HP.8.2 *All other industries as secondary providers of health care*, if provided by enterprises in-house as an ancillary activity;
- Agencies and laboratories involved in activities related to drinking water and food control outside the health care industry (*e.g.* bottled water manufacturing) should be recorded under HP.8.9 *Other industries*;
- Vaccination programmes for children are recorded under the respective HP.3 *Providers of ambulatory health care*, but under HP.6 in the case of provision by institutes for communicable diseases.

Note: While the operative administrative costs of the preventive programmes should be recorded as a part of the function "preventive care", the general regulation of preventive programmes or related legislative measures undertaken by the Ministry of Health should be compiled under HP.7.1 *Government health administration agencies*.

HP.7 Providers of health care system administration and financing

This item comprises establishments that are primarily engaged in the regulation of the activities of agencies that provide health care and in the overall administration of the health care sector, including the administration of health financing. While the former relates to the activities of government and its agencies in handling governance and managing the health care system as a whole, the latter reflects administration related to fund raising and purchasing health care goods and services by both public and private agents. The main reason for inclusion of financing agents in the HP classification is to keep the balance and consistency of the compilation of the tri-axial system of transactions. Thus expenditures captured under HP.7 for health care system administration and financing cover the administrative expenses of financing schemes, presented by their institutional structure as financing agents. Financing agents can be involved in the management of several financing schemes in the HF classification.

Note: The administrative expenditure of primary health care providers (hospitals, physicians etc.) as well as part of the administrative costs related to the provision of health services of secondary health care providers should be included under the respective provider's category.

HP.7.1 Government health administration agencies

This subcategory comprises government administration (excluding social security) that is primarily engaged in the formulation and administration of government health policy, in the administration of health financing, and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics and so on, including the regulation and licensing of providers of health services. Health departments of regional or municipal governments should be included. This item covers also such establishments as the statistical institutes of a ministry of health (but not institutes administering population-based health registers) and public registers of health care providers, as both are part of health care system administration.

Illustrative examples

- Ministry of Health;
- Local and regional departments of the Ministry of Health;
- Board of Health;
- Drug regulation agencies, including law enforcement;
- Agencies for the regulation of safety in the workplace;
- Institute of Health System Information and other institutes affiliated with the Ministry of Health;
- Local health authorities (in case of major administrative activities, such as law enforcement, licensing and registering providers);
- Local centres for drug control inspections;
- Local centres for medical device control;
- Health care financing administration.

Cross references

- Government health agencies mainly engaged in providing public health services, even if predominantly of a collective nature (surveillance, hygiene), are classified under HP.6 *Providers of preventive care*.

Note: *Government administration of employee schemes*. The subcategory also includes administration of compulsory employer-based health insurance covering various groups of state employees (army, veterans, railroad and other public transport, police, state officials and so on in the case of separate financing schemes for these groups). It excludes universal social health insurance administration.

HP.7.2 Social health insurance agencies

This subcategory comprises the social health insurance agencies (sickness funds) that handle the administration of social health insurance schemes. Sickness funds may also provide the administration of employer's health insurance schemes not offered by the government. Also included is the administration of compulsory social health insurance covering various groups of state employees (army, veterans, railroad and other public transport, police, state officials, etc.). Social health insurance agencies may also administer voluntary private health insurance schemes. Organisations subordinated to health insurance funds, like the Medical Advisory Boards, are also to be included.

Illustrative examples

- Administration of health insurance schemes of social insurance;
- Administration of accident insurance schemes (health care part) of social insurance;
- Administration of voluntary health insurance schemes of social insurance.

Cross references

- Compulsory medical savings accounts under government administration should be classified under HP.7.1 *Government health administration agencies,* while compulsory medical savings accounts under private insurance administration should be classified under HP.7.3 *Private health insurance administration agencies;*
- Community-based voluntary health insurance managed by NPISH should be classified under HP.7.9 *Other health administration agencies.*

HP.7.3 Private health insurance administration agencies

This subcategory comprises private insurance corporations that may manage more than one type of health insurance scheme at the same time (for example, compulsory private health insurance and voluntary health insurance). This subcategory includes establishments that are primarily engaged in activities consisting of or closely related to the management of insurance (activities of insurance agents, average and loss adjusters, actuaries and salvage administration). It covers the administration of all types of compulsory and voluntary private health insurance.

Illustrative examples

- Private insurance corporations providing the administration of compulsory health insurance;
- Private health insurance funds;
- Agencies administering complementary health insurance (for example, a French *mutualité*) in the case of non-financial corporations;
- Agencies administering employer private health insurance programmes (other than government social security and government health programmes for state employees).

Cross references

- Agencies administering complementary health insurance (for example, a French *mutualité*) in the case of NPISH are to be classified under HP.7.9 *Other health administration agencies*.

HP.7.9 Other administration agencies

This subcategory is important for organisations or administrative units that cannot be clearly classified into the above categories, for example, these involved in the generation of financial sources as in the case of medical savings accounts. This category comprises also non-profit institutions serving households (other than social insurance). The health administration of the NPISH has to be covered here only if administration of health financing or of services is not covered by the other health provider categories.

Illustrative examples

- NPISH that administer government health care financing schemes for special groups of the population, such as students.
- Community-based voluntary health insurance managed by NPISH.

Note: Excludes doctors associations; hospital associations; associations of the medical professions; and trade unions financed by fees from members, because they provide (intermediate) services to their members and not directly to patients.

Cross references

- *HMO administration units* (other than those providing health care services) primarily engaged in underwriting health and medical insurance policies are classified under HP.7.3 *Private health insurance administration agencies* or HP.7.2 *Social health insurance agencies,* depending on the institutional classification of the schemes.

HP.8 Rest of economy

HP.8.1 Households as providers of home health care

The health care boundary drawn in SHA includes personal home health services provided within households by family members, in cases where they correspond to social transfer payments granted for this purpose. This item therefore comprises private households as providers of home health care. Unpaid care by household members is not included in the core health accounts of SHA. Problems of data comparability across countries and over time may arise when households have the choice between benefits in cash or benefits in kind, in which case both kinds of care (by laypersons within the family and by specially trained nurses) are considered to be close substitutes, but are treated differently in common national accounting practice (as health care benefit in kind or social transfer in cash). However, in SHA, those parts of the cash transfers to private households for care givers of home care for the sick and disabled are treated as paid household production of health care.

HP.8.2 All other industries as secondary providers of health care

This subcategory includes organisations that predominantly offer health care as a secondary activity, *e.g.* occupational health care services provided within enterprises, providers of social care with occasional health services or patient transport services provided by taxis. This category of secondary providers varies greatly among countries, depending on accreditation and licensing rules. In these establishments, the provision of health care goods and services usually constitutes a minority share of the output value. This item comprises all other organisations and industries that deliver health care goods and services as a secondary activity not classified above.

Illustrative examples

- Occupational health care services provided in-house and not delivered by health care establishments;
- Taxis that provide patient transport under the supervision of health personnel;

- Prison health care services not provided in independent/separate health care establishments;
- Wholesale retailers delivering also medical goods directly to consumers;
- Schools with employed health professionals for *e.g.* treatment of ill children or providing health education;
- Social care facilities providing to a limited extent, services related to health and long-term nursing care.

Cross-references

- Establishments that are primarily engaged in providing inpatient long-term nursing and rehabilitative services are classified under HP.2 *Residential long-term care facilities*.

HP.8.9 Other industries n.e.c.

This category in the HP classification comprises establishments that are outside the health care provider universe and do not provide health care goods and services either to individuals or groups of the population, but which are specialised in health-related activities such as those identified within the functional classification: *i) long-term care (social)* and *ii) health promotion with a multi-sectoral approach*.

Establishments of *long-term social care* are those primarily engaged in providing assistance and social care type services for elderly and other persons *1)* unable to fully care for themselves; and/or *2)* unwilling to live independently. This category also includes organisations that focus on social services that aim predominantly to prevent and combat the social isolation of persons with body or functional limitations. Instrumental activities of daily living (IADL), such as housekeeping, laundry, shopping, preparation of meals, help with financial activities, etc., reflect the scope of long-term social care activities and can be provided both in residential settings and at home.

Illustrative examples

- Assisted-living facilities without on-site nursing care;
- Continuing-care retirement communities;
- Homes for the elderly without on-site nursing care;
- Home social care providers, *e.g.* specialised in IADL services, such as home care, meals-on-wheels, etc., with additional nursing care services.

Cross-references

- Health and long-term care services are captured by primary or secondary health care providers HP.1-HP.8.2.

Establishments involved in *health promotion with a multi-sectoral approach* might include various organisations that deal with a wide range of public safety measures, such as food and water security measures, environmental control interventions or road and travel safety measures.

Illustrative examples

- Local food control agencies;

- Waste management enterprises;
- Agencies monitoring the level of noise or pollution;
- Transport Security department/agencies.

Cross-references

- Sanitary Institutes, laboratories testing the quality of human drinking water, food-borne risks, and epidemiological surveillance and disease control centres should be recorded under HP.6 *Providers of preventive care*.

Note: Activities related to health care research and development as well as to training and education in the health care sector are no longer included under health-related items within the functional classification of SHA 2011. These expenditures which are considered a type of investment, are to be re-coded as memorandum items, respectively under Research and Development or Training of Personnel in the capital account (see Chapter 11). Consequently, establishments such as nursing schools, medical research institutes and training centres can be recorded in the capital account (*i.e.* extended account) under HP.8.9 *Other industries n.e.c.* for the purpose of cross-classifying the health care provider classification with the classification of financing agents.

HP.9 Rest of the world

This item comprises all non-resident units providing health care goods and services as well as those involved in health-related activities. In both cases the provision is directed for final use to country residents.[15]

Notes

1. In comparison with the International Standard Industrial Classification (ISIC) or the NACE, the NAICS is based more on a single production-oriented concept under which, in principle, the boundaries between industries demarcate differences in production processes and production technologies.
2. Some categories, such as nursing care facilities, may either provide nursing care in combination with social services or offer various social-type services as secondary activities. As these services go beyond the health care boundary, they should be identified and cross-classified with health-related functions, as appropriate.
3. Depending on the country, the Ministry of Health or health insurance might also provide some functionally defined health care goods and services directly to the patients/population along with their governance or financing activities.
4. See the memorandum items in Table 11.2 "Capital account", for the purpose of cross-classifying the health care provider classification with the classification of financing agents.
5. The expenditure for health care goods and services by the resident population (consumption) must not equal the total sales (outputs) of the health care providers. One reason is that health care goods are provided for non-residents (exports). Another reason could be that some of the services provided do not meet the criteria of health care goods and services, such as in the case of social care. In order to maintain consistency with the two other core classifications in health accounts, expenditures related both to exports and to non-health outputs should be separated.
6. NACE Rev. 2 supports this by the separation between General medical practice 86.21 and Specialist medical practice 86.22; unfortunately, the ISIC does not.
7. Occupations whose practice requires a less extensive understanding that is developed through relatively short periods of formal or informal education and training or informally through the traditions and practices of the communities where they originated are included in unit group 3230.

8. For the decision tree that data compilers should follow when classifying institutional units (the providers of health care goods and services) into private or public providers, as well as identifying those public providers that should be allocated to the government or public corporations sector, see Kawiorska (2008).
9. See Eurostat (2008a), NACE Rev. 2, Definitions and principles.
10. According to NACE Rev. 2, the following are the units that are described in the Council Regulation on statistical units: a) the enterprise group; b) the enterprise; c) the kind-of-activity unit (KAU); d) the local unit; e) the local kind-of-activity unit (local KAU); f) the institutional unit; g) the unit of homogeneous production (UHP); and h) the local unit of homogeneous production (local UHP).
11. In the SNA, the provision of services by members of the household for their own final consumption has traditionally been excluded from measured production. One main reason is that the labour force would include inactive household members if household production were considered. Entries as care of the sick, infirm or elderly are not recorded in the SNA when they are produced by household members and consumed within the same household.
12. However, not all countries have implemented this guideline because of difficulties in measuring home health care provision. Home health care provision is actually not integrated in the Spanish, UK and Swiss health accounts. According to a recent academic study in Switzerland, the costs of unpaid work for care to dependent persons can be estimated at 0.3% of GDP or nearly 3% of the total expenditure on health.
13. SHA gives priority to the classification of establishments from the view point of health care activities. In the ISIC, both prison and military hospitals are classified under code 86.10 hospital activities.
14. In NACE Rev. 2, establishments primarily engaged in collecting, storing and distributing blood and blood products are part of the pharmaceutical industry.
15. A further optional breakdown of ROW providers can be the same as for the other parts of the HP classification to give more detailed information on imports, i.e. HP.9.1 *ROW Hospitals*, HP.9.2 *ROW Nursing health care*, etc.