Revision of the

System of Health Accounts

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT OECD

eurostat

World Health Organization

Comment
Unit 2

RESPONSE TO MEETING OF HEALTH ACCOUNTS

Summary
This note is in response to the presentations at the Meeting of Health Accounts Experts, October 8-9. The following document has been prepared by Jonathan Cylus for USAID's Health Systems 20/20 project and is intended to briefly address some issues which have been highlighted by lower-income African countries as having particular significance.

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UNIT 2

ISSUE- THE EXCLUSION OF NON-MONETIZED CARE, PARTICULARLY IN KIND CONTRIBUTIONS BY DONORS, TRADITIONAL HEALERS, AND HOME CARE.

Policymakers in many Sub-Saharan African countries have expressed keen interest in the level of non-monetized care. The Eurostat presentation, though acknowledging that some countries may want to record all health activities regardless of payments, suggested that SHA only include health care deliveries that involve payments. This is an issue in many lower-income countries, where in kind contributions by external donors constitute a large share of health care resources. In kind contributions could be monetized in SHA using the in-country market value of the good in question, as per the Producer's Guide (pg 94). Furthermore, the presentation stated that only health care delivered by health professionals should be included in SHA. This would appear to exclude traditional healers, who are an accepted provider of health care in many African countries. Although of lesser concern, policymakers in Africa are also interested in understanding the economic implications of caring for family members- more so in recent times as governments are shifting to more home based care programs (i.e. for treating early stages of malaria) though we recognize that a universal methodology to monetize unpaid home care could be problematic.

ISSUE- THE USE OF PRODUCTION OR CONSUMPTION

As mentioned in previous Health Systems 20/20 input documents, consumption is a more reasonable (but still challenging) way to measure expenditures in Sub-Saharan Africa because mismanagement of medical goods in many countries leads to a considerable difference between production and consumption. In many Sub-Saharan African countries, drugs may be stolen from storage and their level of consumption is not known. It would be valuable to policymakers in Sub-Saharan Africa to have a measurement of the difference between the value of the original stock (production) and the known level of consumption to get a better sense of the quantity of drugs that are mismanaged.

ISSUE- IMPORTS AND EXPORTS

It is a challenge for many countries with weak information systems to include imports (care for citizens that is obtained abroad) as well as to exclude exports (care for non-citizens that is obtained within country). These countries do not have a way to keep track of health care expenditures for their citizens when they are outside the country (other than what is recorded by ministries and employers regarding their sponsorship of employees abroad). Moreover, it is difficult for health accounts experts in Africa to differentiate between the spending that occurred for citizens and foreigners in their own country. Despite the obvious difficulties, many participants at the meeting stood firm that

they would like to see imports included and exports excluded from the SHA. We believe that imports and exports should be listed separately in addition to a "domestic consumption by residents + exports" classification (which is what most NHA in developing countries would amount to) so that those countries that cannot include or exclude them, respectively, can accurately report, and those that wish to tease out exports and add imports are able to do so. If these are not listed separately, NHA in countries that cannot make a distinction between imports and exports will not be comparable with other countries.

ISSUE- TRACKING OF INVESTMENT/CAPITAL

The proposal at the meeting suggested that investment/capital be recorded below the line.
We believe that once it is properly defined it should be included above the line. Capital is a substantial investment for lower-income countries, and medical equipment directly contributes to health and well-being.

ISSUES WITH THE DEFINITION INCLUDE THE FOLLOWING, AND SHOULD BE ADDRESSED:

1) Sometimes buildings are not created with the intention of being used for health, but are later converted to health facilities, or vice versa.
2) Health services may be provided in multi-use facilities that also are a venue for non-health services.
3) Construction on health facilities may never be completed.
4) There are health facilities that are geared toward medical tourism, and do not serve the local resident population. Guidance is needed for whether and how to include these examples.
5) Machines are sometimes purchased but never utilized for health. It may be misleading to account for these as health when they are unused.

ISSUE- LONG-TERM CARE

LTC should remain as it is now (including ADL).

CONCLUSION

The issues discussed above represent a sample of the incompatibilities with the SHA proposals outlined at the OECD meeting and some of the NHA needs of lower-income countries. We are excited about the progress that has been made thus far on the SHA revisions and are looking forward to reviewing the units after the regional consultations. Clearly, while many presentations have already emphasized that the key challenge to revising the SHA is considering for differences in the priorities and statistical capabilities between higher and lower income countries, there is still more work that can be done.