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Conceptual and practical boundaries in health accounting

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Conceptual and practical boundaries in health accounting

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by

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I. Context and priorities

Middle- and low- per capita income countries face frequently four major concerns:

- Insufficient public financing.
- Stagnation of resources, limited social protection coverage for health (financed by contributions from the payroll employees in the formal sector) and slow emergence of the Public Insurance (based on government resources and addressing the poor population).
- Very limited access by the poor population to health services.
- Increase in the relative prices of health care, which tends to erase gains in coverage and gains in public financing.

Usefulness of health accounting implies keeping track of:

- The different indexes of administered prices resulting from negotiation or regulation, which are widely used instruments of health policy.
- The degree of coordination/integration between providers and resources in order to produce synergies or, on the contrary, inefficiencies due to segmentation.
- Trends in public financing.
- The degree in which the poor are provided access to health services according to public policy parameters and the way in which resources and protection (insurance) are organized.
- The regressive effect that out-of-pocket expenditure has on the poor population.
- The evolution of the social security for health.

Monitoring consist usually on annual exercises, but the analysis of achievements and/or challenges during other strategic periods such as a presidential administration, stands out as very important.

II. Conceptual and practical boundaries of health accounts

1. NHA do not measure how good health is.

Good health is the product of three sets of very diverse and interrelated factors:

- a. the environment or the presently so-called health determinants,
- b. the genetic background, and
- c. the timely provision of health services within a health organization. These three subsets interact differently for each human group according to specific demographic (age group structure) and socioeconomic structures (exposure to risks). When expenditure is designed to study of determinants of the health status of a society, a whole set of

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previous studies is required that provides a measure of effectiveness that each type of expenditure has of the health outcomes. That may require an inter-sectoral approach.

2. A conservative measurement of the expenditure should include at least the financing, provision, promotion and use of health care services.
 - a. The measurement embraces health services, and not health in its broader and more positive sense, even when institutions may have health responsibilities that are positive or external to health. A good example of this is when the health institutions also carry out sanitation responsibilities.
 - b. Other factors that contribute to good health are subject to an organizational framework different from that of the health services, and the responsibility for their immediate operation usually falls outside of the health authority control.
3. The boundaries of a health service are evolutionary, inter-cultural, and social.
 - a. Measurement relates to points of services that have as their fundamental objective the improvement of health status, regardless of the outcome of the interventions. The services that contribute to an improvement of health without being part of health care services would remain outside the boundaries, though perhaps retained in some memorandum/under the line item (i.e., yoga, fitness, etc.).
 - b. Health services may be provided by different technologies (such as the allopathic and the homeopathic medicines), cultures (Andean, jungle, Western, Chinese medicine), levels of attention (home visit, office visit, hospitalization), legal form (institutional or informal provider, fake provider). The challenge within the operationalization of this choice entails the use of complementary methodologies such as the estimation of the cost of family care during different stages and the attribution of costs of informal and/or illegal activities.
 - c. All inputs and infrastructure used should be included, that is to say: i) transportation, ii) inputs that are labelled as nutritional supplements, but at the same time are prescribed or recommended and, thereby, used in the expectation of healing and/or alleviating illness and improving the condition of the human organism (vitamins); iii) drugs and other inputs, including those that have been altered or have expired.
 - d. All goods produced at the household level whenever a family member gets sick should be included. Hence, when chicken soup is cooked with the aim of curing/alleviating a patient, its cost should be considered as a home remedy. In contrast, the soup is not to be included when it is cooked as part of the family menu.
 - e. A part of the expenditure ascribable to health care associated care provided to children and elderly people who live in assisted living institutions should also be taken into account. This is the case of care provided to elderly people at rest homes and the raising of children in child care centers.
 - f. All health expenses of a collective nature exercised by preventive and promotional health services, in addition to those by curative services, are to be considered. For example, a fumigation carried out by the Ministry of Health is a preventive service that aims at controlling a specific risk: dengue fever control or malaria control.
 - g. The pertinence of including certain types of consumption associated with health in its

positive sense should be examined. Illustrations include drug addiction, alcohol consumption (viewed as social anti-depressing). There are pros and cons. In favour: alcohol consumers claim the need of alcohol to survive. Against: alcohol consumers are aware that it is harmful to their health. Should a knowledge of damaging effect not consistently be an exclusion criteria.

4. To address the evolutionary, intercultural, and social character of health services, it is necessary and to estimate and incorporate modalities and inputs that until now have been excluded, it is necessary to consider:
 - a. The expenditure associated with self-care and long-term services is not easy to estimate and specific studies are required.
 - b. Healing inputs labelled as nutrients and not as medicines may be difficult to identify but their omission should be noted.
 - c. The cost of domestic work needed to prepare the chicken soup mentioned in 3d is usually not estimated. At the household level, the time dedicated to take care of a sick person by another family member (typically a woman) represents an undervalued resource.
 - d. Although the information surrounding the “medical visit” is considered in the case of folk healers and other practitioners of folk medicine, the related expenditure is usually underestimated as is the case for in-kind payments and irregularly reported payments.
5. NHA do not measure the effectiveness of a sanitary system, only the flows associated with the health care function.
 - a. Public financing does not improve effectiveness or health when there is no increase in the number of benefits provided or their quality, but only a shift in payer. When access to services widens for a population group, additional services represent an input that household surveys should recorded.
 - b. Measuring the efficacy of certain groups of services would be useful. For this purpose, appropriate statistics on the production of services are required.
 - c. The expenditure required for a pathology that is a priority for the public health system (along with those who financed it) can be measured.
6. Medicines represent the input by excellence of health care within the allopathic medicine model. Until now, the sum of pharmaceuticals produced at the national level together with those that are imported is measured, thereby underestimating their related cost. Ideally, the measurement of pharmaceutical associated with the underground economy, such as contraband and falsification/adulteration, should be included.
7. Human, infrastructure, and knowledge capital are often neglected in the measurement of health expenditure. Only budgetary and out-of-pocket are de facto counted.
 - a. Human resources are only counted as salaries paid (whatever the labour regime). Investment in professional education of human resources for health is only partially measured². A more elaborate set of methodological guidelines is warranted.

² The inclusion of training activities for the production of health services does not fall in this case.

- b. In regard to infrastructure, it enters the accounting system based on expenditure. A more complete measurement: the use cost (capital consumption, stocks, etc.) is desirable.
- 8. Geographical boundaries. The main recommended methodologies deal with the legal commerce of medicines and of equipment leaving out parallel supply and neglecting the trade facet. Issues to reconsider:
 - a. Limitation to legal commerce and practice only. Illegal commerce or practice, smuggling, fake healers, etc. appear to be only partly captured in the National Accounts, yet its magnitude appears to be much higher than what is estimated.
 - b. Health services for the tourists, largely concentrated in plastic surgery, dentistry, and ophthalmology, concerns relatively low cost areas but even these are only poorly or not estimated at all.
 - c. Services provided to the bordering population. Transborder flows are not constant and depend inter alia on price differentials, as well as on coverage in the insurance plans of the visitors. These are presently poorly estimated.
 - d. Outlays of residents temporarily out of their country using services while abroad should in a domestic product accounting be added just as imports. Foreign residents consumption of services in the country should be deducted. These transactions cannot easily be measured.

III. Operational guidelines

- a. a. The definition of the health expenditure boundary goes through a much needed operative definition of health and the services that favor it.
- b. b. The classification to organize the contents agreed upon will also need to be well defined. It is of utmost importance that those working on classifications open up to other modes that are prevalent and emergent in middle- and low- per capita income countries. For example, inexistent or illicit services in a country may not be illegal in others.
- c. c. A ventilation leading to cross-analyze the expenditure with population socioeconomic criteria and to approach the expenditure distribution according to the needs of services would be required.
- d. d. Measurement of expenditure may be integrated by conforming components with progressive levels of standardization. A first cluster, more standardized, would embrace the measurement of financing, provision, promotion and use of health services. Another cluster could include services that are being provided from a multi-sectoral perspective.
- e. e. Measurement has to be supported by the quality of original registries, which entails the need to deploy a considerable effort in order to better define and fine tune the original compiling of figures. Specifically, strengthening production, products, and consumption registries is required.
- f. f. The conceptual definition include explicit rules related to treatment to joint products as well as to those of a multi-sectoral nature.