Revision of the
System of Health Accounts

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

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Unit 11

Comments from WHO regional consultation

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Unit 11 comments from WHO regional consultation

The World Health Organization has conducted regional three days consultations with separate sessions devoted to each of the Units in the SHA revision. National experts in health accounting and health financing policy have been invited from member states in the respective regions. Because comments represent the views of different regions, they may vary or even contradict each other.

Regional Office for Africa, Nairobi 15-17 April 2009

The meeting expressed a large interest in the proposals made in the unit, and welcomed it as an important complement to SHA.

It was recommended that the name be changed to Distributional Accounts, rather than beneficiaries characteristics. There was a consensus that ethnicity be taken out completely from this chapter, and that it be understood that the need overall is to measure expenditures on health for vulnerable population groups (rural, periurban, PLVHIV, children/elderly, lower income quintile, etc.) .

The age groups were given several comments. One suggestion was to leave the age grouping open to allow countries to select what is nationally relevant. This would however limit the possibility to compare across countries.

In the regional classification there is no mention of health expenditures by Urban and Rural population. Furthermore the relevance of the consumption approach was questioned, because in Africa problems with travel costs and accessibility to providers are relatively large, i.e. even if an equal distribution of health consumption as measured by NHA across regions is achieved, the burden on the population to receive that same level of health consumption, is largely varying. The availability of data, particularly for hospital care, also makes consumption much less feasible.

For several classifications, tabulation with FS is recommended, especially the regional accounts. Even though countries look very differently geographically and administratively, some guidance is needed for dividing the country in policy relevant regions. The unit should contain a table that will cross each population group by each health accounts dimension, and detail how it can be relevant for policy issues (this would also include NHA matrices by population group). The purpose is to help countries evaluate which data to collect, produce, and report.

The AFRO region recommends to use quintiles for the socio-economic groups. Furthermore it recommended to change the wording from disease to condition, as it is a more correct comprehensive terminology.

Regional Office for South-East Asia and Regional Office for the Western Pacific, Seoul 6-8 May 2009

Generally the meeting agreed that all four principle classifications suggested in Unit 11 are relevant and important. It was however questioned to what extent this unit belongs to a manual aiming at international classifications. All four classifications, but especially the regional classification, are relatively the other dimensions more useful for country analysis than international comparisons.

To reach an international standard of these four classifications, and comparability, more details of implementation are needed in the unit. Currently its relatively conceptual.

In the regional accounts, there was a consensus that the consumption approach was the most feasible.

The classification of socioeconomic groups has been done differently in the region. Bangladesh and India have used consumption quintiles, while the Philippines has used income, although income is recognized to be underreported. Consumption is recommended by the region.

The disease classifications have varied between the countries; ICD-9 (India), ICD-10 (Philippines, China, Thailand for OP) and Diagnosis Related Group (DRG) by Thailand for IP. Even though recommendations are asked for, it will inevitably vary by availability.

The meeting gave four suggestions for names of the Unit;

- Distribution of Expenditure by Beneficiaries
- Expenditures by Beneficiaries
- Expenditure by Beneficiary Characteristics
- Distribution Expenditure by Beneficiary Groups

The table shows what has been implemented so far by the countries;

Country	**Accomplishments so far**				**Feasibility**
	Age/ gender	**Disease**	**Socio-economic**	**Region**	
Bangladesh	√	√	√	√	ALL
China	√	√	-	√	F – ??
India	√	-	-	-	SE, Region
Indonesia	-	-	-	-	F - ??
Malaysia	-	-	-	-	ALL
Mongolia	-	-	-	-	F - ??
Myanmar	-	-	-	-	F – Disease, region
Philippine	√	-	√	√	Disease

South Korea	√	√	-	√	F - ??
Sri Lanka	√	√	√	√	ALL
Thailand	√	√	-	√	ALL

The Regional Office for the Eastern Mediterranean and the Regional Office for Europe, Geneva 26-28 May 2009

The Unit is strongly supported by the meeting, being very important for planning and policy making as a tool for equity issues, sustainability, and access to the health care services and efficiency.

This unit can be implemented by countries depending on need, feasibility and reliability of the data for different dimensions. Flexibility is therefore recommended over compulsory production of expenditure by population groups. However, the meeting recommends using the FS and HP classifications by the proposed dimensions as these tables are more relevant for health policy.

Regional classification including urban and rural is very important. For comparability, a standardized definition of rural and urban is needed. WB definition/separation can possibly be used. Both region of residence and region of productions are interesting to study, so should not recommend one over another. In addition, measuring trade between regions is interesting (could highlight quality of services issues, or access difficulty).

It was also discussed in the session that socioeconomic status should ideally be complemented by an additional dimension, which is capturing the insurance coverage of the population. For access to health, and financial protection, different systems' ability to cover households can vary considerably within same income segment. Make sure that the chapter mentions a recommendation for quintiles, and discuss issues of measurement of income through proxies. The issue of socio-economic is not only about differences in income, but could also be education level, dwellings, etc.

Ethnicity as a population grouping should be excluded.

Age groupings of 5 years seem too detailed, and unless clear policy issues can be shown to benefit from such a disaggregation, it is better to recommend larger groups of age (10 years).

Expenditure by disease could focus only on priority disease in each country rather than a longer classification. Mention of DRG and its relationship with ICD should be made. Also, the classes should not be limited to ICD.10. We need to add another category for health expenditures that are not related to any disease, such as check-ups.

In general it is important to highlight the caveats of analysing expenditure by groups, without further analysis. For example, expenditure by region may be equal between regions, yet

geographical access to care may vary a lot, adding a transportation bill that could double the health care costs of some compared to others.

Regional Office for the Americas, Cuernavaca 17-19 June 2009

General comments

The chapter should be entitled “Distribution of expenditure by beneficiary population characteristics” or “Classification according to population characteristics” because the use of the expression “beneficiaries” in an isolated fashion gives an idea of persons enrolled in a specific social protection scheme.

The existence of this chapter in the accounts manual is crucial because it supports the generation of evidence for decision making, as well as for policy assessment in terms of equity, justice, efficiency and financial protection. This is definitely the purpose of health accounts. The primary use of this type of analysis is aimed at the country level, and therefore, international comparability is secondary in order.

The beneficiary population is defined as those specific groups to whom resources are directed to as a result of an intervention. In this sense, this is about recipient population groups or potentially recipients of resources.

Specific comments

With respect to age and sex distribution, the following considerations were given: (a) ask a gender specialist about the proper use of the terms “sex” and “gender” because it seems that in this case the first term “sex” is more appropriate; (b) the age distribution is proposed to observe international criteria, such as the Global Burden of disease.

Observations on methodology aspects: (a) the group concurred that the five dimensions of spending distributions are valid; (b) it strongly recommends that guidelines on how to make the distribution by population characteristics be included in the manual itself or in a guideline similar to the Producers Guideline; (d) The use of individual-based and top-down approaches is valid provided that it clearly states that they are mechanisms to help distribute the spending among beneficiary population groups; however, for age and disease groups, starting from larger group aggregates and moving towards greater detail or segregation should be the option; (f) The document could suggest certain categories for the distribution of disease-oriented spending and age-based spending in consistency with internationally valid criteria, which could be used for comparisons between countries; (g) The design of matrices to allow the cross-tabulation of information on spending distribution by characteristics of beneficiary population with information on providers is recommended; this would facilitate the design of another matrix to cross-tabulate them with functions. This information could be then cross-tabulated with financial schemes in order to analyse the impact of each one of them.