

Input Document Unit 2

GLOBAL BOUNDARIES OF HEALTH CARE

Summary

The designated boundaries of health care should be logical, practical, and reasonably compatible with data collection capabilities. A number of activities either border on the definition of health care or are non-health related but occur in the provision of health care services. While it is essential that the definition of health care not be muddled by non-health services to prevent total health care spending from appearing greater than it actually is, practical consideration must be given as to what data can reasonably be collected (e.g. how to exclude spending by foreign nationals at local health facilities? This is difficult to distinguish). There is especially need for a better definition of “health-related.” Some questions that should be addressed in understanding the global boundary of health care are: How do we determine what is a true health function? What are the needs and priorities of policymakers? On a practical level, what resources for the measurement of NHA are available? Who are the users of NHA data (MoF, MoH, health financing planners, international organizations, donors)?

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ACRONYMS

USAID	United States Agency for International Development
PHR	Partners for Health Reform
PHRplus	Partners for Health Reformplus
SHA	System of Health Accounts
NHA	National Health Accounts
PEPFAR	President's Emergency Plan for AIDS Relief
MoH	Ministry of Health
ECSA	East, Central, and Southern Africa
NGO	Nongovernmental Organization
MoF	Ministry of Finance
MDG	Millennium Development Goals
IMF	International Monetary Fund
NPISH	Non Profit Institutions Serving Households
NASA	National AIDS Spending Assessment
GDP	Gross Domestic Product
SNA	System of National Accounts

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EXECUTIVE SUMMARY

The following SHA input document reflects the authors' experiences with implementation of National Health Accounts (NHA) in low- and middle-income countries, particularly those countries that have worked with the Health Systems 20/20 project and its predecessor projects namely Partners for Health Reform (PHR) and Partners for Health Reformplus (PHRplus). These projects together represent over 10 years of experience in NHA in low- and middle-income countries, largely in Africa, the Middle East, and Latin America and the Caribbean.

While we comment on many areas suggested by the Invitation for Input Documents, we have attempted to focus our attention on those areas with which we have had the most experience.

1. UNIT 2. GLOBAL BOUNDARIES OF HEALTH CARE

1.1 SUMMARY

The designated boundaries of health care should be logical, practical, and reasonably compatible with data collection capabilities. A number of activities either border on the definition of health care or are non-health related but occur in the provision of health care services. While it is essential that the definition of health care not be muddled by non-health services to prevent total health care spending from appearing greater than it actually is, practical consideration must be given as to what data can reasonably be collected (e.g. how to exclude spending by foreign nationals at local health facilities? This is difficult to distinguish). There is especially need for a better definition of "health-related." Some questions that should be addressed in understanding the global boundary of health care are: How do we determine what is a true health function? What are the needs and priorities of policymakers? On a practical level, what resources for the measurement of NHA are available? Who are the users of NHA data (MoF, MoH, health financing planners, international organizations, donors)?

1.2 HIGHLIGHTED RECOMMENDATIONS

- 1) Better definitions of core-health, health-related, and non-health functions are needed.
- 2) Guidance for how and if to include non-monetized health functions (e.g., in-kind payments to traditional healers, informal payments in the form of gifts to providers, other indirect spending such as non-reimbursed caring for a family member) is needed.

1.3 ACTIVITIES AT THE BORDER OF HEALTH CARE

There are various levels of consideration in determining the boundaries or scope of NHA. A balance must be struck between maintaining a purely theoretical definition of national health spending and a practical definition that yields to data limitations. In the end, the prevailing definition of health spending used in the SHA must be one that best meets the needs of policymakers. Discussion regarding those activities that are at the definitional border of health care is essential in revising the SHA. The following items were designated as needing special attention in the *Invitation to Submit Input Documents*.

1.3.1 THE MIX AND DELINEATION OF HEALTH AND SOCIAL CARE

One of these issues is how to account for the mix of health and social care. In many low- and middle-income countries, particularly low-income countries, there is little social care other than for HIV/AIDS. Some advocate the inclusion of general nutrition

support as an element of health in certain circumstances. For example, patients undergoing antiretroviral (ARV) drug therapy for HIV/AIDS often must be given nutritional support so that they are physically strong enough to be able to consume ARV drugs. However, other examples such as food supplements provided under the Progresa/Oportunidades program in Mexico should continue to be considered health-related expenditures because the main objective is to improve nutritional status. Nutrition support can be tough to define—at what point is the provision of food considered the delivery of a health service? Malnutrition centers? Emergency food aid? Food subsidies? While better definitions of core health, health-related, and non-health functions are needed, a distinction should generally be made between core health activities and other social interventions.

1.3.2 LONG-TERM CARE

Another issue to be addressed is how to define long-term care. Most long-term care in the developing world takes place at the household level and is not monetized. Currently, this type of indirect care is excluded from health accounts. However, there is value from a policy standpoint to estimate household investment to provide this type of care for family members. In particular, interest has grown because of the growing number of home-based care initiatives. Data collection is problematic, but the inclusion of this type of care in health accounts should be discussed. Middle-income countries may have an easier time accounting for long-term care as their disease burden continues to shift from infectious diseases to chronic diseases, which often require longer duration of care.

1.3.3 HEALTH SERVICES PRODUCED AT HOME

Health services that are produced at home or outside of the normal delivery of care are another issue. While a large share of health care is certainly produced at home, few data about it are available, and much of this care is not currently accounted for in health accounts because it is not monetized. Furthermore, if data existed, it would be even more difficult to quantify the amount spent on home care. How would NHA measure the opportunity cost of caring for a family member? Most of these caregivers are unemployed or underemployed family members, and though their actions are certainly within the definitional boundaries of health care delivery, it would be very difficult to assign a labor valuation to their services. Nonetheless, an understanding of the level of household investment in home care would be beneficial to policymakers.

1.3.4 PREVENTION AND PUBLIC HEALTH SERVICES

More clarity is needed to determine how much is spent on prevention. In many low- and middle-income countries, preventive medicine consumes a large share of public health expenditures. However, expenditures for many preventive activities are embedded in curative care. For example, immunizations given in an outpatient facility are accounted for in the SHA as outpatient curative care. Policymakers would be better served if all preventive activities were accounted for together in a prevention-specific category. SHA 2.0 should provide guidance on how to tease out preventive activities from curative care.

1.3.5 HEALTH GOODS AND SERVICES EXPORTED AND IMPORTED

The importation and exportation of health goods and services is of varying significance in low- and middle-income countries. Although it is nearly impossible to exclude health expenditures on non-citizens, the SHA currently mandates that health services only be included in NHA if they are performed on the local resident population. While this is to maintain the accuracy of per capita data, it presents an issue in countries where medical tourism is prevalent, or where large numbers of foreigners are treated. Countries that engage in medical tourism invest large amounts of money in creating health facilities for foreigners. For example, Jordan plans to build cancer centers with the aim of attracting foreign patients. Even in other countries with fewer foreign patients, it is impossible to exclude foreigners from NHA. A strategy for dealing with this should be suggested, or health care for foreigners should be reconsidered for inclusion in NHA. Additionally, the measurement of imported and exported goods is not feasible. Record-keeping for imported drugs may not be strong in low- and middle-income countries, and these drugs sometimes expire while in storage before being consumed. Drugs in some regions, including ECSCA, are often stolen from storage and health facilities or otherwise mismanaged, making their level of consumption unknown. While only drugs that are consumed are accounted for in the SHA, a measure of the difference between the value of the original stock of drugs and the value of those drugs that are known to have been consumed would be worthwhile for policymakers. If the original stock of drugs is to be accounted for, guidance should be given as to which prices to use: wholesale, retail, or government subsidized.

1.4 FURTHER BOUNDARY ISSUES

Other boundary issues not mentioned in the *Invitation for Input* also require attention.

- 1) There is ambiguity between HP.5 Provision and Administration of Public Health Programs and HP.6.1 Government Administration of Health. A distinction should be made between these categories, or they should be combined.
- 2) Many countries have also expressed interest in the inclusion of donor spending on planning and administration. These countries want to highlight the difference between resources spent on activities to improve health and the administrative cost that is associated with that care. Policymakers are greatly interested in the costs of getting resources to beneficiaries. Though it is not a function of health, this spending could be included in a sub-account. Separating program administration costs from personal costs would be valuable for identifying administrative inefficiencies. In general, a more specific definition of the term administration is needed.
- 3) Guidance is needed for certain time boundary issues. One of those issues is to advise countries how to create calendar year (CY) data from the fiscal year (FY) data that are often used by providers. The *Producers' Guide* suggests a few methods, including evenly distributing FY data across each month to create CY data. This is likely an inaccurate method to estimate spending, as expenditures commonly fluctuate throughout the year. Attention should be given to this issue, and a consistent

methodology should be used across all countries. Another issue is how to convert cash to accrual.

4) Training health professionals is a huge expense for low- and middle-income countries and should be accounted for above the line in a sub-account.