

Revision of System of Health Accounts

Unit 11 - Classification by beneficiary/ recipient characteristics

Nathalie Van de Maele
World Health Organisation
vandemalen@who.int

May 2009



Presentation plan

- Purpose of Unit 11
- How are the proposed guidelines structured
- Methodology for each of the 4 different types of expenditures by beneficiaries
 - by disease
 - by age / sex
 - by region
 - by socioeconomic status
- Discussion: what are your needs/wishes?



Purpose of Unit 11

- No such guidelines in SHA (nor in PG)
- But more and more countries are building or expressing wishes to build expenditures by beneficiary
- SHA.2 was seen as an opportunity for a first set of guidelines, written using country experiences and existing partial guidelines, including:
 - work done by countries, particularly on equity in health expenditure
 - WHO regional subaccounts
 - OECD expenditure by disease, age and sex
- By end of tomorrow: yes/no for unit 11; if yes, feedback on proposed guidelines



Guidelines structure

1. policy use for each of the 4 types of expenditure by beneficiary proposed
 - examples of uses
 - proposal of indicators
 2. ... from which the health care boundaries are to be defined:
 - should we distribute current + capital, current only, personal health expenditures?
 - should we distribute functions only? other health accounts dimensions?
 3. ... then we need classifications to define population groups
 - for each of the 4 types : disease groups, age groups, regions, socio-economic groups
 - help manage overlapping categories (e.g., HIV/TB)
- Unit 11 will NOT explain how to build expenditure by beneficiaries
 - only recommendations for methodology (bottom-up, top-down, or mixed)

Global policy needs (1)

- information on differences in resource uses, necessary for making and evaluating policy decisions:
 - in general, policy makers look for information on expenditure by population groups to help explain disparities in health outcomes, health care utilization, etc.
 - policy makers, or civil society, are interested in measuring success/impact of policies
 - monitoring of health financing for sustainability purposes
- shape health financing policies : equitable mobilisation of resources, equitable government subsidies, protection against large out of pocket spending shares
=> equity assessment of the health financing system

Global policy needs (2)

- Do we want global guidelines for international comparability? Is it of interest to compare countries expenditure by beneficiary?
 - Exp by disease, age/sex, socio-economic group
 - Exp by region
- How are existing tools different?
 - Beneficiary incidence studies : concentrates on government expenditures only
 - Catastrophic spending : concentrates on households out of pocket spending
 - Cost of illness studies : broader than medical direct costs

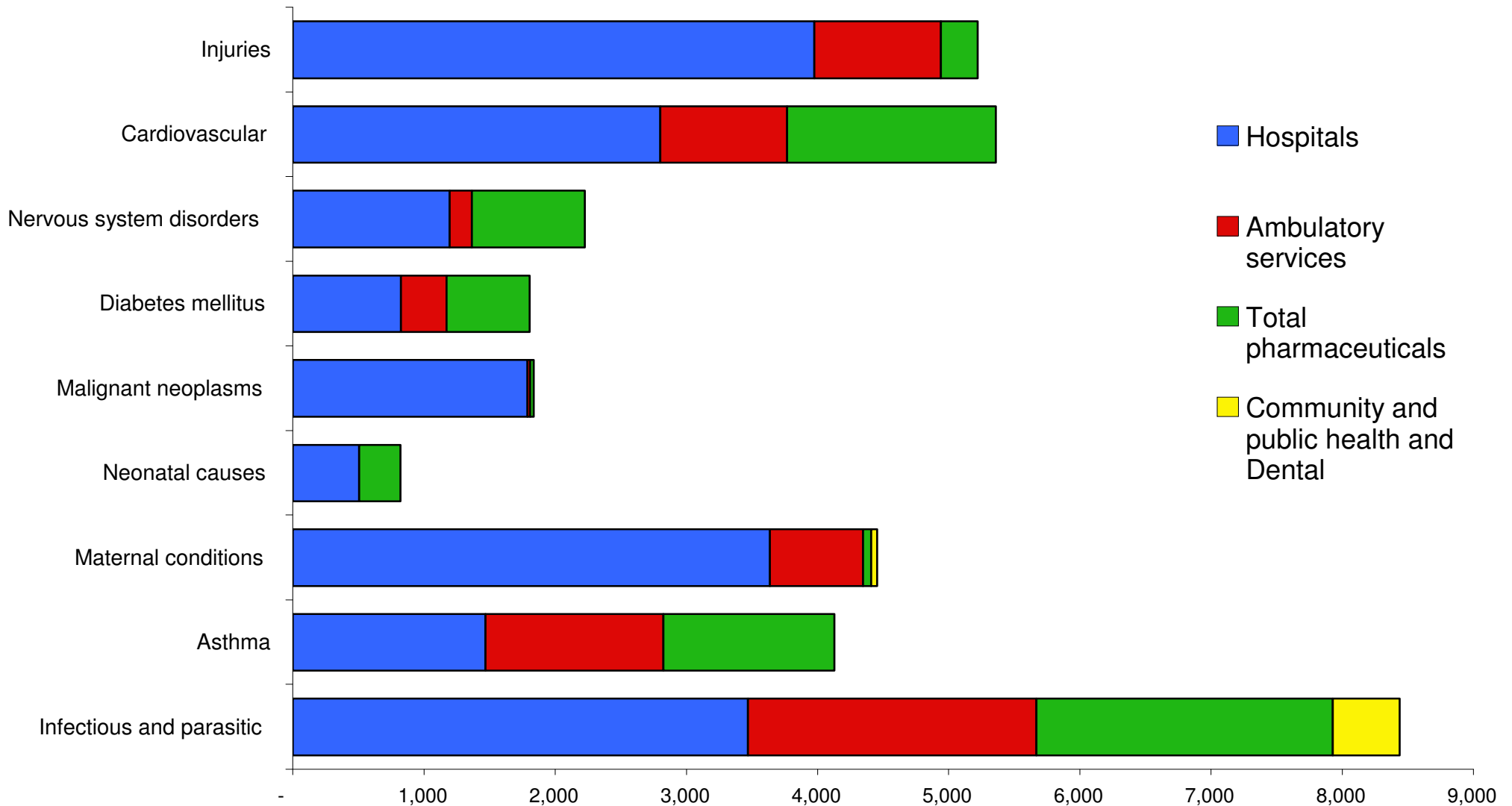
Health care boundaries

- In general, for each population group
 - personal and collective health expenditures
 - personal care: always attributed to an individual of a group
 - collective care: attributed to a group of individual or the whole population
 - Additional **optional** boundaries? capital expenditure?
 - How does this translate in terms of PG health accounts dimensions?
 - (HC.1 – HC.5) + (HC.6 – HC.7)
 - may be HC.R.1 for targeted capital expenditures
 - FS, HF, HP, HC ?

1) accounts by disease (1)

- Policy use : allocation and priority setting
 - Analysis of expenditure by disease per patient
 - Efficiency analysis with additional information on costing of treatments
 - Analysis of expenditure by disease, and their composition
 - by health function (care vs prevention)
 - by type of provider
 - Time trends analysis and projections of future resource use

Total costs of disease by sector, Sri Lanka 2005



Total expenditure by disease (Rupees million)

● Disease classification

- for reporting: use global burden of disease (GBD)
 - developed for all types of country health profiles
- co-morbidity?
 - The most widely accepted solution would be to apportion the relevant expenditures across all the relevant conditions
 - But in practice, often use alternative option, which allocates expenditures to primary cause of treatment
 - For HIV/TB, GBD proposes a separate HIV/TB classification

- Recommendations for estimation process

- Approach:

- bottom up (using cost of each disease x number of cases)

- AND/OR

- top down (# of cases weighted by average cost to produce distribution key)

- Need data on # of cases per disease by cost-unit (i.e., in-patient care, ambulatory, laboratory services, etc.)
 - Useful classification is that of ICD-10 (2nd digit level)
 - But other classifications: national classification; ICPC for primary care; ATC for medicines; ISHMT; others
 - END goal is to link back to reporting GBD classification

- Recommendations for estimation process (cont.)

- Other:

- administrative/non targeted expenditures should be distributed proportionately
- data caveats :
 - quality of reported prevalence indicators
 - patients report symptoms not necessarily care
 - hospitals report detailed information only for severe cases
 - ambulatory providers could report better information but requires surveys

2) accounts by region

- Policy use: accounts by regions help reflect upon issues such as:
 - success of decentralization policies
 - questions whether transfers from central government to regions are consistent with health sector development plan
 - brings to attention inequalities between regions: rural/urban; poorer/richer; ... (efficiency issue? financing mechanisms?)



● regional classification

- needs to be able to respond to policy questions:
 - what is a significant regional breakdown of the country in terms of health (administrative regions? political regions? health regions? ...)
- we want to measure what is consumed in a region, not produced in a region
 - residents of one region could be seeking care in another region
 - if care paid by a resident/institution of another region, expenditure is still accounted under region of residence of patient

- recommendations on the data production methodology :
 - ideally, only consumption data should be collected or measured;
 - however, often accountants measure production expenditure in lieu of consumption due to lack of data:
 - this should be avoided, and banned when we know of high trade of care between 2 regions
 - issue of non targeted expenditures is addressed as in disease expenditures

3) accounts by age/sex

- Policy use:

- "growing attention being given to the implications of population ageing for health care systems and health care financing"
- or information on expenditures on under-5

- Age classification

- recommended
 - detailed : 0, 1-4, and every 5 years, up to 95 (depending on policy needs)
- in case of data unavailability:
 - 0, 1-4, 5-14, 15-29, 30-39, 40-49, 50-59, 60-79, 80+.
- specific issues to address:
 - overlapping cases: pregnancy ? age of the mother, unless complication at birth for the child, then related spending under 0

4) accounts by socioeconomic group

- Policy use :

- "policy-makers and others are interested in understanding how healthcare resources and expenditures are distributed across people at different socioeconomic levels. ... Commission on Social Determinants of Health ... called to routinely measure () disparities."
- how are quintiles funding their health expenditures (out of pocket spending, government subsidies, prepaid schemes, NGOs, etc.)

- Classification of income level:

- most often use consumption information as proxy for income quintile for breaking down population in socio-economic quintile

	Policy	boundaries	classification	specific issues
age/sex	<ul style="list-style-type: none"> ● ageing population 	<ul style="list-style-type: none"> ● Binding: Current; HC ● Non binding: Capital; FS, HF, HP 	<ul style="list-style-type: none"> ● Recommended: every 5 years; up to 95; female/male ● If data lacks : every 10 years 	Pregnancy: which age? Which sex?
disease	<ul style="list-style-type: none"> ● allocation and priority setting 		<ul style="list-style-type: none"> ● data collection: ICD-10, 2nd digit ● data reporting: GBD ● co-morbidity: apportion across relevant conditions; GBD proposes a HIV/TB class 	distribution of non targeted and private expenditure
region	<ul style="list-style-type: none"> ● decentralization policies ● rural vs urban 	<ul style="list-style-type: none"> ● Binding: Current; FS, HF, HP, HC 	recommendation is to measure expenditure of health related to residents of each regions	
socio-economic	Inequities: exp. distribution across population	<ul style="list-style-type: none"> ● Binding: Current; HC ● Non binding: Capital; FS, HF, HP 	In preferred order: consumption, expenditure, income	



Other general issues to be solved

- Name of the chapter
- Agreeing on the possible flexibility of the guidelines
- Align ourselves with other SHA.2 chapters
- More ?

