Assessment of Health Expenditure Estimation Efforts in Palestine

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Outline

- Assessment of current situation
- International trends & standards
- Assessment of recent household survey estimates of health expenditure
- Next Steps
  - Short term
  - Long term

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Background

- National Health Accounts - System for compiling and reporting total health sector expenditures (including private sector)
- Palestine NHA process
  - Small-scale, locally-initiated efforts since 2002?
    - MOH & PCSB
  - Limited sporadic contact with WHO/EMRO at regional meetings
  - Italian Cooperation support for health expenditure estimation since 2004
  - Recent controversies over health expenditure surveys

Assessment of Current Situation

- High levels of interest, motivation and cooperation involving PCSB and MOH CIS
- Consensus that Palestine should work towards establishment of permanent, routinely updated system and not study
- High levels of technical competency
- Good level of availability of underlying data systems
- Substantive work done
  - Compilation of spending by MoH
  - Health Expenditure Survey July 2004

Assessment of Current Situation

- Lack of Road Map
  - Limited knowledge and understanding of implications of international standards for process
  - Significant data or analytic gaps - lack of experience in how to handle data inconsistencies
  - No work plan leading to full NHA establishment
- Organizational roles and functions to support sustainable NHA development not finalized
  - Data collection delegated to individuals, with no overall coordination function
  - Respective roles of MoH and PCBS not clarified
  - Limited involvement & connection to policy formulation

Assessment of Current Situation

- What's possible
  - Palestine has sufficient institutional capacity, technical human resources, routine data systems to establish and sustain a NHA system meeting international standards
- Challenges
  - Establish clear institutional arrangements & strategy
  - Acquire technical expertise through guided learning-by-doing
  - Funding?

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International Trends

- NHA first developed in USA in mid-1960s to track Medicare costs
- OECD efforts to encourage routine reporting by OECD member states 1970s -
- Spread of NHA systems to developing world 1990s -
- Publication of OECD SHA standard 2000
- Endorsement of OECD SHA standard by WHO and World Bank
- WHO NHA Producers Guide
- Trend for MoH to mandate, but technical production in specialized research/statistical agencies

A "System of Health Accounts" OECD (2000)

Developed by OECD:

- To provide standard reporting tables for international comparison
- To provide an internationally harmonized boundary for health care activities
- To provide a consistent framework for analyzing health systems
- To provide a rigid framework for building NHA to permit consistent reporting over time

Features of OECD SHA

- Provides explicit and comprehensive boundary of health and health-related production
- Analyzes health expenditures in three dimensions: sources, providers and functions
- Detailed sets of classifications for the uses of spending: providers and functions
- Linkages with other international classifications, including SNA, ISIC, ICD, etc
- Basis for adaptation to meet specific national requirements

International Classification of Health Expenditure (ICHA)

- Health care by function (ICHA-HC)
- Health care by provider industry (ICHA-HP)
- Agents of financing health care (ICHA-HF)

ICHA Classification of Functions

- HC.1 Services of curative care
  - HC.1.1 Inpatient care
  - HC.1.2 Day cases of curative care
  - HC1.3 Outpatient care
  - HC1.4 Home care
- HC.2 Services of rehabilitative care
- HC.3 Services of long-term nursing care
- HC.4 Ancillary services to health care
- HC.5 Medical goods dispensed to out-patients
- HC.6 Prevention and public health services
- HC.7 Health administration and health insurance

ICHA Health-related Functions

- HC.R.1 Capital formation of health providers
- HC.R.2 Education and training of health personnel
- HC.R.3 Research and development in health
- HC.R.4 Food, hygiene and drinking water control
- HC.R.5 Environmental health
- HC.R.6 Administration and provision of social services in-kind to assist living with disease and impairment
- HC.R.7 Administration and provision of health-related cash-benefits

ICHA-HC key elements

- Defines functional boundaries of health care
- Basic breakdowns of health functions
  - core health activities vs. health-related activities
  - personal services vs. collective services
  - Inpatient vs. outpatient
- Totals for health reporting
  - Total Current Expenditure on Health (HC.1-7)
  - Total Expenditure on Health (HC.1-7 + HC.R.1)
  - General Expenditure on Health (HC.1-7 + HC.R.1-7)

Reporting National Spending

HC.1 Services of curative care
HC.2 Services of rehabilitative care
HC.3 Services of long-term nursing care
HC.4 Ancillary services to health care
HC.5 Medical goods dispensed to out-patients
HC.6 Prevention and public health services
HC.7 Health administration and health insurance
HC.R.1 Capital formation
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HC.R.4 Food, hygiene and drinking water control
HC.R.5 Environmental health
HC.R.6 Social services in-kind
HC.R.7 Health-related cash-benefits

Total Current Expenditure on Health

Total Expenditure on Health (TEH)

General Expenditure on Health (GEH)

Implications of OECD SHA for Palestine

- Quasi-global standard - benefits of international comparison for policy
- Need to establish conceptual framework for exercise - linked to SHA
- Challenge of estimating functional classification of spending
- Technically demanding - should base production in PCBS or equivalent agency, but retain ownership in MoH
- Could be first to develop sustainable SHA system in region

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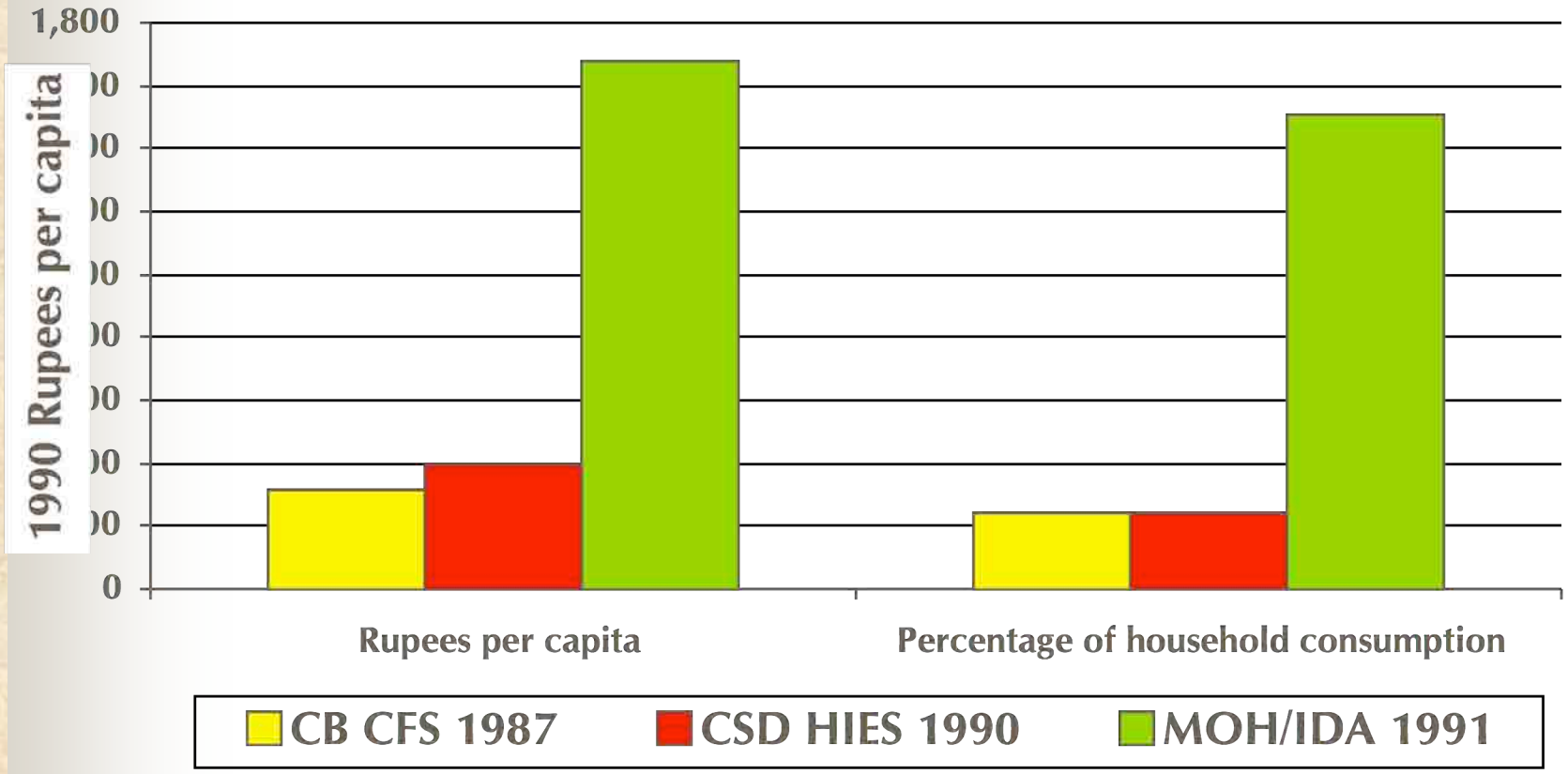
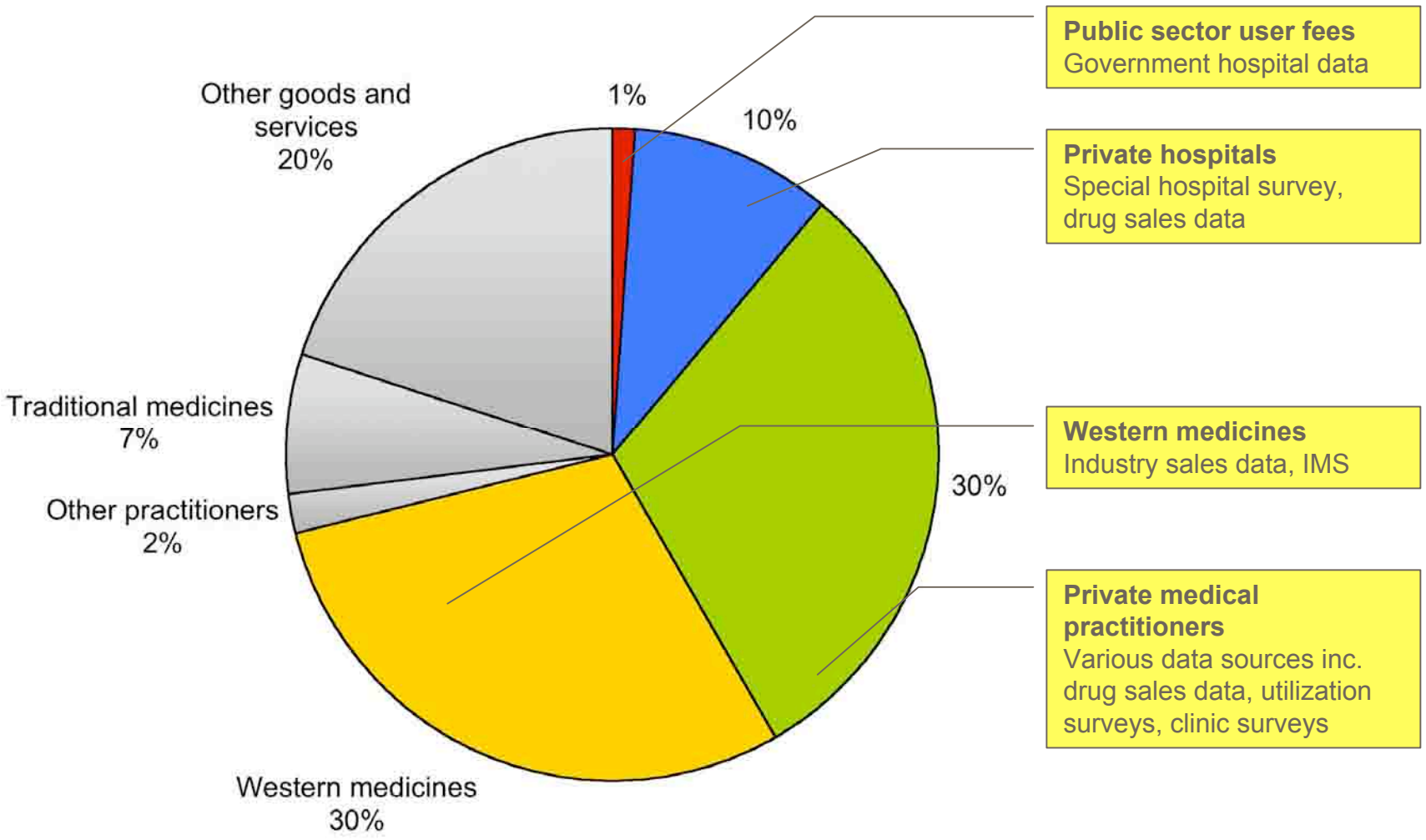
Household Survey Estimates

- Need for caution in relying on surveys
  - ALL household surveys subject to non-sampling error - can bias estimates *upwards* or *downwards*
  - Not possible to quantify non-sampling error by examining only household survey data
  - Best practice NHAs rely on mix of production and consumption data - mostly production data, E.g., USA, Australia, Canada, Sri Lanka, Hong Kong
- Other issues
  - Household surveys often not available on annual basis - costly to undertake
  - Special health surveys often over-estimate, consumption surveys can under-estimate

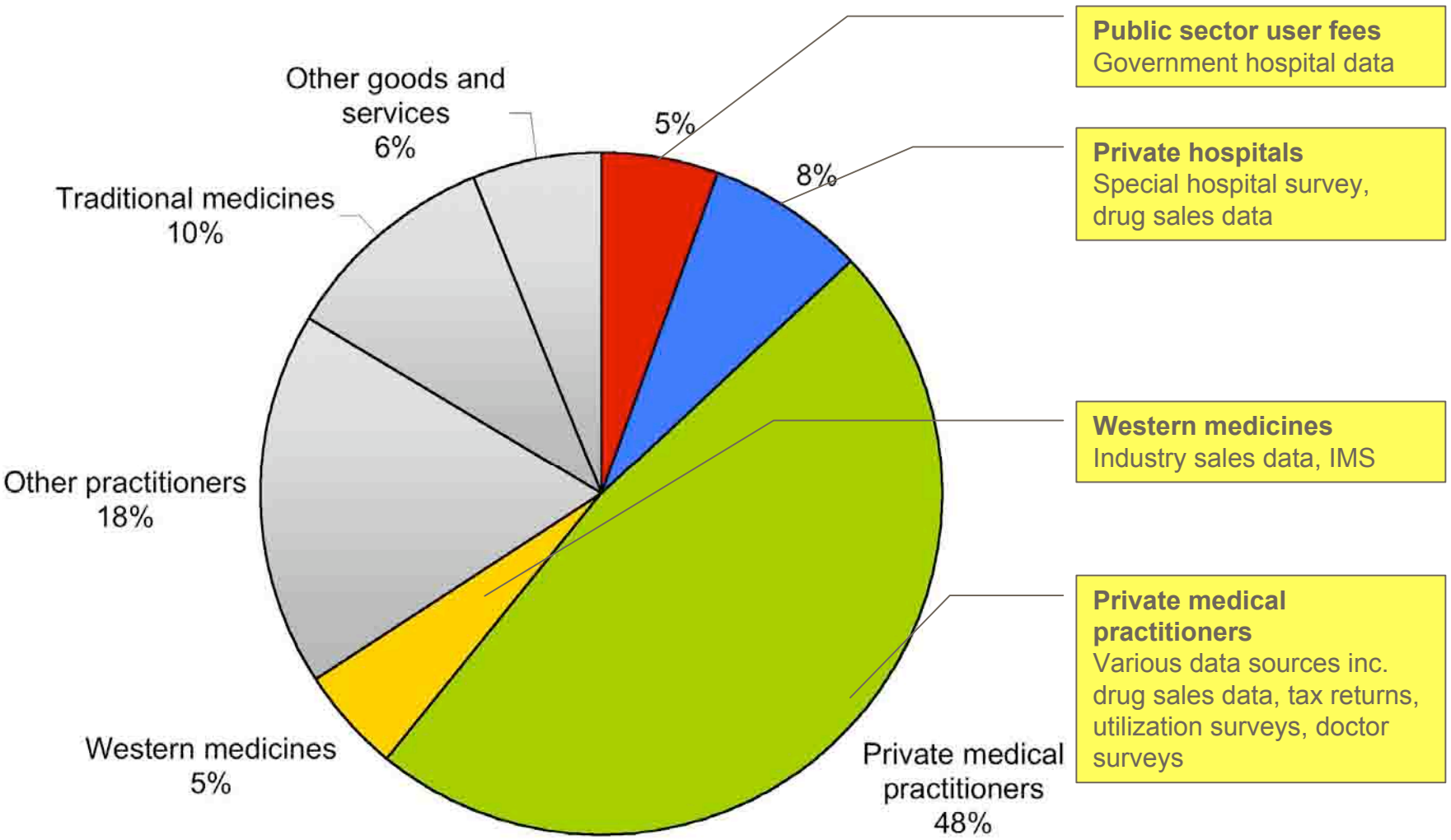
Example of potential discrepancies



Example: Sri Lanka


Other goods and services 20%
1%
10%
Traditional medicines 7%
Other practitioners 2%
30%
Western medicines 30%
Public sector user fees
Government hospital data
Private hospitals
Special hospital survey, drug sales data
Western medicines
Industry sales data, IMS
Private medical practitioners
Various data sources inc. drug sales data, utilization surveys, clinic surveys

Household Spending in Hong Kong



Recent Palestine Survey Findings

- Household Health Expenditure Survey 2004
  - One month survey, reported totals include transport, insurance premia
  - Specialized survey - likely to be over-estimate
  - Household expenditure = US$ 453 million (11.3% of GDP)
- Palestine Expenditure & Consumption Survey (PECS) 2004
  - 12 month survey, repeated every 2-5 years
  - Household expenditure = US$ 265 million (6.6% of GDP)

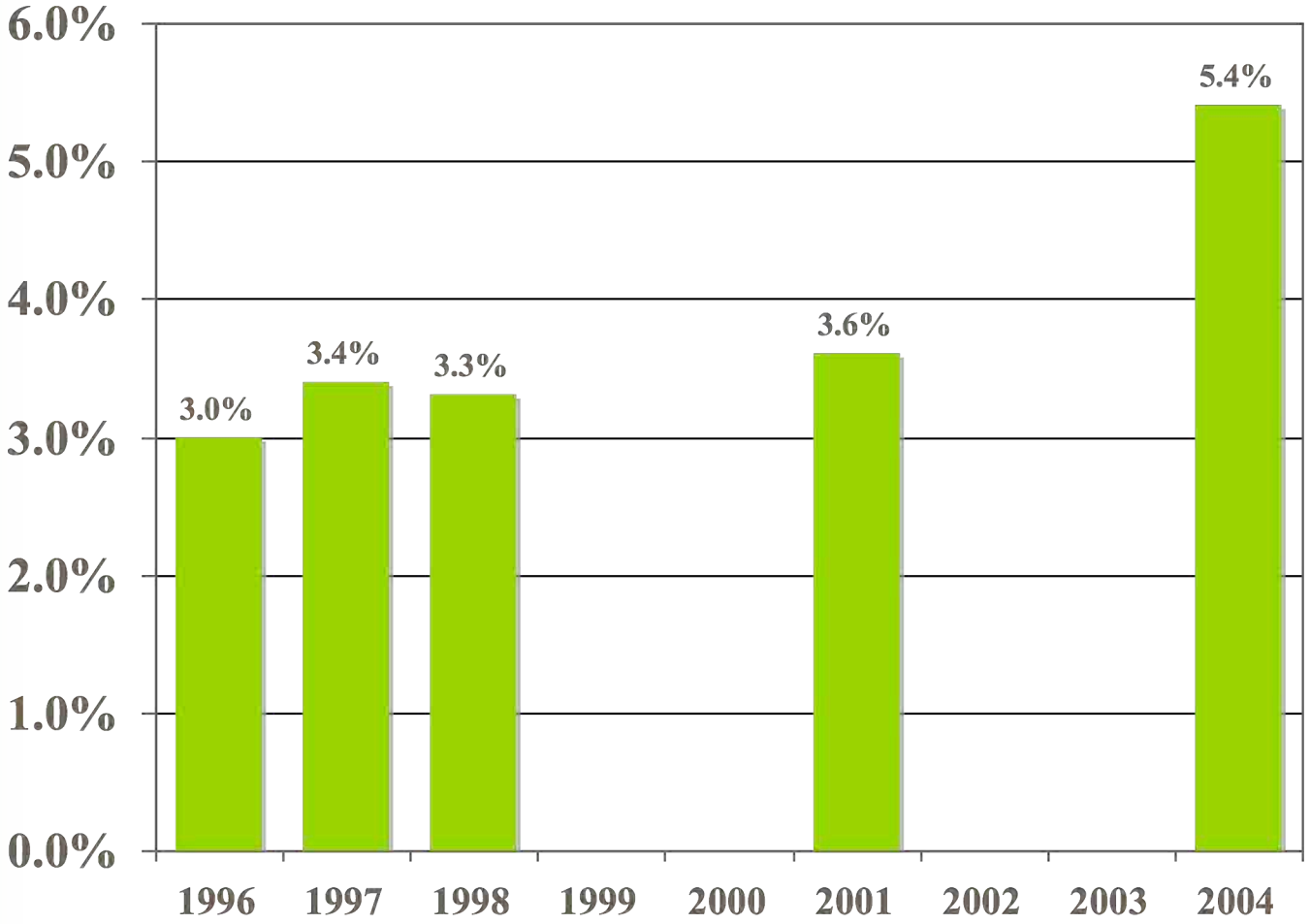
Triangulating the PECS estimates

- Household expenditure in PECS = Household Final Consumption in National Income Accounts
  - Adjust by scaling PECS expenditures using income accounts
- Two estimates (2004):
  - UNADJUSTED - US$ 265 million (6.6% GDP)
  - ADJUSTED - US$ 216 million (5.4% GDP)

Potential data for validation

- MOH records of patient payments
- MOH records of patient utilization volumes
- PCBS enterprise surveys of hospitals, doctors' offices
- Analyses of drug market sales
- Provider survey
  - Focus on estimates of utilization volume by provider
  - Avoid financial questions with doctors?
  - Potentially check prices at clinics

Household out-of-pocket spending, % GDP (PECS 1996-2004)



Preliminary conclusions

- Whatever the true level of household spending, it has been increasing over time
- Likely level closer to 5% of GDP
- The levels of 3-5% of GDP are very high by international comparison
- High expenditure levels suggest likelihood that many families face impoverishing expenditures - lack of social protection

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Short-term

- Compile PCBS data from enterprise surveys and develop preliminary estimate of household spending

- Decide whether to commit to long-term goal of NHA system meeting international standards
  - Establish clear strategy and institutional arrangements

Long-term

- Assuming decision to establish NHA system
- Agree conceptual framework for NHA
  - Statistical standards
  - Classifications, definitions
- Work plan to fill in data gaps
  - Rely primarily on existing data
  - Other ministries, NGOs, donors, provider survey
- Functional analysis of expenditures

Other policy analyses

- High level of spending suggests high incidence of catastrophic expenditures
  - Use PECS surveys to assess catastrophic impacts using World Bank guidelines
- Health Survey 2004
  - Revised more comprehensive final report, covering expenditures, utilization patterns and insurance status
- Distributional analyses of government expenditures, health status, health care use