

Meeting Report

14TH ANNUAL MEETING OF ASIA PACIFIC HEALTH ACCOUNTS EXPERTS



24–26 April 2018
Seoul, Republic of Korea

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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MEETING REPORT

14th Annual Meeting of Asia Pacific Health Accounts Experts

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NOTE

The views expressed in this report are those of the participants of the 14th Annual Meeting of Asia Pacific Health Accounts Experts and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the 14th Annual Meeting of Asia Pacific Health Accounts Experts in Seoul, Republic of Korea from 24 to 26 April 2018.

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Keywords:

Healthcare financing / Health expenditures – standards / Medical savings accounts /
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BACKGROUND

Countries have made progress in their capacities to monitor universal health coverage (UHC) and the Sustainable Development Goals (SDGs). The UHC action framework for the WHO Western Pacific Region, *Universal Health Coverage: Moving Towards Better Health* (WPR/RC66.R2), provides guidance to countries on taking actions to advance UHC. Further, the Region's UHC Technical Advisory Group recommends countries to routinely monitor their health system performance and use evidence to inform health policy in a timely and reliable manner. Countries aim to institutionalize the production and use of health expenditure data to support policy dialogue and development. Tracking health expenditures is critical for policy use and can improve health planning, allocation of resources and spending practices. Health accounts information helps countries monitor health system performance and facilitate evidence-based policy-making.

The 14th Annual Meeting of Asia Pacific Health Accounts Experts convened health accounts experts from 26 countries in the WHO Western Pacific, South-East Asia and Eastern Mediterranean regions. This is the second meeting jointly organized by the World Health Organization, the Organisation for Economic Co-operation and Development (OECD) in Paris and the OECD Korea Policy Centre. It offers a platform for sharing experiences and expertise on the development of health accounts in the Asia Pacific region and enables an open discussion about methodologies and approaches in tracking health expenditures. The main discussion topics included the System of Health Accounts 2011 health financing schemes and revenues, data gaps and quality improvements, private sector expenditures, disease distribution, and primary care expenditures.

SUMMARY

National health accounts production is a widely accepted and used framework to help governments and others analyse all health financing and expenditure flows so as to monitor health system performance and facilitate evidence-based policy-making.

Countries in Asia are facing key common challenges in producing and using health accounts information, including capturing capital and private sector expenditures as well as estimating disease-specific expenditures. Challenges and priorities vary according to health system development and the stage at which the country is producing health accounts. More advanced economies routinely produce and use health accounts, and are more interested in tracking long-term care expenditures. Low- and middle-income countries are interested in institutionalizing the production of health accounts and better understanding how to best collect data from different sources, while at the same time increasing the use of health accounts.

Given that WHO has now transitioned their Global Health Expenditure Database (GHED) into the System of Health Accounts 2011 (SHA 2011) framework and the majority of countries have transitioned, this meeting was focused around SHA 2011 migration. The topics of the sessions in this meeting were based on the feedback from countries in the previous meeting and centred on technical issues with SHA 2011 classifications, data collection and estimation methods, and policy relevance of health accounts.

Specific topics included private sector, capital, disease and primary health care expenditures. The private sector discussions focused more on how to best collect data and trying to share experiences across countries on innovative and alternate ways to collect data from the private sector. Additionally, given the increasing demand across countries in the regions in measuring primary health care to advocate for more investments in primary health care, discussions entailed how to best capture primary health care expenditures using the SHA 2011 framework.

1. INTRODUCTION

1.1 Meeting organization

The 14th Annual Meeting of Asia Pacific Health Accounts Experts was held in Seoul, Republic of Korea from 24 to 26 April 2018. It was organized by the WHO regional offices for the Western Pacific, South-East Asia and Eastern Mediterranean and co-sponsored by the Organisation for Economic Co-operation and Development (OECD).

The workshop brought together 70 participants from 26 countries in the WHO Western Pacific, South-East Asia and Eastern Mediterranean regions, WHO headquarters, OECD Paris and its Korea Policy Centre, and experts from the different regions. The Regional Office for the Eastern Mediterranean participated in the meeting for the first time. This included 15 external experts from various WHO regions, 23 country representatives from 12 countries from the Western Pacific Region, 13 country representatives from 10 countries from the South-East Asia Region, seven country representatives from four countries from the Eastern Mediterranean Region, one person from OECD, seven from the OECD Korea Policy Centre as well as two from the Korean National Health Insurance Service and one Abt Associates representative from the United States Agency for International Development Health Finance and Governance Project.

1.2 Meeting objectives

The objectives of the meeting were:

- (1) to discuss the latest methodologies and approaches in tracking health expenditures and to share experiences across countries in data quality improvements;
- (2) to discuss developments on private sector and primary care expenditures (the use of results); and
- (3) to share lessons and challenges of countries in the implementation and institutionalization of health accounts.

2. PROCEEDINGS

Opening session

Session 2: Health expenditure tracking as a global public good

In this session, WHO and OECD presented an overview of their National Health Accounts (NHA) agenda. WHO is committed to producing internationally comparable country health expenditure data with the highest possible quality in a timely manner as well as ensuring the wide sharing of health expenditure information. WHO headquarters discussed their work streams, which include: annual data reporting and publication, in-depth studies and analysis for policy, global and regional health expenditure analysis reports, and building country capacity in collecting, analysing and using the NHA data. WHO is also making more efforts for its regional and country offices to work jointly to improve efficiency in reporting and collecting health accounts information. The regional offices emphasized their support to countries in building country capacity as well as links with other areas of work such as funding flows, public financial management, monitoring financial protection, resource allocation and strategic purchasing.

OECD discussed their health accounts work, specifically the technical areas such as their long-term care guidelines, as well as an upcoming report highlighting long-term care expenditure trends in OECD member countries. Some of their planned areas of work include: how to best measure out-of-pocket (OOP) spending and the best practices (specifically to understand how countries are estimating OOP spending), improving mental health expenditure indicators through the System of Health Accounts 2011 (SHA 2011) framework. They also presented some in-depth country studies and topic-specific publications such as on OECD countries' spending on preventive care

In December 2017, WHO published estimates for all countries based on SHA 2011, including financing schemes and revenue sources for 2000–2015. The Global Health Expenditure Database (GHED) migration was a significant undertaking and a major challenge, but a success story. By the end of 2018, WHO will publish data for selected countries to capture their disease expenditures and primary health care expenditures based on the agreed-upon definitions. Additionally, WHO headquarters presented on the increasing number of countries producing and reporting health accounts data. The specifics on the classifications and level of details being reported in terms of financing schemes (HF) and revenues of financing schemes (FS) were highlighted, and the importance of equalizing HF and FS was mentioned. Country participants raised their concerns about making them equal and requested further information as to why these should be equal. Finally, WHO headquarters mentioned their global report highlighting trends such as: a health sector growing at a faster rate than the global economy, significant reduction in external aid, and significant inequities in health expenditure distribution across countries.

Session 3: SHA 2011 classifications

This session highlighted the key SHA 2011 framework classifications of “financing scheme” and “financing scheme revenues” as important components for analysis and policy purposes. This was particularly to engage the newcomers to the meeting. Following this was a presentation from the Republic of Korea to provide an overview of the different SHA 2011 classifications and how they had mapped their country expenditures to the SHA 2011 framework. This was followed with a case study about an imaginary country with a social health insurance scheme. The purpose of the case study was to reach a common understanding of the HF and FS classifications. Countries were separated into groups and responded to the various questions in the case study, and how to follow the classifications according to the SHA 2011 framework. Participants found this exercise helpful to understand the nuances of the SHA 2011 framework.

Session 4: Policy implications and relevance of financing scheme revenues classifications

This session highlighted the importance of HF and FS, how both classifications are required to get the full health financing situation in a country, and how powerful they can be as an analytical tool for policy-makers. The HF and FS classifications have important implications on equity (FS data can provide insights into the equity in financing, for example in terms of: who is carrying the burden of financing the system, whether the scheme covers the financial burden of those most vulnerable groups, etc.); efficiency (for example, for each HF the FS can provide information on how efficiently resources are generated); sustainability (for example, data on FS allow for a better monitoring of the funding mix and can highlight unsustainable high donor funding); and transparency and accountability (the HFxFS table makes the funding flows transparent and government (or other actors) can be held accountable if their spending commitments do not match their pledges).

Japan discussed the policy implications of tracking health expenditures. The presenter showed how increasing prioritization of long-term care in terms of policy and budget allocations saw a similar increase in health expenditure towards long-term care over time, thus how health expenditures can be used to track policy effectiveness. Also mentioned was how Japan has seen an increase in government priority to health, specifically a shift in the proportion of government contributions as compared to social insurance contributions.

Session 5: Parallel group discussions

This session split the participants into two groups to discuss topics of relevance in various countries in Asia (both the South-East Asia and Western Pacific regions): capital expenditures and disease expenditure tracking.

Capital expenditures

Many countries are not yet capturing health expenditures, either due to lack of availability but also due to the remaining challenges in grasping the concept. The session therefore entailed an overview of the definition of capital and its components as well as examples of how the data were obtained in some countries. Separating capital expenditures from current health expenditures is important, because a separate capital account allows countries to monitor and control changes in health investment and also because capital is an essential component for service provision. Countries raised issues about only being able to collect public spending data through the ministry of finance, against the seemingly low response when requesting this information from private providers. Some countries also find it challenging to collect data from donors. However, some countries have used business survey, customs and trade data to triangulate and collect such information.

Disease expenditures

This group discussed the methodologies used to capture disease expenditures, assumptions/methods that can be used when data are not available, and ways to better use the information on disease expenditures. Elements to consider include capturing both direct and indirect expenditures allocated to diseases, but normally a significant portion of spending is indirect (shared expenditures such as human resources, medicines, administration, buildings and equipment). To capture indirect expenditures (or shared expenditures), they should be allocated by disease using a top-down approach making use of disease utilization (headcount) and unit expenditure (to capture the intensity of resource), for which data are needed by different facility types, providers, services, capital and disease. Utilization data can be taken from facility records as well as from household survey. To capture costs of services, a potential last resort would be to use the WHO CHOICE (CHOosing Interventions that are Cost-Effective) model, which captures a regional average of costs.

Countries shared common challenges, including: the lack of available utilization data and breakdown, lack of availability of the unit expenditure, as well as the limitation in the framework to incorporate co-morbidities and how to capture these.

Session 6: Primary health care expenditures

Primary health care is defined as the first point of contact for the patient with a health facility. The Declaration of Alma-Ata states that primary health care is essential health care based on scientifically sound and socially acceptable methods, universally accessible to individuals and families with their full

participation at a cost that the community and country can afford in a spirit of self-reliance and self-determination. Countries have different boundaries and definitions as to what encompasses primary health care, therefore making it challenging to find a global definition of primary health care .

However, even with these challenges, there are efforts at global level to measure primary health care spending with the SHA 2011 framework, which is classified into functions and providers. Across countries, what should and should not be included varies. For example, numerous OECD countries aim to include dental services in the primary health care definition under SHA 2011 to capture the high expenditures on dental care in these countries; for other low- and middle-income countries, this may not be as relevant. Some high-income countries were keen to find out the ideal primary health care spending. However, middle-income countries were more interested in knowing how to best capture it globally and nationally.

Session 7: OECD Health at a Glance

In this session, OECD presented their preliminary results for their annual publication *Health at a Glance*, which showed health expenditure trends across OECD countries and selected countries in Asia and the Pacific. This meeting provided an excellent forum for feedback in terms of various publications from OECD and WHO.

Session 8: Marketplace

In the marketplace session, participants presented their NHA work. Specifically, countries highlighted their biggest challenges in terms of conducting NHA studies and their approach to tackle this; some countries presented on how their NHA studies have shed light on policy dialogues and policy-making. China, the Republic of Korea, Maldives, Thailand, Nepal and IHP presented in this session. Country posters followed a template, which included key health indicators. They presented funding flows and highlighted information on service delivery models including the public–private mix.

IHP presented on their methodology to map pharmaceutical expenditure by disease. Given the limited available prescribing data, the methodology was designed to distribute retail medicine sales to outpatients by disease. Using a sample of country data sources they were able to identify a generalized distribution key with estimation properties. Countries need to further understand the drivers of pharmaceutical expenditures, given that pharmaceutical spending accounts for a significant proportion of out-of-pocket spending.

Session 9: Private sector expenditures

This session focused on the importance of quality private sector data. In terms of the availability of out-of-pocket spending data more generally, low- and middle-income countries are relying on their household income and expenditure surveys to make estimates. However, relying solely on household income and expenditure survey comes with challenges, especially as regards the timeliness of the surveys (every 3–5 years) and the reliability of the data. China provided an alternative way to collect data from the private sector, specifically deriving from various sources such as their National Health Resources and Medical Service Investigation System for the volume of visits. The expenditure per visit data are collected via a sample institution survey. Data from retailers and other providers of medical goods were obtained from statistical reports. Thailand presented their sources to collect private provider data, which varied depending on the financing source. If providers are publicly financed, data can be

obtained directly from the hospital database, and Thailand also relies on a primary survey for these data. However, if providers are not publicly financed, these data are collected through interviews or household surveys. The limitations with this is that private hospital surveys are conducted every five years. Professor Pu presented an example of sources used for out-of-pocket spending, including: hospital utilization census (annual), long-term agency census (annual), household medical spending survey, hospitals financial statement and national health insurance database, including non-ministry of health sources such as industry, commerce and service census. In the case of Professor Pu, since 95% of the hospitals and clinics are contracted with the national health insurance service, data collection is facilitated, but estimating private health insurance reimbursements remains a significant challenge.

In terms of capturing out-of-pocket spending, India makes use of a variety of sources for private expenditures, including: Health and Morbidity Survey, Consumption Expenditure Survey, National Family and Health Survey and Intercontinental Marketing Services Data base (IMS). Indonesia uses a top-down and bottom-up approach to triangulate the data – that is, national accounts as well as household income and expenditure surveys to estimate out-of-pocket spending.

Session 10: Help desk/Café consultation

The café consultation split the participants into eight groups and consisted of different groupings for three rounds. Country participants were grouped based on their preferences, similar country contexts and topics. The discussion topics across the eight groups encompassed private sector data collection and institutionalization of NHA, among other topics.

Session 11: Data quality

Data quality is of utmost importance in health accounts production and “factors” associated with data quality include: scope of health expenditure, mapping with policy (HF, FS, HP, HC), data sources, estimation methods, consistency/logic checks and amongst others. Several countries provided good examples of how to ensure the quality of the data. Bangladesh mentioned that a way to ensure quality data is by not relying solely on one source and triangulating data using multiple sources. Additionally, they also re-estimate previous data rounds based on updated information and/or methodologies; they then have to translate the resulting changes effectively to policy-makers. For example in Bangladesh, private sector spending increased dramatically with the increasing number of people going abroad for specialized treatments. Thailand defined four key aspects in selecting which data source is most appropriate: (1) accessibility (ability to check through electronic database), (2) availability, (3) time series and regular updates, and (4) consistency with the methodology. Thailand has seen significant improvements in data collection through monitoring and checks using an electronic database, as is now done. Mongolia shared their experience in how they ensure the quality of the data: they first estimate the different components separately (donor, private insurance, out of pocket), then verify the estimates by checking for possible double-counting and triangulating with other sources, and then integrate the data once the quality of each component is ensured. They also make use of various sources to triangulate and verify their estimates. OECD and WHO discussed methods used at the global level to ensure that the data are quality data and comparable, including through triangulation and quality checks.

Session 12: Closing

Survey findings: 2019 meeting suggestions

The final session of the meeting consisted of discussions on the potential topics of interest to include in next year's agenda. An evaluation form was also distributed to all participants, with 50 of the 73 participants responding in detail.

Overall, the feedback was positive as regards the topics and the format that the Secretariat had selected for this year's meeting from the selected topics in the evaluation form of previous years.

Topic suggestions for Secretariat to incorporate in WHO–OECD meeting in 2019

1. **Disease expenditures.**
2. **Primary health care expenditures.** More detail and include more concrete data once there is a global definition.
3. **How to better analyse and use health accounts.** Participants would like to see more country examples as to how to better analyse data as well as how to translate data for policy makers.
4. **How to collect data from the private sector and estimate out-of-pocket expenditures.** Country participants continuously try to find alternate and innovative ways to collect data from the private sector. It would therefore be useful to incorporate more country cases on how data are collected from the private sector.
5. **Health Accounts Production Tool (HAPT).** Countries are interested in knowing about any potential changes and updates in the tool.
6. **How to estimate pharmaceutical expenditures.** Given the significant spending on pharmaceuticals across country as a share of current health expenditure, countries are keen to find the drivers of pharmaceutical expenditures as well as how to best estimate and learn from other countries.
7. **How to project health expenditures.** Several countries were interested in learning more how to project health expenditures in order to incorporate them within the medium-term-expenditure framework.
8. **Further sharing of information products.** Countries were interested in obtaining more products from other countries to take home and learn from, including analyses or other results-based information products.
9. **Issues around data quality.**

Format suggestions for Secretariat to incorporate in WHO–OECD meeting in 2019

In terms of format, countries found it useful to have greater opportunities for group discussions. The preferred sessions were case study (split into four groups), parallel group discussions (two groups), marketplace and “café consultation”.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

Countries in Asia face several key common challenges in producing and using health accounts information and will therefore encounter similar priorities in the coming years. These challenges and

priorities vary depending on what stage countries are in as regards producing health accounts as well as their level of development. For example, the priorities for OECD countries included long-term care spending and how to best capture this. For most middle-income countries, challenges included how to improve data collection from the private sector such as how to best measure out-of-pocket spending as well as how to best measure disease expenditures given numerous assumptions made and limitations in the data available. Countries in the Eastern Mediterranean Region are at different stages in terms of producing health accounts and are still producing health accounts based on the previous SHA 1 framework. In contrast, the majority of countries (if not all) in the South-East Asia and the Western Pacific regions have transitioned to SHA 2011. Therefore, the meeting needs to address the needs of the countries that are at different stages.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged to consider the following:

1. Continue to aim for routine data collection, estimation and use of health expenditures.
2. Review and improve the quality of data as a part of their annual updating process.
3. Further disseminate and translate health accounts information to policy makers in countries to support the health policy development process.

3.2.2 Recommendations for WHO

WHO is requested to consider the following:

1. Continue and strengthen its support to Member States in the production, use and institutionalization of health accounts, specifically in the following areas:
 - a. Based on country needs, facilitate further discussions and policy dialogue with in-country stakeholders on the use of their health accounts information.
 - b. Continue to provide technical support in producing and institutionalizing health accounts tailored to country contexts.
 - c. Facilitate sharing of experiences and best practices among Member States through various channels, including regional workshops, publications and other products.
2. The Regional Office for the Western Pacific will work more closely with country offices and headquarters to ensure quality health expenditure information.
3. The Regional Office will build on the workshop, including incorporating multiple uses of the workshop to engage with health accounts experts, and continue the collaboration with the South-East Asia Regional Office, WHO headquarters and OECD to strengthen the linkage between health accounts and health financing policy.

ANNEXES

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Annex 2. Meeting agenda

	Day 1 (April 24, Tuesday)		Day 2 (April 25, Wednesday)		Day 3 (April 26, Thursday)
08:00-08:30	Registration	08:00-08:30		08:00-08:15	
08:30-09:15	Session 1: Welcome and introduction <ul style="list-style-type: none"> Welcome remarks Round of introductions Administrative announcements 	08:30-08:45	Recap of day 1	8:15 – 8:30	Recap of day 2
09:15-10:45	Session 2: Health expenditure tracking as a global public good <ul style="list-style-type: none"> WHO-HQ, SEARO, EMRO, WPRO OECD NHA program GHED migration Discussion 	08:45-10:30	Session 3: Parallel group discussions continued <ul style="list-style-type: none"> Plenary discussion 	8:30 – 10:00	Session 10: Help Desk <ul style="list-style-type: none"> Experts paired with other experts
10:45-11:00	Coffee break	10:30-10:45	Coffee break	10:00-10:30	Coffee break
11:00-12:00	Session 3: SHA 2011 classifications <ul style="list-style-type: none"> Korea presentation Brief overview of SHA2011 Classifications Case study exercise (HF and FS) 	10:45-12:15	Session 6: Primary care <ul style="list-style-type: none"> Global developments Country experiences (Korea, Sri Lanka, Malaysia and Viet Nam) Panel discussion 	10:30 – 12:00	Session 11: Data Quality <ul style="list-style-type: none"> Scope of health expenditure Mapping with policy (FS, HF, HC, HP) Data sources Estimation methods Quality checks
12:00-13:00	Lunch	12:15-13:15	Lunch	12:00-13:00	Session 9: Closing <ul style="list-style-type: none"> Open discussion and future topics Closing remarks by OECD, WHO
13:00-14:30	Session 3: SHA 2011 classifications continued <ul style="list-style-type: none"> Case study continued 	13:15-14:15	Session 7: Private sector expenditures (SEARO) <ul style="list-style-type: none"> Data collection from private providers and estimation of OOP Country experiences 	13:00 – 14:00	
14:30-15:45	Session 4: Policy implications and relevance of financing scheme revenues classifications <ul style="list-style-type: none"> Japan introductory presentation Country experiences Plenary Discussion 	14:15 – 15:30	Session 8: Marketplace <ul style="list-style-type: none"> Posters are placed around the room and presented 		
15:45-16:00	Coffee break	15:30-15:45	Coffee break		
16:00-17:00	Session 5: Parallel group discussions <ul style="list-style-type: none"> Disease distribution Capital expenditures 	15:45-17:15	Session 9: OECD Health-at-Glance		
18:00		18:00	RECEPTION		

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