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National Health Accounts development: lessons from Thailand

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National Health Accounts (NHA) are an important tool to demonstrate how a country's health resources are spent, on what services, and who pays for them. NHA are used by policy-makers for monitoring health expenditure patterns; policy instruments to re-orientate the pattern can then be further introduced. The National Economic and Social Development Board (NESDB) of Thailand produces aggregate health expenditure data but its estimation methods have several limitations. This has led to the research and development of an NHA prototype in 1994, through an agreed definition of health expenditure and methodology, in consultation with peer and other stakeholders. This is an initiative by local researchers without external support, with an emphasis on putting the system into place. It involves two steps: firstly, the flow of funds from ultimate sources of finance to financing agencies; and secondly, the use of funds by financing agencies. Five ultimate sources and 12 financing agencies (seven public and five private) were identified. Use of consumption expenditures was listed under four main categories and 32 sub-categories.

Using 1994 figures, we estimated a total health expenditure of 128 305.11 million Baht; 84.07% consumption and 15.93% capital formation. Of total consumption expenditure, 36.14% was spent on purchasing care from public providers, with 32.35% on private providers, 5.93% on administration and 9.65% on all other public health programmes. Public sources of finance were responsible for 48.79% and private 51.21% of the total 1994 health expenditure. Total health expenditure accounted for 3.56% of GDP (consumption expenditure at 3.00% of GDP and capital formation at 0.57% of GDP). The NESDB consumption expenditure estimate in 1994 was 180 516 million Baht or 5.01% of GDP, of which private sources were dominant (82.17%) and public sources played a minor role (17.83%). The discrepancy of consumption expenditure between the two estimates is 2.01% of GDP. There is also a large difference in the public and private proportion of consumption expenses, at 46:54 in NHA and 18:82 in NESDB.

Future NHA sustainable development is proposed. Firstly, we need more accurate aggregate and disaggregated data, especially from households, who take the lion's share of total expenditure, based on amended questionnaires in the National Statistical Office Household Socio-Economic Survey. Secondly, partnership building with NESDB and other financing agencies is needed in the further development of the financial information system to suit the biennial NHA report. Thirdly, expenditures need breaking down into ambulatory and inpatient care for monitoring and the proper introduction of policy instruments. We also suggest that in a pluralistic health care system, the breakdown of spending on public and private providers is important. Finally, a sustainable NHA development and utilization of NHA for planning and policy development is the prime objective. International comparisons through collaborative efforts in standardizing definition and methodology will be a useful by-product when developing countries are able to sustain their NHA reports.

Introduction

The World Health Organization developed a manual for the estimation and data collection of health expenditure in developing countries in 1983 (Mach and Abel-Smith 1983). It provides several useful dummy tables for adaptation to suit each country's health system and policy needs. However, few developing countries have attempted to develop a sustainable mechanism to estimate and report health expenditure on a regular basis. Health expenditure information in these countries is based mostly on ad hoc surveys (Newbrander et al. 1994). The World Bank recently reiterated the importance of having a system to monitor efficiency and equity in health care spending (World Bank 1993).

Myers et al. were pioneers in exploring health care expenditure in Thailand (Myers et al. 1985). They found that two-thirds of health expenditure was financed directly by households. Third-party payment represented a minuscule portion. Most public health care finance was paid by the Ministry of Public Health (MOPH) which financed one-fifth of the total. Based on the National Economic and Social Development Board (NESDB) data on health expenditure from 1979 to 1983, they predicted that health expenditure would increase