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HEALTH SYSTEMS 20/20

SYSTEM OF HEALTH ACCOUNTS INPUT DOCUMENTS



(July, 2008)



Mission

The **Health Systems 20/20** cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. HS 20/20 works to strengthen health systems through **integrated approaches to improving financing, governance, and operations, and building sustainable capacity** of local institutions.

Date: July 16, 2008

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Cooperative Agreement No.: GHS-A-00-06-00010-00

Submitted to: International Health Accounts Team



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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

ACKNOWLEDGMENTS

These documents are the results of a collaborative effort of members of the Health Systems 20/20 team, including Jonathan Cylus, Susna De, Yann Derriennic, Takondwa Mwase, Lisa Fleisher, Manjiri Bhawalkar, Stephanie Boulenger, MariFer Merino, Ellie Brown, Jenna Wright, and Darwin Young.

Additionally, this paper received significant input and guidance from many country NHA counterparts including Thomas Maina (Kenya), Stephen Muchiri (Kenya), Dan Osei (Ghana), Tesfaye Dereje (Ethiopia), Stephen Karengera (Rwanda), Dr. Hossein Salehi (Iran and WHO), Solomon Kagulula (Zambia and WHO), Thomas Mbeeli (Namibia), Marie-Jeanne Offosse (Ivory Coast), Ricardo Valladares Cardona (Guatemala), and Rafael Esquivel (Guatemala). The opinions of low- and middle-income countries are critical to enhancing the System of Health Accounts' (SHA) effectiveness as a universal tool in national health accounting.

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. The units that we have addressed are:

Unit 1. Purposes and Principles of the SHA

Unit 2. Global Boundaries of Health Care

Unit 5. Types of Health Accounts

Unit 7. ICHA-HC Functional Classification of Health Care

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.

I. UNIT I. PURPOSES AND PRINCIPLES OF THE SHA

I.1 SUMMARY

Countries with pluralistic health systems and limited data capacity have much to gain from the practical approach of NHA as described in the *Producers' Guide* and country estimations to date. It is also essential that the SHA revisions incorporate the perspectives of policymakers and decision-makers, in addition to health accountants. For nations, particularly low- and middle-income ones, to dedicate scarce resources to the development and implementation of the SHA, they must be certain that the revisions firmly address current and future policy needs.

I.2 HIGHLIGHTED RECOMMENDATIONS

- 1) The SHA 2.0 should serve not only as a classification system, but also as a "How-to" instruction manual, as per the *Producers' Guide*.¹
- 2) The SHA 2.0 should accommodate the possibility of multiple layers of financing agents and a potential need to examine the "source of the financing source" level.

I.3 HEALTH SYSTEMS IN LOW- AND MIDDLE-INCOME COUNTRIES

The structure of health systems in low- and middle-income countries is largely based on how revenue collection, risk pooling, and purchasing are organized and financed. Factors including a country's income level, private sector involvement, organizational set-up, and level of external donor participation shape its health system. Many low- and middle-income country health systems consist of a mix of public and private sectors, with the private sector growing significantly in some countries. There are often major structural differences, even among countries in the same region or of similar income level.

From the authors' experiences, low-income countries' health systems are generally geared toward providing basic health care services at a minimum. In sub-Saharan Africa in particular, the government and households have historically been the primary source of health care expenditures, though external donors have recently

¹ World Health Organization (WHO), World Bank and United States Agency for International Development (USAID). 2003. *The guide for producing National Health Accounts, with special application for low- and middle-income countries*. Geneva: WHO.

begun to fund a greater share of total health expenditures through large health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan for AIDS Relief (PEPFAR).² Results from recent NHA activities have shown that this shift has resulted in an overall increase in total health spending in many low- and middle-income countries, but has not necessarily led to a significant decrease in the economic burden on households. The private insurance sector is small in many low-income countries and efforts to improve the equity of financing are needed and ongoing. Private providers, including faith-based organizations, street vendors, and traditional healers, are significant players, though the size of their role varies from country to country.

Middle-income countries may not depend on external donors to the extent that lower-income countries do. In Eastern Europe and Central Asia, health systems are often employer-based, financed akin to the Bismarck social insurance model.³ However, a significant share of health spending in this region is paid for out-of-pocket. In Latin America, many countries also have social insurance programs. These countries' impoverished populations usually receive basic care through national health programs.

I.4 CASE STUDY: HEALTH SYSTEMS IN AFRICA AND SELECT ISSUES WITH SHA

Much of the formal health sector in African countries is funded by government and/or external donors, and although the formal private funding sector is underdeveloped in some countries, it is growing. Households make up a large share of health financiers, and in some West African countries, external donors fund up to 30 percent of health care.⁴ A large share of household spending is in the form of direct payments to providers, with much of this out-of-pocket spending paying for pharmaceuticals and medical supplies at informal providers or providers whose main function is not necessarily health, such as shops, mobile street vendors. These payments are not classified specifically as informal purchases under the current SHA framework. Rather, they are captured under HP. 4.1 Dispensing Chemists. It is of great importance to track out-of-pocket expenditures on pharmaceuticals in informal settings because of the high volume of drugs that are bought in this manner. The revised SHA 2.0 could include payments on these items under an "informal provider of medicines and commodities" category. Additionally, private health insurance, social insurance, and community-based health insurance in West African countries cover approximately 8–15 percent of the population.⁵ Health care providers in many African countries are poorly distributed and generally are in short supply. Providers in these countries sometimes accept in-kind payments. The SHA currently focuses on monetary transactions; It would

² World Bank. 2008. *World Development Report*. Washington, DC.

³ Gottret, Pablo and George Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. World Bank: Washington DC.

⁴ World Bank. 2008. World Development Indicators Database.

⁵ Waelkens, Maria-Pia and Bart Criel. March 2004. *Les mutuelles de santé en Afrique sub-saharienne, Etat des lieux et réflexion sur un Agenda de Recherche*. Health and Population Discussion Paper. Washington, DC: World Bank.

be helpful for SHA 2.0 to provide guidance on how to account for these payments, given their high volume in many African countries. Similarly, guidance is requested on how to account for informal payments given to providers to document “under-the – counter” or “envelope” payments (which may be both in-kind and monetary) to providers to facilitate receipt of higher quality services or to jump the waiting list etc.

In many African countries, like Rwanda, the Ministry of Health (MoH) finances local health offices, which provide primary care services. Approximately 40 percent of health facilities in East, Central, and Southern African (ECSA) countries are private, faith-based facilities, though they follow government policies and are integrated into the public health care system. This has presented an issue as to whether or not these facilities should be accounted for as private, public, or some other category representing privately funded health centers that are mostly controlled by the government. Like West African countries, many ECSA countries are currently experiencing growth in their private sector, causing traditional medicine to decline in some areas; in other areas, traditional healers still play a significant role in the delivery of health care.

I.5 HEALTH FINANCING SYSTEMS IN LOW- AND MIDDLE INCOME COUNTRIES

Health financing systems in the developing world differ greatly from country to country. Low-income countries often face major institutional, fiscal, economic, and political constraints in providing even a basic package of health services for populations. Notably, it is difficult for many of these countries to generate general revenues, partially due to their sizable informal sectors.⁶ This limits the ability of the public sector to increase its health financing. Revenues for health care typically originate with households and external donors. In sub-Saharan African countries, donors provide approximately 18 percent of total health expenditures, compared with 1.5 percent in South Asia, the region with the next highest level of external assistance as a share of total health expenditures.⁷ Financing and management of funds in many low-income countries in Africa involve multiple financing agents, each of which demands their own administrative expenses. In contrast, middle-income countries typically have a greater ability to generate general revenue. Revenue for health care originates primarily with payroll and general taxes, household out-of-pocket expenditures, and private insurance in many of these countries; primary care for the poor is often government funded.

⁶ Gottret and Schieber, Op cit.

⁷ Atim, Chris, Lisa Fleisher, Laurel Hatt, Steve Musau, and Aneesa Arur. Not yet published. *Health Financing in Africa Today: Challenges and Opportunities*. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

I.6 CASE STUDY: HEALTH FINANCING SYSTEMS IN AFRICA

Health care in West African countries is financed by three main sources: households, governments, and external donors. Private sources excluding households are an insignificant source of funding. The majority of financing is through health ministries, which designate money to public sector providers. Private sector financing agents, mostly nongovernmental organizations (NGOs), play a minor role. Other African countries have additional levels of financing. Some ECSA countries have four main sources of financing: Ministry of Finance (MoF), employers, households, and donors. In some instances, these sources provide funding directly to providers. However, funds often travel through one or more levels of financing agent, which may include the MoH, NGOs, and community-based organizations.

I.7 PROPOSED FLOW-OF-FUNDS MODEL

There is demand for a flexible health-financing model that takes into account the policy needs of low- and middle-income countries and recognizes that the priorities and structure in many of those countries will shift over time. Policy needs include an understanding of the burden of financing on households, interest to meet Millennium Development Goal (MDG) targets, and many others. Due to the diversity of health financing systems in low- and middle-income countries, there is no “one-size fits all” framework to describe the flow of health care funds. The best way to achieve cross-country comparability is to utilize a simple framework that can be amended to fit individual countries. Project experience and consultations with countries have revealed that low- and middle-income country financing can best be described by a four-dimension system that is malleable enough to allow for additional layers of financing agents and financing sources to be included in optional tables (see chart below). These additional layers are useful because many health initiatives flow through multiple groups before reaching providers and the efficiency of such transfers has become a policy concern.

The suggested format begins with financing sources, such as households, external donors, government, and other private sources. An optional preceding table should be included to account for the entities that finance some financing sources. For example, a country’s MoF might be a financing source; however, a substantial portion of ministry funds may come from an external donor, such as the International Monetary Fund (IMF) or World Bank, as loans to the country. This ultimate financing source should be accounted for because the money did not originate in the MoF, and was not necessarily initially earmarked for health. This has implications for measurement of countries’ meeting the Abuja Declaration (where all African countries committed to allocate 15 percent of their government budgets to health). There has been some question as to whether this should be measured based on the financing source or financing agent level, as there can be a considerable difference on the amount of donor funds that are incorporated at the MoF (In Rwanda for example, approximately 41% of MoF funds are derived from donor grants) or the MoH (donor transfers to a MoH make up over 50 percent of MoH funds in some countries). In the absence of the

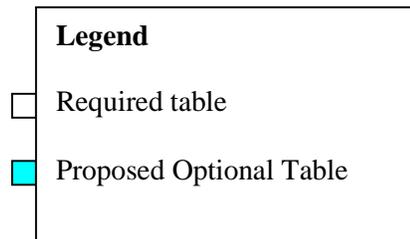
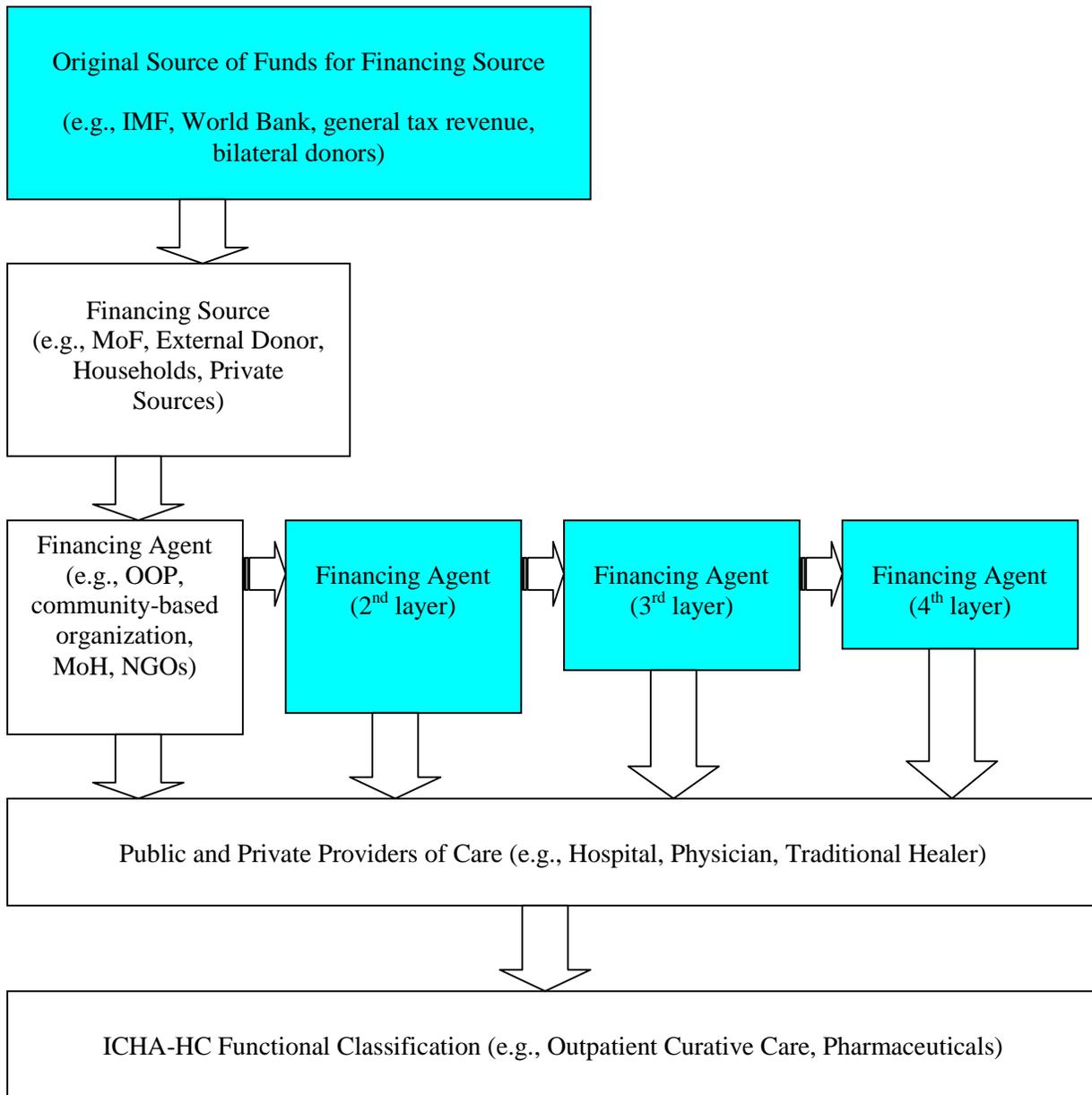
proposed optional table, guidance is needed for how to account for the “so-called” source of sources.

Next, the flow of funds should include financing agents that pay for the provision of health care services. These will include out-of-pocket payers, private sources (NGOs, private insurance), and public sources (MoH, local/district agents). Sometimes a financing source may also be the financing agent if it pays a provider directly. A distinction between financing agents and those financing sources that pay providers directly must be made clear. Essentially, this model is followed in the *NHA Producers' Guide*. Additionally, funds may pass between multiple financing agents before reaching health care providers. Thus, a revised flow-of-funds framework should allow for multiple levels of financing agents. These optional tables would show the intermediate transfer of funds that takes place before funding ultimately reaches providers. Currently, many countries arbitrarily assign a single financing agent to account for money (based on general perceptions of which entity has programmatic control over resource allocation) that passes between multiple levels of financing agents, ignoring the compounding administrative costs that are incurred in a multi-layer financing agent system. Awareness of these inefficiencies would be of utmost importance to policymakers and foster greater accountability of both government and donor funds.

After accounting for the final financing agent, the flow of funds framework should offer guidance for countries wishing to break providers down by ownership, in addition to by provider level (e.g., referral, district hospital). Basic ownership could be accounted for either as public, private (not traditional), or traditional. It would also be useful for policymakers to know whether providers are for-profit or not-for-profit. Tracking the growth of private providers would be a valuable tool for policymakers in low- and middle-income countries.

Though it will be discussed more in depth in Unit 7, most low- and middle-income countries may have difficulties completing the full functional classification as it currently stands. Many countries will be able to account for a limited set of functions, which may include curative inpatient care, curative outpatient care, pharmaceuticals, preventive public health programs, administration/stewardship, as well as non-personal health functions such as investments, training, and research. Training is particularly relevant to policymakers because it is a large expense in low- and middle-income countries. An understanding of the level of personal care expenditures on prevention (currently embedded in curative care) is another critical policy concern.

FIGURE I



I.8 DEFINITIONS OF BOUNDARIES, CLASSIFICATIONS, AND OTHER GENERAL RECOMMENDATIONS

A selection of specific issues that require guidance are presented below:

- 1) The SHA 2.0 should include target tables, including optional tables for transfers between financing agents and to understand the “source of the source.”
- 2) Guidance is needed on how to implement boundaries, for example, how to convert from cash to accrual (as SHA recommends), or how to exclude health spending on expats at the provider level. In this respect, it would be useful for the SHA 2.0 to be not just a classifications document but also a practical “how to implement” manual.
- 3) Better guidance on how to classify state-owned enterprises also is needed. In some countries, the enterprises are considered largely public; in others (depending on the degree of autonomy), they are considered private.
- 4) Further clarification is needed for why HF.2.1.1 Government employee insurance programs are classified as HF.2 Private sector. In the System of National Accounts (SNA) and in the SHA, activities in which governments act in a fashion similar to private firms are classified as private activities. However, some policymakers may prefer to include this spending with other government spending for health. One suggestion may be to introduce the concept of a public sector and nonpublic sector to the International Classification of Health Account (ICHA)-HF scheme (see *Producers’ Guide* 4.07-4.09).
- 5) There is a need to clarify what constitutes Non Profit Institutions Serving Households (NPISH) both at the financing source and financing agent level. At the source level, it is taken to mean local foundation/NGOs that generate their own resources for health. At the agent level, it is often not clear how to classify implementing agencies (nongovernment), which can be private for-profit firms, not-for-profit firms, or international NGOs that may receive funds from donors locally in addition to generating their own funds (e.g., World Vision, Clinton Foundation); with respect to the last, clarification is needed to determine if they are donors or NPISH. Criteria are needed to better differentiate between a donor and NPISH at the agent level.
- 6) It should be clarified that loans are FS.1 General government (or whatever entity is responsible for repayment), whereas grants should be categorized in the financing sources dimension as Rest of world funds (FS.3), as in the *Producers’ Guide*.
- 7) Guidance is needed on how to treat medical savings accounts. Employers consider that a health expense occurs the year of the transfer of funds, but those funds may not be used to purchase health services until later. This issue needs to be explicitly addressed, both in terms of classification and how to capture it, because the use of medical savings accounts is expanding.

8) In-kind payments as well as informal payments by households should be explicitly discussed for developing countries.

9) The need to clearly define and possibly rename HP.5/HP.6 and HP.6/HP.7 is very important, because both category names include the word "administration." This has led policymakers in some countries to combine these costs and assert that administrative costs are too high. Either a clear distinction must be made between what SHA calls administrative costs as opposed to what policymakers, health accountants, and health economists refer to as merely indirect health care costs, or a health care category for pure administrative costs that exclude direct health care costs such as clinical staff time must be created. (This would require teasing out administrative costs that are embedded in curative and preventive functions.) Another suggestion to prevent confusion is to change HP.5 to Provision of Public Health Programs; HP.6 General health administration and insurance should also be renamed to distinguish it from HC.7 Health administration and insurance. This can be accomplished by adding "providers" to the health provider classification name.

10) Harmonize SHA and *Producers' Guide* classifications of traditional medicine providers. The category currently is listed as HP3.3 in SHA and HP3.9.3 in the *Producers' Guide*.

11) HP.3.4.5 All other outpatient multi-specialty and cooperative service centers and HP.3.4.9 All other outpatient community and other integrated care centers should be more easily distinguishable. Low- and middle-income country health centers have been alternatively classified as one or the other due to the lack of a clear definition. Health centers in low- and middle-income countries may be staffed by one person who is rarely a specialist, but serves multiple purposes.

12) Separate the stewardship function (and name it as such) from the function of managing insurance schemes.

13) In the developing world, public sector physicians sometimes work in the private sector in the evenings. How should this be accounted for?

14) Discussion is needed to determine whether gross domestic product (GDP) or gross national product (GNP) is better to use as the denominator when measuring the proportion of health expenditure and why.

15) While there has been work in the past to develop software to make the NHA process more user-friendly, some countries would like to see these efforts continued to more easily link the four dimensions of the flow-of-funds model.

2. UNIT 2. GLOBAL BOUNDARIES OF HEALTH CARE

2.1 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)?

2.2 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.

2.3 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*.

2.3.1 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 Progres/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.

2.3.2 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.

2.3.3 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.

2.3.4 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.

2.3.5 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 ECSA, 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.

2.4 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.

3. UNIT 5. TYPES OF HEALTH ACCOUNTS

3.1 SUMMARY

A link between health expenditures and the rest of the economy is critical for gauging the relative magnitude of health care spending. From the authors' experience, this is often a challenge particularly in countries with a paucity of data. Other methods to contextualize health care spending should be addressed. Namely, the development of disease-specific or priority area specific sub-accounts that mirror the NHA framework would be a useful tool that would allow policymakers to better assess resource allocation. Additionally, a connection between NHA and other resource accounts, such as the National AIDS Spending Assessment (NASA), is a worthwhile objective.

3.2 HIGHLIGHTED RECOMMENDATIONS

- 1) Ongoing efforts to develop disease-specific or priority area specific sub-accounts within the ICHA classifications that mirror the NHA framework should be acknowledged and incorporated.
- 2) SHA revisions should acknowledge and endorse the ongoing efforts to create a connection between NHA and other resource accounts, such as the NASA; those sub-account frameworks will need to be updated once SHA is revised.

3.3 HEALTH ACCOUNTS IN CONTEXT

There is considerable value in understanding health expenditures in the context of other macroeconomic variables. In many low- and middle-income countries, health care spending accounts for a comparatively small amount of GDP and investment. For example, countries in the ECSA region spend an average of only 7 percent of their GDP on health care. Health care spending in the developing world is comparatively high in relation to personal consumption.

Nevertheless, it may be premature for some low- and middle-income countries to incorporate balancing items other than GDP (e.g., operating surplus, disposable income, saving and net lending/net borrowing) into health accounts. The accounting systems of many countries are still maturing since the revision of the SNA 1993 (SNA93) and some countries have just recently completed revisions of their GDP data after

discovering that they had been underestimating. Utilizing inaccurate macroeconomic variables erroneously portrays health spending in the context of the whole economy.

This does not mean that the relative contribution of health sector components cannot be assessed. It is still pertinent to contextualize elements of health care spending in terms of total health spending to develop a greater understanding of the overall health economy. For example, a table that illustrates the public share of total health expenditures reveals the burden of health care spending on the government. Similarly, the donor share of total health expenditures provides an idea of the financial responsibility that the government will face once donor aid ceases. The out-of-pocket burden is demonstrated by evaluating households' share of total health expenditures. Maintaining a focus on indicators and tables that are within a developing country's health sector gives a greater context to spending, while avoiding the uncertainties of macroeconomic variable measurement error.

Additional types of accounts within the health care context are disease-specific or priority area specific health accounts. Disease-specific health accounts are an important area of focus for policymakers and donors in the developing world. Disease and priority area expenditure reviews are useful to inform many international agreements, including MDGs and International Conference on Population and Development and United Nations General Assembly Special Sessions declarations. Many diseases, including malaria and tuberculosis, place a tremendous burden on the health care systems of low-income countries. An understanding of where the financial burden of these diseases lies is one tool for policymakers and donors aiming to more cost-effectively allocate resources. Using the NHA framework, disease-specific health accounts show who is financing care for a specific disease and who is delivering it, better enabling financing sources to efficiently direct their funds. In the developing world, resources should be dedicated to assess the feasibility and value of creating disease-specific health accounts. Work on disease-specific accounts is already in progress in Zambia and some other ECSA countries.

NHA should also be linked to other resource accounts, such as the NASA. These ongoing efforts should be acknowledged in the SHA revisions.

3.4 ACCOUNTS OF GROSS CAPITAL FORMATION IN THE HEALTH SECTOR

One policy-relevant set of accounts is to report capital formation in the health sector. A methodology must be established well before low- and middle-income countries devote their resources to measuring these expenditures. We present three options for accounting for gross capital formation. The first option is to include total gross fixed capital formation (e.g., construction of hospitals) in the first year as investment. In subsequent years, a methodology to deduct consumption and depreciation of gross fixed capital from capital stock must be implemented. Another option is to include gross fixed capital formation in the first year, but not to account for depreciation or consumption. While this would be the simplest method and is currently

commonly used by many countries, it would not provide policymakers with an accurate measurement of health sector capacity. A third approach would be to include only the consumption of fixed assets. This would involve a determination of how much capital is consumed in each year until the end-of-life of that capital. Total expenditure on gross capital formation would not be accounted for in this method to prevent double counting. Discussion should be encouraged to determine if one of these approaches, or another option, is most appropriate.

4. UNIT 7. ICHA-HC FUNCTIONAL CLASSIFICATION OF HEALTH CARE

4.1 SUMMARY

At this time, many low- and middle-income countries face challenges in accounting for health care spending according to the functional classification. Health spending data in many countries are structured to account for inputs, and often do not link to SHA functional categories. Further complicating the matter, financing sources, financing agents, and providers within countries often utilize different budgeting systems, making data crosswalks extremely tedious. The functional estimates produced by countries that are able to complete them are frequently weak and require many assumptions. Additionally, many policy-relevant areas are not possible to account for using the functional classifications. For example, the total expenditure on both preventive care and on drugs is not possible to tease out from the current classifications. Without creating a solid link between the SHA functional classifications, financial management systems, and health policy in low- and middle-income countries, these countries will not devote resources to functional estimates.

4.2 HIGHLIGHTED RECOMMENDATIONS

- 1) Total and household spending estimates of preventive care (including personal preventive care, currently embedded in curative care) and pharmaceuticals are critical to policymakers.
- 2) Capital formation must be redefined before consideration as an health care function.

4.3 KEY ISSUES

Though there are many issues to address, aggregate categories are generally the level at which functional classifications can be 'accurately' estimated by many low- and middle-income countries, due to a lack of detailed data. Further detail and breakdown by classifications often requires use of allocation factors and estimation techniques. Discussion of the policy relevance of some of these aggregate categories would be useful in the SHA revisions as well as further guidance on how to obtain more detailed information (e.g. estimation techniques) including approaches on how to strengthening the health information system to retrieve better data and minimize production of 'guesstimates' (e.g. provision of an 'ideal' expenditure module that can

be incorporated into district health information systems entered at the facility level). Some key issues that were identified in the *Invitation to Submit Input Documents* require debate and are discussed below.

4.3.1 CONSTRUCTION OF CLASSES INDEPENDENTLY OF MODE-OF-PRODUCTION

The construction of classes independent of mode-of-production is not particularly relevant in low- and middle-income countries. Among the personal health care classes (HC.1-HC.3), most care in low- and middle-income countries is curative; rehabilitative care and long-term care do not play a major role, and are difficult to quantify. An aggregate curative care spending category may be possible to complete.

4.3.2 DISAGGREGATION OF HC.1 INTO THE VARIOUS PRODUCTS OF THE HOSPITALS

Many countries, including most low- and middle-income ones, do not have the resources to disaggregate curative care into the various products of hospitals. Rather, guidance for how to strengthen health information systems would be helpful.

4.3.3 REVIEW HC.2 AS A CLASS OF ITS OWN OR POSSIBLY MERGE WITH ANOTHER

There is generally no distinction between rehabilitative care and curative care in low- and middle-income countries. Decision-makers and health accountants in low- and middle-income countries would be best served to combine these categories, or to at least include an aggregate category that encompasses curative and rehabilitative care.

4.3.4 DEFINITION OF HC.3 TO REFLECT HEALTH-SOCIAL CARE DISTINCTION

Long-term care is not easy to account for in the developing world because it is primarily administered at home and not monetized. Caregivers are usually unemployed family members, and placing a valuation on their labor is problematic; currently, these expenditures are usually not included in health accounts. However, due to the growing number of home-based care initiatives, there is increasing interest from policymakers to gain an understanding of the household investment in long-term care. With respect to the health–social care distinction, social care that is necessary to ensure the delivery of health services should be included as core health functions. One example is nutritional support for HIV/AIDS patients undergoing ARV drug therapy (see Unit 2). A better definition of core health, health-related, and non-health functions is needed.

4.3.5 HC.5 TO BE ANALYZED REGARDLESS OF MODE-OF-PRODUCTION

Policymakers are interested in the level of total spending and household spending on pharmaceuticals. A large share of drugs in the developing world is purchased by households in informal settings – in Mali in 2004, 40% of pharmaceuticals were purchased illicitly. The current structure of SHA contains HC.5, Private pharmacy purchasing. However, we do not know how much is being spent elsewhere. In order to provide decision-makers with evidence of the extent of informal pharmaceutical sales, West African NHA technical teams have proposed adding “Street Medical Sellers” (pharmaceuticals in informal settings) as a provider classification. Some countries have also questioned whether expenditures on pharmaceuticals that are part of inpatient services can be teased out, so that total expenditures on drugs can be ascertained. Sometimes these drugs are paid for out-of-pocket, but they may be accounted for as inpatient services. Guidance on how to account for these expenditures is needed so that total spending and household spending on drugs can be determined.

In addition, capturing expenditures on traditional or alternative medical goods is useful, but data on these items may be difficult to acquire. SHA does not specify how to monetize in-kind payments. This needs to be clearly specified for traditional healer-related payments (as well as for donor shipments of commodities). The preference is for it to be done at market prices if the commodities are given completely free to consumers.

4.3.6 HC.6 TO BE REDEFINED

Prevention and public health services should account for all preventive medicine, including those preventive measures that are currently embedded in curative care. In the SHA 1.0, immunizations administered in an outpatient setting are listed as outpatient curative care. This misrepresents the level of total spending on preventive medicine. Prevention programs geared toward the general community and personal preventive medicine should be accounted for together.

Furthermore, the subcategories of Prevention and public health services overlap and are not mutually exclusive. For example, HC.6.1 includes maternal health, which in the developing country context often includes prevention of mother-to-child transmission—this is also prevention of a communicable disease (HC.6.3). The same is true of prevention of communicable diseases such as HIV and AIDS in a school setting (HC.6.2). Additionally, Prevention and public health services are typically “programs” in the developing world, not “services.” This category should be renamed to reflect that distinction.

4.3.7 HC.R.I TO BE ACCOUNTED IN A SEPARATE CLASSIFICATION

Although capital formation (e.g., hospital construction) is certainly an activity that promotes health care, it requires a better definition before it is accounted for as an HC function, so that it does not distort health expenditures. Sometimes buildings are not created with the intention of being used for health, but are later converted to health

facilities, or vice versa. Health services may be provided in multi-use facilities that also are a venue for non-health services. In addition, there are health facilities that are geared toward medical tourism, and do not serve the local resident population. Guidance is needed for whether and how to include these examples. Also, machines are sometimes purchased but never utilized for health. It may be misleading to account for these as health when they are unused. Capital formation should be a health care function, but how to account for these expenditures and how to determine what should be included must be more clearly defined.

4.3.8 ADDITIONAL ISSUES

Other issues demand attention:

- 1) Clarity of the boundaries of HC.6.3 Prevention of communicable diseases and HC.7.1 General government administration of health regarding the surveillance of communicable diseases.
- 2) Guidance of where routine surveys that are used for monitoring should fit HC.7.1 General government administration of health or HC.R.3 Research and development in health. Routine surveys are part of the information system, which is part of the stewardship functions of the government and would therefore be included as HC.7. This is also consistent with the Health Metrics Network framework, but needs to be explicitly stated.
- 3) Clarity of treatment of on-the-job training or training of community health workers. These are usually integral parts of programs that are classified under HC.6 Prevention and public health services. Countries reject the suggestion that it falls under HC.R.2 Education and training of health personnel.
- 4) The discussion of transport costs needs to be broadened to address low- and middle-income countries. Patient often incur transportation costs, and it is not clear whether and how these expenses should be classified. The current SHA only accounts for these transportation costs when they are reimbursed. Country counterparts identified this as an important area of concern.
- 5) The distinction between HC.1.2 Day cases of curative care and HC.1.3 Outpatient curative care needs to be made clear. Most countries do not account for day cases as a separate mode of production. Health accountants and policymakers would be best served if these categories were combined.
- 6) The issue of treatment of non-market production versus market production needs to be explored in much greater detail. For instance, pharmaceuticals that are sold in private pharmacies are accounted for at market prices, which include capital and other intermediate costs. Non-market production is valued at input prices, which do not take these other costs into consideration.
- 7) The functional classifications should be expanded to accommodate disease-specific and policy area specific sub-account classifications. The acknowledgement and

incorporation of ongoing disease-specific and policy area specific sub-account efforts should be included in the revisions.

8) Several countries are interested in primary care as a function. While we recognize that these services are really either preventive or curative, some countries want to keep primary care separate. Language to address this issue would be helpful.

9) The translated form of some HC lines should be renamed. For example, HC.1.1 "Soins curatifs en milieu hospitalier" means "all curative care provided in a hospital." In order to avoid confusion or double counting, HC.1.1 should be renamed "Soins curatifs en hospitalization avec nuitée"