I. General questions on health accounting concepts and boundaries of SHA 2011

I.1 Some notes on NPI and their distinction in government or non-government:

Government control of non-profit institutions

4.92 Control of an NPI is defined as the ability to determine the general policy or programme of the NPI. All NPIs allocated to the general government sector should retain their identity as NPIs in statistical records, to facilitate analysis of the complete set of NPIs. To determine if an NPI is controlled by the government, the following five indicators of control should be considered:

a. The appointment of officers. The government may have the right to appoint the officers managing the NPI either under the NPI’s constitution, its articles of association or other enabling instrument.

b. Other provisions of enabling instrument. The enabling instrument may contain provisions other than the appointment of officers that effectively allow the government to determine significant aspects of the general policy or programme of the NPI. For example, the enabling instrument may specify or limit the functions, objectives and their operating aspects of the NPI, thus making the issue of managerial appointments less critical or even irrelevant. The enabling instrument may also give the government the right to remove key personnel or veto proposed appointments, require prior approval of budgets or financial arrangements by the government, or prevent the NPI from changing its constitution, dissolving itself, or terminating its relationship with government without government approval.

c. Contractual agreements. The existence of a contractual agreement between a government and an NPI may allow the government to determine key aspects of the NPI’s general policy or programme. As long as the NPI is ultimately able to determine its policy or programme to a significant extent, such as by being able to renege on the contractual agreement and accept the consequences, by being able to change its constitution or dissolve itself without requiring government approval other than that required under the general regulations, then it would not be considered controlled by government.

d. Degree of financing. An NPI that is mainly financed by government may be controlled by that government. Generally, if the NPI remains able to determine its policy or programme to a significant extent along the lines mentioned in the previous indicator, then it would not be considered controlled by government.

e. Risk exposure. If a government openly allows itself to be exposed to all, or a large proportion of, the financial risks associated with an NPI’s activities, then the arrangement constitutes control. The criteria are the same as in the previous two indicators. A single indicator could be sufficient to establish control in some cases, but in other cases, a number of separate indicators may collectively indicate control. A decision based on the totality of all indicators will necessarily be judgmental in nature.
I.2 Cash benefits for sickness leave, maternity leave, pensions for disabilities or work accidents – are they part of the SHA 2011 core accounting framework?

Cash benefits for sickness leave, maternity leave, pensions for disabilities or work accidents are granted for the purpose of income maintenance and are therefore excluded from the core accounting framework.

II. Classification of health care functions (HC)

II.1 Should we account the administrative costs of a project funded by Rest of the World, which occur outside the recipient country (Governance and health system and financing administration HC.7)?

In the case of the external funds coming to a recipient country as aid, there is an amount entering clearly for the implementation of a project, but there is also a cost of administration of this project which may occur at the HQ of the donor agency outside the recipient country e.g. the cost of the monitoring of the project.

The boundary of SHA 2011 is limited to the domestic market. That means that costs related to projects not made within the domestic boundary are not part of the health spending of the country.

II.2 How should we make the distinction between the subcategories under “Epidemiological surveillance and risk and disease control programmes HC.6.5” and under “Governance and health system and financing administration HC.7”?

II.3 Where should we classify hospital units devoted to produce limbs, which are used in the hospital?

If the people in that unit are employed in the hospital, than all the costs are related to the provision of the services and this should be included above the line as it is part of the services to be used. They make the limbs to be used on patients and as such they are part of the complete treatment in the hospital. It is a type of ancillary service but then for medical durables – HC.4 nec.

II.4 How to classify communication/information field trips by the polio programme to communicate to the population overall about the upcoming vaccination (i.e., inviting parents to bring in their children)? Is this Information, education and counselling programmes (HC.6.1) or vaccination programmes (HC.6.2)?

The information to the population is in HC.6.1 Information, education and counselling programmes. The technical component to plan and M&E of the vaccination programme should be under HC.6.5 (Epidemiological surveillance and risk and disease control programmes) and the vaccination should be classified under HC.6.2 (Immunisation programmes).

In the beneficiary by disease category, this amount should be classified under Vaccine preventable disease DIS.1.7 and specifically disaggregated under polio, if possible. Also it should be classified under AGE.1 (below 5 years old).
Similar logic will be applied for HIV/STD campaigns or condom campaigns.

**II.5 How to treat delivery kits?**

The delivery kit is an input into the delivery service (HC.1.1 – Inpatient curative care) rather than a medical good (HC.5.2 Therapeutic appliances and other medical goods).

**II.6 How to classify under the Functional classification the expenditure accounted under FP.3.3.1 Training?**

The staff training can be crossed with any type of services – hospital or ambulatory, home care, preventive care, etc. If there is no detailed information the class HC.9 can be used, although the training is not a health product.

**II.7 Where to classify expenditures on necropsy activities in terms of Functions?**

The most important thing is to identify whether the expenditures related to necropsy activities should be included in the accounting framework. When the primary objective of the autopsy is to determine or clarify the diagnosis, provide additional information and improve the quality of services, this act is part of the accounting framework. However, when the autopsy is done in the context of criminology and justice - this act should be excluded from the accounting framework. Regarding the function – it should be HC.6.5 - Epidemiological surveillance and risk and disease control programmes. However, most of the autopsy are made in universities’ hospitals and probably it will not be easy to separate these expenditures.

**III. Classification of health care providers (HP)**

**III.1 How to classify the specific programmes within the Ministry of health which provide preventive care in addition to the administrative / regulatory activities - HP.6 (Providers of preventive care) or HP.7.1 (Government health administration agency)?**

The disease specific programmes within the Ministry of health which provide preventive care in addition to the administrative / regulatory activities, can be considered as an independent provider, whose main activity is to provide preventive care. This means that an MoH programme would be classified as HP.6, and whatever regulatory activity they do would be HC.7.

**III.2 New subcategory HP.3.4.5 non-specialized ambulatory health care centres**

*Justification:* contrary to hospitals or medical practices, SHA 2011 broken down ambulatory health care centres into specialized categories, excluding any specific class for general ambulatory health care centres. However, in lower income countries, health care centres are one of the key health structure where households can access care, and through which preventive actions are being implemented (or from which they are being implemented). In terms of expenditures, spending on general HCC often represents some 15-20% of total current health exp. As such, for these countries,
having a class for general HCC is an important recognition of the importance of these facilities in their health systems. Ideally, it would have been coded HC.3.4.1.

**Definition:** This item comprises establishments that are engaged in providing a wide range of outpatient services by a team of medical and paramedical staff, often along with support staff, that usually bring together several specialties and/or serve specific functions of primary and secondary care. These establishments generally treat patients who do not require inpatient treatment. These establishment do not specialize in any one range of services relating to a condition or disease.

**III.3 New subcategory HP.8.3 Community health workers (or village health workers, community health aide, etc.)**

**Justification:** in lower income countries, health systems quite extensively rely on community health workers for basic health care needs. in some countries, community health care workers are part of the health care workforce in that their health care activity is their primary activity. In which case they are either deployed from a health care centre and therefore included under HP.3.4.5, or they are independent and are classified as HP.3.3. In other countries, community health care workers are providing basic health care services on the side of their primary activity.

**Definition:** this subcategory includes individuals contracted out to provide basic health care services to their community, on the side of their primary activity (e.g., as farmers), for a compensation.

**IV. Classification of health care financing schemes (HF)**

**IV. 1 Cost sharing with NPISH schemes – HF.3.2**

An additional sub-class may be inserted under HF.3.2 Cost sharing with third-party payers – HF.3.2.3 Cost sharing with NPISH schemes.

In some countries e.g. Kenya and Uganda, there are schemes funded by a donor and implemented by an NGO. The government has no say (does not participate, did not provide official agreement, does not regulate, etc.).

The NGO is for pregnant women to incite them to undergo 4 prenatal care visits + give birth in a facility + postnatal care visit. Pregnant women buy a voucher that gives them right to access these cares in a given list of facilities without having to pay more than the price of the voucher. Their contribution is considered OOPs (cost sharing of the scheme) and the NGO scheme (Marie Stopes) pays for the rest of the care.

**IV.2 Compulsory pension scheme part of which can be used for health – compulsory medical saving accounts (CMSA) HF.1.3**

When there is a compulsory pension scheme, in which the law sets that although the primary purpose is the pension, those resources can be used in % amount for health of the person involved and their families and the pension fund is handled without pooling we should record it as
compulsory medical saving accounts. (The entitlement can be used or not, based on the convenience of the user.)

This example is from Fiji.

V. Classification of revenues of health care financing schemes (FS)

V.1 How SHA 2011 deals with “debt cancellation” and interests?

SHA 2011 treats cancelled debts as if foreign funds were transferred to the government, which would then be used to pay the debt back to the donors.

SHA 2011 doesn’t deal with debt repayment, therefore doesn’t deal with debt cancellation either. Only the reduction of the interest payments is part of the SHA as the cancelled debt no longer accrues interest payments.

SHA 2011 does not track debt pay-back but only tracks interest payments. Therefore, only the relief of the interests should be tracked as foreign funds transferred to government and used for paying interests.

The HIPC (heavily indebted poor countries) funds used for health expenditure would fall under “Transfers from government domestic revenue FS.1”

The equivalent of the cancelled interests would be tracked and accounted as funded by donors under “Transfers distributed by government from foreign origin FS.2”.

The interest paid (whether on capital goods loans or other types of loans taken out for health purposes) are to be treated as running costs and as such should be remunerated in the revenues of the providers.

Moreover a provider that runs a deficit and needs to take out a loan has to pay interest but that interest has to be remunerated in the future sales/turnover, otherwise that provider keeps on running a deficit accumulatively valued as the sum of all the interest payments for which continuous higher loan need to be taken. This is not sustainable.

Another issue relates to the non-market providers. The turnover of these providers is created by the sum of the costs related to the functioning of the provider. The interest paid on loans is an inherent part of the total spending structure of the provider and as such should be included in the total spending to be equalled to the revenues and to the consumption.

In this case the two types of providers are treated consistently.

For both market and non-market providers interest is included in CHE.
Some additional points in SHA 2011: interest payments from market providers are included in the prices charged and as such included in the consumption value. In analogy for the non-market providers the interest paid should be included for consistency reasons. It is not about payment by consumers it is about the value of the consumption.

V.2 Can the “Transfers distributed by government from foreign origin FS.2” be in-kind?

All revenues can also be in kind transfers (for example, in-kind foreign assistance to government financing schemes).

V.3 How to differentiate “Transfers distributed by government from foreign origin FS.2” from “Direct foreign transfers FS.7”?

V.4 What is the definition of “subsidies” according to SHA 2011?

Subsidies (FS.1.3) refer to the funds allocated from government domestic revenues to financing schemes operated by institutional units other than government units or NPISH. Includes: subsidies for compulsory or voluntary health insurance schemes (managed by private insurance companies). Tax allowances provided to households who buy private health insurance may be accounted under this category.

V.5 How to classify “La mutuelle de la fonction publique”?

“La mutuelle de la fonction publique” should be classified as HF.1.2.1 – Social health insurance scheme even if it is not defined as a social health insurance.

V.6 Where to classify the schemes of the international organizations offices e.g. WHO or development bilateral agencies offices?

If their offices are based in the country for which the health accounts are being developed they should be considered as Resident foreign development agencies schemes HF.2.2.2.

VI. Classification of Factors of health care provision (FP)

VI.1 What is the definition of diagnostic equipment under “FP.3.2.2 Other health care goods” used in the process of provision of health care?

These are small inexpensive (relative to the country context) diagnostic tools which are not for repeat use. If their value is significant and they can be repeatedly used – they should be accounted under Capital formation (HK).

VI.2 How to classify per diem and or accommodation – as a good or as a service?

In principle accommodation or per diem can be treated as a good
a) if the hospital offers their personnel free accommodation it is part of their salary (salary in kind) – FP.1.1; the same is true for a provided per diem to reduce the costs of getting an accommodation
b) if the hospital offers per diem for their personnel to attend a meeting it is intermediate consumption of goods (non-health care) – FP.3.4
c) if the hospital offers accommodation to relatives of patients it is an HC related and as such below the line.

**VI.3 How to classify the overtime pay for health care workers?**
The overtime pay is should be treated as part of the salary – FP.1.1

**VII. Where do we account the payment for the rental of equipment and buildings?**
Rentals paid on the use of equipment or buildings, and fees, commissions, royalties, etc., payable under licensing arrangements are included as the purchase of services under FP.3.3 Non-health care services.

**VII. Capital formation in health systems (HK)**

**VII.1 What is the distinction between capital formation and consumption?**

SNA definition:

1.52 Before considering the difference between consumption and investment, though, it is necessary to look more closely at the nature of consumption. Consumption is an activity in which institutional units use up goods or services, but there are two quite different kinds of consumption. Intermediate consumption consists of goods and services used up in the course of production within the accounting period. Final consumption consists of goods and services used by individual households or the community to satisfy their individual or collective needs or wants. The activity of gross fixed capital formation, like intermediate consumption, is restricted to institutional units in their capacity as producers, being defined as the value of their acquisitions less disposals of fixed assets. Fixed assets are produced assets (such as machinery, equipment, buildings or other structures) that are used repeatedly or continuously in production over several accounting periods (more than one year). The distinction between intermediate consumption and gross capital formation depends on whether the goods and services involved are completely used up in the accounting period or not. If they are, the use of them is a current transaction recorded as intermediate consumption; if not it is an accumulation transaction recorded in the capital account.

10.35 The second exclusion is pragmatic rather than conceptual and concerns small tools. Some goods may be used repeatedly, or continuously, in production over many years but may nevertheless be small, inexpensive and used to perform relatively simple operations. Hand tools such as saws, spades, knives, axes, hammers, screwdrivers and spanners or wrenches are examples. If expenditures on such tools take place at a fairly steady rate and if their value is small compared with expenditures on more complex machinery and equipment, it may be appropriate to treat the tools as materials or supplies used for intermediate consumption. Some flexibility is needed, however, depending on the relative importance of such tools. In countries in which they account for a significant part of the value of the total stock of an industry’s durable producers’ goods, they may be treated as fixed assets and their acquisition and disposal by producers recorded under gross fixed capital formation.

Theoretically a good that can be used for more than one year is considered as capital.
The small medical goods can be treated as current spending (if replenished on a regular basis), such as laboratory glasses. However, in case the spending is seen as important (relatively to the other spending amounts) also laboratory glass could be treated as capital. It depends on the national situation.

If a country has bought a significant stock of pharmaceutical products e.g. stock of vaccines against an epidemic – they may be considered as capital formation although the unit cost of a vaccine may not be high.

**VIII. Health spending by diseases**

**VIII.1 Where do we classify “obesity” ?**

Obesity is a non-communicable disease, endocrine disorders. A new sub-class needs to be created under DIS.4.2 - Endocrine disorders.