

Input Document
Unit 7ICHA-HC FUNCTIONAL
CLASSIFICATION OF
HEALTH CARE**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.

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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

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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.

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.

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

1.1 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.

1.2 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.

1.3 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.

1.3.1 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.

1.3.2 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.

1.3.3 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.

1.3.4 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.

1.3.5 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.

1.3.6 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.

1.3.7 HC.R.1 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.

1.3.8 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"