# WORKING WITH SYSTEM OF HEALTH ACCOUNTS, 2011

## ORIENTATION, DISCUSSION, AND NEXT STEPS


August 2015

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**The Health Finance and Governance Project**

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# ACRONYMS

| | |
|---|---|
| **ESIC** | Employees' State Insurance Corporation |
| **HA** | Health Accounts |
| **HFG** | Health Finance and Governance |
| **HSHRC** | Haryana State Health Resource Center |
| **JSSK** | *Janani Shishu Suraksha Karyakra*m |
| **NHA** | National Health Accounts |
| **NHATS** | National Health Accounts Technical Secretariat |
| **NHM** | National Health Mission |
| **PHFI** | Public Health Foundation of India |
| **RSBY** | *Rashtriya Swashtya Bima Yojana* |
| **SHA** | System of Health Accounts |
| **USAID** | United States Agency for International Development |

# ACKNOWLEDGMENTS

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We are grateful to Dr. Vinod Annigeri for sharing his experiences from working on the Karnataka HA estimates. We thank our HFG trainers Mr. Yann Derriennic and Ms. Karishmah Bhuwanee for sharing their knowledge and experiences across sessions and providing valuable insights and overall guidance throughout the workshop, and Mr. Bhavesh Jain and Mr. Afaq Ahmed of HFG India for sharing their experiences.

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The team would like to express to all the stakeholders its sincere appreciation of the assistance received in the successful accomplishment of this initiative. It has been a great experience during the entire orientation and we believe it will further help the states and other stakeholders' determination for conducting state HA on a regular basis.

# INTRODUCTION

Health Accounts (HA) is an approach for health resource tracking: it tracks the flow of expenditures in a health system according to consumption, provision, and financing. Findings are used to make effective policy decisions, allocate resources according to country or state priorities regarding diseases or socio-economic groups, and engage in more efficient health expenditures. Conducting periodic health account exercises is necessary to have expenditure information over time.

India did two National Health Accounts (NHA) exercises, on data from 2001/02 and 2004/05. However, most health budgeting and spending in India is done by state-level government, which is why it was necessary to create state-level health accounts.

The Health Finance and Governance (HFG) project in India, led by Abt Associates, hosted a three-day (May 18-20, 2015) orientation on estimating HA using the System of Health Accounts (SHA) 2011 methodology. Attending were representatives from Haryana and Punjab, who will develop the HA exercise in their states. In both states, peoples' out-of-pocket expenditures are very high and health expenditure as part of budgetary expenditures is very low.

The orientation was presented by international and national experts to 20 participants from the Haryana State Health Resource Center (HSHRC); the Directorate General of Health Services, part of the Ministry of Health and Family Welfare; the School of Public Health Post Graduate Institute; the Public Health Foundation of India; and HFG India. Also attending were officials from Punjab and other guests.

The sessions were designed to give the participants an understanding of all the key components of developing HA; they included discussion sessions and group exercises. By the end of the orientation, participants had drafted comprehensive work plans and timelines for continuing the development of the HA exercise in Haryana, and had begun designing the HA exercise in Punjab.

The orientation was a first step in laying the foundation of building HA in Haryana and Punjab, and the knowledge the participants gained and the partnerships that were formed will hopefully lead to the completion of HA exercises in the two states by the end of 2015 and 2016, respectively.

# ORIENTATION OVERVIEW

The three-day orientation comprised presentations, discussions, and group exercises.

The first day included an opening and introduction. Presentations covered the conceptual overview of SHA 2011 including its purpose, history, and use, the characteristics and boundaries of SHA 2011, the results and lessons learned from the health accounts exercise in Karnataka, and the steps in developing a state-level Health Accounts exercise. There also was a discussion session on the potential policy use of HA estimates in Haryana and Punjab, and a group exercise of mapping spending flows in Haryana and Punjab.

The second day consisted of a presentation of the core and extended accounting framework and thorough explanations of the tri-axial framework: the Financing Interface (revenues of financing schemes, financing schemes and financing agents), Provision Interface (health care providers, factors of provision and capital formation), and Consumption Interface (health care function and disease). It also included a data collection overview and planning session, and it ended with a discussion and group work on data sources available at state level.

The third day introduced the concepts of allocation keys, double-counting and weighting, a presentation of the institutionalization of National Health Accounts in India, as well as group work on drafting plans for producing HA in Punjab and Haryana.

# ORIENTATION PROCEEDINGS: DAY 1

## *Session 1: Welcome and Introduction*

**Presenters: Mr. Bhavesh Jain, HFG India; Mr. Yann Derriennic, HFG**

Mr. Jain welcomed everyone and thanked the participants from HSHRC, Directorate General of Health Services, School of Public Health PGI, Punjab, Public Health Foundation of India, and the National Health Mission, as well as faculty members and HFG India, for taking the time to attend the orientation. He explained that the orientation would be an important step in doing health accounts for Haryana and Punjab. Mr. Derriennic then gave an overview of the three days of the orientation.

## *Session 2: Conceptual Overview of SHA 2011: Purpose, History, and Use*

**Presenters: Mr. Yann Derriennic, HFG**

Mr. Derriennic introduced SHA 2011, a tool that tracks the magnitude and flow of resources in the health sector, whether they are public, private, or donor contributions; its main purpose is to help policymakers make better informed policy decisions. Some of the key points Mr. Derriennic made were:

- HA estimates are most needed in countries like India, where there is not enough secondary data available for a conclusive analysis of the health sector, which is a common procedure in Western countries.
- India did two NHA exercises, in 2001/02 and 2004/05. However, because most health budgeting and spending in India is done by the government at the state level, HA need to be done at the state level. State HA would also be able to capture more details than national-level accounts, given the large size of some Indian states.
- SHA 2011 allows for the input of country-specific categories or sub-categories, which are currently being revised for India. It is important to standardize categories across different Indian states in order to analyze and compare results.
- Budgeted funds are only tracked for major institutions. They reflect future needs and might not be spent accordingly, which is why it is important to track expenditures that reflect financial cost, as well as validate data through triangulation.
- Some of the important policy-related questions that HA findings can help answer relate to the health financing burden on households, the amount of off-budget funds spent, the dependency on donors, and whether disease priorities are respected within the budget allocation. The information obtained after analyzing HA data can be used to make better resource allocation decisions, change the status of Millennium Development Goal priority areas, increase the government investment in health, monitor progress toward spending goals, or hold stakeholders accountable.

- The session ended with a discussion on the policy use of HA data in Haryana and Punjab. Participants from Haryana agreed that the most pressing issues they want to address are monitoring the direction of health costs and spending, and reducing out-of-pocket spending. Participants from Punjab said their priorities are obtaining data to create the basis of health spending from state and state insurance schemes, as well as reducing out-of-pocket spending.

## *Session 3: Conceptual Overview of SHA 2011: Characteristics and Boundaries*

**Presenters: Mr. Yann Derriennic, HFG**

Mr. Derriennic gave an overview of the space and time boundaries of health expenditures.

- He defined health care as the activities with the primary purpose of improving, maintaining, or preventing the deterioration of the health status, regardless of the provider or financing agent. All the spending needed for the final consumption of health services should be captured in the health expense category.
- Health-related activities are activities that overlap with other fields of study and should not be included in the direct health functions; SHA 2011 does not include water and sanitation, environmental health, nutrition programs, or health-enhancing non-prescription drugs. While these health-related activities should not be part of the total health expenditure reported to the World Health Organization, they can be part of National Health Expenditure in order to facilitate data analysis and policy.
- Mr. Derriennic explained the space boundaries using exercises; examples discussed included medical tourism, migrant laborers who work in a state other than the one in which they reside, Indian nationals getting health procedures abroad, housewives who stay at home to take care of sick members of the family, and so forth.
- The time boundary is one fiscal year (in India, April through March), with accounting done using the accrual method, where goods and services are accounted for during the period they were provided, even if not paid for. Time boundaries are important for distinguishing between current and capital spending. Mr. Derriennic mentioned that it is almost impossible to account for the depreciation of capital spending, although it should be the case. The participants then took part in a group exercise discussing which items in a scenario would be included as health spending.

## *Session 4: Conceptual Overview of SHA 2011: Characteristics and Boundaries*

**Presenters: Dr. Vinod Annigeri, Centre for Multi-Disciplinary Development Research, Dharwad**

Dr. Annigeri presented his findings from the HA exercise he led in Karnataka in 2004/05, showing how the findings can be applied to the HA exercises in Haryana and Punjab. He emphasized how two-dimensional tables should be read and interpreted, and allowed the participants to practice interpretation through exercises using the Karnataka results.

Dr. Annigeri discussed the results: the data showed that an extremely large percentage of health expenditures in Karnataka are incurred by households (63.7 percent), mostly for purchasing drugs; the largest expenditure by the level of health care function is on family welfare (36.94 percent); public health and administration represents a very large percentage of expenditures (19.45 percent) compared with primary health services, which account for only 8.06 percent; most expenditures by health care function are on medical goods dispensed to outpatients (46.4 percent), with very low expenditures on

prevention and public health services (9.83 percent). Dr. Annigeri said some of the lessons learned are the following:

- A high level of household expenditure is on the purchase of medicines and other health products from the retail sector
- The bulk of spending goes to hospitals followed by providers of ambulatory health care
- The majority of the spending is on curative services
- Expenditures on the retail sale of medicines and drugs makes these retailers the major provider of services to the community
- Households are the prominent sources for spending on health care, followed by the state and central governments, respectively
- External contributions seem to be very minimal
- The present pattern of spending seems to ignore the following
    - Primary health care
    - Prevention of diseases
    - Public health
    - Maternal and child health
    - Education and training
    - Research and development

Dr. Annigeri emphasized the need for information on the burden of disease in order to make effective funding allocations. He then explained the differences between Current Health Expenditure (includes spending for personal health care, plus spending for collective health services and for the operation of the system's financing agents), Total Health Expenditure (includes all direct health expenditures, and current and capital expenditure), and National Health Expenditure (may include health-related spending and best addresses the needs of policymakers at a national level).

## *Discussion: Policy Use of Health Accounts Data in Haryana and Punjab*

State representatives continued their discussion about the state priorities for using HA. The 2004/05 NHA revealed that 70 percent of health expenditure at that time was household out-of-pocket payments, and that 6 percent of the Haryana households are under the poverty line because of excessive health care costs, despite the implementation of Rashtriya Swashtya Bima Yojana (RSBY), the national-level health insurance scheme. Moreover, Haryana ranks last in state health insurance as percentage of the budgetary expenditure. Therefore, HA data are needed for more-informed resource allocation, as well as for answering policy questions such as: Who pays for health care? How much spending is associated with each type of service (primary vs tertiary care, as well as in terms of the seriousness of disease)? How are funds distributed across levels of health care (urban vs rural)? Who benefits from public health care? What is the burden on households? Is spending according to the state's strategic plan? What is the role of the private sector (including the Corporate Social Responsibility tax of 2 percent of profit)? How is the financing of health care structured and managed? One important point made was that access does not only mean providing free health care, but also enabling people in different schemes to obtain health care. Haryana's 2009 Free Drug Scheme and its 2014 Free Diagnostic Scheme were brought up. Discussants also mentioned informal sector payments, discrimination, and the disappearance of medicine and other health care products.

## *Session 5: Developing State Accounts: The Way Forward*

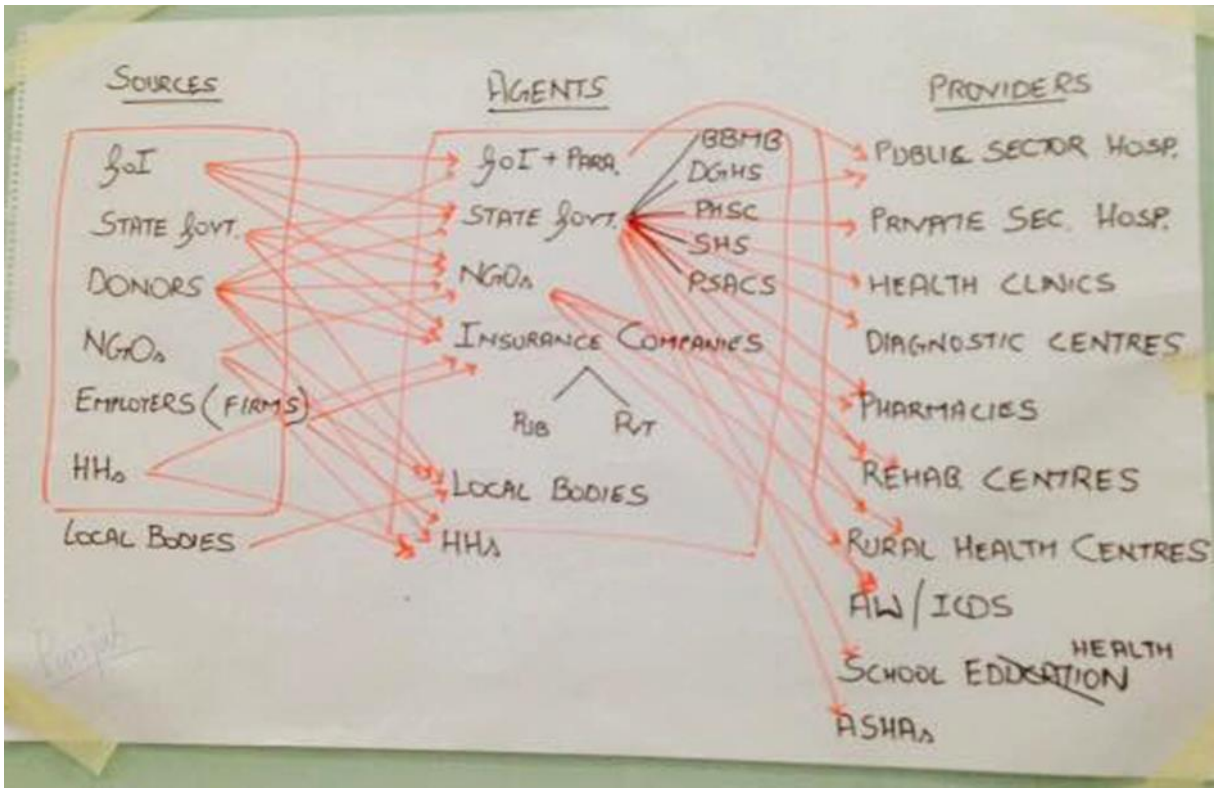
**Presenter: Mr. Bhavesh Jain, HFG India**

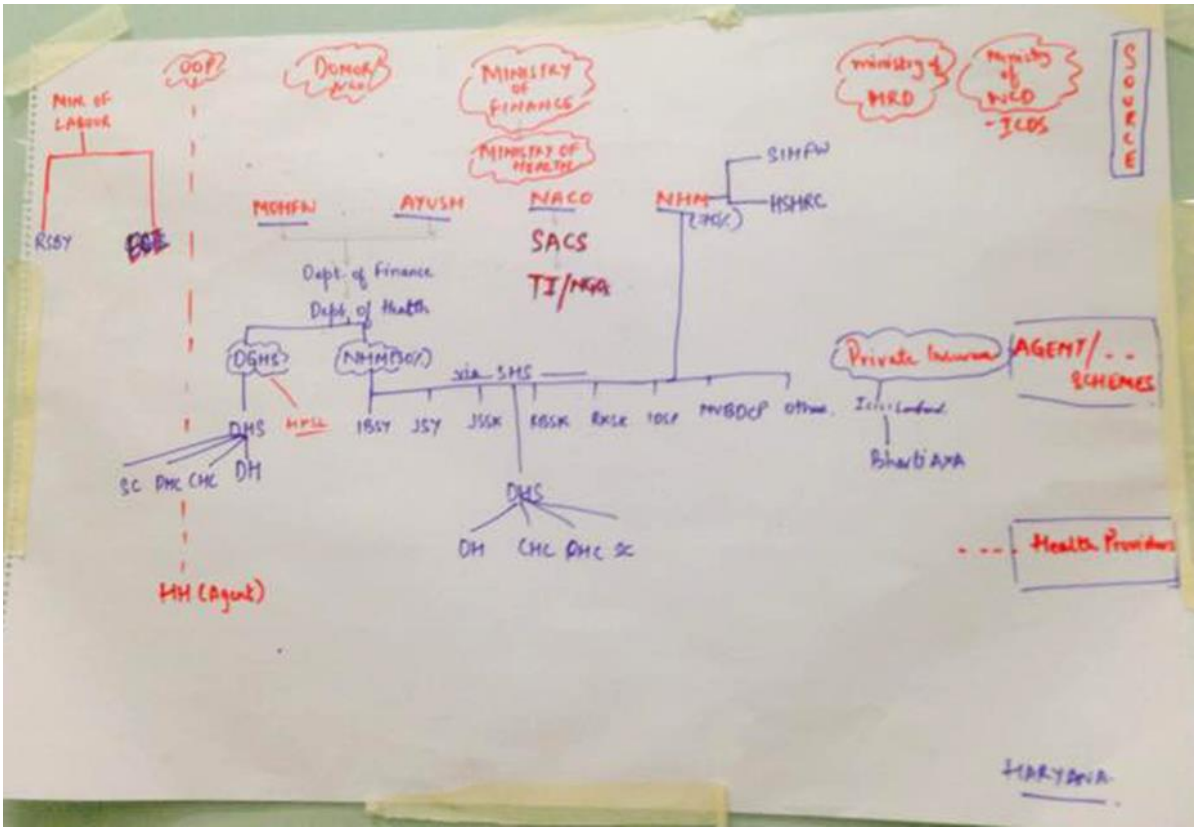
Mr. Jain presented the key elements of a HA exercise, expanding on each step of the process.

- The first step, planning and scoping, involves laying the groundwork through locating the home government, stakeholders, and team members of the exercise, building demand for the results and engaging the HA Steering Committee to define policy priorities, mobilize resources, and agree on timelines and plans.
- The launch stage includes defining the parameters of the HA estimation such as process, classifications, and boundaries in collaboration with stakeholders, and training a HA technical team and data collectors who will identify primary and secondary data sources and develop a HA work plan. It would further consist of holding an official launch event that provides an overview of the exercise plan and solicits input, and developing a detailed work plan for the HA, including key strategies and actions, responsible individuals, and a timeline.
- During the data collection stage, teams identify and collect secondary data, input it, and document sources, references, and calculations. They define the sampling approach for each institutional respondent type, such as donors, NGOs, insurance companies, and employers, customize surveys for each group, send surveys, and follow up, as well as collect primary data through household surveys, if needed. This is the lengthiest stage, during which follow-up with institutions is extremely important in order to collect as much data as possible. Moreover, surveys received from institutions need to be checked for completion and validity.
- The fourth phase is data analysis and validation, which includes data cleaning, validation, and import, mapping the data to SHA codes, producing the HA tables, and validating the data with the technical team and stakeholders, with the possibility of combining HA data with other secondary data, if available.
- The report-writing and dissemination stage includes presenting the results to the HA steering committee and stakeholders to check for validity and relevance, generating dissemination products such as reports, policy briefs, and brochures, disseminating these products at events, and discussing their policy implications.

## *Group Work: Understanding and Mapping Spending Flows in Haryana and Punjab*

The participants took part in an exercise to identify the financing sources and agents, and providers of health care in Haryana and Punjab, which they then discussed.

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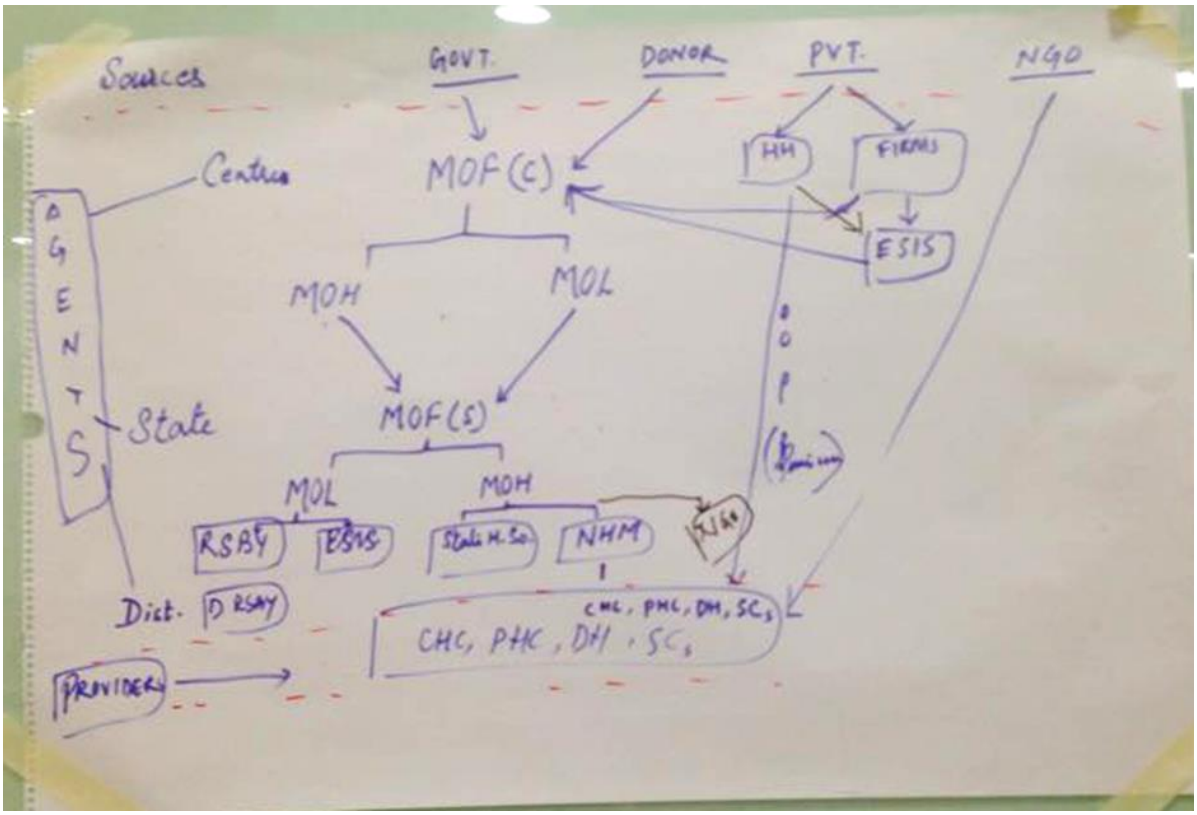
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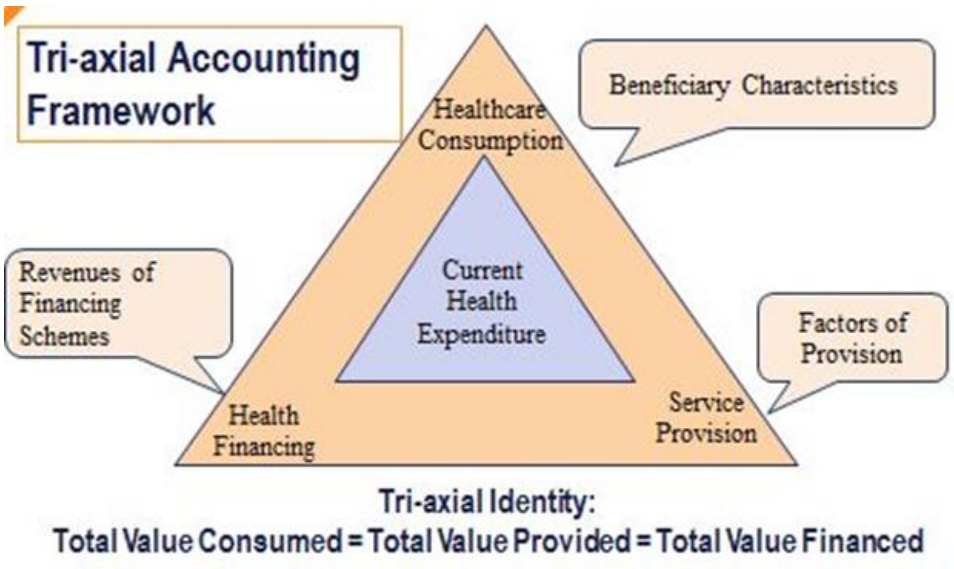
## *Session 6: Core and Extended Accounting Framework*

**Presenter: Mr. Yann Derriennic, HFG**

After a review of the content of day 1, Mr. Derriennic presented the key components of the SHA 2011 framework and the tri-axial accounting (below), distinguishing between core and extended components. Key points were:

- SHA can show the health resources flow in a country through the three fundamental financing functions of health systems: raising revenue for health, managing and pooling resources, and purchasing services.
- SHA classifications include revenues of Financing Schemes (ICHA-HF), Financing Agents (ICHA-FA), Health Providers (ICHA-HP), and Functions (ICHA-HC).
- The tri-axial framework can be understood from a policy question perspective: what kind of health goods and services are consumed? How are goods and services paid for? Who provides the service? Alternatively, it can be represented by the identity Total Value Consumed = Total Value Provided = Total Value Financed, with specific boundaries.
- The Health Financing Interface includes Revenues of Financing Schemes (FS – extended), Financing Schemes (HF – core) and Financing Agents (FS – extended); the last is perhaps the most powerful group in the health sector. The Provision Interface includes Providers, Factors of Provision and Gross Capital Formation. The Consumption Interface includes Functions differentiated by type of service (preventive vs curative) rather than level of service (primary vs secondary, tertiary) and Characteristics of beneficiaries (disease, age, gender, income).

The session concluded with a quiz on the components of SHA's Core and Extended Accounting Framework and the Tri-Axial Framework.



## *Session 7: Financing Interface*

Presenter: Ms. Karishmah Bhuwanee, HFG

Ms. Bhuwanee explained the relationships between the three classifications of the Financing Interface, as well as the way of navigating the decision tree for financing scheme classification with examples from the Indian health sphere. The key takeaways were:

- Financing Schemes are a core dimension of the SHA 2011 Financing Interface and the main types of financing arrangements that enable individuals to access health goods and services, such as voluntary private health insurance, compulsory health insurance, such as Employees' State Insurance Corporation (ESIC), and RSBY. Financing Schemes answer policy questions about how health resources are managed and organized, including who is entitled to participate in the scheme and what the basis of entitlement to health care is, and to what extent resources are pooled.
- Financing Schemes are classified into two categories: direct payments (household out-of-pocket payments) and third-party payments, such as central government schemes (RSBY), state health insurance schemes (the Bharat Puran Singh scheme in Punjab), private voluntary schemes (private health insurance, community-based health financing, the Self Employed Women's Association), and non-profit institution schemes.
- Financing Agents are the institutions that manage schemes. One financing agent can manage multiple schemes at a time; for example, the National Health Mission (NHM) State Health Society provides coverage through multiple schemes, including Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), and untied funds. Schemes can also be managed by more than one agent; for example, RSBY in Punjab is administered by the Ministry of Labour and Employment (MoLE), ICICI Lombard GIC., and the Punjab Health Systems Corporation.
- Ms. Bhuwanee explained how the SHA 2011 Financing Schemes classification breaks down into the following categories: HF.1 Government schemes and compulsory contributory health care financing schemes, HF.2 Voluntary health care payment schemes, HF.3 Household out-of-pocket payments, and HF.4 Rest of the world financing schemes. She expanded on Financing Scheme criteria such as mode of participation and entitlement, as well as the rules including pooling and the method of raising funds. Using these four criteria, she explained how the decision tree (below) can be used to determine the Financing Scheme category for any financing flow, and walked the participants through every decision node of the financing tree. Participants proceeded to classify various financial schemes based on the financing tree, including RSBY, JSSK, ESIC, out-of-pocket payments without insurance scheme, and voluntary private health insurance schemes bought by households.
- Ms. Bhuwanee mentioned that the public sector includes government, parastatals, and public corporations. Government schemes are not solely managed by the government; they also can be managed by an enterprise. Moreover, it is important to analyze schemes beyond national labels, as they can represent a different type of scheme in SHA 2011 regardless of their local naming.
- Revenues of Financing Schemes is an extended dimension of the SHA 2011 Financing Interface, and refers to the types of revenue collected by financing schemes, such as contributions international donors make to NGOs, treasury transfers, and compulsory prepayments from employers. Data on this revenue answer policy questions like how much revenue is collected, in which ways, and from which institutional units.

- Ms. Bhuwanee explained that revenues of financing schemes can be classified into FS.1 Transfers from government domestic revenue, FS.2 Transfers distributed by government from foreign origin, FS.3 Social insurance contributions, FS.4 Compulsory payment, FS.5 Voluntary prepayment, FS.6 Other domestic revenue, and FS.7 Direct foreign transfers. Participants classified revenues of financing schemes such as the central Ministry of Health and Family Welfare, donors providing funds to NGOs at the state level, employer contributions to ESIC, and individual contributions to voluntary private health insurance.
- Financing Agents is an extended dimension of the SHA 2011 Financing Interface. Financing agents are institutional units that manage health financing. The data answer policy questions regarding who manages financing arrangements for raising revenue, pooling and managing resources, and purchasing services. Financing agents can be governments, schemes such as NHM, commercial insurance companies, corporations, households, NGOs, and the rest of the world.

In teams, participants applied the financial interface to the financial flow diagram they had developed in Day 1, assigning codes for financing schemes, revenues of financing scheme, and financing agents to each institution and scheme included in their flow.

## *Session 8: Provision Interface*

**Presenter: Mr. Bhavesh Jain, HFG India**

Mr. Jain presented the classifications of the provision interface, making the following key points:

- Health Care Providers are the organizations and actors that primarily deliver health care, or whose activities include health care services. Analyzing providers enables policymakers to understand who provides goods and services to consumers and how the health provision organizational structure functions within a country.
- Health providers can be either primary (over 50 percent of turnover, value-added, or input of an institution), or secondary, if they contribute a lower percentage. The Primary Providers category includes HP.1 Hospitals, HP.2 Residential long-term care facilities, HP.3 Providers of ambulatory health care, HP.4 Providers of ancillary services, HP.5 Retailers of other providers of medical goods, and HP.6 Providers of preventive care. Secondary Providers include HP.7 Providers of health care system administration and financing, HP.8.1 Households as providers of home care, and HP.8.2 All other industries who act as Secondary Providers, such as residential care institutions or medical clinics within large entities such as manufacturing companies or universities. Mr. Jain explained that there is also HP.8.9, Providers of health-related activities, which can be captured as spending on various industries, such as providers of health care-related spending (HC.R example: continuing care retirement communities) and capital formation-related spending (HK.R example: health R&D within medical research institutes, staff training). The Rest of the world providers category includes health goods and services provided by foreign/external entities to country/state residents. The participants engaged in a coding exercise and assigned codes to providers such as ESIC and Central Government Health Scheme hospitals, NHM Society, Panchkula District Hospital, Primary Health Centres, privately owned pharmacies, and specialty hospitals managed abroad.
- Factors of Provision are inputs used to produce the goods and services within the SHA 2011 health boundary. They allow policymakers to understand what mix of production inputs are used by providers. Mr. Jain expanded on what is included in factors of provision: labor, wages and income, capital consumption such as office equipment, materials and rent, and intermediate material and services used in provision. The factors are FP.1 Compensation of employees, FP.2 Self-employed professional remuneration, FP.3 Materials and services used, FP.4 Consumption of fixed capital, and

FP.5 Other items of spending on inputs. It is important to note that capital formation is not included in factors of provision, and that household factors of provision are to be included only when the transaction is documented. The participants took part in an exercise where they coded various factors of provision, including petrol, oil and lubricant, outsourcing of district ancillary and cleaning services, subcontracted diagnostic services, and employee fringe benefits.

- Capital Formation refers to investments made by health providers during the accounting period that are used for more than one year in the production of health services. It is important to note the boundaries of Gross Fixed Capital Formation, as only assets legally owned can be included, and the recording of the acquisition and disposal of fixes assets is done when ownership is transferred. Participants took part in an exercise and coded capital formation items including the construction of buildings on government Ayurvedic colleges and hospitals, the hospital information system developed by the HSHRC, funds paid by pharmaceutical companies to develop new drugs, and the procurement of an MRI machine by the Rohtak Medical College.

## *Session 9: Consumption Interface*

**Presenter: Dr. Vinod Annigeri, Centre for Multi-Disciplinary Development Research, Dharwad**

Dr. Annigeri presented the classification of the Consumption Interface, making the following key points:

- Health Care Functions represent a core dimension of the SHA 2011 framework and are the types of health goods and services consumed and activities performed within the health sphere. Dr. Annigeri talked about the boundaries of health care and the "functional approach" to health care accounting by including the goods and services whose primary purpose is health, such as health promotion and prevention, diagnosis, treatment, and rehabilitation of illness, caring for persons affected health-related impairment or disability caused by chronic illness, palliative care, and the governance and administration of the health system. Dr. Annigeri noted that activities that would be considered health consumption locally might not be included SHA 2011 (such as orphanages), and that these classifications have changed over time between NHA 1.0 and SHA 2011.
- Dr. Annigeri drew the distinction between specified and not specified by function. Categories that are specified by function are HC.1 Curative care, HC.2 Rehabilitative care, HC.3 Long-term care, HC.6 Preventive care, and HC.7 Governance and financing administration. Categories that are not specified by function are HC.4 Ancillary services and HC.5 Medical goods. He also talked about Memorandum Items, including HC.RI Reporting items that overlap with other health expenditures and are therefore not easily isolated, and HC.R Health care-related items, whose primary purpose is not health. Participants then coded functions such as voluntary counselling testing, blood testing services, implementation of the SHA, drugs, training of auxiliary nurse-midwives at auxiliary nurse-midwife training centers, and salaries of department staff working in health.
- Dr. Annigeri noted that spending such as training and R&D is reported as Memorandum Items in Capital Account, while capital formation expenditures that support health services over time are reported in Capital Account.

## *Session 10: Overview and Planning, Tips for Data Collection*

**Presenter: Mr. Afaq Ahmed, HFG India**

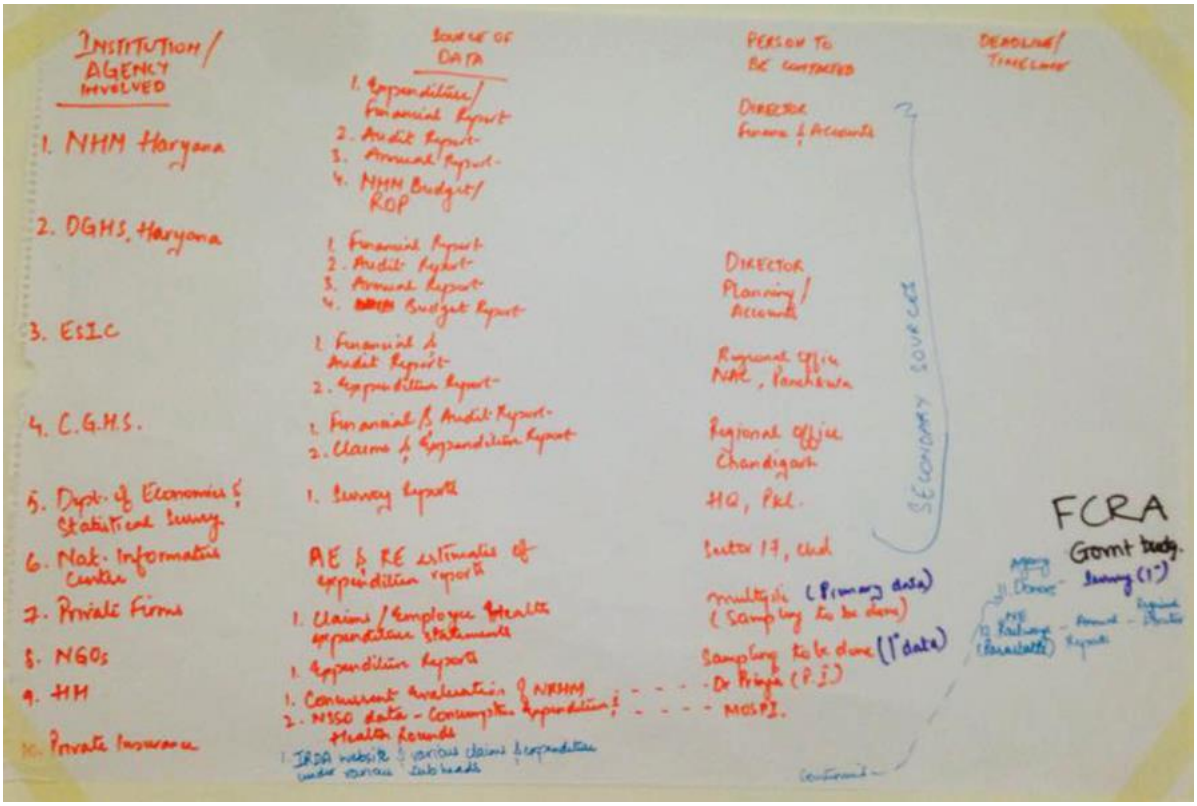
Mr. Ahmed gave an overview of the data collection process and its associated challenges, emphasizing different examples of issues that might arise and how to overcome them. Some of the challenges discussed with the participants were the potential for human error when respondents fill out surveys, the difficulty of respondents to provide the breakdown of their expenditures, the time required for data entry and potential of human error, and the low response rate from surveyed organizations.

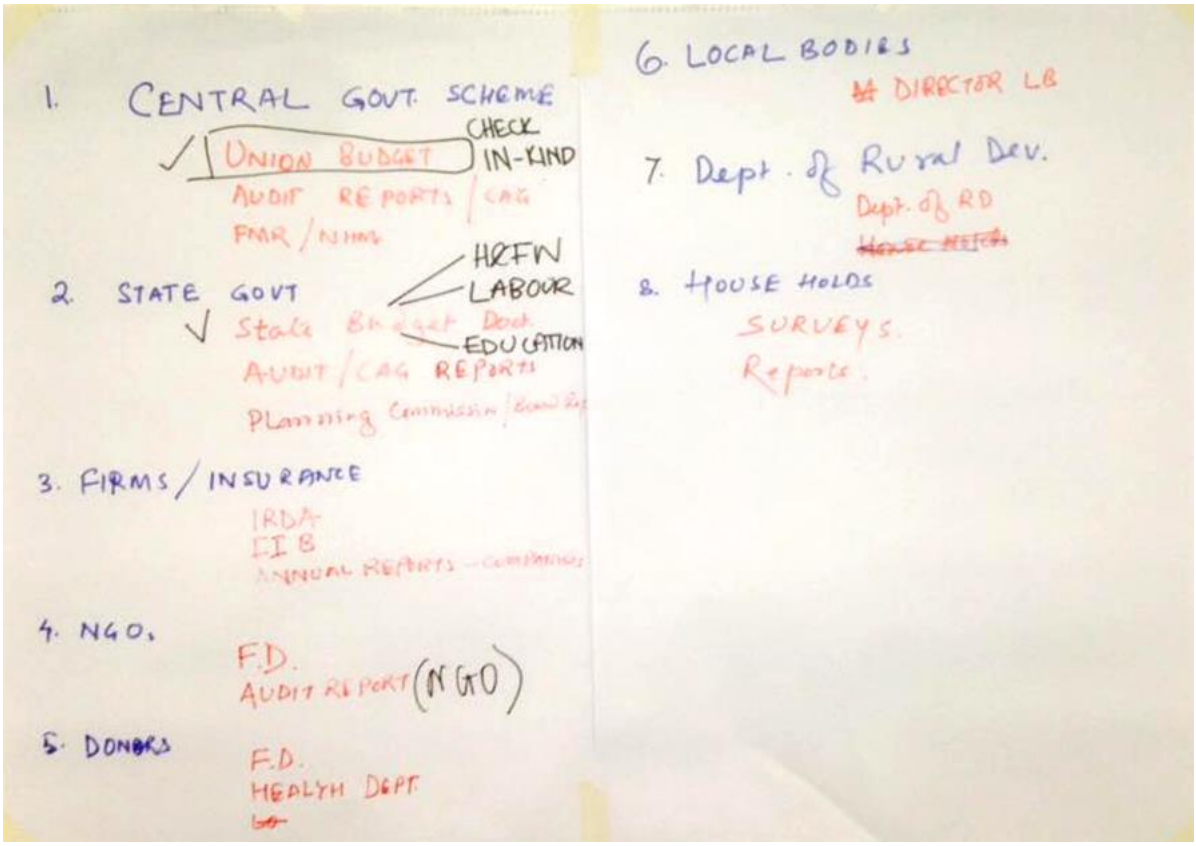
Mr. Ahmed also provided an overview of the data collection process that includes developing a data collection plan, the collection and review of secondary data and reports, designing and customizing data collection instruments, mobilizing a data collection team, training data collectors, sending out surveys and following up with respondents, and tracking progress to completion. He then provided details on each of these data collection steps.

One of the important points he made was choosing the sample to survey; if the sample is too large, it is necessary to get a representative sample and as much data with as little effort as possible, since there ultimately needs to be a data set large enough to make regional estimates. For example, this would mean choosing to survey the companies with the largest number of employees and total health-related expenses about the health insurance they provide when the data collection team has limited resources, rather than trying to reach out to a large number of small firms, which would produce less data for more effort. Mr. Ahmed also noted that it is important to collect and review data that exist in secondary sources, before identifying the needed primary sources. It is preferable to triangulate data in order to verify the validity of the information and obtain results that are as accurate as possible. Moreover, there needs to be consensus on the methodology before collecting and analyzing data, as methodological flaws can invalidate information.

## *Discussion: Available Data Sources at State Level*

Participants broke up into teams and drafted lists of what type of data they would need for the HA exercise, and where it would be available at the state level in Haryana and Punjab.




1. CENTRAL GOVT SCHEME
UNION BUDGET
CHECK IN-KIND
AUDIT REPORTS / CAG
FMR / MHRD
2. STATE GOVT
HRFW
LABOUR
EDUCATION
State Budget Dept.
AUDIT / CAG REPORTS
Planning Commission
3. FIRMS / INSURANCE
IRDA
CII B
ANNUAL REPORTS
4. NGO.
F.D.
AUDIT REPORT (NGO)
5. DONORS
F.D.
HEALTH DEPT
6. LOCAL BODIES
DIRECTOR LB
7. Dept. of Rural Dev.
Dept. of RD
8. HOUSE HOLDS
SURVEYS.
Reports.

# ORIENTATION PROCEEDINGS: DAY 3

## *Session 11: Introducing the Concept of Allocation Keys*

**Presenter: Ms. Karishmah Bhuwanee, HFG**

After a review of the content discussed in day 2, Ms. Bhuwanee presented an overview of allocation keys, with the following main ideas:

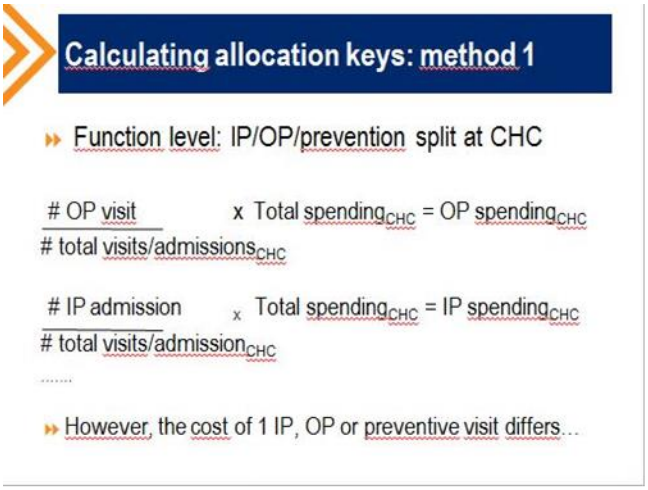
- Beneficiary expenditures can be classified as earmarked expenditures for specific diseases or programs, a directly allocable percentage of shared expenditures, and a non-directly allocable percentage of shared expenditures; the last two need to be disaggregated using allocation keys.
- Ms. Bhuwanee presented a step-by-step approach:
    1. Identify the spending that needs to be disaggregated (before data collection)
    2. Identify the level of disaggregation, i.e., at function level? at disease level? (before data collection)
    3. Collect the necessary secondary data for allocation keys
    4. Calculate the distribution key
    5. Apply the distribution key to the spending identified in (1)

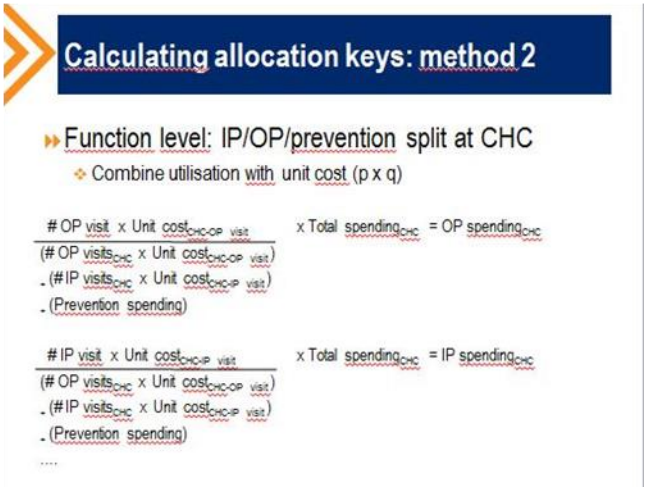
Or, alternatively:

1. Obtain total health spending
2. Separate health spending into homogenous units
3. Construct cost-unit specific keys based on utilization for each homogenous unit
4. Multiply health spending for the homogenous unit (2) with the utilization key (3)
5. Aggregate partial tables for each unit to establish total allocation accounts

- Ms. Bhuwanee presented examples of what a distribution key should look like, emphasizing that quantity (utilization) and price (unit cost) need to be consistent in terms of measurement; the allocation key needs to reflect cost, and there can be as many sub-categories as necessary in order to have homogenous distribution. Moreover, all sub-categories need to be mutually exclusive.

- There are two methods for calculating allocation keys, as shown in the figure below; the second method is preferred, because it incorporates unit cost.




- Spending can be mapped by disease and health area; data on the full disease burden can then be used to measure disease spending by planned spending or priorities in the state budget.
- Ms. Bhuwanee explained how allocation keys should be considered during data collection and planning. Utilization and costing data should be used to divide the spending at a facility by disease, health area, or age, and should come from a single source. Some of the challenges that data collectors can encounter are getting utilization and costing data from facilities, both public and private; getting data for a combination of diseases and non-differentiated conditions; or not adding prevention to utilization data and thus not adjusting for its cost.
- Some data sources for unit costs can be state-specific costing studies, country-specific studies, regional estimates from UNAIDS/Global Resource Needs Estimates, and Unit Cost Database; utilization data can be collected from DHIS data, facility data, or country and state-specific studies.
- The participants took part in a group exercise simulating setting up a hospital in Panchkula. Ms. Bhuwanee emphasized the importance of looking for simple solutions, as the numbers used were estimates, and of asking health workers the right questions in order to get the needed data.

## *Session 12: The Concepts of Double-Counting and Weighting*

**Presenter: Mr. Afaq Ahmed, HFG India**

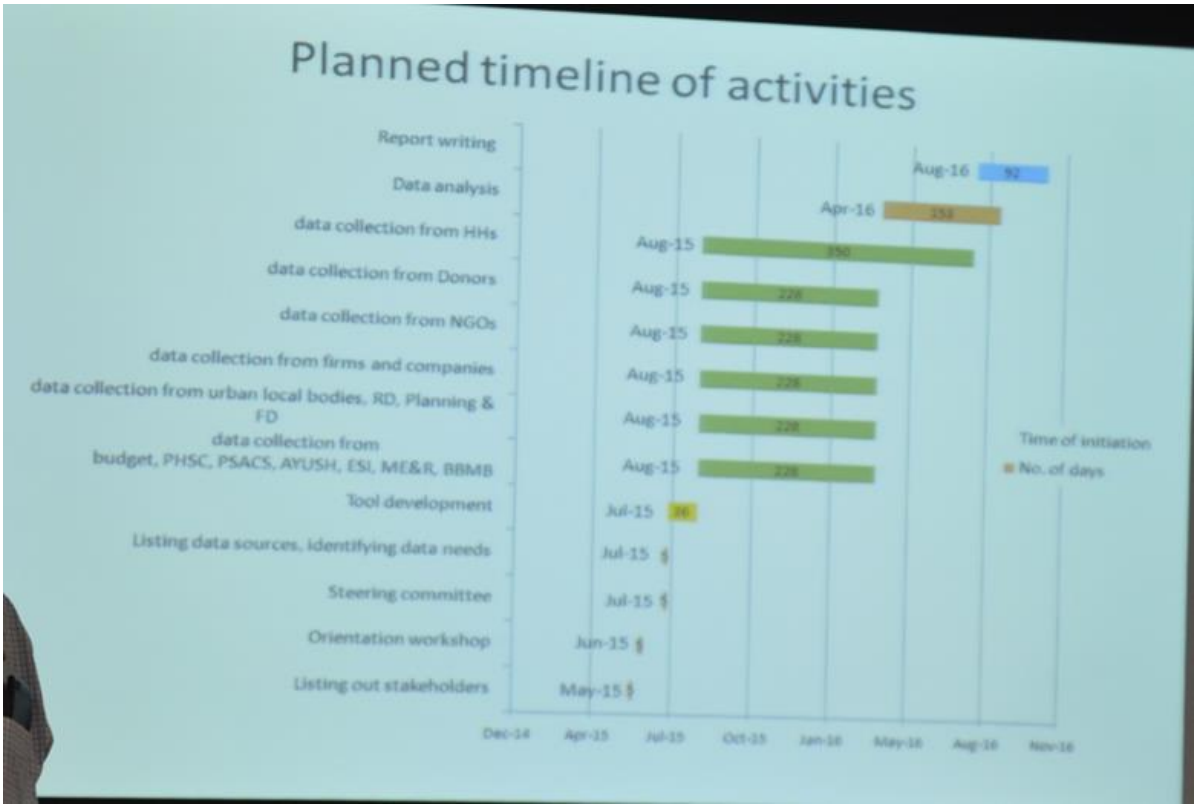
Mr. Ahmed presented the concept of double-counting and how to avoid it; he also discussed the purpose of weighting in estimation.

- Double-counting refers to counting a single expenditure item that has been reported twice, which if not eliminated will lead to overestimating total health expenditure. Some of the most common sources of double-counting are central and state-level government spending, employer and insurance reporting, household and insurance reporting of expenditures on premiums, co-payments, and reimbursements, and other household and employer reimbursements. The HA team needs to identify any potential sources of double-counting and ask the right questions that will give them the most accurate data, as well as track the expenditure items of the reporting entity.
- It is necessary to weight data by their relative magnitude (for example, employers who make most expenses, by number of employees) since entities are not all the same, in order to obtain accurate estimations from a representative sample.

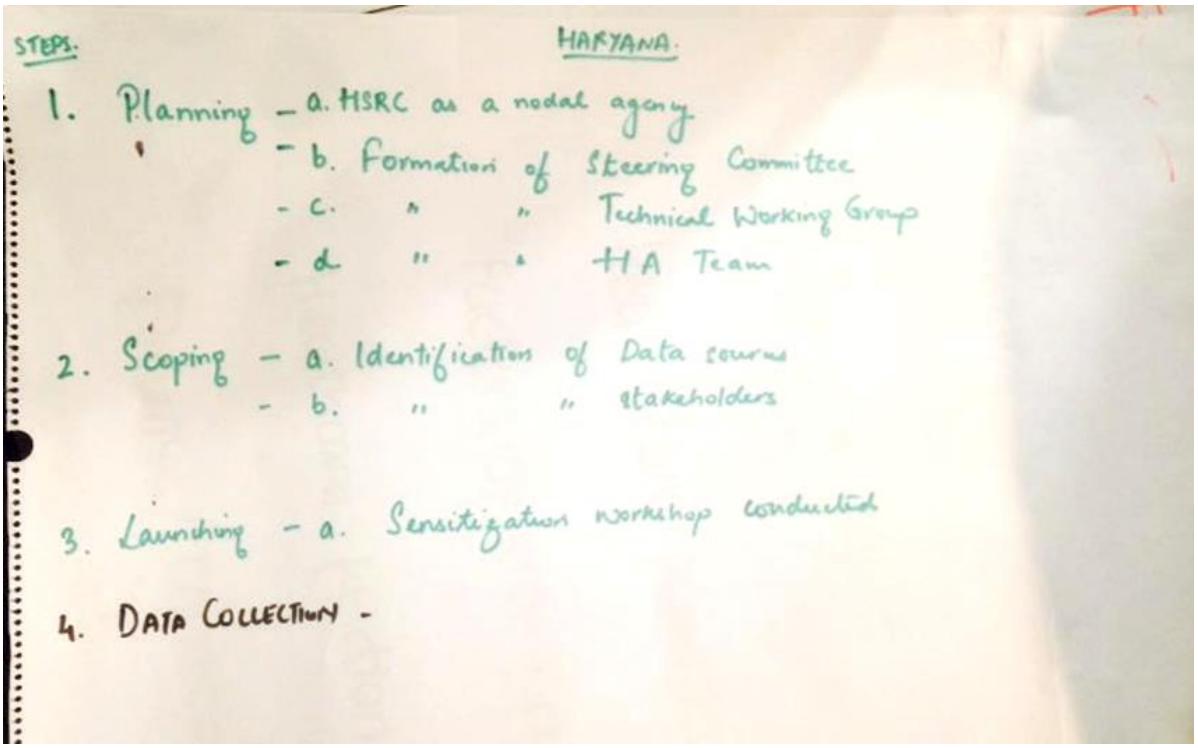
## *Group Work on the Next Steps for Producing Health Accounts*

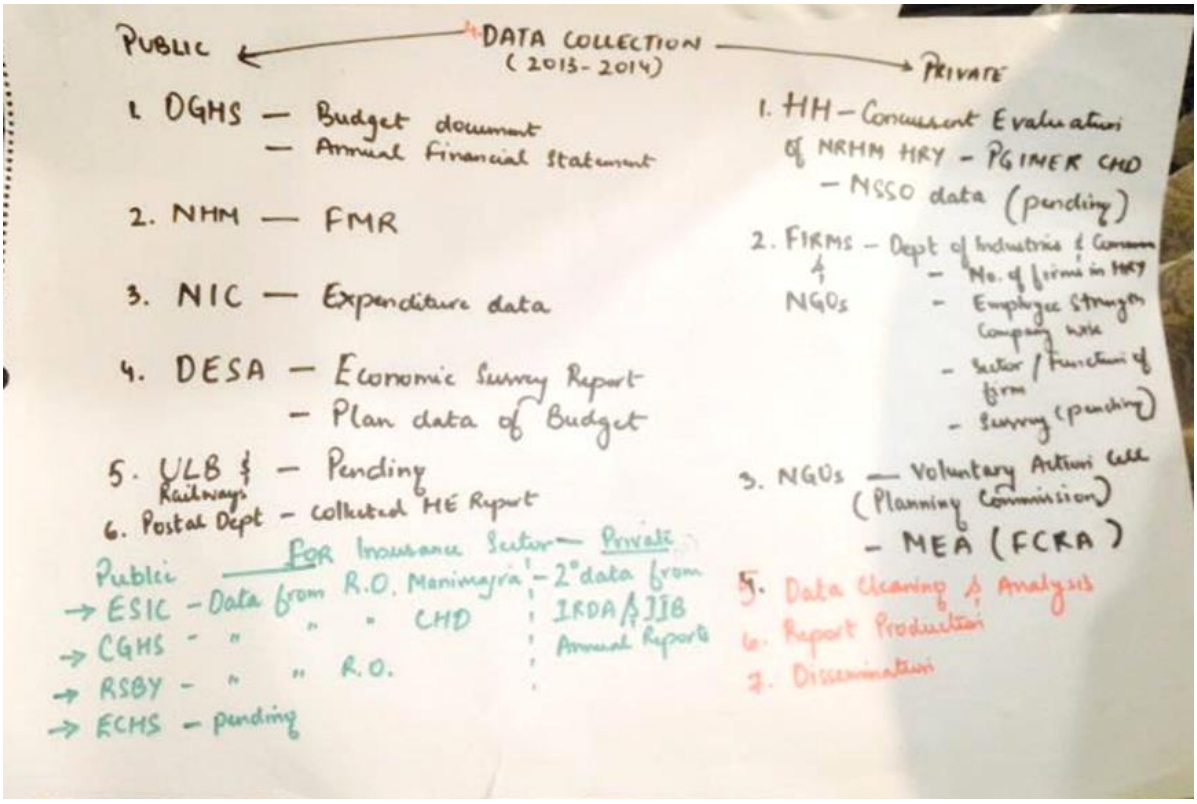
The participants split into groups and planned the next steps of producing health accounts in Punjab and Haryana, which they then presented.

The proposed timeline of the Punjab group (below) includes listing stakeholders, attending the orientation, creating a steering committee, listing data sources, identifying data needs, and developing tools during the first quarter of 2015; the next steps, which are to begin in August 2015, are data collection from the budget and various institutions such as the Public Health System Corporation, Punjab State AIDS Control Society, Ministry of Ayurveda, Yoga, Naturopathy, Yunani, Sidha and Homeopathy, Employee State Insurance, Medical Education & Research, from urban local bodies, the Revenue Department, the Planning and Finance Department, and from firms and companies, NGOs, donors, and households. The Punjab team plans to begin data analysis in the first quarter of 2016, and have the HA report ready for dissemination by November 2016.


Planned timeline of activities
Report writing
Data analysis
data collection from HHs
data collection from Donors
data collection from NGOs
data collection from firms and companies
data collection from urban local bodies, RD, Planning & FD
data collection from budget, PHSC, PSACS, AYUSH, ESI, ME&R, BBMB
Tool development
Listing data sources, identifying data needs
Steering committee
Orientation workshop
Listing out stakeholders
Aug-16
92
Apr-16
153
Aug-15
350
Aug-15
228
Aug-15
228
Aug-15
228
Aug-15
228
Aug-15
228
Jul-15
76
Jul-15
Jul-15
Jun-15
May-15
Dec-14
Apr-15
Jul-15
Oct-15
Jan-16
May-16
Aug-16
Nov-16
Time of initiation
No. of days

The Haryana HA exercise has already finished some of the steps, including planning (HSRC as a nodal agency, and formation of a steering committee, technical working group, and a HA team), scoping (identification of data sources and stakeholders), and launching through a sensitization orientation. The next steps for the Haryana HA team are data collection for 2013/14 from both public and private bodies, according to the plan presented below. This will be followed by data cleaning and analysis, and report production and dissemination by the end of 2015, depending on the speed of SHA customization for India.






## *Group Work on the Next Steps for Producing Health Accounts*

**Presenter: Mr. Rahul Reddy, NHATS**

Mr. Reddy gave an overview of the work done by the National Health Accounts Technical Secretariat (NHATS). NHATS tasks include establishing a governance structure and developing the NHA framework through a Steering Committee and an Expert Group, developing the NHA framework for India, setting standards for boundaries for health expenditure, definitions, and cross-walks, establishing standard processes to collect, validate, and analyze data, building capacity and developing a nationwide network of state-level institutions and organizations that will periodically conduct NHA, disseminating the NHA framework, and estimating regular updates to its methodology. Thus far, NHATS has held three Expert Group meetings, held a training on SHA 2011, started developing the NHA Framework and defining boundaries, established a standard methodology, collection, validation, and analysis of data, and initiated the collection of public and private health expenditures from a number of bodies.

In the future, NHATS will continue collecting public and private health expenditure data, hold capacity-building orientations on the standard framework, hold a national consultation on NHA and use of data, and provide technical support at the state level by setting up state-level governance structures, training nodal officers and teams in standard framework, developing work plans, and assisting with the use of methodologies, studies, review, and dissemination of results. According to Mr. Reddy, the policy issues that NHA India will address include the financial investments and requirements of the New Health Policy and universal health coverage, measuring the performance of the health system, understanding the relative financial contributions of different sectors, assessing funding allocations to different diseases and socio-economic groups according to national priorities, and analyzing the efficiency of fund allocation for

certain treatments and programs. Mr. Reddy then answered participants' questions on NHATS priorities.

## *Closing Remarks*

Mr. Jain, Mr. Derriennic, Ms. Bhuwanee, and Dr. Annigeri thanked everyone for participating in the orientation, and congratulated them on the concrete plans they had produced over the three days. They are looking forward to seeing how the two state teams proceed on completing the exercise, and they offered to provide any assistance the teams would need going forward.

# NEXT STEPS

During the orientation, both the Haryana and Punjab teams gained an understanding of HA concepts, developing an HA exercise using SHA 2011, including planning and scoping, launch, data collection, data analysis and validation, and report writing and dissemination. The teams drafted work plans with specific activities and timelines, as explained above (see Group Work on the Next Steps for Producing Health Accounts, page 25).

The Haryana team continue to work on the HA exercise and expect to produce and disseminate a report by the end of 2015.

The Punjab team will undertake its exercise by designing the bodies that will be responsible for the exercise, specifically identifying data needs and sources in order to start collecting budget and expenditure data from government agencies, health practices, the private sector, NGOs, donors, and households in the second quarter of 2015. The collection process will be completed by the first quarter of 2016, when the Punjab team will begin data analysis in order to create a final report by November 2016.

# ANNEX A: ORIENTATION AGENDA

**SHA 2011 ORIENTATION WORKSHOP FOR STATE LEVEL HEALTH ACCOUNTS**
**18-20TH MAY 2015, CHANDIGARH**

| Time | Monday 18th May | Tuesday 19th May | Wednesday 20th May |
|---|---|---|---|
| 08.30 - 09.00 | | Recap Day 1 | Recap Day 2 |
| 09.00 - 10.00 | **Session 1: BJ and YD**<br>* Opening and introductions<br>* Agenda and objectives | **Session 6: YD**<br>Core and extended accounting framework | **Session 11: KB**<br>Introducing the Concept of Allocation keys |
| 10.00 - 11.00 | **Session 2: YD**<br>Conceptual overview of SHA 2011: purpose, history and use | **Session 7: KB**<br>Financing interface<br>* FS, HF and FA (with State specific examples) | **Session 11: KB**<br>Introducing the Concept of Allocation keys |
| 11.00 - 11.15 | **Tea break** | **Tea break** | **Tea break** |
| 11.15 - 12.15 | **Session 3: YD**<br>Conceptual overview of SHA 2011: characteristics and boundaries | **Session 7 (Continued): KB**<br>Financing interface<br>* FS, HF and FA (with State specific examples) | **Group work: distribution keys**<br>(disease example) |
| 12.15 - 13.15 | **Session 4: VA**<br>Results and lessons learnt from Karnataka HA accounts | **Session 8: BJ**<br>Provision interface<br>*HP, FP and HK (with State specific examples) | **Session 12: AA**<br>The concepts of double-counting and weighting |
| 13.15 - 14.00 | **Lunch** | **Lunch** | **Lunch** |
| 14.00 - 15.00 | **Discussion: ED, HSHRC** Policy use of Health Accounts data in Haryana and Punjab | **Session 9: VA**<br>Consumption interface<br>* HC, DIS (with State specific examples) | **Punjab: SP**<br>Group work on next steps for producing Health Accounts |
| 15.00 - 16.00 | **Session 5: BJ**<br>Developing State Health Accounts - The Way Forward | **Session 10: BJ and AA**<br>Data collection: overview and planning, tips for data collection | **Haryana: KB**<br>Review of data collected<br>*Groups will report back on their discussion* |
| 16.00 - 16.15 | **Tea break** | **Tea break** | **Tea break** |
| 16.15 - 17.15 | **Group work: VA**<br>Understanding and mapping spending flows in Haryana and Punjab | **Discussion: VA**<br>Available data sources at the state level, e.g. Haryana | **Question & Answers**<br>Vote of thanks |

*Note*: BJ = Bhavesh Jain, YD = Yann Derriennic, KB = Karishmah Bhuwanee, VA = Vinod Annigeri, AA = Afaq Ahmed, ED = Executive Director Ashish Gupta, SP = Shankar Prinja.

# ANNEX B: LIST OF PRESENTERS AND PARTICIPANTS

| Sr. NO | Name | Designation | Department/Organization |
|---|---|---|---|
| **Faculty Members** | | | |
| 1 | Ms Karishmah Bhuwanee | International Expert | HFG |
| 2 | Mr Yann Derriennic | International Expert | HFG |
| 3 | Dr Vinod Annigeri | Director | Centre for Multi-Disciplinary Development Research, Dharwad |
| **Participants** | | | |
| | **Haryana** | | |
| 1 | Mr PK Singh | DD M&E | HSHRC |
| 2 | Dr Jyotendra Mishra | Consultant Planning | HSHRC |
| 3 | Dr Vikas Sharma | Consultant Planning | HSHRC |
| | **HFG India** | | |
| 5 | Mr Bhavesh Jain | Advisor | HFG India |
| 6 | Mr Punit Kumar Mishra | Health Financing Consultant | HFG India |
| 7 | Mr Afaq Ahmed | Health Financing Consultant | HFG India |
| 8 | Ms. Mara Zafiu | Intern | HFG India |
| | **PGI Chandigarh** | | |
| 10 | Dr Shankar Prinja | Asst Professor | School of Public Health PGI |
| 11 | Mr Pankaj Bahuguna | Sr Statistician | School of Public Health PGI |
| 12 | Dr Akash deep Singh Chauhan | PhD candidate | School of Public Health PGI |
| 13 | Dr Gunjeet Kaur | Jr Demonstrator | School of Public Health PGI |
| 14 | Mr Saroj Kumar Rana | Research Associate | School of Public Health PGI |
| 15 | Dr Atul Sharma | Project Coordinator | School of Public Health PGI |
| 16 | Dr Parul Chaudhary | Sr Demonstrator | School of Public Health PGI |
| | **Punjab** | | |
| 15 | Mr Neeraj Singla | Manager Finance | Punjab |
| 17 | Dr Satish Mahajan | Medical Officer | Punjab |
| | **Public Health Foundation of India (PHFI)** | | |
| 19 | Mr Amit Sahoo | Research Associate | PHFI |
| 20 | Mr Montu Bose | Research Associate | PHFI |

# ANNEX C: PHOTOS


Speakers during sessions at workshop
Bhavesh Jain
Afaq Ahmed
Yann Derrienic
Karishmah Bhuwanee
Dr Vinod Annigeri



BOLD THINKERS DRIVING
REAL-WORLD IMPACT